2021 HOUSE APPROPRIATIONS

HB 1012

Department 325 - Department of Human Services
House Bill No. 1012

Executive Budget Comparison to Prior Biennium Appropriations

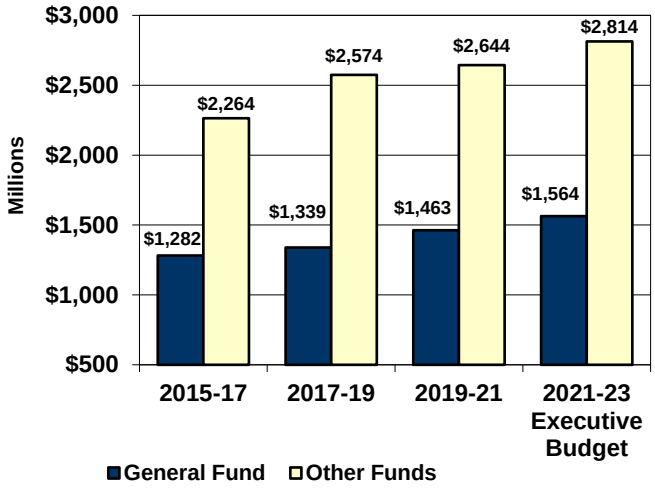
	FTE Positions	General Fund	Other Funds	Total
2021-23 Executive Budget	2,221.63	$1,563,943,856	$2,813,620,360	$4,377,564,216
2019-21 Legislative Appropriations[1]	2,230.23	1,462,663,487	2,644,160,504	4,106,823,991
Increase (Decrease)	(8.60)	$101,280,369	$169,459,856	$270,740,225

[1]The 2019-21 biennium agency appropriation amounts have not been adjusted for additional Coronavirus (COVID-19) spending authority of $215,186,966 resulting from Emergency Commission action during the 2019-21 biennium.

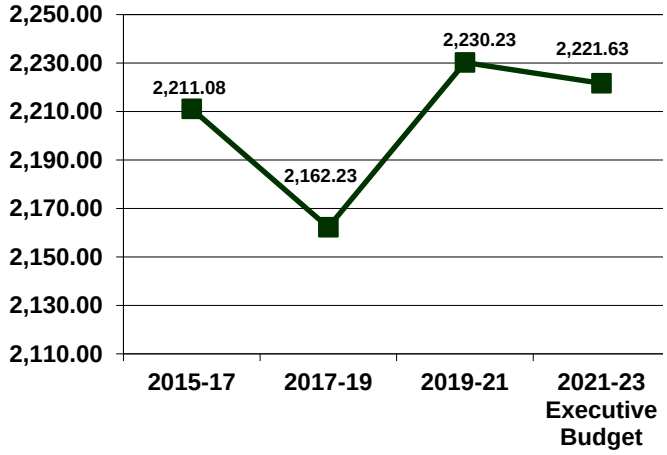
Ongoing and One-Time General Fund Appropriations

	Ongoing General Fund Appropriation	One-Time General Fund Appropriation	Total General Fund Appropriation
2021-23 Executive Budget	$1,537,969,170	$25,974,686	$1,563,943,856
2019-21 Legislative Appropriations	1,461,150,884	1,512,603	1,462,663,487
Increase (Decrease)	$76,818,286	$24,462,083	$101,280,369

Agency Funding



FTE Positions



Executive Budget Comparison to Base Level

	General Fund	Other Funds	Total
2021-23 Executive Budget	$1,563,943,856	$2,813,620,360	$4,377,564,216
2021-23 Base Level	1,461,150,884	2,623,604,181	4,084,755,065
Increase (Decrease)	$102,792,972	$190,016,179	$292,809,151

Attached as an appendix is a detailed comparison of the executive budget to the agency's base level appropriations.

Executive Budget Highlights

DEPARTMENTWIDE

1. Provides funding for state employee salary and benefit increases, of which $9,368,646 is for salary increases, $108,150 is for health insurance increases, and $1,908,797 is for retirement contribution increases	$8,737,712	$2,647,881	$11,385,593
2. Underfunds salaries and wages by $4,694,730 from the general fund in anticipation of savings from **vacant positions and employee turnover**	($4,694,730)	$0	($4,694,730)
3. Adjusts funding to reduce general fund support for traditional Medicaid ($50,919,245) and increase general fund support for Medicaid Expansion ($3,916,989) and the children's health insurance program ($1,222,892) due to changes in the state's federal medical assistance percentage (FMAP)	($45,779,364)	$45,779,364	$0

4. Adds funding for **cost, caseload, and utilization changes,** including $156,789,851 for medical services, $77,698,712 for long-term care, and $41,567,021 for developmental disabilities (DD)	$124,345,846	$174,944,195	$299,290,041
5. Provides a 1 percent **inflationary increase** for human service providers during each year of the 2021-23 biennium	$13,883,837	$14,417,097	$28,300,934
6. Reduces ongoing funding appropriated during the 2019-21 biennium from the community health trust fund from $32.4 million to $24 million and replaces ongoing funding provided from the tobacco prevention and control trust fund ($6 million) and health care trust fund ($1 million)	$15,400,000	($15,400,000)	$0
7. Adds funding for the Capitol grounds agency rent proposal	$474,286	$0	$474,286
8. Adds funding for Microsoft Office 365 expenses	$200,315	$50,079	$250,394
9. Adds ongoing funding to develop an early childhood integrated data system	$500,000	$0	$500,000
10. Provides **one-time funding** to replace the child welfare management and payments system	$15,000,000	$15,000,000	$30,000,000
11. Provides **one-time funding** to modernize the Medicaid management information system	$4,326,686	$30,673,314	$35,000,000
PROGRAM AND POLICY			
Medical services			
12. Provides $1,477.4 million for medical services, of which $385.2 million is from the general fund, an increase in total of $63.7 million, or 4.5 percent, compared to the 2019-21 biennium appropriation of $1,413.7 million. The executive budget:			
• Provides $623.8 million for Medicaid Expansion grants, of which $73.5 million is from the general fund, a decrease in total of $10.9 million, or 1.7 percent, compared to the 2019-21 biennium appropriation of $634.7 million, of which $64.1 million is from the general fund. The executive budget adds 12 FTE positions to transfer the administration of Medicaid Expansion to the department and changes the payment rates from commercial rates to fee-for-service rates.	$9,400,000	($20,300,000)	($10,900,000)
• Underfunds Medicaid grants	($9,580,913)	($9,955,925)	($19,536,838)
Long-term care			
13. Provides $822.6 million for **long-term care**, of which $404.2 million is from the general fund, an increase in total of $85.2 million, or 11.6 percent, compared to the 2019-21 biennium appropriation of $737.4 million. The executive budget:			
• Reprioritizes agency special funds by transferring $2.3 million from the basic care program to information technology services			
• Adds **one-time funding** to transition to a new nursing facility payment methodology	$3,348,000	$3,852,000	$7,200,000
• Adds **one-time funding** for a nursing bed buyback program to buy back approximately 250 licensed nursing home beds	$3,300,000	$0	$3,300,000
Developmental disabilities			
14. Provides $739.3 million for DD, of which $344.8 million is from the general fund, an increase in total of $68.1 million, or 10.1 percent, compared to the 2019-21 biennium appropriation of $671.2 million. The executive budget:			
• Adds funding for **equipment over $5,000**, which includes tymp machines ($10,000)	$979	$9,021	$10,000
• Adjusts department budget reporting by transferring certain FTE positions and funding relating to DD duties from the human service centers to the Developmental Disabilities Division			

Vocational rehabilitation

15. Provides $37.7 million for vocational rehabilitation services, of which $7.3 million is from the general fund, an increase in total of $11 million, or 41.2 percent, compared to the 2019-21 biennium appropriation of $26.7 million. The executive budget:

    - Adjusts department budget reporting by transferring certain FTE positions and funding relating to vocational rehabilitation duties from the human service centers to the Vocational Rehabilitation Division

Aging services

16. Provides $34.5 million for aging services, of which $12.4 million is from the general fund, an increase in total of $9.3 million, or 36.9 percent, compared to the 2019-21 biennium appropriation of $25.2 million. The executive budget:

    - Adjusts department budget reporting by transferring certain FTE positions and funding relating to aging services duties from the human service centers to the Aging Services Division

Behavioral health services

17. Provides $85 million for behavioral health services, of which $36.7 million is from the general fund, an increase in total of $12.6 million, or 17.4 percent, compared to the 2019-21 biennium appropriation of $72.4 million. The executive budget:

    - Increases funding for the substance use disorder voucher program from $8 million to $17 million — $9,000,000 | $0 | $9,000,000

Economic assistance

18. Provides $275 million for economic assistance, of which $11.9 million is from the general fund, an increase in total of $13.1 million, or 5 percent, compared to the 2019-21 biennium appropriation of $261.9 million. Major program changes include:

    - Provides $34.7 million for **child care assistance**, of which $5.6 million is from the general fund, an increase of $6.9 million, or 24.8 percent, compared to the 2019-21 biennium appropriation of $27.8 million — $2,952,579 | $3,970,653 | $6,923,232
    - Increases federal funding for the **supplemental nutrition assistance program (SNAP)** or food stamp benefits to provide a total of $168 million, an increase of $2.8 million, or 1.7 percent, compared to the 2019-21 biennium appropriation of $165.2 million — $0 | $2,760,000 | $2,760,000
    - Increases federal funding for the **low-income home energy assistance program (LIHEAP)** to provide a total of $36.1 million, an increase of $1.6 million, or 4.6 percent, compared to the 2019-21 biennium appropriation of $34.5 million — $0 | $1,634,000 | $1,634,000

Children and family services

19. Provides $165.6 million for children and family services, of which $72 million is from the general fund, a decrease in total of $10.6 million, or 6.0 percent, compared to the 2019-21 biennium appropriation of $176.2 million. The executive budget:

    - Transfers certain FTE positions and funding relating to children and family services duties from the human service center budget to the Children and Family Services Division

INSTITUTIONS

20. Provides $126.7 million for institutions, of which $84.3 million is from the general fund, a decrease in total of $17.7 million, or 24.2 percent, compared to the 2019-21 biennium appropriation of $144.4 million. Major items in the executive budget relating to institutions are as follows:

State Hospital

21. Authorizes the construction of a new **state behavioral health hospital and clinic** through a public-private partnership

22. Provides funding for **extraordinary repairs** as follows: $1,292,499 $0 $1,292,499

Sidewalk repairs	$35,000
Roof repairs	28,000
Door lock replacement	85,000
Auto shop oil interceptor	18,000
Oil control and steam valves	45,800
Water main valve replacement	6,500
Flooring updates	197,672
Paint client rooms	29,750
Sewer line cleanout	7,750
Penal fixture hook and cleanout pins	18,000
Boiler control upgrade	209,000
Remove water treatment loop	85,000
Automation control upgrades	235,750
Tuck pointing	291,277
Total	$1,292,499

23. Provides funding for **equipment over $5,000**, which includes: $60,800 $0 $60,800

Utility vehicle	$28,000
Pressure washer	6,800
Floor scrubber	7,500
Camera equipment replacement	18,500
Total	$60,800

Life Skills and Transition Center

24. Provides funding for **extraordinary repairs**, as follows: $637,106 $0 $637,106

Asbestos abatement	$30,000
Concrete work and repairs	156,760
Cottage repairs	25,000
Level cemetery markers	20,000
Painting	30,000
Skylight repairs	76,500
Parking lot maintenance	60,000
Tunnel repairs	25,000
Door repair and replacement	65,000
Flooring	90,000
Elevator pit coating	19,096
Colette fitness building roof	39,750
Total	$637,106

25. Provides funding for **equipment over $5,000**, which includes: $208,055 $0 $208,055

Dishwasher	$90,000
Security cameras	38,727
Mower/blower	31,765
Utility vehicle	22,135
Floor scrubber	5,200
Washing machines	14,228
Gym divider	6,000
Total	$208,055

HUMAN SERVICE CENTERS

26. Provides $167.5 million for human service centers, of which $96.2 million is from the general fund, a decrease in total of $37.2 million, or 18.2 percent, compared to the 2019-21 biennium appropriation of $204.7 million. The executive budget:

- Adds funding to contract with a private service provider for civil sex offender treatment $917,004 $0 $917,004
- Adds funding for **extraordinary repairs** at the southeast human service center, which includes $80,000 for an air unit replacement $80,000 $0 $80,000

• Transfers 238.12 FTE positions to program and policy and management to adjust the budget reporting for the department			
COUNTY SOCIAL SERVICES			
27. Transfers $174.4 from the tax relief fund to the human service finance fund and appropriates the funding, along with funding from the general fund and other funds, for costs associated with the state takeover of county social services expenses. The transfer from the tax relief fund is an increase of $680,767 from the 2019-21 biennium transfer.	$1,323,223	$2,135,515	$3,458,738
28. Adds 3 FTE home- and community-based case management staff	$0	$498,673	$498,673

Other Sections Recommended to be Added in the Executive Budget (As Detailed in the Attached Appendix)

Medicaid Expansion - Section 3 would amend North Dakota Century Code Section 50-24.1-37 to extend the expiration date for the Medicaid Expansion program to June 30, 2022. Section 4 would provide for the Medicaid Expansion program to be a fee-for-service program administered by DHS effective July 1, 2022.

Personal care - Section 5 would repeal Section 50-24.1-18.1 relating to personal care services for eligible medical assistance recipients.

Transfers - Section 6 would allow DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1.

Transfers - Section 7 would allow DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.

Community health trust fund - Section 8 would identify $24 million of the recommended appropriation for the Medical Services Division is from the community health trust fund.

Human service finance fund - Section 9 would identify $174,380,767 of the recommended appropriation for the county social and human service project is from the human service finance fund.

Nursing home bed reduction - Section 10 would appropriate $3.3 million from the general fund to provide incentives to nursing facilities to reduce licensed bed capacity. This amount is also appropriated in Section 1 of the bill.

Medicaid Expansion appropriations - Section 11 would provide DHS may not spend more for the Medicaid Expansion program than the amount appropriated in the bill with certain exceptions. Section 27 would provide this section is effective through June 30, 2022.

Nursing facility appropriations - Section 12 would provide DHS may not spend more for nursing facility payments than the amount appropriated in the bill.

Health home for individuals with chronic conditions - Section 13 would require DHS to develop a plan to implement a state Medicaid option to provide coordinated care through a health home for individuals with a chronic condition.

Carryover authority - Sections 14 through 19 would allow DHS to continue unexpended appropriations for various projects into the 2021-23 biennium.

Conveyance of land - Section 20 would authorize DHS to convey land at the Life Skills and Transition Center to the Grafton Parks and Recreation Department.

Capital projects and payments - Section 21 would authorize the payment of special assessments at the State Hospital and Life Skills and Transition Center and would authorize the demolition of the chapel and employee building at the State Hospital. The section would also allow DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.

State Hospital facility - Section 22 would authorize DHS to enter a public-private partnership for the purpose of constructing a new State Hospital facility.

Provider outcomes - Section 23 would require providers that receive funding from DHS to submit process and outcome measures.

Residential treatment providers - Section 24 would require DHS to adopt rules establishing a ratesetting process and other requirements for foster care maintenance rates for qualified residential treatment providers.

Legislative intent - Section 25 would provide legislative intent that DHS and the Adjutant General enter an agreement to lease up to 20 acres of property at the State Hospital for a National Guard training and storage center.

Continuing Appropriations

Child support collection and disbursement - Section 14-09-25 - Allows the department to receive child support payments and provide the funds to the custodial parent or appropriate governmental entity for those custodial parents receiving governmental assistance.

Child support improvement account - Section 50-09-15.1 - Allows the department to receive federal child support incentive funds and spend the funds in accordance with its business plan to improve the child support collection process.

Child support cooperative agreements - Section 50-09-33 - Allows the department to accept federal funds and other income generated by the department under a cooperative agreement with an Indian tribe for child support enforcement services for hiring staff and payment of other expenses as necessary for carrying out the department's duties under the agreement.

Transition to independence - Section 50-06-34 - Allows the department to receive grants and other sources of funding for the development of a program for services to transition-aged youth at risk.

Deficiency Appropriation

There are no deficiency appropriations requested for this agency.

Estimated Unspent General Fund Appropriation Authority (Turnback)

The 2021-23 executive budget recommendation includes estimated unspent general fund appropriation authority of $92.5 million for DHS for the 2019-21 biennium.

Significant Audit Findings

The June 30, 2019, State Auditor report for the Department of Human Services identified the following audit findings:

- Payments after death (prior audit finding) - A total of $108,425 may have been paid in Medicaid benefits for medical services billed for services dated after a beneficiary's date of death.
- Child care correction orders not resolved (prior audit finding) - Child care providers are operating without proper reinspection of correction orders, potentially jeopardizing the health and safety of children.
- Monitoring child care providers with memorandums of understanding (prior audit finding) - The department is not properly monitoring child care providers operating under a memorandum of understanding agreement resulting in increased risks to the health and safety of children when in child care.
- Failure to timely contact suspected victims of child abuse and neglect (prior audit finding) - Prior audit recommendations have not been implemented which may cause a child to stay in an at-risk environment susceptible to abuse or neglect for an additional amount of time.
- Not performing quality assurance for child protection services (prior audit finding) - Without sufficient monitoring procedures the department is unable to ensure that services will protect the health and welfare of children.
- Confirmed child abusers not listed on index (prior audit finding) - Background check search results of the child abuse and neglect index may be inaccurate.
- Financial errors - The department reported incorrect financial information for the state's comprehensive annual financial report.
- Medicaid drug rebate system errors (prior audit finding) - There is increased potential for fraud and errors to occur and be undetected within the Medicaid drug rebate program.

Major Related Legislation

House Bill No. 1065 - Nursing Home Operating Costs - Amends Section 50-24.4-10 relating to nursing home payment rates and determination of occupancy rates.

House Bill No. 1066 - Accreditation of human service centers - Amends Section 50-06-05.2 to require DHS to request appropriations to ensure maintenance of the accreditation of human service centers and allows accreditation to be used as a basis for licensing in lieu of adopted rules for the operation of the centers.

House Bill No. 1076 - Children's Cabinet membership - Amends Section 50-06-43.1 to allow the chairman of the Legislative Management to appoint a member of the Legislative Assembly as the presiding officer of the Children's Cabinet.

House Bill No. 1090 - Nursing home payment methodology - Amends various sections to adjust the payment methodology of nursing homes.

Senate Bill No. 2083 - Child abuse - Amends various sections relating to reporting and duties relating to child abuse.

Senate Bill No. 2084 - Treatment facility capacity - Amends various sections to provide public treatment facilities are required to receive involuntary treatment patients only if below capacity.

Senate Bill No. 2085 - Medical services program adjustments - Amends various sections relating to the medical assistance program, including eligibility of Medicaid waivers for in-home services, services provided by advanced practice nurses, and payment methods for medical assistance providers.

Senate Bill No. 2086 - County social and human service project - Amends various sections relating to the county social and human service project, including the duties of counties and human service zones, payments to human service zones, and the process to inform county commissioners regarding options to transition zone employees to state employment, and transfers 16 FTE foster care licensing positions from zone employment to state employment.

Senate Bill No. 2087 - Medical assistance prior authorization - Amends Section 50-24.6-04 relating to prior authorization of medications for the medical assistance program.

Senate Bill No. 2088 - Adoption assistance - Amends Sections 50-28-02 and 50-09-02.2 relating to adoption assistance for children with special needs and payments to adoptive parents.

Senate Bill No. 2089 - Housing stabilization assistance and autism spectrum disorder voucher program - Amends Section 50-06-05.1 relating to housing stabilization assistance and repeals Section 50-06-32.1 to eliminate the autism spectrum disorder voucher program.

Department of Human Services - Budget No. 325
House Bill No. 1012

	FTE	General Fund	Other Funds	Total
2021-23 Base Level				
Management	107.95	$64,690,274	$90,021,088	$154,711,362
Program and Policy	383.25	1,181,597,942	2,232,568,138	3,414,166,080
Field Services	1,599.03	214,862,668	127,314,955	342,177,623
County Social Services	140.00	0	173,700,000	173,700,000
Total 2021-23 Base Level	2,230.23	$1,461,150,884	$2,623,604,181	$4,084,755,065

	FTE	General Fund	Other Funds	Total
Executive Budget Adjustments to Base Level				
Management	(10.10)	$34,833,722	$47,997,229	$82,830,951
Program and Policy	269.22	101,030,598	153,456,234	254,486,832
Field Services	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)
County Social Services	3.00	1,323,223	2,135,515	3,458,738
Total Adjustments	(8.60)	$102,792,972	$190,016,179	$292,809,151

	FTE	General Fund	Other Funds	Total
2021-23 Executive Budget				
Management	97.85	$99,523,996	$138,018,317	$237,542,313
Program and Policy	652.47	1,282,628,540	2,386,024,372	3,668,652,912
Field Services	1,328.31	180,468,097	113,742,156	294,210,253
County Social Services	143.00	1,323,223	175,835,515	177,158,738
Total 2021-23 Executive Budget	2,221.63	$1,563,943,856	$2,813,620,360	$4,377,564,216

DHS - Management - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation			
	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	107.95	$64,690,274	$90,021,088	$154,711,362
2021-23 Ongoing Funding Changes				
2019-21 transfers and adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Base payroll changes		(508,525)	732,079	223,554
Salary increase		385,855	82,012	467,867
Retirement contribution increase		79,629	16,925	96,554
Health insurance increase		3,903	830	4,733
Administration				
Continued program changes		341,831	841,290	1,183,121
Savings plan	8.00	431,068	440,358	871,426
Capitol complex rent model change		474,286		474,286
Information Technology Services				
Data processing costs and other program changes		14,822,924	4,401,791	19,224,715
Savings plan		(4,396,355)	(3,012,157)	(7,408,512)
Technology contractual services and repairs		4,010,886		4,010,886
Early childhood data system		500,000		500,000
Microsoft Office 365		200,315	50,079	250,394
Other funds reprioritization			2,324,362	2,324,362
Total ongoing funding changes	(10.10)	$15,507,036	$2,323,915	$17,830,951
One-time funding items				
Upgrade MMIS system		$4,326,686	$30,673,314	$35,000,000
Child welfare technology project		15,000,000	15,000,000	30,000,000
Total one-time funding changes	0.00	$19,326,686	$45,673,314	$65,000,000
Total Changes to Base Level Funding	(10.10)	$34,833,722	$47,997,229	$82,830,951
2021-23 Total Funding	97.85	$99,523,996	$138,018,317	$237,542,313
Total ongoing changes as a percentage of base level	*(9.4%)*	*24.0%*	*2.6%*	*11.5%*
Total changes as a percentage of base level	*(9.4%)*	*53.8%*	*53.3%*	*53.5%*

DHS - Program and Policy - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation			
	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080
2021-23 Ongoing Funding Changes				
2019-21 transfers and adjustments	257.22	$22,005,318	$23,196,444	$45,201,762
Base payroll changes		2,029,128	624,013	2,653,141
Salary increase		1,480,781	1,276,969	2,757,750
Retirement contribution increase		304,799	262,848	567,647
Health insurance increase		17,084	14,732	31,816
Provider inflation increases		13,478,022	14,417,097	27,895,119
Federal medical assistance percentage changes		(45,779,364)	45,779,364	0
Economic Assistance				
Continued program changes		(210,585)	3,276,939	3,066,354
Grant cost and caseload changes		2,952,453	8,382,789	11,335,242
Child Support				
Continued program changes		36,397	(91,785)	(55,388)
Agency savings plan		(103,906)	(357,788)	(461,694)
Medical Services				
Continued program changes		2,493,060	5,504,976	7,998,036
Agency savings plan, including adjustments to Medicaid Expansion administration and rates	12.00	(11,725,352)	(80,633,115)	(92,358,467)
Grant cost and caseload changes		55,976,251	100,813,594	156,789,845
Other funds reprioritization			(40,000)	(40,000)
Funding source change - Community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	0
Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Long-Term Care				
Agency savings plan		(7,871,872)	(960,285)	(8,832,157)
Grant cost and caseload changes		40,219,972	37,478,740	77,698,712
Other funds reprioritization			(2,284,362)	(2,284,362)
Funding source change - Health care trust fund		1,000,000	(1,000,000)	0
DD Council				
Continued program changes			124,949	124,949
Aging Services				
Continued program changes		126,302	2,384,246	2,510,548
Agency savings plan		(248,240)	(163,425)	(411,665)
Children and Family Services				
Continued program changes		3,172,228	(394,323)	2,777,905
Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Behavioral Health Division				
Continued program changes		156,645	(1,957,536)	(1,800,891)
Agency savings plan		(832,173)		(832,173)
Grant cost and caseload changes		5,427,067		5,427,067

Expand substance use disorder voucher		9,000,000		9,000,000
Vocational Rehabilitation				
Continued program changes		(416,293)	(381,081)	(797,374)
Agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Developmental Disabilities				
Continued program changes		(11,821)	163,017	151,196
Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)
Grant cost and caseload changes		19,323,007	22,244,014	41,567,021
Total ongoing funding changes	269.22	$94,382,598	$149,604,234	$243,986,832
One-time funding items				
Nursing facility payment methodology change		$3,348,000	$3,852,000	$7,200,000
Nursing facility bed buyback program		3,300,000		3,300,000
Total one-time funding changes	0.00	$6,648,000	$3,852,000	$10,500,000
Total Changes to Base Level Funding	269.22	$101,030,598	$153,456,234	$254,486,832
2021-23 Total Funding	652.47	$1,282,628,540	$2,386,024,372	$3,668,652,912
Total ongoing changes as a percentage of base level	*70.2%*	*8.0%*	*6.7%*	*7.1%*
Total changes as a percentage of base level	*70.2%*	*8.6%*	*6.9%*	*7.5%*

DHS - Field Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation			
	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	1,599.03	$214,862,668	$127,314,955	$342,177,623
2021-23 Ongoing Funding Changes				
2019-21 transfers and adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Base payroll changes		(7,659,868)	12,248,626	4,588,758
Salary increase		4,975,231	523,871	5,499,102
Retirement contribution increase		1,003,529	108,416	1,111,945
Health insurance increase		59,867	5,710	65,577
Provider inflationary increases		405,815		405,815
Human Service Centers				
Continued program changes		3,116,890	(2,911,912)	204,978
Cost and caseload changes		2,624,029		2,624,029
Civil sex offender treatment contract		917,004		917,004
Agency savings plan		(6,414,994)		(6,414,994)
Institutions				
Continued program changes		(4,250,920)	3,154,778	(1,096,142)
Agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)
Total ongoing funding changes	(270.72)	($34,394,571)	($13,572,799)	($47,967,370)
One-time funding items				
No one-time funding items				$0
Total one-time funding changes	0.00	$0	$0	$0
Total Changes to Base Level Funding	(270.72)	($34,394,571)	($13,572,799)	($47,967,370)
2021-23 Total Funding	1,328.31	$180,468,097	$113,742,156	$294,210,253
Total ongoing changes as a percentage of base level	*(16.9%)*	*(16.0%)*	*(10.7%)*	*(14.0%)*
Total changes as a percentage of base level	*(16.9%)*	*(16.0%)*	*(10.7%)*	*(14.0%)*

DHS - County Social Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation			
	FTE Positions	**General Fund**	**Other Funds**	**Total**
2021-23 Biennium Base Level	140.00	$0	$173,700,000	$173,700,000
2021-23 Ongoing Funding Changes				
Base payroll changes			$1,653,466	$1,653,466
Salary increase		$351,365	292,562	643,927
Health insurance increase		3,287	2,737	6,024
Retirement contribution increase		72,382	60,269	132,651
Continued program changes		896,189	(372,192)	523,997
Home- and community-based services staff	3.00		498,673	498,673
Total ongoing funding changes	3.00	$1,323,223	$2,135,515	$3,458,738
One-time funding items				
No one-time funding items				$0
Total one-time funding changes	0.00	$0	$0	$0
Total Changes to Base Level Funding	3.00	$1,323,223	$2,135,515	$3,458,738
2021-23 Total Funding	143.00	$1,323,223	$175,835,515	$177,158,738
Total ongoing changes as a percentage of base level	*2.1%*		*1.2%*	*2.0%*
Total changes as a percentage of base level	*2.1%*		*1.2%*	*2.0%*

Department of Human Services - Budget No. 325
House Bill No. 1012
Other Sections

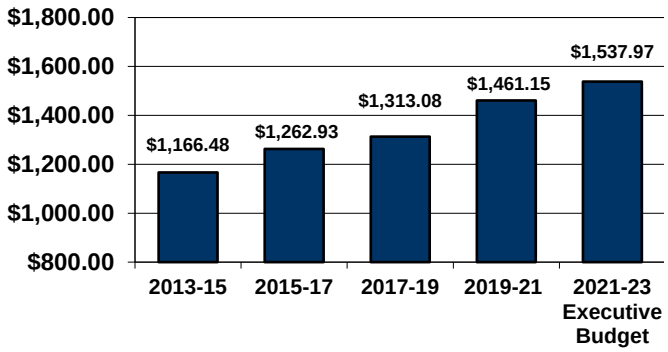
	Executive Budget Recommendation
Medicaid Expansion	Section 3 would amend North Dakota Century Code Section 50-24.1-37 to extend the expiration date for the Medicaid Expansion program to June 30, 2022. Section 4 would provide for the Medicaid Expansion program to be a fee-for-service program administered by DHS effective July 1, 2022.
Personal care	Section 5 would repeal Section 50-24.1-18.1 relating to personal care services for eligible medical assistance recipients.
Line item transfers	Section 6 would allow DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 7 would allow DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.
Community health trust fund	Section 8 would identify $24 million of the recommended appropriation for the Medical Services Division is from the community health trust fund.
Human service finance fund	Section 9 would identify $174,380,767 of the recommended appropriation for the county social and human service project is from the human service finance fund.
Nursing home bed reduction	Section 10 would appropriate $3.3 million from the general fund to provide incentives to nursing facilities to reduce licensed bed capacity.
Medicaid Expansion appropriations	Section 11 would provide DHS may not spend more for the Medicaid Expansion program than the amount appropriated in the bill with certain exceptions. Section 27 would provide this section is effective through June 30, 2022.
Nursing facility appropriations	Section 12 would provide DHS may not spend more for nursing facility payments than the amount appropriated in the bill.
Health home for individuals with chronic conditions	Section 13 would require DHS to develop a plan to implement a state Medicaid option to provide coordinated care through a health home for individuals with a chronic condition.
Carryover authority	Sections 14 through 19 would allow DHS to continue unexpended appropriations for various projects into the 2021-23 biennium.
Conveyance of land	Section 20 would authorize DHS to convey land at the Life Skills and Transition Center to the Grafton Parks and Recreation Department.
Capital projects and payments	Section 21 would authorize the payment of special assessments at the State Hospital and Life Skills and Transition Center and would authorize the demolition of the chapel and employee building at the State Hospital. The section would also allow DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.
State Hospital facility	Section 22 would authorize DHS to enter a public-private partnership for the purpose of constructing a new State Hospital facility.
Provider outcomes	Section 23 would require providers that receive funding from DHS to submit process and outcome measures.
Residential treatment providers	Section 24 would require DHS to adopt rules establishing a ratesetting process and other requirements for foster care maintenance rates for qualified residential treatment providers.
Legislative intent	Section 25 would provide legislative intent that DHS and the Adjutant General enter an agreement to lease up to 20 acres of property at the State Hospital for a National Guard training and storage center.

Department 325 - Department of Human Services

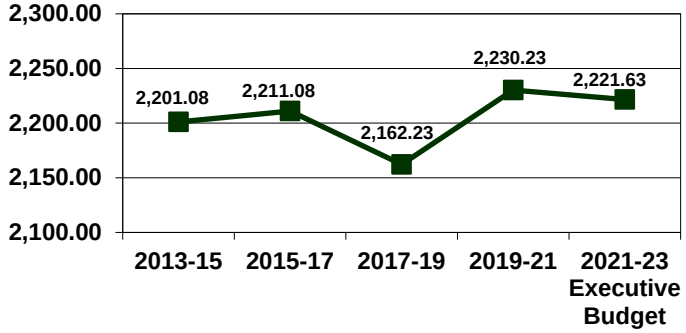
Historical Appropriations Information

Ongoing General Fund Appropriations Since 2013-15

Ongoing General Fund Appropriations (in Millions)



FTE Positions



Ongoing General Fund Appropriations					
	2013-15	2015-17	2017-19	2019-21	2021-23 Executive Budget
Ongoing general fund appropriations	$1,166,482,508	$1,262,925,021	$1,313,081,350	$1,461,150,884	$1,537,969,170
Increase (decrease) from previous biennium	N/A	$96,442,513	$50,156,329	$148,069,534	$76,818,286
Percentage increase (decrease) from previous biennium	N/A	8.3%	4.0%	11.3%	5.3%
Cumulative percentage increase (decrease) from 2013-15 biennium	N/A	8.3%	12.6%	25.3%	31.8%

Major Increases (Decreases) in Ongoing General Fund Appropriations

2015-17 Biennium

1.	Added state matching funds due to changes in FMAP	$3,584,150
2.	Added funding for the state's share of Medicaid Expansion costs	$8,187,466
3.	Provided a 3 percent inflationary increase for providers for the 1st year of the biennium	$24,727,201
4.	Added funding of $19,312,165 for property tax relief to counties for costs previously paid by counties for child welfare programs, the SPED programs, and technology costs; and $3.9 million for grants to counties that have imposed an emergency human service levy	$23,212,165
5.	Transferred the high-risk sex offender treatment program to the Department of Corrections and Rehabilitation	($2,290,297)
6.	Added funding for physical, occupational, and speech therapy service provider rate increase to a 50 percent fee schedule	$468,629
7.	Added funding for Medicare drug clawback payments to reflect a premium rate increase	$2,183,214
8.	Added funding for basic care provider payment changes	$704,148
9.	Added funding for senior meals program	$502,300
10.	Added funding to establish and administer a substance abuse voucher system	$375,000

2017-19 Biennium

1.	Removed 33 FTE positions from the department	($3,127,902)
2.	Reduced funding for staff overtime	($1,082,857)
3.	Adjusted funding for child care assistance eligibility	($2,160,357)
4.	Adjusted the professional fee schedule to 100 percent of Medicare and provided other policy changes	($10,612,966)
5.	Added funding to continue Medicaid Expansion for 19 and 20 year olds as managed care	$1,653,008

6. Changed a portion of funding sources for various programs from the general fund to the community health trust fund ($18,000,000) and the tobacco prevention and control trust fund ($22,175,000)	($40,175,000)
7. Added funding for nursing home operating margin, rebasing, and incentives	$1,783,181
8. Added funding for money follows the person grants	$527,954
9. Added funding to increase the autism waiver maximum age to 11 years old	$183,609
10. Reduced funding for vacant positions and employee turnover at institutions	($3,250,499)

2019-21 Biennium

1. Added funding for provider inflationary increases of 2 percent the 1st year of the biennium and 2.5 percent the 2nd year of the biennium	$30,155,090
2. Adjusted funding for anticipated changes in the regular FMAP	($25,682,840)
3. Adjusted funding for anticipated changes in the FMAP for Medicaid Expansion ($20,254,376) and the children's health insurance program ($6,152,757)	$26,407,133
4. Added funding for grant cost and caseload changes	$51,128,377
5. Replaced funding provided in the 2017-19 biennium from the tobacco prevention and control trust fund	$34,175,000
6. Replaced one-time funding provided in the 2017-19 biennium for Medicaid Expansion commercial rates	$13,300,000
7. Adjusted funding sources to use funding from the community health trust fund rather than the general fund	($32,400,000)
8. Added funding for the free through recovery program to provide services to individuals outside of the corrections system	$4,000,000
9. Added funding to expand crisis services	$4,096,174
10. Added funding for the substance use disorder voucher program	$3,053,523

2021-23 Biennium (Executive Budget Recommendation)

1. Adds funding for cost, caseload, and utilization changes, including $156,789,851 for medical services, $77,698,712 for long-term care, and $41,567,021 for developmental disabilities	$124,345,846
2. Underfunds salaries and wages by $4,694,730 from the general fund in anticipation of savings from vacant positions and employee turnover	($4,694,730)
3. Reduces ongoing funding appropriated during the 2019-21 biennium from the community health trust fund from $32.4 million to $24 million and replaces ongoing funding provided from the health care trust fund ($1 million)	$9,400,000
4. Provides a 1 percent inflationary increase for human service providers during each year of the 2021-23 biennium	$13,883,837
5. Increases funding for the substance use disorder voucher program from $8 million to $17 million	$9,000,000
6. Adjusts funding to reduce general fund support for traditional Medicaid ($50,919,245) and increase general fund support for Medicaid Expansion ($3,916,989) and the children's health insurance program ($1,222,892) due to changes in the state's FMAP	($45,779,364)
7. Underfunds Medicaid grants	($9,580,913)
8. Adds funding to contract with a private service provider for civil sex offender treatment	$917,004
9. Adds funding for the Capitol grounds agency rent proposal	$474,286
10. Adds ongoing funding to develop an early childhood integrated data system	$500,000

GOVERNOR'S RECOMMENDATION FOR THE DEPARTMENT OF HUMAN SERVICES AS SUBMITTED BY THE OFFICE OF MANAGEMENT AND BUDGET

SECTION 1. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from special funds derived from federal funds and other income, to the department of human services for the purpose of defraying the expenses of its various divisions, for the biennium beginning July 1, 2021, and ending June 30, 2023, as follows:

Subdivision 1.

MANAGEMENT

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and Wages	$ 16,939,176	$ 2,509,310	$ 19,448,486
Operating Expenses	133,329,751	84,689,076	218,018,827
Capital Assets	50,000	25,000	75,000
Total All Funds	$150,318,927	$87,223,386	$237,542,313
Less Estimated Income	86,467,434	51,550,883	138,018,317
Total General Fund	$ 63,851,493	$35,672,503	$ 99,523,996

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and Wages	$ 111,785,293	$ 7,772,728	$ 119,558,021
Operating Expenses	155,887,808	9,993,200	165,881,008
Capital Assets	10,000	0	10,000
Grants	449,002,998	6,686,742	455,689,740
Grant – Medical Assistance	2,742,681,743	184,832,400	2,927,514,143
Total All Funds	$3,459,367,842	$209,285,070	$3,668,652,912
Less Estimated Income	2,255,764,582	130,259,790	2,386,024,372
Total General Fund	$1,203,603,260	$ 79,025,280	$1,282,628,540

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human Service Centers	$162,984,547	$ 4,533,765	$167,518,312
Institutions	138,383,749	(11,691,808)	126,691,941
Total All Funds	$301,368,296	($ 7,158,043)	$294,210,253
Less Estimated Income	107,672,165	6,069,991	113,742,156
Total General Fund	$193,696,131	($13,228,034)	$180,468,097

Subdivision 4.

PROPERTY TAX RELIEF

	Base Level	Adjustments or Enhancements	Appropriation
County Social Services	$173,700,000	$3,458,738	$177,158,738
Total All Funds	$173,700,000	$3,458,738	$177,158,738
Less Estimated Income	173,700,000	2,135,515	175,835,515
Total General Fund	$ 0	$1,323,223	$ 1,323,223

Subdivision 5.

BILL TOTAL

	Base Level	Adjustments or Enhancements	Appropriation
Grand Total General Fund	$1,461,150,884	$102,792,972	$1,563,943,856
Grand Total Special Funds	2,623,604,181	190,016,179	2,813,620,360
Grand Total All Funds	$4,084,755,065	$292,809,151	$4,377,564,216
Full-time Equivalent Positions	2,230.23	(8.60)	2,221.63

SECTION 2. ONE-TIME FUNDING - EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY. The following amounts reflect the one-time funding items approved by the sixty- sixth legislative assembly for the 2019-21 biennium and the 2021-23 biennium one-time funding items included in section 1 of this Act:

One-Time Funding Description	2019-21	2021-23
Technology Projects	$13,785,658	$ 0
Capital Projects – Life Skills and Transition Center	4,277,165	0
Capital Projects – State Hospital	2,493,500	0
Medically Complex Children Provider Funding Adjustment	977,603	0
Hyperbaric Oxygen Therapy Grant	335,000	0
State Hospital Study	200,000	0
MMIS Modernization	0	35,000,000
Nursing Facility Payment Reform	0	7,200,000
Nursing Home Bed Buy Back	0	3,300,000
Frame/CCIPS Replacement	0	30,000,000
Total All Funds	$22,068,926	$75,500,000
Less Estimated Income	20,556,323	49,525,314
Total General Fund	$1,512,603	$25,974,686

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 3. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective ~~January~~August 1, ~~2020~~2021, through ~~July 31~~June 30, ~~2021~~2022 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.
4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even- numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 4. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion ~~- Legislative management report~~. (Effective ~~January~~July 1, ~~2020~~2022, through July 31, ~~2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. ~~Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.~~
4. ~~The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even- numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~
5. ~~Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 5. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 6. FUNDING TRANSFERS - EXCEPTION - AUTHORIZATION. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022, any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 7. FUNDING TRANSFERS - EXCEPTION - AUTHORIZATION. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority from line items within subdivisions 1, 2, and 3 of section 1 of this Act to subdivision 4 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022 any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 8. ESTIMATED INCOME - COMMUNITY HEALTH TRUST FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $24,000,000 from the community health trust fund for defraying expenses in the medical services division.

SECTION 9. ESTIMATED INCOME - HUMAN SERVICE FINANCE FUND. The estimated income line item in subdivision 4 of section 1 of this Act includes the sum of $174,380,767 from the human service finance fund for state-paid economic assistance and social and human services.

SECTION 10. APPROPRIATION – NURSING HOME BED REDUCTION. There is appropriated the sum of $3,300,000, from the general fund or so much of the sum as may be necessary, to the department of human services for the purpose of providing incentives to nursing homes to reduce licensed nursing facility bed capacity for the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 11. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM.

1. Subdivision 2 of section 1 of this Act includes the sum of $325,521,229, of which $36,606,115 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021 and ending June 30, 2022. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:
   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $5,120,064 included in subdivision 2 of section 1 of this Act.
   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $34,364,628 included in subdivision 2 of section 1 of this Act.
2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.
3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.
4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.
5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.
6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through June 30, 2022. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION – NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $635,373,451, of which $296,019,558 is from the general fund, for nursing home rates for the biennium beginning July 1, 2021 and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 13. HEALTH HOMES - REPORT TO LEGISLATIVE MANAGEMENT. During the biennium beginning July 1, 2021 and ending June 30, 2023, the department of human services shall develop a plan to implement, in accordance with section 1945 of the Social Security Act, health homes to coordinate care for people with Medicaid who have chronic conditions during the biennium beginning July 1, 2023 and ending June 30, 2025. Prior to October 1, 2022, the department shall report to the legislative management on the implementation plan.

SECTION 14. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54- 44.1-11. Any unexpended funds from these appropriations approved under section 54-44.1-11 are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 15. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54- 44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 16. EXEMPTION. The amount appropriated for the development of the childcare licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019- 21 biennium are available for the completion of the childcare licensing and data system during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 17. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 18. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavior health pilot projects during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 19. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 20. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to Grafton Parks and Recreation. The department may convey a portion of two parcels of land commonly referred to as “the bowl” on the terms and conditions determined appropriate by the department and the attorney general. Section 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 21. CAPITAL PROJECTS AND PAYMENTS. During the period beginning with the effective date of this Act, and ending June 30, 2023, the department of human services is authorized to expend funds for the following capital projects and payments:

1. The payment of special assessments at the state hospital and life skills and transition center; and
2. The demolition of the chapel and employee building and associated tunnels at the state hospital.

Notwithstanding sections 54-16-04 and 54-27-12, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services for the department to expend funds on the demolition of the identified buildings and associated tunnels and for emergency capital projects. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department of human services shall report to the

budget section after June 30, 2022 any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 22. STATE HOSPITAL BUILDING PROJECTS. The department of human services is authorized to construct a new state hospital on the property owned by the state of North Dakota, in Stutsman County, near or on state hospital's current campus. The new state hospital may include space for the operation of the regional human service center. The department of human services shall utilize chapter 48-02.1 and have a private operator to build, transfer, and operate the facility through a development agreement on leased property owned by the state of North Dakota. The continuing cost to support the new state hospital through a development agreement must be included in the department of human services' 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 23. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 24. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new rate setting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation received by the sixty-seventh legislative assembly.

SECTION 25. LEGISLATIVE INTENT – CONVEYANCE OF LAND. It is the intent of the sixty-seventh legislative assembly that the department of human services and national guard enter into an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to build a new training and storage center.

SECTION 26. EFFECTIVE DATE. Section 4 of this Act becomes effective on July 1, 2022.

SECTION 27. EXPIRATION DATE. Sections 3 and 11 of this Act is effective through June 30, 2022 and after that date is ineffective.

SECTION 28. EMERGENCY. Sections 21 and 22 of this Act are declared to be an emergency measure.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1012
1/7/2021

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chairman Delzer- Opened the meeting for HB 1012 at 8:30 AM

Attendance	P/A
Representative Jeff Delzer	P
Representative Keith Kempenich	P
Representative Bert Anderson	P
Representative Larry Bellew	P
Representative Tracy Boe	P
Representative Mike Brandenburg	P
Representative Michael Howe	P
Representative Gary Kreidt	P
Representative Bob Martinson	P
Representative Lisa Meier	P
Representative Alisa Mitskog	P
Representative Corey Mock	P
Representative David Monson	P
Representative Mike Nathe	P
Representative Jon O. Nelson	P
Representative Mark Sanford	P
Representative Mike Schatz	P
Representative Jim Schmidt	P
Representative Randy A. Schobinger	P
Representative Michelle Strinden	P
Representative Don Vigesaa	P

Discussion Topics:

- Overview of ND Human Services

Chris D. Jones Director of ND Human Services overview of Human Services. #933

Additional written testimony: No Additional Testimony

Chairman Delzer- Closes the meeting for HB 1012 at 9:42 AM

Risa Berube,

House Appropriations Committee Clerk and Donna Whetham

NORTH Dakota | Human Services

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Presentation to House Appropriations Committee

Chris D. Jones, Director

January 7, 2021

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

#1

DHS in NDCC, with major statutory responsibilities

DHS AUTHORITY ESTABLISHED IN NDCC 50-06

Administration of human services programs related to:

- Children and families
- Individuals with developmental disabilities
- Aging services
- Behavioral health
- Economic assistance
- Medical service
- General assistance
- Child support

CHAPTER 50-06
DEPARTMENT OF HUMAN SERVICES

50-06-01. Definitions.
As used in this chapter, unless the context otherwise requires:

1. "Behavioral health" means the planning and implementation of preventive, consultative, diagnostic, treatment, crisis intervention, rehabilitative, and suicide prevention services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions.
2. "Behavioral health provider" means any licensed or accredited behavioral health provider in this state.
3. "Department" means the department of human services.
4. "Human services" means:
   a. A service or assistance provided to an individual or an individual's family in need of services or assistance, including child welfare services, economic assistance programs, medical services programs, and aging services programs, to assist the individual or the individual's family in achieving and maintaining basic self-sufficiency, including physical health, mental health, education, welfare, food and nutrition, and housing.
   b. A service or assistance provided, administered, or supervised by the department in accordance with chapter 50-06.
   c. Licensing duties as administered or supervised by the department or delegated by the department to a human service zone.

50-06-01.1. Department of human services to be substituted for public welfare board of North Dakota and social service board of North Dakota, members of board, and executive director.

When the terms "public welfare board of North Dakota", "social service board of North Dakota", "executive director of the public welfare board", "executive director of the social service board", "member of the public welfare board", or "member of the social service board", or any derivative of those terms which, when used in context indicates an intention to refer to those persons or that board, appear in the North Dakota Century Code, the term "department of human services", or the term "executive director of the department of human services", as the case may be, must be substituted therefor. It is the intent of the legislative assembly that the department of human services must be substituted for, shall take any action previously to be taken by, and shall perform any duties previously to be performed by the public welfare board of North Dakota or by the social service board of North Dakota.

#2

Purpose of Agency divisions, including organizational chart

DHS Mission and Operating Principles

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

NORTH Dakota | Human Services

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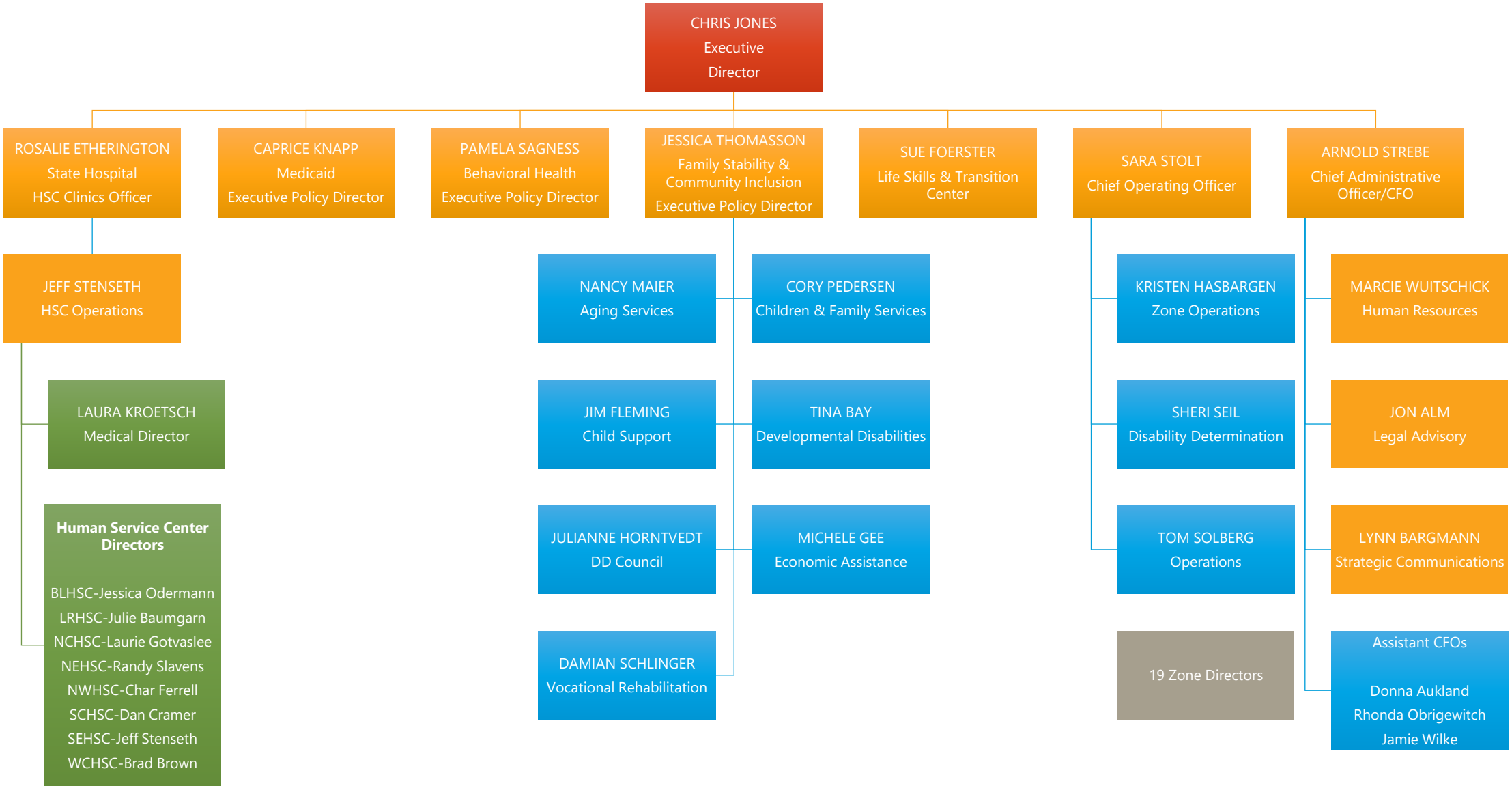
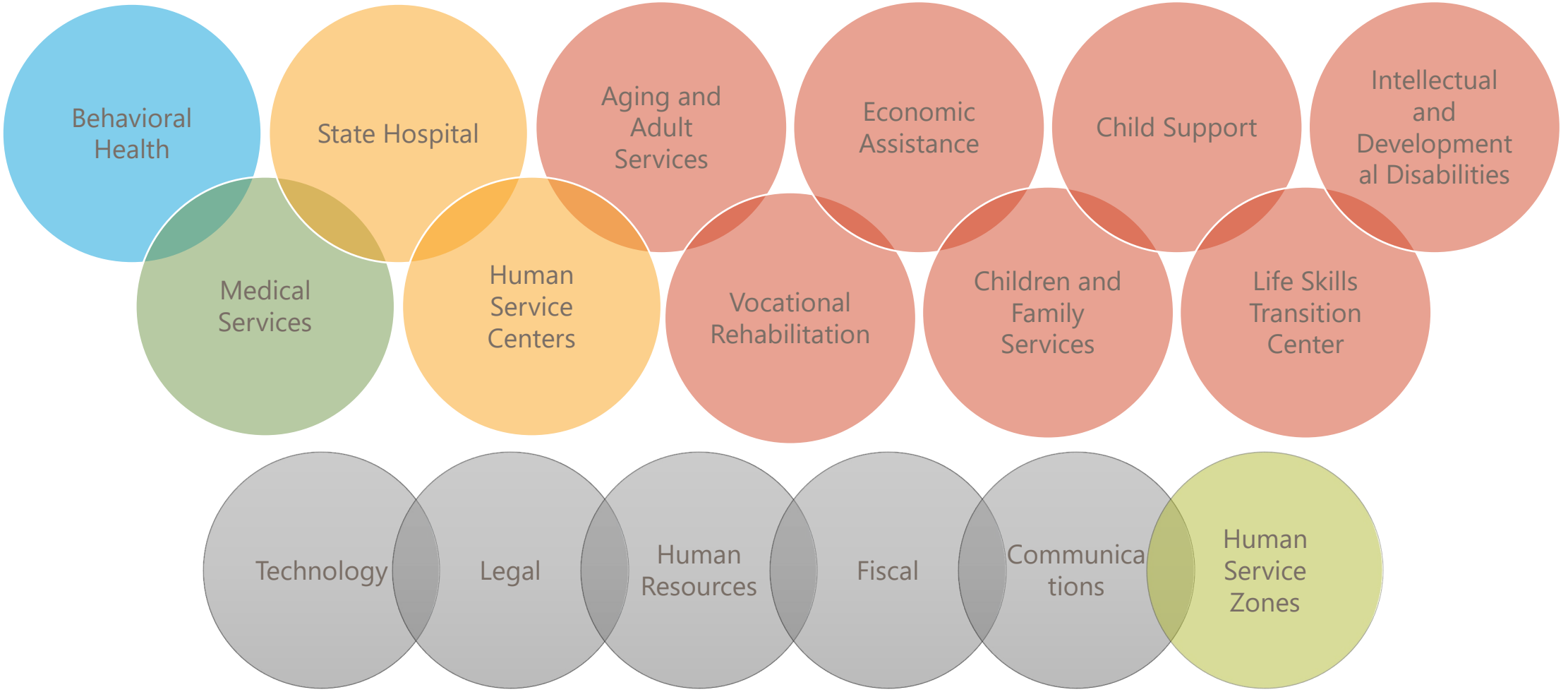


ND DEPARTMENT OF HUMAN SERVICES

Helping North Dakotans realize their potential through targeted, evidence-based interventions that deliver meaningful results



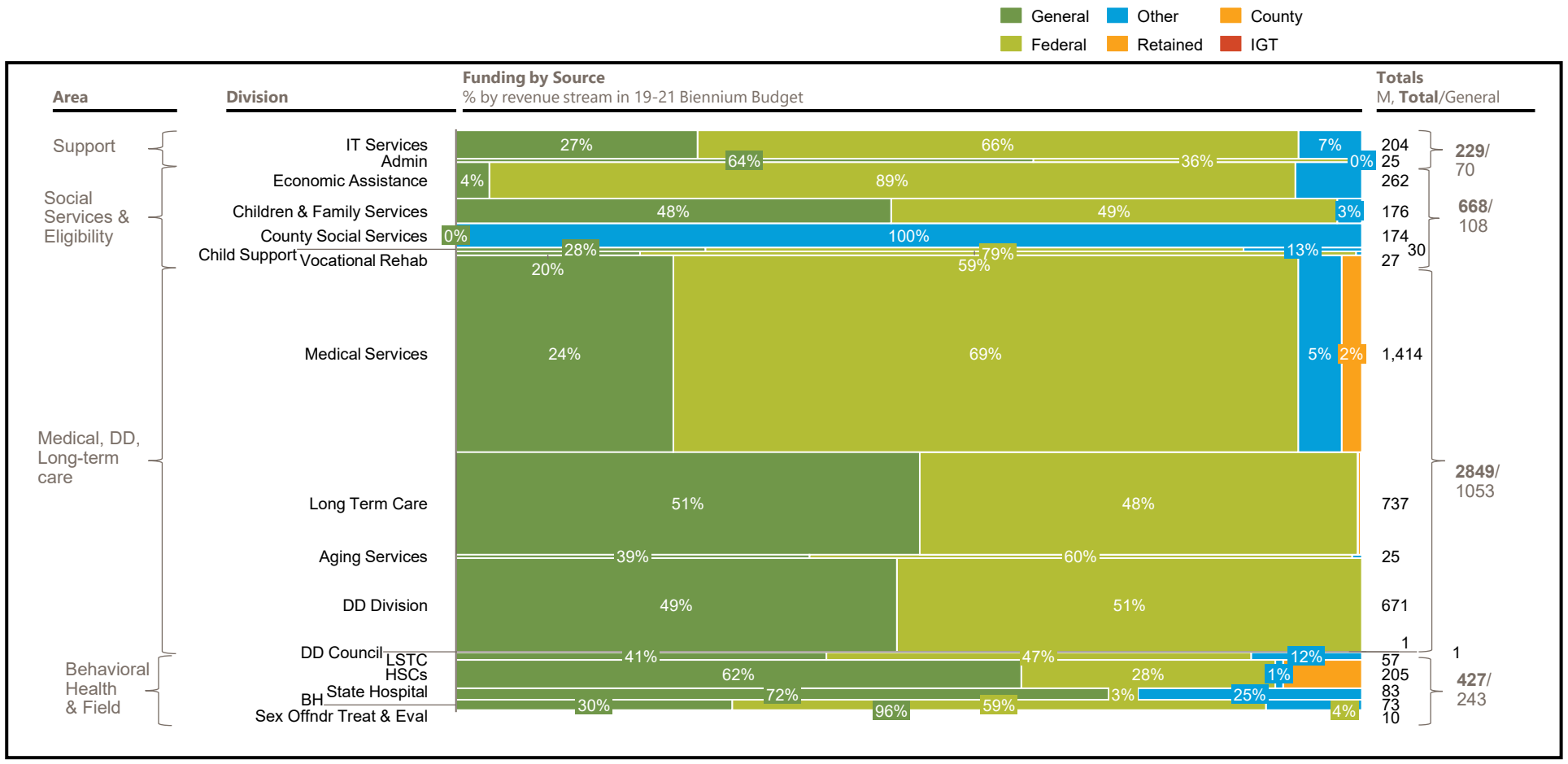
2021-2023 EXECUTIVE BUDGET

Total budget by agency / group



DHS BY FUNCTIONAL AREA

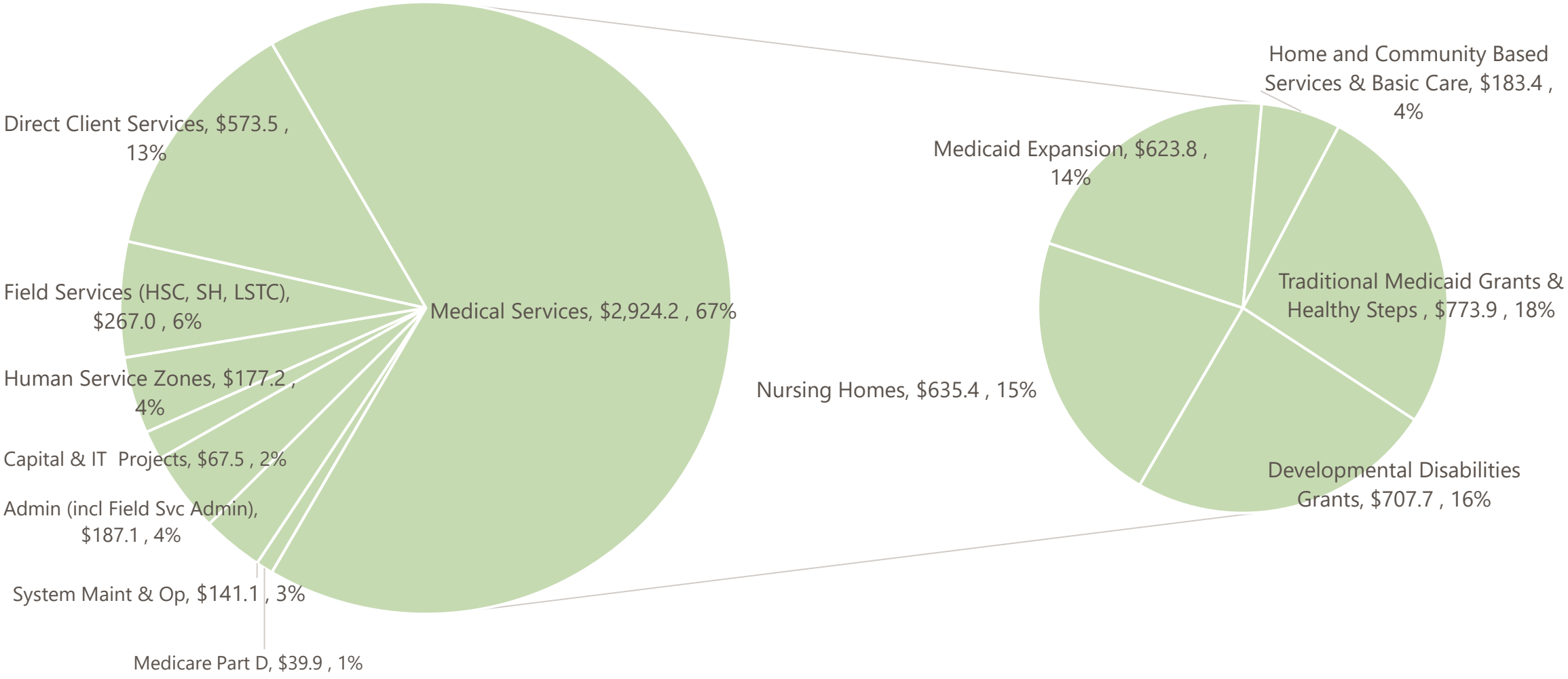
The majority of DHS funds are spent on medical, DD, & long-term care services



March 2020

2021-2023 EXECUTIVE BUDGET DHS

Total budget $4.378 billion, by category of expenditure



Direct Client Services include Economic Assistance Programs, Child Welfare Programs, and grants and service contracts for Aging, Behavioral Health, Vocational Rehabilitation, Medical Services, and Developmental Disability.

#3

Financial Audit findings and corrective actions

SFY19 AUDIT OF DHS
Findings and Programmatic Recommendations

MEDICAID AND SNAP

- Payments After Death. Ensure payments are not made for the benefit of deceased individuals. *New system to be implemented April 2021*
- Child Care Correction Orders Not Resolved. Improve procedures to ensure child care correction orders are resolved at the end of each allowed correction period. *Updated tracking system; new early childhood database to be implemented April 2021*
- Not monitoring child care facilities with MOUs. Perform additional monitoring of child care providers to ensure compliance with memorandum of understanding agreements. *Department no longer uses MOUs*

CHILD PROTECTION SERVICES

- Failure to timely contact suspected victims of child abuse and neglect. Ensure timely face-to-face contact with suspected victims of child abuse and neglect. *Redesign of CPS in process*
- Not performing quality assurance for child protection svc. Ensure consistent and complete quality assurance procedures surrounding reports of child abuse and neglect, investigations, and decisions. *Redesign of QA for CPS implemented Dec 2019; regional field specialists joined QA efforts SFY20*
- Confirmed child abusers not listed on index. Ensure individuals with confirmed child abuse or neglect are properly listed on the Child Abuse and Neglect Index. *Implemented new system reporting March 2019*

OTHER RESULTS

- Financial errors. Strengthen procedures surrounding the CAFR reporting process to ensure accurate amounts are reported to the Office of Management and Budget. *Continued collaboration with OMB and SAO.*
- Medicaid drug rebate system errors. Strengthen controls surrounding the Drug Rebate and Analysis Management System (DRAMS) to ensure receivables balances are properly calculated and interest is properly calculated for overdue drug rebate balances. *System updates in process*

#4

Current Biennium accomplishments and challenges; next biennium goals and plans

DHS 19-21 BIENNIUM ACCOMPLISHMENTS

Optimizing Return on Investment by helping avoid crises

- North Dakotans now receive 50 percent of their behavioral health services from a human service center within a community versus a clinic setting.

Behavioral Health Embedded in Community



- Over the last year, behavioral health clients who received services at a human service center experienced a 53 percent reduction in arrests.

Positive Results from Effective Treatment Delivery



- North Dakotans now have access to 24/7 mobile crisis response. We've provided 5,628 crisis services in the last year, with crisis psychotherapy and triage services doubling in the last three months.

24/7 Crisis Response



- Since updating eligibility criteria for home and community-based services in January 2020, 730 individuals have been able to access services in their home, which is a 25 percent increase from CY2019.

Increased community services to older adults



- We've provided increased access to Medicaid services for pregnant women (increased eligibility from 138 percent to 147 percent of poverty) and children with disabilities (from 225 percent to 250 percent of poverty).

More pregnant women and children with access to health care



- HSC accreditation: The agency's human service centers received four-year national accreditation from the Council on Accreditation for its outpatient behavioral health services.

Accreditation for HSC behavioral health team



- Peer support specialists: DHS provided training to more than 460 individuals, and 30 people are newly certified in delivering behavioral health peer support services.

Peer supports available to more people in more places



DHS 19-21 BIENNIUM ACCOMPLISHMENTS & WORK IN PROGRESS

Improved access to effective services



Process Improvement & Redesign Efforts

- Long term care eligibility team
- Child Protective Service Redesign
- Human Service Zones
- Centralized approach to childcare licensing
- Move to functional teams for child support
- Electronic Visit Verification & case management systems



Treatment & Recovery Supports

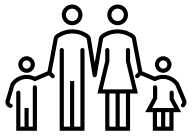
- Medication Assisted Treatment
- Expanded use of SUD voucher
- Behavioral health crisis services



In-Community Services

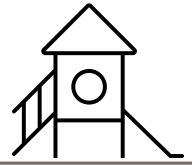
- Peer supports, Companionship, and Adult Foster Care
- Social Determinants of Health via Medicaid (1915i)
- Centralized connection point for home & community-based svc (ADRL)
- Extended Free Through Recovery

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



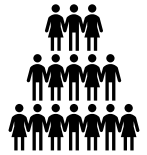
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

#5

Compare agency's request/ recommendation totals, including FTE for next biennium, compared to current biennium

DHS IN THE 21-23 BIENNIUM

Quality services, Proven results, Closer to home

1. Invest resources in **prevention** and **early intervention** resulting in a **reduction in foster care** and facility-based placements of children.

2. Support for new **small-scale settings** for **children and adults** with **complex needs**.

3. Continued investment in **behavioral health** initiatives that **expand access** to vital services.

4. Expansion of **home and community-based services** to older adults and people with disabilities.

5. Focus on **efficiency and effectiveness** in contracting and service delivery.

6. **Expansion** of peer support, supported housing, supported employment, and other **community-based support services**.

7. Across the board **cost savings** related to changes in travel, space utilization, and discretionary grant programs.

DHS OVERVIEW OF BUDGET CHANGES

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	$ 383,915,369	$ 10,643,629	$ 394,558,998
Operating	333,049,456	91,063,140	424,112,596
Capital	2,339,430	25,000	2,364,430
Grants	3,365,450,810	191,077,380	3,556,528,190
Total	**$ 4,084,755,065**	**$ 292,809,150**	**$ 4,377,564,215**
General Fund	$ 1,461,150,884	$ 102,792,973	$ 1,563,943,857
Federal Funds	2,266,624,651	205,560,722	2,472,185,373
Other Funds	356,979,530	(15,544,545)	341,434,985
Total	**$ 4,084,755,065**	**$ 292,809,150**	**$ 4,377,564,215**

DHS STAFFING / FULL TIME EQUIVALENTS

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Management FTE	89.85	8.00	97.85
Program & Policy FTE	640.47	12.00	652.47
Human Service Centers FTE	637.95	-	637.95
Institution FTE	721.96	(31.60)	690.36
County Social Service Financing FTE	140.00	3.00	143.00
Total Regular FTE	**2,230.23**	**(8.60)**	**2,221.63**

HUMAN SERVICE ZONE STAFFING / FTES

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
FTEs approved	1,207	0	1,207
FTEs budgeted	985	0	985

Total FTEs filled as of Dec 20
(fluctuates to meet HSZ needs)
*only filled if within approved budget (attrition, vacancy, etc)

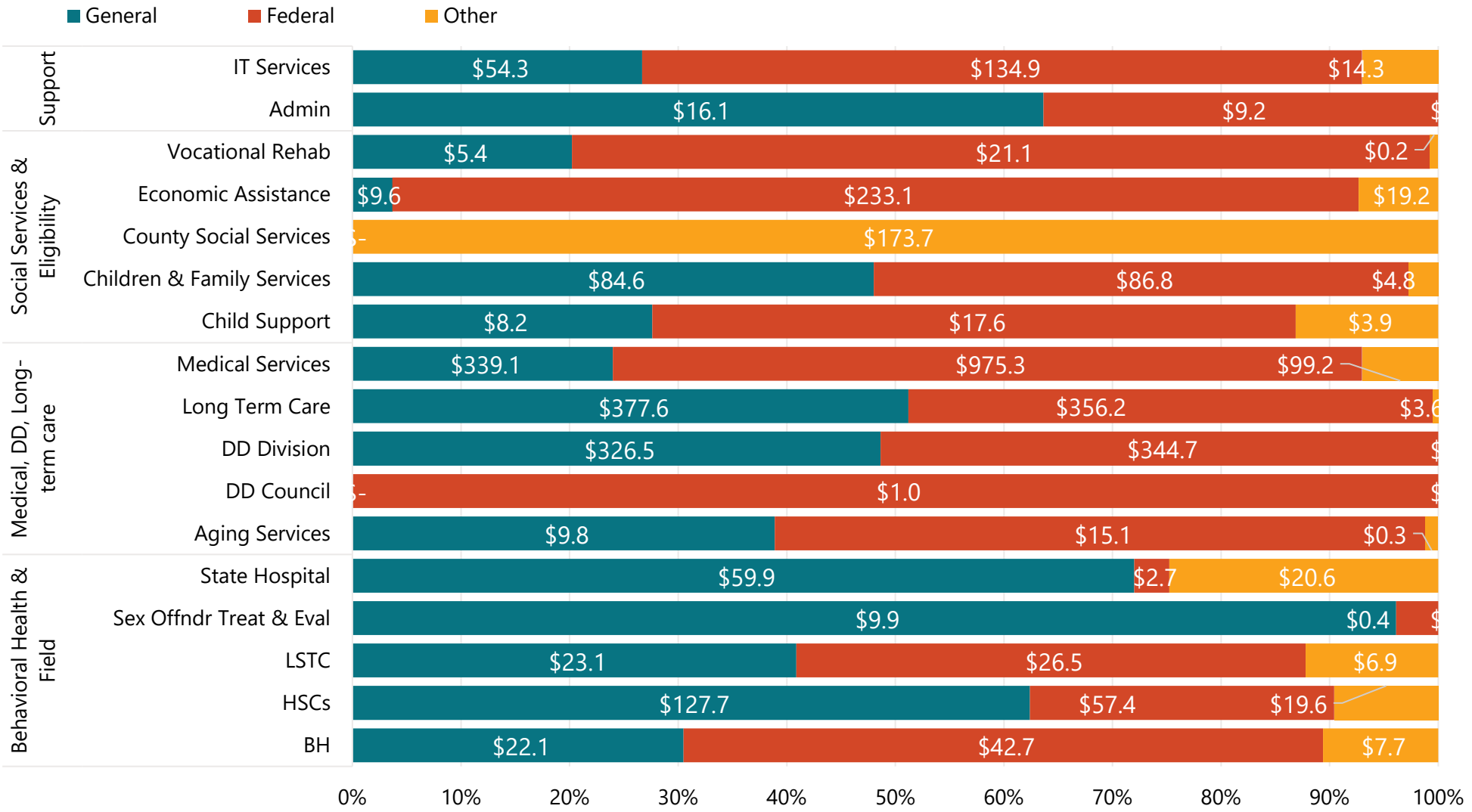
1,030

#6

Explain funding by division including amount in base budget (purpose and use), as well as amount included in request/reco and justification for change from base budget

2019-2021 LEGISLATIVELY APPROVED BUDGET

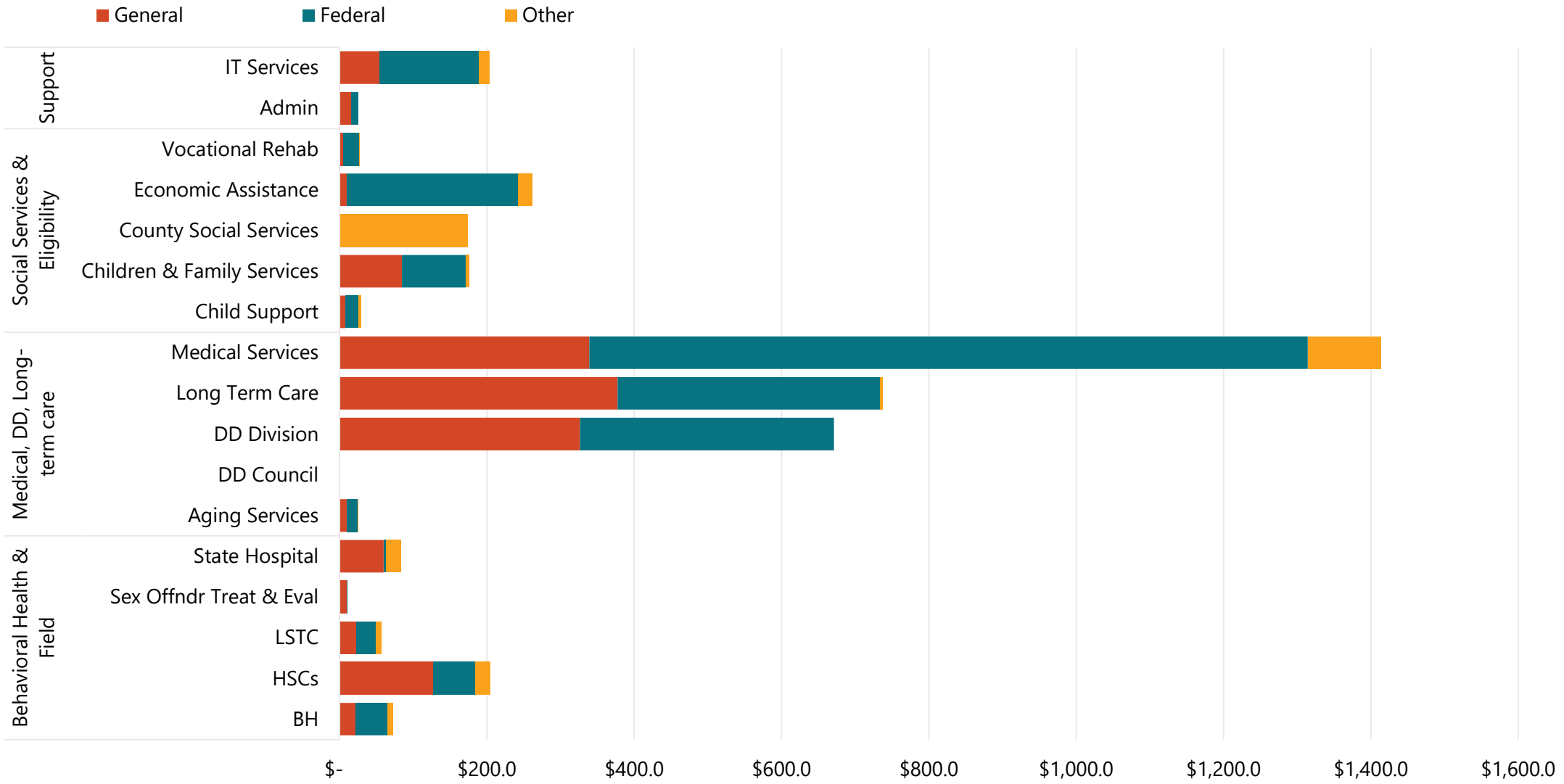
Funding Source, proportional, by division



Budget as of March 30, 2020

2019-2021 LEGISLATIVELY APPROVED BUDGET

Total budget (millions) by division

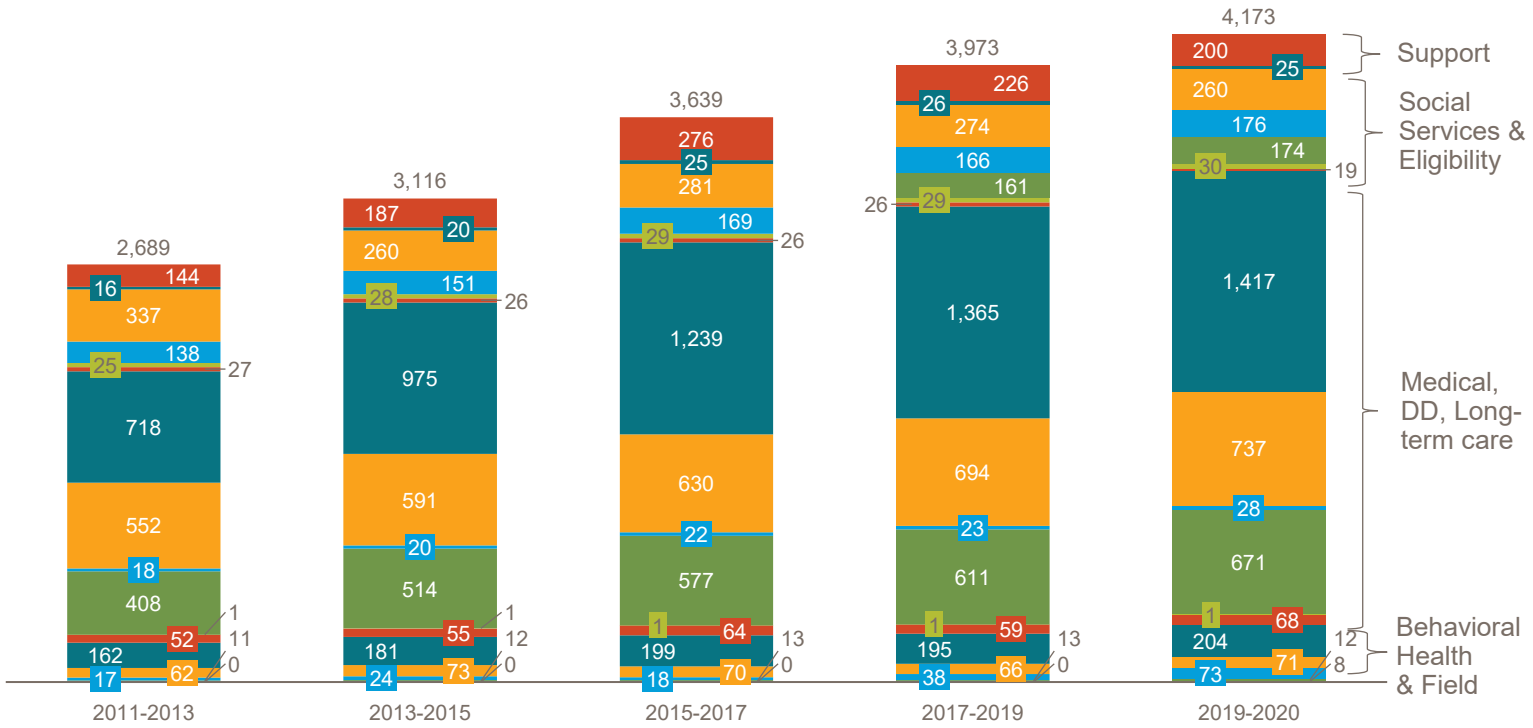


Budget as of March 30, 2020

OVER THE LAST 5 BIENNIA, DD, MEDICAL, AND LONG-TERM CARE HAVE DRIVEN GROWTH IN SPENDING

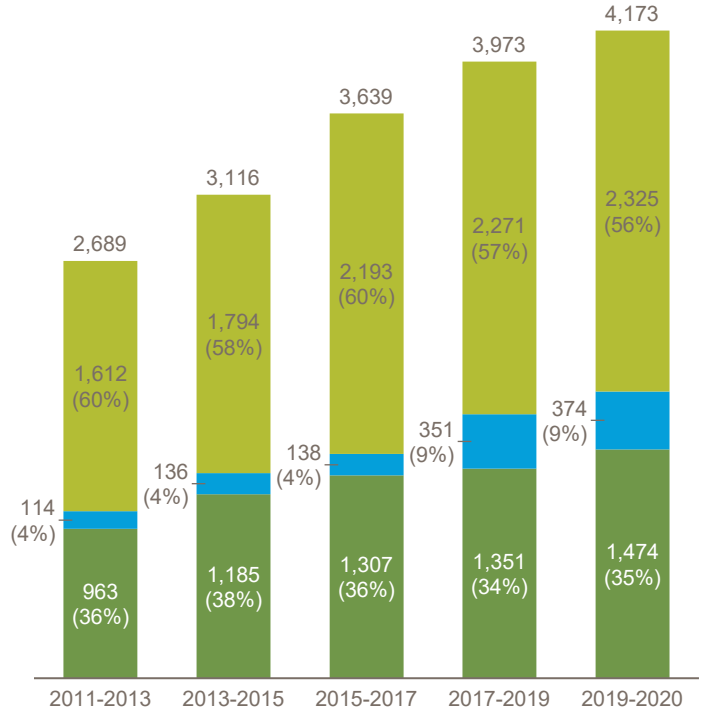
Biennium budget by use division (Compounded Annual Growth Rate (CAGR))
$M for biennium

IT Services (8.97%) | Child Support (1.83%) | DD Division (5.96%) | BH (17.10%)
Admin (5.16%) | Vocational Rehab (-3.37%) | DD Council (-0.02%) | Sex Offndr Treat & Eval (1.39%)
Economic Assistance (-2.70%) | Medical Services (8.91%) | LSTC (2.12%) | Disability Determination
Children & Family Services (2.80%) | Long Term Care (3.29%) | HSCs (3.05%)
HSZs (Cty Social Srvs) | Aging Services (5.18%) | State Hospital (1.42%)



Biennium budget by source (CAGR)
$M for biennium

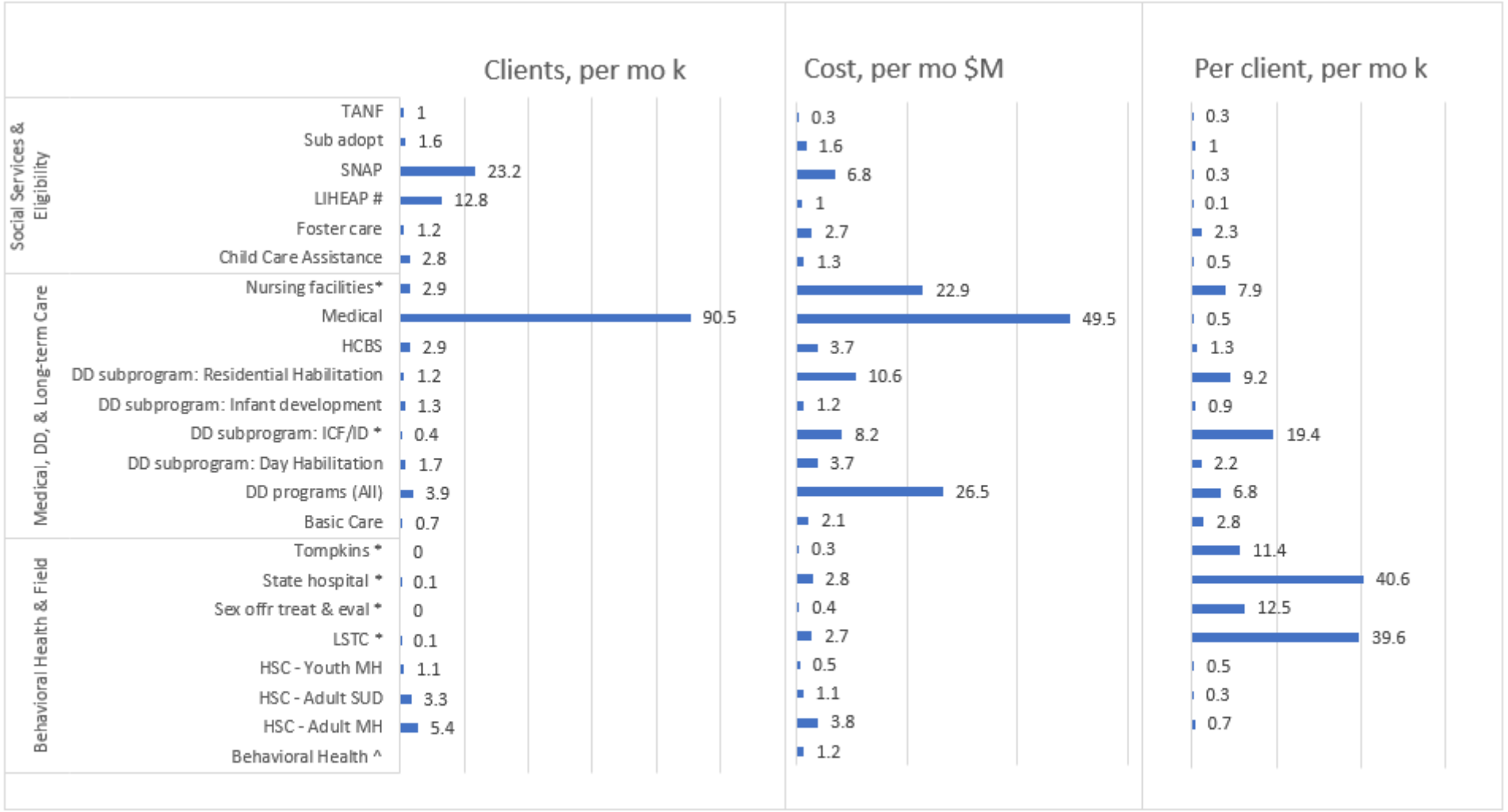
Federal Funds (3.59%)
Other Funds (10.84%)
General Funds (7.66%)



Source: Peoplesoft

HIGHEST PER CLIENT COSTS OCCUR IN INSTITUTIONAL SETTINGS

Expenditures and clients served by program area, SFY20



* Institutional Setting

^ Behavioral Health services are delivered in a manor that does not allow for accurate reporting of clients; reported funds includes administrative dollars.

Based on heating year of October 1 to May 31

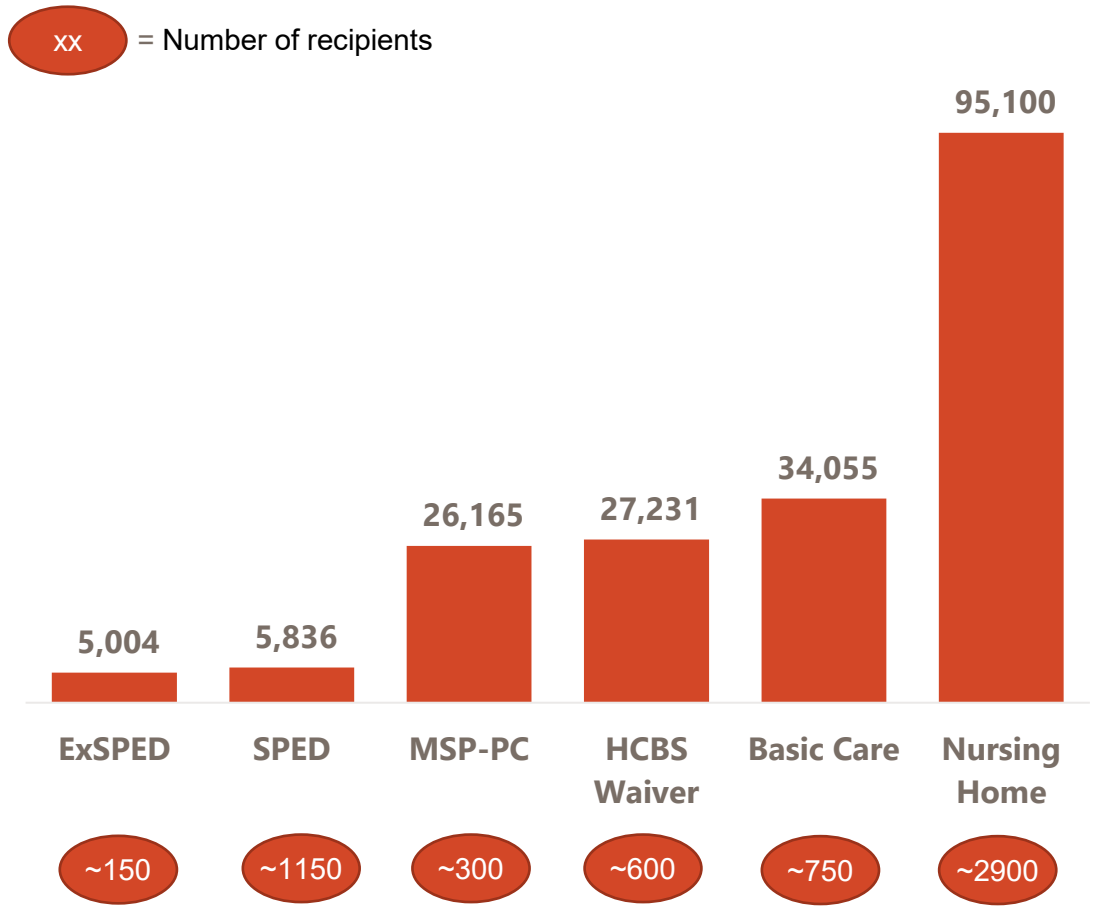
Source: DHS Quarterly Budget Insight, Spend downs, and Institutional Reports

DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

- **Service Payments for the Elderly and Disabled (SPED):** Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- **Expanded SPED (Ex-SPED):** Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- **Home and community-based services (HCBS) waiver:** This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- **Medicaid State Plan personal care (MSP-PC):** Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

MEDICAL SERVICES
Budget Highlights



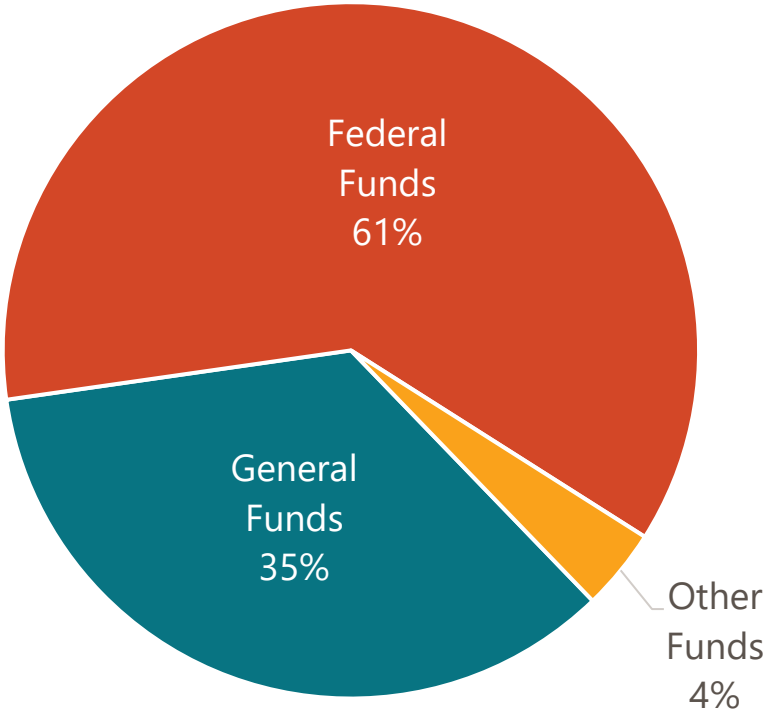
19-21 Budget **$2,155,696,220**

21-23 Budget (exec) **$2,238,065,931**

Includes Traditional, LTC & Expansion

98.5 FTE projected (increase of 12 FTEs); $82.4 million increase in total budget

- Nursing home payment reform and bed buyback
- Reduction in basic care utilization (support study) and increase in HCBS
- Transition administration of Medicaid Expansion to department
- Quality initiative in Medicaid fee for service
- Transition autism voucher to Medicaid program



21-23 Exec Budget

AGING & ADULT SERVICES
Budget Highlights

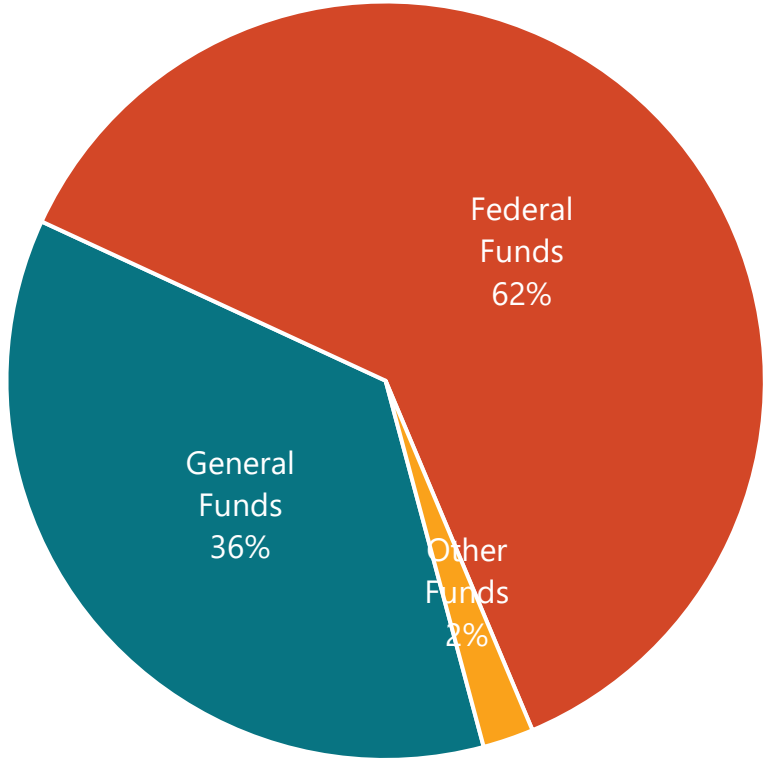


19-21 Budget **$31,214,295**

21-23 Budget (exec) **$34,452,766**

44 FTEs; no change in FTEs projected; $3,238,471 budget increase (98% in federal funds)

- Implementation of in-reach and out-reach and centralized intake for home and community based services
- Continuation of Money Follows the Person
- Eliminate Tech Dependent Waiver
- Various programmatic and operating efficiencies



21-23 Exec Budget

DEVELOPMENTAL DISABILITY SERVICES
Budget Highlights

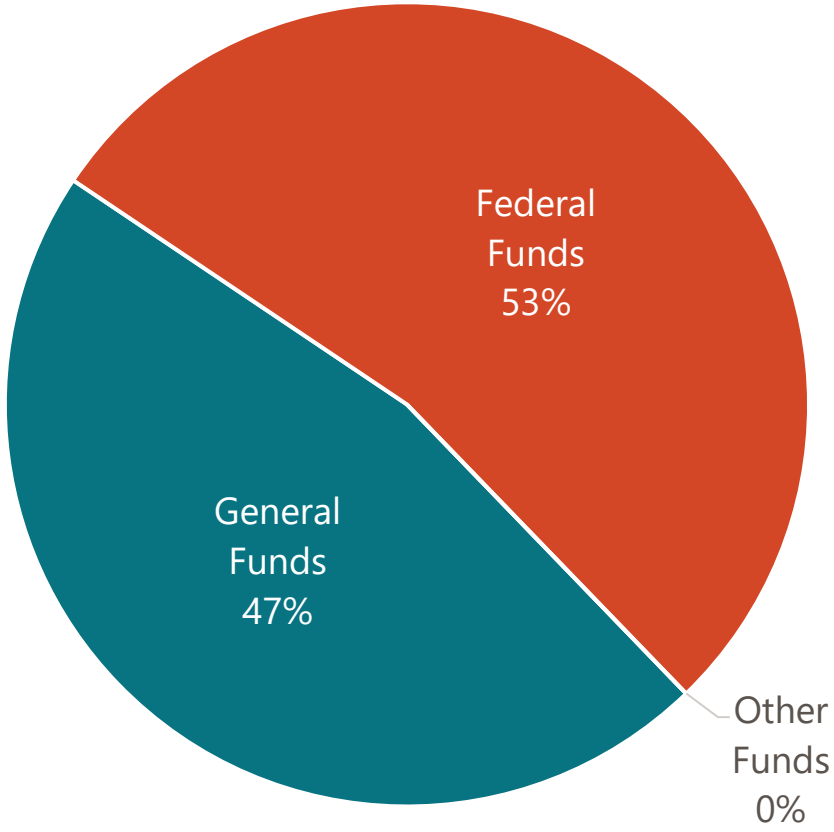


19-21 Budget **$689,016,522**

21-23 Budget (exec) **$739,269,819**

125.87 FTEs; no change in FTEs projected; $50.2 million increase in total budget (83% of increase is from federal funds)

- Diversion/Transition initiative with LSTC
- Payment system adjustments for ICF and Residential Group Homes
- Elimination of recreation and Section 11 grants
- Operating efficiencies related to travel and occupancy



21-23 Exec Budget

LIFE SKILLS TRANSITION CENTER
Budget Highlights

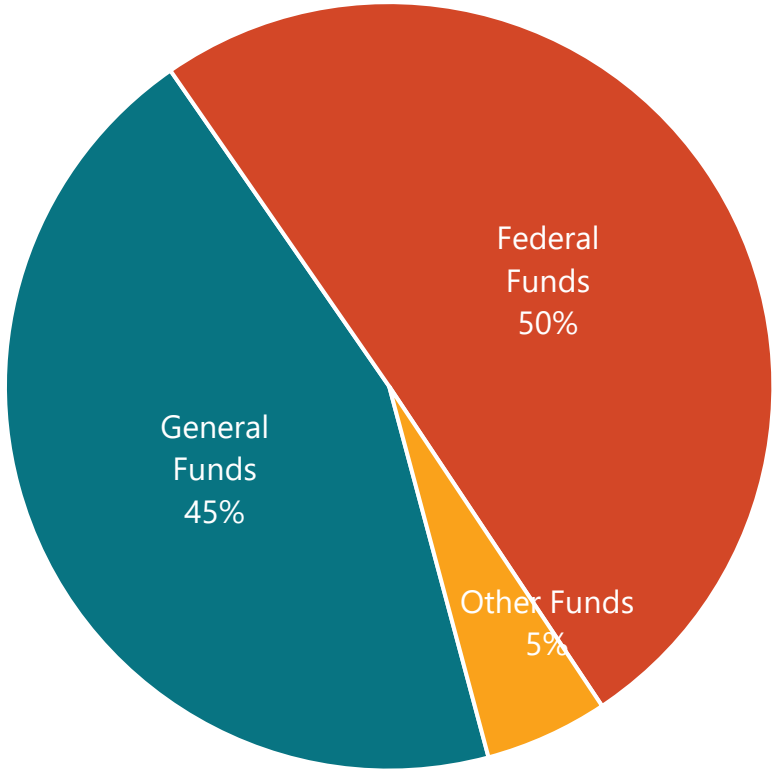


19-21 Budget	**$58,794,948**
21-23 Budget (exec)	**$48,619,605**

308.34 FTEs projected, includes reduction of 14.5 FTEs; $10,175,343 budget reduction (50% in federal funds)

- Reduce census by 26 (16 youth, 10 adults) via both transitions and diversions
- Shift operations to re-orient toward crisis and stabilization service
- Reduce general fund contribution to adaptive equipment service, seeking alternate revenue sources

NOTE: Interconnection between LSTC, CFS, and DD budgets as service models shift



21-23 Exec Budget

CHILDREN & FAMILY SERVICES
Budget Highlights

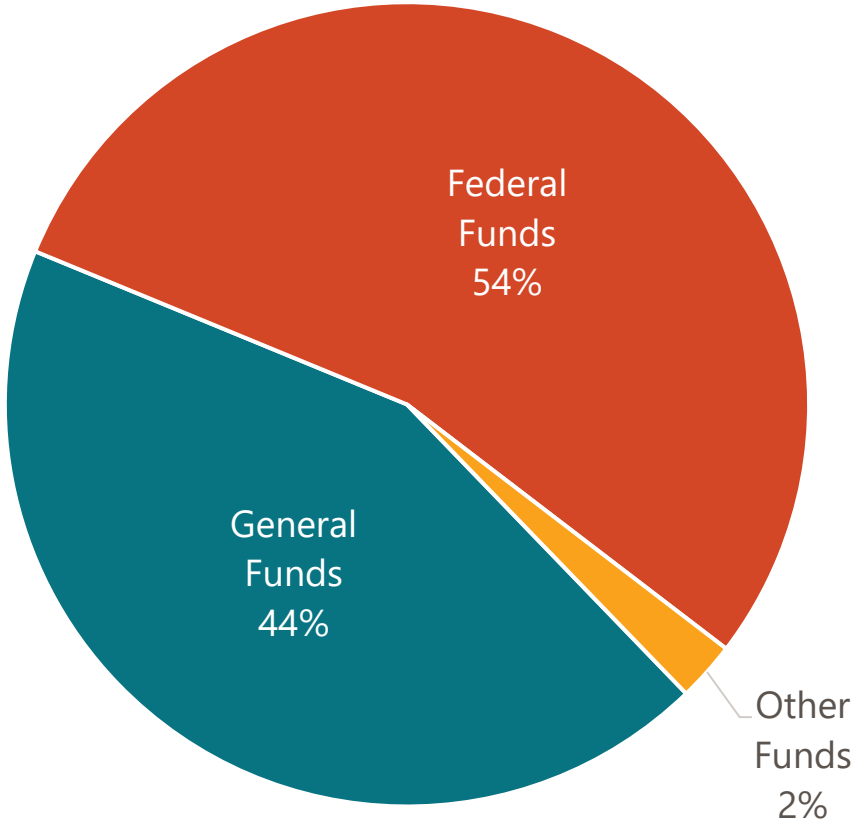


19-21 Budget **$181,171,041**

21-23 Budget (exec) **$165,637,720**

41.6 FTEs; no change in FTEs projected; $15.5 million decrease in total budget (7% of reduction is from federal funds)

- Reduce foster care and residential placements, accomplished in part by investing in evidence-based parent skill building and mental health services to families
- Implement equity in payments for services to families (QRTP, subsidized adoption, targeted case mgmt.)
- Investment in early childhood integrated data system
- Replacement of child welfare technology platform



21-23 Exec Budget

ECONOMIC ASSISTANCE
Budget Highlights

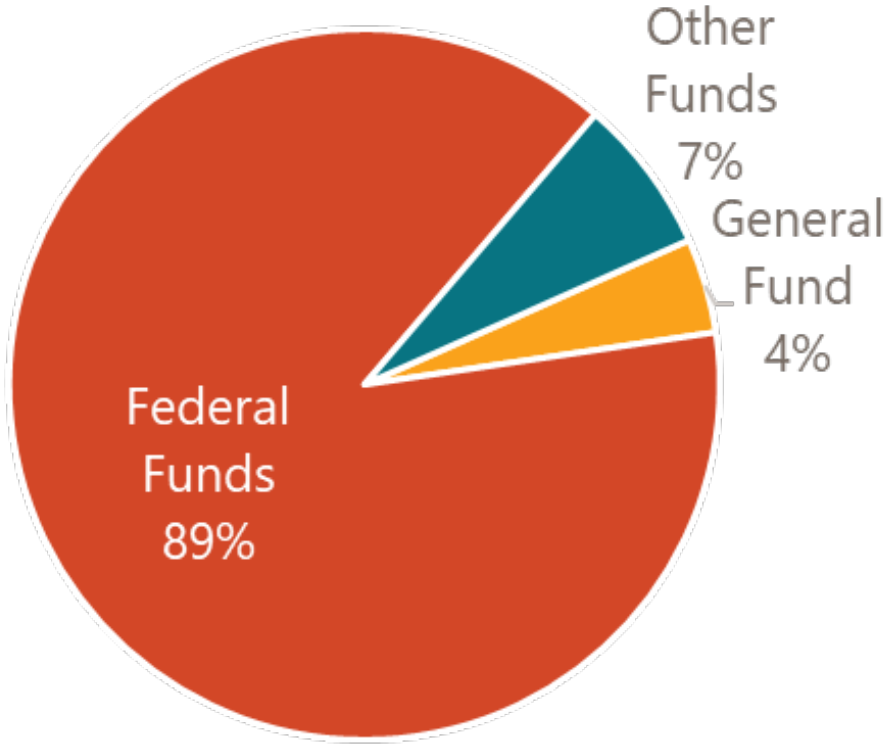


19-21 Budget **$259,846,264**

21-23 Budget (exec) **$274,998,084**

39.8 FTEs; no change in FTEs projected; $15.1 million increase in total budget (77% from federal funding)

- Complete the integration of LIHEAP into integrated eligibility platform
- Finish converting cases from legacy mainframe systems to SPACES
- Administer federal COVID relief funds for low and moderate income households
- Integrate department's housing assistance initiatives into the administration of economic assistance resources



21-23 Exec Budget

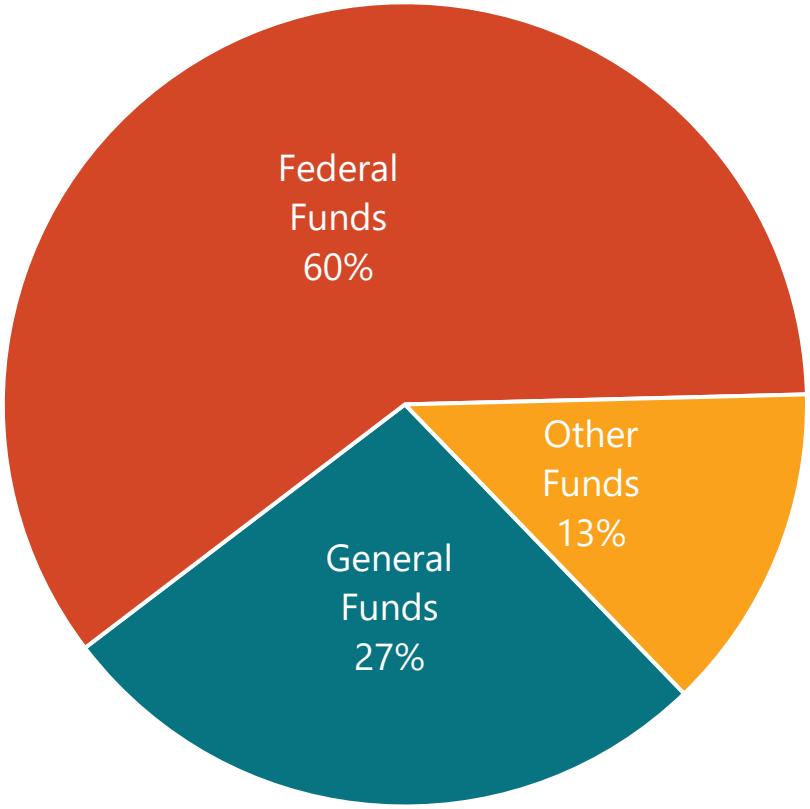
CHILD SUPPORT
Budget Highlights



19-21 Budget	**$29,805,507**
21-23 Budget (exec)	**$30,539,102**

157.7 FTEs; no change in FTEs projected; $733,595 increase in total budget (60% federal funds)

- Operating efficiencies related to travel and occupancy



21-23 Exec Budget

VOCATIONAL REHABILITATION SERVICES
Budget Highlights

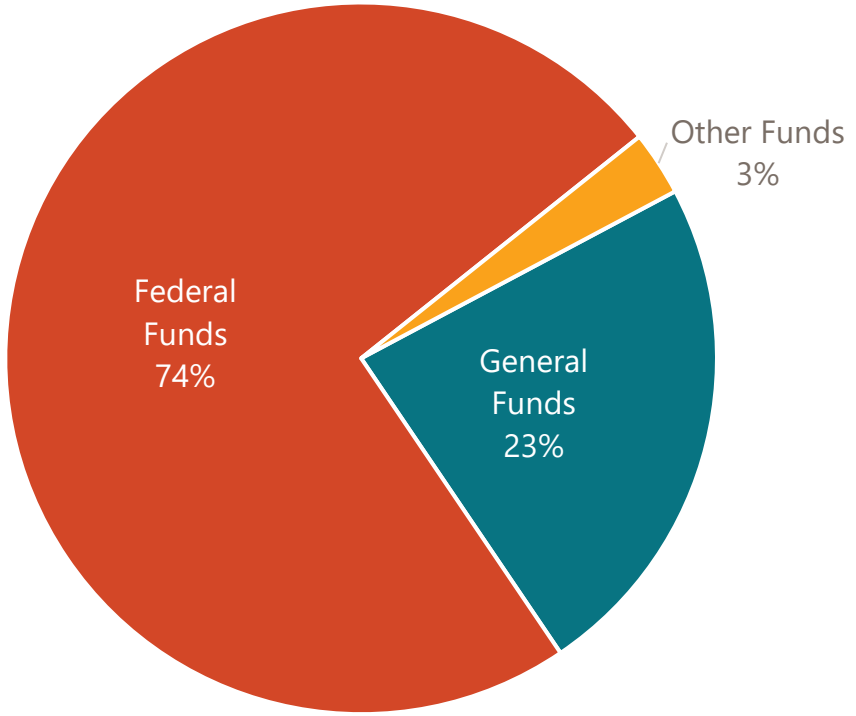


19-21 Budget **$31,853,039**

21-23 Budget (exec) **$30,528,323**

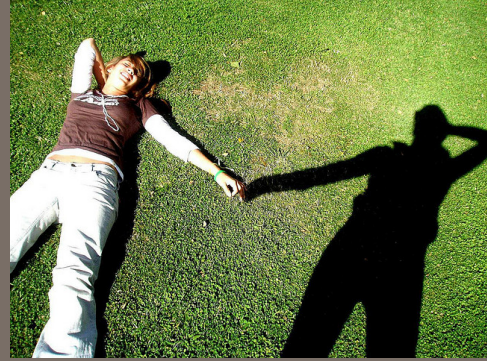
85 FTEs; no change in FTEs projected; $1.3 million decrease in total budget (0% federal funds)

- Operating efficiencies related to travel and occupancy
- Discontinuation of grant to private recreational facility



21-23 Exec Budget

BEHAVIORAL HEALTH
Budget Highlights

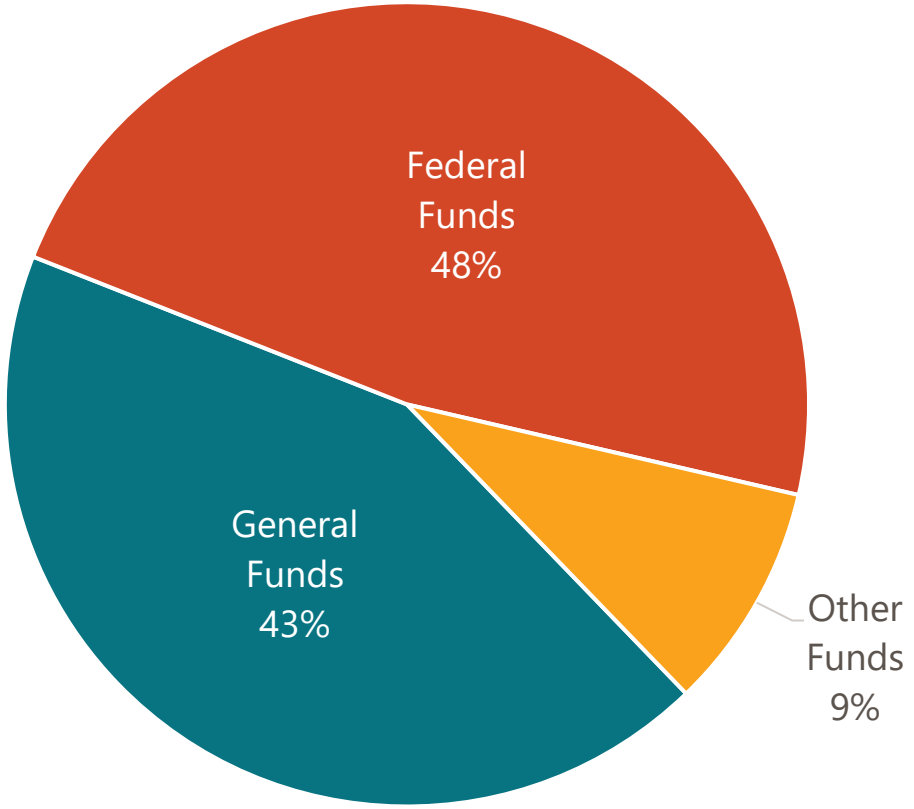


19-21 Budget **$72,069,770**

21-23 Budget (exec) **$85,003,305**

36 FTE; no change in FTEs projected; $12.9 million increase in total budget (0% of reduction from federal funds)

- Substance Use Disorder Voucher
- Expanded Free Through Recovery for non-justice involved families
- Behavioral Health in schools



21-23 Exec Budget

STATE HOSPITAL
Budget Highlights

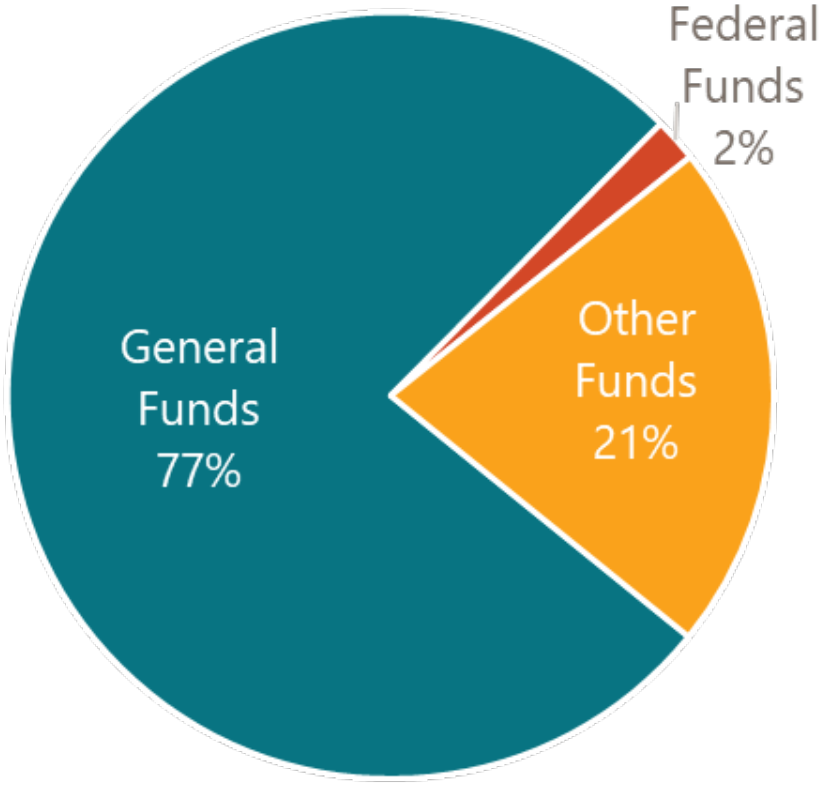


19-21 Budget **$68,801,489**

21-23 Budget (exec) **$65,954,923**

310.52 FTEs; includes reduction of 20.1 FTEs; $2.8 million budget reduction (19% in federal funds)

- Construction of new treatment campus, utilizing operating savings to retire debt service
  - Requires addition of 6-10 hospital beds in western North Dakota
  - Statutory authority to decline admissions when full
  - Reduction of state hospital inpatient services to 75 beds
- Various operating efficiencies at current campus
- Discontinuation of DOCR treatment contract



21-23 Exec Budget

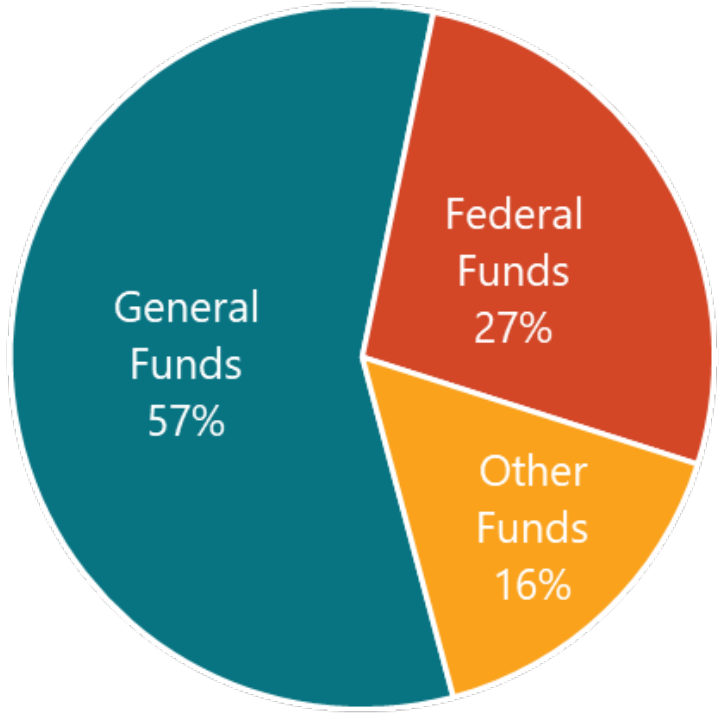
HUMAN SERVICE CENTERS
Budget Highlights



19-21 Budget	**$162,984,547**
21-23 Budget (exec)	**$167,518,311**

637.95 FTEs; no change in FTEs projected; $4.5 million budget increase (27% in federal funds)

- Operating efficiencies across the network of human service centers
- Reduction in various supported housing and employment contracts to facilitate a shift in payment from general fund to 1915i for services delivered to eligible individuals
- Program efficiencies involving transition of case aid and related service contracts



21-23 Exec Budget

HUMAN SERVICE ZONES
Budget Highlights

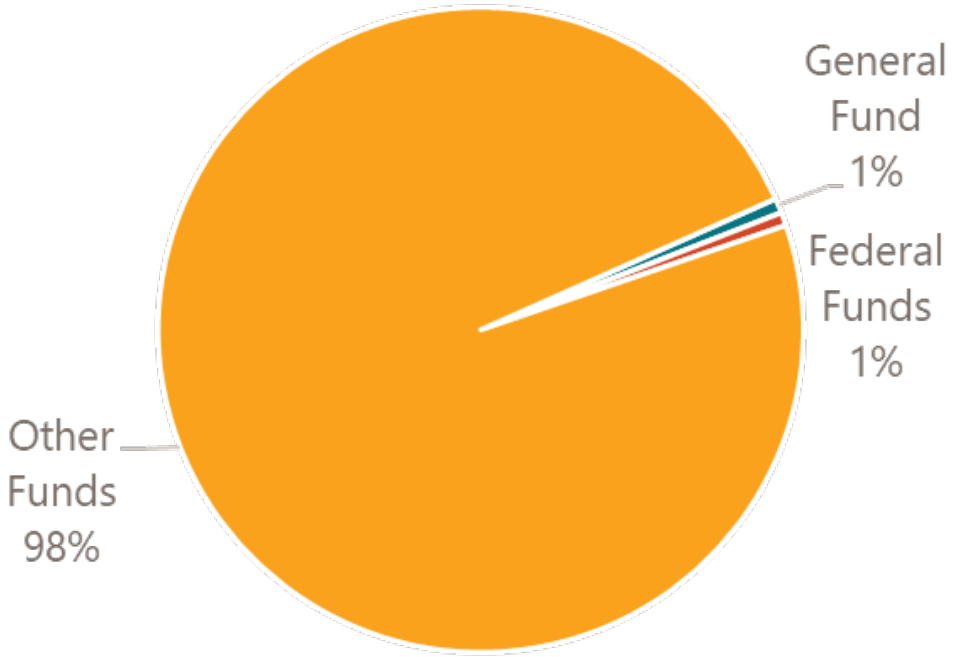


19-21 Budget **$173,700,000**

21-23 Budget (exec) **$177,158,738**

143 FTEs; includes 3 additional FTEs; $3.5 million increase in total budget (34% from federal funding)

- Adding authority to include targeted case management in HSZ budgets
- Redesign eligibility processes to improve customer experience and level workloads



21-23 Exec Budget

#7

Purpose and use of one-time funding items for current biennium

DHS ONE TIME FUNDING

Strategic infrastructure investments support delivery of service

One-Time Funding Description	2019-21	2021-23
Technology Projects	$13,785,658	$ 0
Capital Projects – Life Skills and Transition Center	4,277,165	0
Capital Projects – State Hospital	2,493,500	0
Medically Complex Children Provider Funding Adjustment	977,603	0
Hyperbaric Oxygen Therapy Grant	335,000	0
State Hospital Study	200,000	0
MMIS Modernization	0	35,000,000
Nursing Facility Payment Reform	0	7,200,000
Nursing Home Bed Buy Back	0	3,300,000
Frame/CCIPS Replacement	0	30,000,000
Total All Funds	$22,068,926	$75,500,000
Less Estimated Income	20,556,323	49,525,314
Total General Fund	$1,512,603	$25,974,686

#8

Identify and justify the need for any one time funding being requested / recommended

DHS ONE TIME FUNDING
Replacement of FRAME/CCWIPS

DIVISION
Children & Family Services

BUDGET AMOUNT
$30,000,000
- $15 M general fund
- $15 M federal funds

PURPOSE
Develop and deploy system to manage child protection, foster care, in-home supports to families, and adoption

Supports administrative efficiencies, retirement of mainframe, and requirements for continued federal program compliance



DHS ONE TIME FUNDING

Nursing Home Bed Buyback

DIVISION
Medical Services

BUDGET AMOUNT
$3,300,000
- $3.3 M general fund
- $0 M federal funds

PURPOSE
Right size and support nursing facilities due to COVID and other changes in state regarding HCBS.



DHS ONE TIME FUNDING

Nursing Home Payment Reform

DIVISION
Medical Services

BUDGET AMOUNT
$7,200,000
- $3.35 M general fund
- $3.85 M federal funds

PURPOSE
Modify the nursing home payment system to reward and promote efficiency and support renovation of properties



DHS ONE TIME FUNDING

State Hospital

DIVISION
State Hospital

BUDGET AMOUNT
$0

- $0 M general fund
- $0 M federal funds

PURPOSE
Build new treatment campus is Jamestown to replace aging infrastructure and realize operational savings; finance via public private partnership that applies operational savings to debt service



#9

Agency collections deposited in the general fund or a special fund, and anticipated changes from 2019-21

DHS AGENCY COLLECTIONS

Anticipating increase in fee for service collections at HSCs

2019-21
$20,556,323

2021-23
$26,659,485



$6.1 million

#10

Discuss need for other sections that are included or recommended to be included in agency appropriation bill

SECTIONS IN AGENCY BUDGET BILL

References support quality and efficient service delivery

1. Amendment to section 50-24.1-37 to extend Medicaid expansion and to transition administration of Medicaid expansion to DHS
2. Repeal section 50-24.1-18.1 relating to consumer-directed health maintenance service.
3. Nursing home bed reduction authorization and appropriation
4. Medicaid expansion and nursing home rates expenditures may not exceed appropriation language.
5. Develop a plan to implement health homes and report to legislative management
6. Exemptions to carry-over 2019-23 funds
7. Authorization to convey land at Life Skills and Transition Center and to enter into an agreement to lease state hospital land to the national guard
8. Capital projects and payment language, including authorization to construct a new state hospital
9. Provider process and outcome measures
10. A requirement to the department to establish a new rate setting process and requirements for qualified residential treatment providers

#11

Any other bills being considered by legislative assembly and their potential budgetary impact on agency

OTHER DHS-RELATED BILLS
As of 1-5-21

HB1015 – OMB's appropriation; guardianship grants

HB1034 – Preliminary treatment and involuntary treatment hearings

HB1035 – Juvenile Justice reform bill

HB1048 – Allowance for guardians to be required by Court to furnish a bond

HB1065 – Nursing home operating costs

HB1066 – Accreditation of Human Service Centers

HB1089 – Seclusion, restraint, and prohibition of shock treatment and aversive reinforcement

HB1090 – Nursing home rates

HB1091 – Use of ACH for foster care and shelter care payments

OTHER DHS-RELATED BILLS
As of 1-5-21

SB2004 – Dept of Health appropriation; prevention and behavioral health

SB2015 – DOCR's appropriation; Free Through Recovery / community behavioral health program

SB2082 – Transferring Child Support responsibilities from Court to Department

SB2083 – Child abuse and neglect

SB2084 – Involuntary treatment and emergency detention

SB2085 – Utilization of ACH for medical assistance providers

SB2086 – Operation and financing of Human Service Zones

SB2087 – Medical assistance prior authorization program

SB2088 – Adoption assistance and utilization of ACH for adoptive parents

SB2089 – DHS authority and housing stabilization

OTHER DHS-RELATED BILLS
Un-assigned bills (DHS pre-filed)

- Bill relating to the repeal of section 50-06-32.1 regarding autism spectrum disorder voucher program; and
- Bill relating to the remedial eye care (within limits of legislative appropriation) and Medicaid waivers – In-home services (extending the waiver by two additional years - up to the age of sixteen).

#12

Impact of any budget changes made to meet the Governor’s budget guidelines

2021-2023 Budget Development Framework

DHS asked to provide a 15% reduction in general fund spending

Identified total of $218 million in reductions to achieve targeted general fund savings
- 30% general fund
- 70% federal/other





Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being

21-23 Executive Budget

- Reduced utilization of out-of-home placements, including foster care
- Utilize and support Kinship care for at-risk kids
- Redesign child welfare processes to incorporate improved safety planning practices
- Intensive in-home and evidence-based behavioral health supports for kids and families
- Care coordination for families struggling with mental health and substance abuse
- Optimize opportunity for Title IV-E to become a means to upstream reinvestment
- Substance Use Disorder voucher
- Free Through Recovery



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment

21-23 Executive Budget

- Integrate data sets to facility decision making via Early Childhood Integrated Data System
- Evidence based in-home support for young families through Families First Prevention Plan implementation
- Maintenance of state investment in infant development and early intervention services for children with developmental delays
- Maintenance of child care inclusion specialists to support access to child care for children with special needs



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

21-23 Executive Budget

- Connect in-reach/out-reach with timely follow up to connect individuals to services that can be provided outside of institutional settings
- Centralized intake for home and community based services
- Develop non-institutional residential options for behaviorally complex and medically fragile children and adults
- Build HCBS provider capacity for private pay, MA, waivers and SPED
- Streamline provider enrollment processes
- Connect housing and support services to create scattered site supported housing
- Integrate Social Determinants of Health into Medicaid model via 1915i and other Medicaid

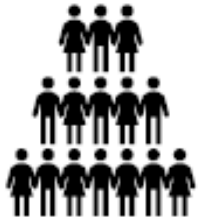


Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service

21-23 Executive Budget

- Re-design eligibility model from policy through determination, focusing on the systemic changes that will improve both access and quality
- Incorporate Tech Dependent and Autism waivers into existing MA framework
- Re-focus HSCs as Community Behavioral Health
- Create focused TANF statewide eligibility team
- Embed HSC behavioral health staff in community settings
- Replace technology platform that supports child welfare and child protective services
- Invest in modernization of MMIS
- Integrate LIHEAP into integrated eligibility platform



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

21-23 Executive Budget

- Reduce our agency's physical footprint
- Integrate person-centered practices into DHS administrative framework
- Increase Leadership Everywhere by 50%,
- Deploy Gallup Employee Engagement Survey and improve scores by .25 in the second year
- Develop DHS Succession plan



Safety Net Services & System Supports

- Operate Medicaid as public health insurance provider
- Deliver behavioral health services to hardest-to-serve populations
- Support service delivery infrastructure
- Administer federal programs, contracts and payment systems

21-23 Executive Budget

- Administer programs that are delivered privately via contract
- Reform Long Term Care payment system to create incentives toward home and community-based services
- Shift contractual services to 1915i
- Transition administration of Medicaid Expansion to DHS
- Reduce extended services contracts
- Rate and payment adjustments for PACE services, telehealth, targeted case management, and I/D Disability services
- Eliminate PCCM provider payment
- Quality Initiative in Medicaid fee for service

#13

One-page itemized listing of changes your agency is requesting the committee make to the executive recommendation

CHANGES FROM EXECUTIVE BUDGET RECOMMENDATION

Adjustments

N/A

We anticipate that there will be adjustments needed as we move through the budget process.

#14

Comparison of agency Optional Adjustment Requests to those recommended in executive budget

OPTIONAL ADJUSTMENT REQUESTS
Comparison of proposed and approved

	To OMB				Executive Budget			
IBARS Description	FTE	General	Federal	Other	FTE	General	Federal	Other
15% Savings		(63,335,882)	(155,923,691)	(467,184)		(55,084,020)	(101,024,656)	(467,184)
5% Other funds reprioritization decrease				(2,429,283)				(2,429,283)
5% Other funds reprioritization increase				2,429,283				2,429,283
Nursing Home Bed Buy Back		6,000,000				3,300,000		
Nursing Facility Payment Reform		3,348,000	3,852,000			3,348,000	3,852,000	
Increase Supervision rate (in State Plan)		566,683	651,991					
Building Maintenance - Heat Pump Replacement		455,000						
Building Maintenance - Base Energy Management System		453,600						
Building Maintenance - Carpet Replacement		269,000						
Building Maintenance - Lighting Retrofit		116,000						
Sex Offender		917,004				917,004		
Duct Cleaning - All Patient Care Buildings		605,000						
Roof - New Horizons Building		575,000						
Door Upgrades/Card Access - LaHaug Building		105,000						
SUD Voucher		9,000,000				9,000,000		
MMIS Module replacement		4,326,686	30,673,314			4,326,686	30,673,314	
New State Hospital		3,366,000						
Early Childhood Integrated Data System (ECIDS)		500,000				500,000		
VAPS Workers from contract to state	6	163,959			(6)			
HCBS Case Management/ ADRL staff	3			498,673	3			498,673
FRAME/CCWIPS Replacement		18,000,000	18,000,000			15,000,000	15,000,000	
Random Moment Time Study (RMTS) system		150,000						
Contract, Payment, and Reporting System		2,000,000						
Inflation for Providers						13,883,837	14,417,097	
Inflation for Employee Compensation		(6,139,260)	2,412,077	12,846,105		2,598,447	4,703,702	13,202,364
Total	9	111,027,839	136,578,541	(39,893,596)	(3)	102,792,972	205,560,725	(15,544,546)

Executive Budget fully supported
Executive Budget partially supported
Executive Budget did not support
Executive Budget supported, adjustment for timing
Fully supported in OMB budget

#15

Amount of federal funding available to agency related to COVID-19 pandemic, actual amount spent and for what purpose

FEDERAL FUNDS AVAILABLE TO DHS FOR COVID RESPONSE

Topical summary of emergency assistance to support basic needs

Child Care

Child Care Em Op Grnt	$48.9 MM (CRF)
Child Care Assistance	$6 MM (CCDBG-CV)

Behavioral Health

Mental Health Grant	$2 MM (SAMHSA)
Crisis Counseling	$1.1MM (SAMHSA)
Community BH	$1.7 MM (CRF)
HSC/Rural	$3.5 MM

Food Assistance

P-EBT	$10 MM (USDA-CV)
P-SNAP	$25.7 MM (USDA FNS)
Sr Meals	$3.6 MM (OAA-CV)
Sr Meals	$1.1 MM (CRF)
Food Bank	$430k (FEMA)

Housing

ERB	$2.9 MM (CRF)
Homeless Coord	$xxx
Rent Assistance	$6.5 MM (CDBG-CV)

Energy Assistance

P-LIHEAP	$5.2 MM (ACF)

Child Welfare

IV-E FMAP	$2.5 MM (ACF)
Violence Prev	$80k
CW Svcs	$76k

Medical Services

FMAP	$85 MM (CMS)
Family caregiver	$500k

Aging Services

Fam Caregiver	$500k
ADRL ACL	$305k
Supportive svc	$1 MM
Ombudsman	$100k
Sr Employ	$889k (SECEP)
SNF Air Pur	$2.6 MM (CRF)

Ops & PPE

Connect Karts	$100k (CRF)
QSP PPE	$50k (CRF)
SNAP Access	$250k (CRF)
Data tools/Ops	$3.5 MM (CRF)

Total Available	**$215,678,868**
Total Spent	**$142,181,611**
(thru 12/21/20)	

DHS COVID RELATED FEDERAL AWARDS & EXPENSE (thru 12-21-20)

Majority of unspent funds as of 12-21-20 related to authorized FMAP

Subdivision	Program	Federal Award/EC Approval	Paid as of 12/21/2020	Notes
Aging Services	Supportive Services	1,000,000	312	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	1,200,000	1,195,618	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	2,400,000	2,385,440	Project period ends 9/30/2021
Aging Services	Family Caregiver Support Program	500,000	460,574	Project period ends 9/30/2021
Aging Services	ADRL ACL Grant	305,454	41,094	Project period ends 9/30/2021
Aging Services	Ombudsman Program	100,000	62,388	Project period ends 9/30/2021
Aging Services	Senior Community Services Employment Program (SCSEP)	889,285	-	Project period ends 12/31/2022
Aging Services	Coronavirus Relief Funds from OMB: Nutrition Services	1,131,800	1,001,729	Coronavirus Relief Funds
Behavioral Health	Emergency Grant to Address Mental & Substance Use Disorders COVID-19 (SAMHSA)	2,000,000	135,136	Project period ends 8/19/2021
Behavioral Health	Crisis, Counseling, and Training Program (SAMHSA)	835,629	-	Project period ends 6/8/2021
Behavioral Health	Crisis Counseling Assistance and Training Program Grant, ISP	251,053	226,738	Project period ends 9/7/2020
Behavioral Health	Coronavirus Relief Funds from OMB: Community-based behavioral health services	1,700,000	-	Coronavirus Relief Funds
Children and Family Services	FMAP IV-E Foster Care & Sub Adopt	2,500,000	1,412,772	Paid is through 9/30/2020 - 6.2% increase
Children and Family Services	Family Violence Prevention and Services Grant	79,837	-	Project period ends 9/30/2021
Children and Family Services	Child Welfare Services State Grant	76,858	-	Project period ends 9/30/2021
Economic Assistance	SNAP - School Meals USDA Replacement	10,058,706	9,543,681	Paid is through Nov. 2020
Economic Assistance	SNAP Increased Benefits	25,752,708	23,795,212	Paid is through Nov. 2020
Economic Assistance	Child Care Development Fund (CCDF)	6,037,905	-	Project period ends 9/30/2023
Economic Assistance	Low Income Home Energy Assistance Program (LIHEAP)	5,176,454	2,144,286	Project period ends 9/30/2021
Economic Assistance	FEMA Share: Great Plains Food Bank pass through	430,200	464,670	FEMA is open ended during the declared emergency
Economic Assistance	Emergency Rent Bridge (Community Development Block Grant)	6,534,942	6,919	Awarded to Department of Commerce
Economic Assistance	Coronavirus Relief Funds from OMB: Childcare Emergency Operating Grant (CEOG)	48,850,000	46,758,287	Coronavirus Relief Funds
Economic Assistance	Coronavirus Relief Funds from OMB: Emergency Rent Bridge (Dept. ID 3080)	2,900,000	2,738,939	Coronavirus Relief Funds
HSC/Institution	Rural Stimulus Payment	3,445,927	1,875	
Management	Coronavirus Relief Funds from OMB: HVAC Air Purification systems for Skilled Nursing Facilities	2,600,000	738,387	Coronavirus Relief Funds
Medicaid Grants	FMAP for Traditional Medicaid, Long-Term Care, and Developmental Disabilities	85,000,000	47,520,244	Paid is through 9/30/2020 - 6.2% increase
Department of Human Services	Coronavirus Relief Funds from OMB: Human Service Zones expenses, agency PPE and telework expenses, temporary staff, Connect Karts, Consultants, LTC portable air purifiers, QSP PPE grants, Grocer EBT Grant, Great Plain Food Bank, Telehealth upgrades	3,922,111	1,477,906	Coronavirus Relief Funds
Department of Human Services	FEMA Share: Agency Expenses	-	69,403	FEMA is open ended during the declared emergency
		215,678,868.99	142,181,611	

Final award different than estimated award approved by Emergency Commission and Budget Section

#16

Additional Information



DHS Invests in People

Human services is the infrastructure of well being.

Human services can help people realize their full potential.

Our communities are stronger when <u>all</u> people can realize their full potential.

NORTH Dakota | Human Services

Be Legendary.™

Appendix

DHS Division Budget Summary Tables

MEDICAL SERVICES – LONG TERM CARE
Budget Summary

Description	Budget 2019-2021	Increase/ (Decrease)	Executive Budget 2021-2023
Grants	853,200	(330,000)	523,200
Medical Grants	736,510,531	85,531,242	822,041,773
Total	**737,363,731**	**85,201,242**	**822,564,973**
General Fund	377,567,931	26,612,730	404,180,661
Federal Funds	356,199,438	61,872,874	418,072,312
Other Funds	3,596,362	(3,284,362)	312,000
Total	**737,363,731**	**85,201,242**	**822,564,973**
Full Time Equivalent (FTE)	0.00	0.00	0.00

MEDICAL SERVICES – TRADITIONAL AND EXPANSION

Budget Summary

Description	2013-2015 Appropriation	2015-2017 Appropriation	2017-2019 Appropriation	2019-2021 Appropriation	Changes	2021-2023 Executive Budget
Salary and Wages	9,361,167	11,006,399	9,217,240	17,631,821	798,183	18,422,004
Operating	39,355,085	44,241,160	53,320,237	48,290,789	8,712,126	57,002,915
Grants						
Medical Grants	806,717,552	1,215,896,867	1,303,690,959	1,352,417,879	(12,341,840)	1,340,076,039
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
General Fund	289,891,636	313,547,595	284,162,440	342,465,788	35,847,622	378,194,515
Federal Funds	514,107,184	914,467,704	962,268,730	977,292,683	(24,294,880)	952,997,802
Other Funds	51,434,984	43,129,127	119,797,266	98,574,018	(14,265,377)	84,308,641
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
Full Time Equivalent (FTE)	**59.50**	**59.50**	**48.00**	**86.50**	**12.00**	**98.50**

AGING & ADULT SERVICES

Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	7,531,996	1,115,342	8,647,338
Operating	20,507,197	1,178,638	21,685,835
Grants	3,175,102	944,491	4,119,593
Total	31,214,295	3,238,471	34,452,766
General Fund	12,128,232	297,546	12,425,778
Federal Funds	18,109,325	3,171,725	21,281,050
Other Funds	976,739	(230,800)	745,938
Total	31,214,295	3,238,471	34,452,766
Full Time Equivalent (FTE)	44.00	0.00	44.00

DEVELOPMENTAL DISABILITIES
Budget Summary

	2019-2021Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	21,041,554	2,147,049	23,188,603
Operating	8,402,117	(562,834)	7,839,283
Capital	10,000	-	10,000
Grants	672,928	(150,000)	522,928
DD Grants	658,889,923	48,819,082	707,709,005
Total	689,016,522	50,253,297	739,269,819
General Fund	336,131,217	8,629,327	344,760,545
Federal Funds	352,885,305	41,623,970	394,509,274
Other Funds	-	-	-
Total	689,016,522	50,253,297	739,269,819
Full Time Equivalent (FTE)	125.87	0.99	125.87

LIFE SKILLS TRANSITION CENTER
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	48,807,542	(8,851,333)	39,956,209
Operating	9,141,275	(1,324,010)	7,817,265
Capital	846,131	0	846,131
Total	58,794,948	(10,175,343)	48,619,605
General Fund	29,426,161	(7,777,688)	21,648,473
Federal Funds	26,880,105	(2,430,575)	24,449,530
Other Funds	2,488,682	32,920	2,521,602
Total	58,794,948	(10,175,343)	48,619,605
Full Time Equivalent (FTE)	322.84	(14.50)	308.34

CHILDREN AND FAMILY SERVICES

Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	8,346,639	153,632	8,500,271
Operating	6,531,727	396,770	6,928,497
Grants	166,292,675	(16,083,723)	150,208,952
Total	181,171,041	(15,533,321)	165,637,720
General Fund	87,651,918	(15,698,254)	71,953,664
Federal Funds	88,707,220	1,028,817	89,736,037
Other Funds	4,811,903	(863,884)	3,948,019
Total	181,171,041	(15,533,321)	165,637,720
Full Time Equivalent (FTE)	41.60	0	41.60

ECONOMIC ASSISTANCE
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	6,777,828	750,224	7,528,052
Operating	10,183,362	(129,940)	10,053,422
Grants	242,885,074	14,531,536	257,416,610
Total	259,846,264	15,151,820	274,998,084
General Fund	8,605,617	3,256,938	11,862,555
Federal Funds	231,997,094	11,701,119	243,698,213
Other Funds	19,243,553	193,764	19,437,317
Total	259,846,264	15,151,820	274,998,084
Full Time Equivalent (FTE)	39.80	0.0	39.80

CHILD SUPPORT
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	25,753,469	1,250,677	27,004,146
Operating	4,052,038	(517,082)	3,534,956
Total	29,805,507	733,595	30,539,102
General Fund	8,088,500	117,317	8,205,817
Federal Funds	17,605,475	704,203	18,309,678
Other Funds	4,111,532	(87,925)	4,023,607
Total	29,805,507	733,595	30,539,102
Full Time Equivalent (FTE)	157.70	0	157.70

VOCATIONAL REHABILITATION
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	14,101,052	687,464	14,788,516
Operating	7,533,223	(144,686)	7,388,537
Grants	10,218,764	(1,867,494)	8,351,270
Total	31,853,039	(1,324,716)	30,528,323
General Fund	9,308,268	(2,024,678)	7,283,590
Federal Funds	22,370,770	678,961	23,049,731
Other Funds	174,001	21,001	195,002
Total	31,853,039	(1,324,716)	30,528,323
Full Time Equivalent (FTE)	85.00	0.00	85.00

BEHAVIORAL HEALTH
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	6,317,092	745,543	7,062,635
Operating	48,314,144	1,523,449	49,837,593
Grants	17,438,534	10,664,543	28,103,077
Total	72,069,770	12,933,535	85,003,305
General Fund	21,655,789	15,075,517	36,731,306
Federal Funds	42,723,467	(2,236,632)	40,486,835
Other Funds	7,690,514	94,650	7,785,164
Total	72,069,770	12,933,535	85,003,305
Full Time Equivalent (FTE)	36.00	0.00	36.00

STATE HOSPITAL
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries	55,100,672	(1,670,825)	53,429,847
Operating	12,367,468	(1,195,691)	11,171,777
Capital	1,333,349	19,950	1,353,299
Total	68,801,489	(2,846,566)	65,954,923
General Fund	48,936,041	1,594,398	50,530,439
Federal Funds	1,759,125	(543,618)	1,215,507
Other Funds	18,106,323	(3,897,346)	14,208,977
Total	68,801,489	(2,846,566)	65,954,923
Full Time Equivalent (FTE)	330.62	(20.10)	310.52

HUMAN SERVICE CENTERS
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	117,595,353	6,901,854	124,497,207
Operating	16,435,561	(969,915)	15,465,646
Capital	80,000	$0	80,000
Grants	28,873,633	(1,398,175)	27,475,458
Total	162,984,547	4,533,764	167,518,311
General Fund	104,546,617	(8,374,845)	96,171,772
Federal Funds	40,391,387	4,295,666	44,687,053
Other Funds	18,046,543	8,612,944	26,659,487
Total	162,984,547	4,533,764	167,518,311
Full Time Equivalent (FTE)	637.95	0	637.95

HUMAN SERVICE ZONES
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries & Benefits	24,186,261	2,934,741	27,121,002
Operating	4,621,303	(432,414)	4,188,889
Grants	144,892,436	956,411	145,848,847
Total	173,700,000	3,458,738	177,158,738
General Fund	0	1,323,223	1,323,223
Federal Funds	0	1,176,874	1,176,874
Other Funds	173,700,000	958,641	174,658,641
Total	173,700,000	3,458,738	177,158,738
Full Time Equivalent (FTE)	140	3	143

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/11/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 9:00 a.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- DHS Overview
- Child Support Budget
- Vocational Rehabilitation Eligibility
- Disability Determination Statistics

Rep Jon Nelson (9:03 am) introduced the bill

Chris Jones, DHS (9:13 am) testified about strategy and overview #1149

Jessica Thomasson, DHS Policy Director (9:27 am) testified about DHS overview #1149

Jim Fleming (9:50 am) testified about child support budget overview #1151

Damian Schlinger, Vocational Rehab (11:15 am) testified about vocational rehab budget overview #1150

Sheri Seil, Disability Determination Services (11:46 am) testified about DDS Budget Overview #1152

Chair Nelson closed the hearing at 12:03 p.m.
Cole Fleck, Committee Clerk

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Presentation to House Appropriations Committee

Chris D. Jones, Executive Director

January 7, 2021 #1149

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

#1

DHS in NDCC, with major statutory responsibilities

DHS AUTHORITY ESTABLISHED IN NDCC 50-06

Administration of human services programs related to:

- Children and families
- Individuals with developmental disabilities
- Aging services
- Behavioral health
- Economic assistance
- Medical service
- General assistance
- Child support

CHAPTER 50-06
DEPARTMENT OF HUMAN SERVICES

50-06-01. Definitions.
As used in this chapter, unless the context otherwise requires:

1. "Behavioral health" means the planning and implementation of preventive, consultative, diagnostic, treatment, crisis intervention, rehabilitative, and suicide prevention services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions.
2. "Behavioral health provider" means any licensed or accredited behavioral health provider in this state.
3. "Department" means the department of human services.
4. "Human services" means:
   a. A service or assistance provided to an individual or an individual's family in need of services or assistance, including child welfare services, economic assistance programs, medical services programs, and aging services programs, to assist the individual or the individual's family in achieving and maintaining basic self-sufficiency, including physical health, mental health, education, welfare, food and nutrition, and housing.
   b. A service or assistance provided, administered, or supervised by the department in accordance with chapter 50-06.
   c. Licensing duties as administered or supervised by the department or delegated by the department to a human service zone.

50-06-01.1. Department of human services to be substituted for public welfare board of North Dakota and social service board of North Dakota, members of board, and executive director.

When the terms "public welfare board of North Dakota", "social service board of North Dakota", "executive director of the public welfare board", "executive director of the social service board", "member of the public welfare board", or "member of the social service board", or any derivative of those terms which, when used in context indicates an intention to refer to those persons or that board, appear in the North Dakota Century Code, the term "department of human services", or the term "executive director of the department of human services", as the case may be, must be substituted therefor. It is the intent of the legislative assembly that the department of human services must be substituted for, shall take any action previously to be taken by, and shall perform any duties previously to be performed by the public welfare board of North Dakota or by the social service board of North Dakota.

#2

Purpose of Agency divisions, including organizational chart

DHS Mission and Operating Principles

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

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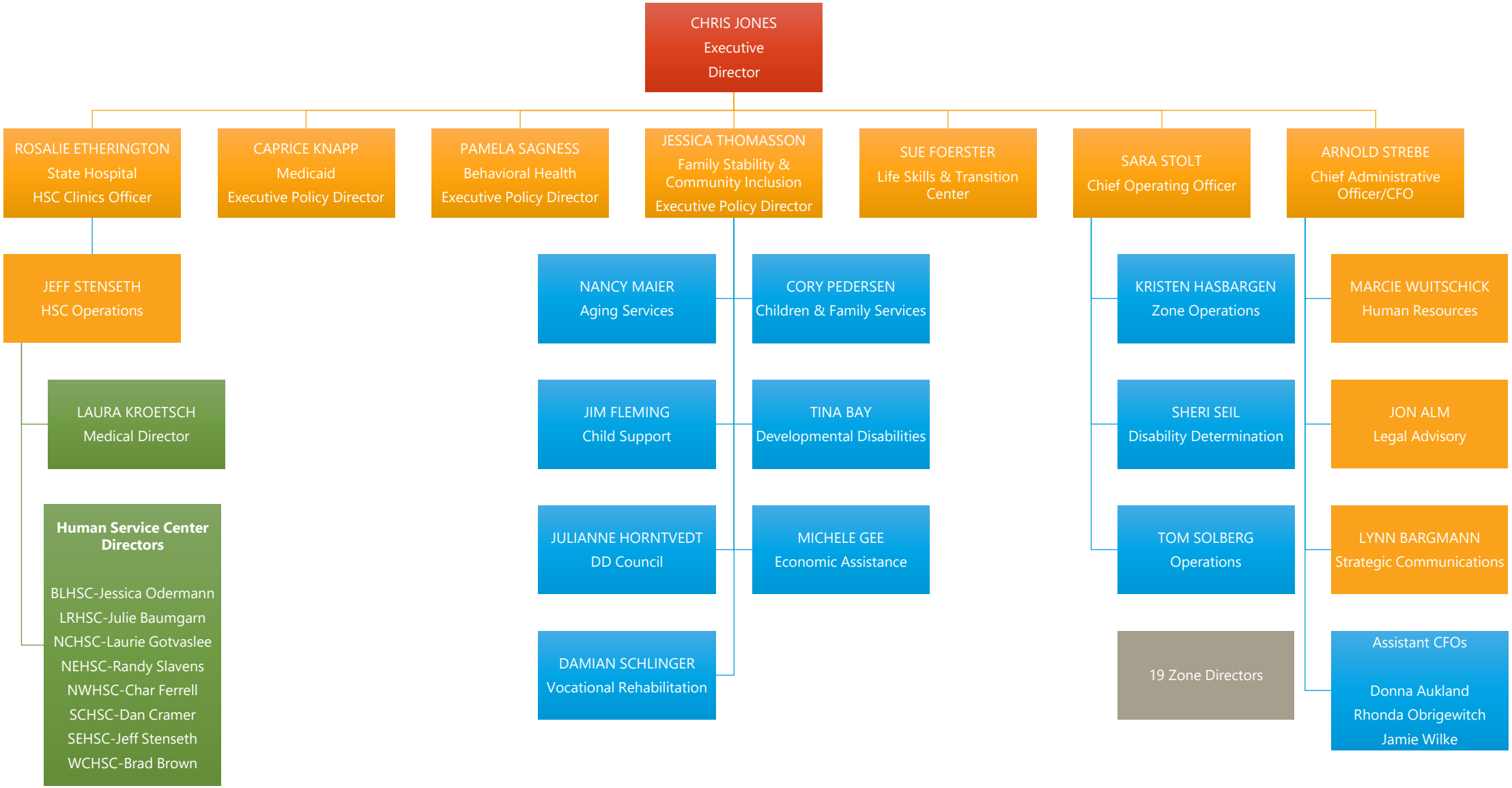
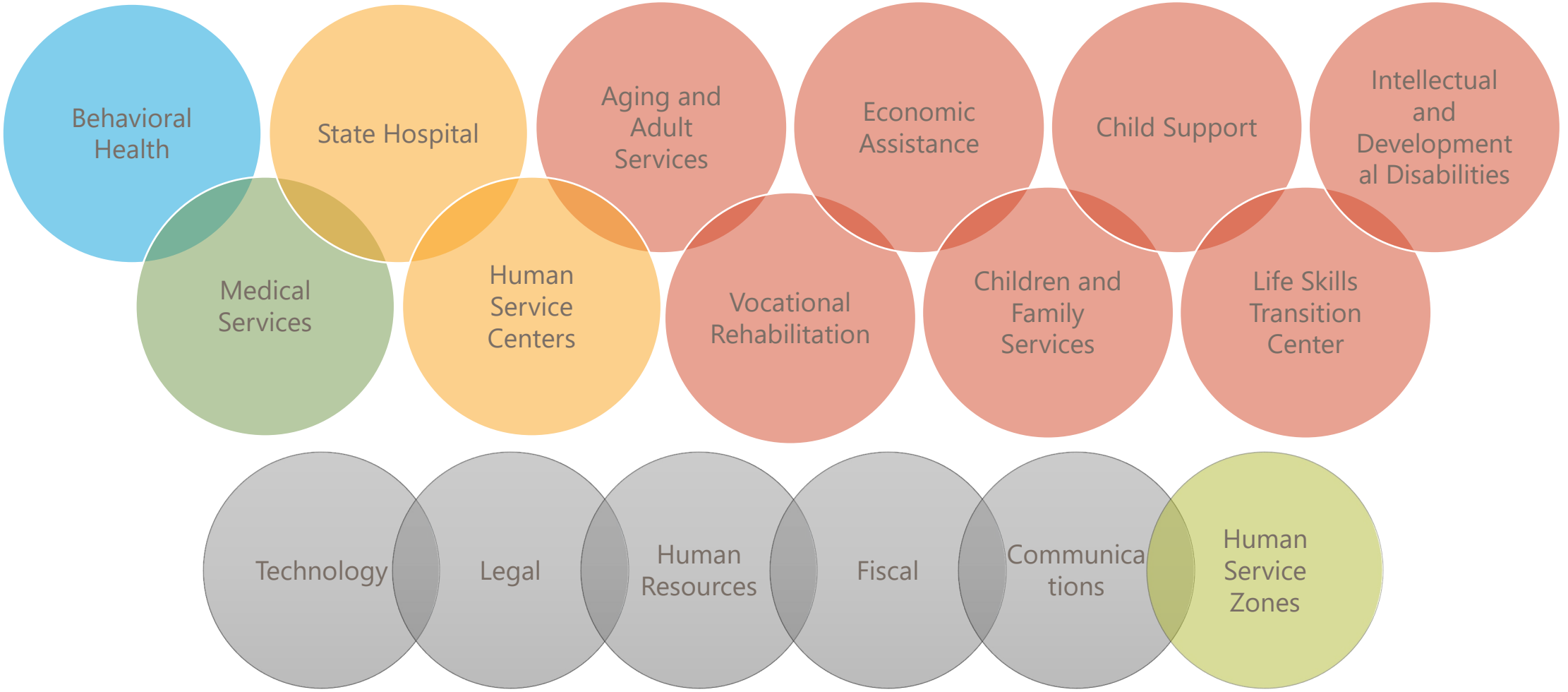


ND DEPARTMENT OF HUMAN SERVICES

Helping North Dakotans realize their potential through targeted, evidence-based interventions that deliver meaningful results



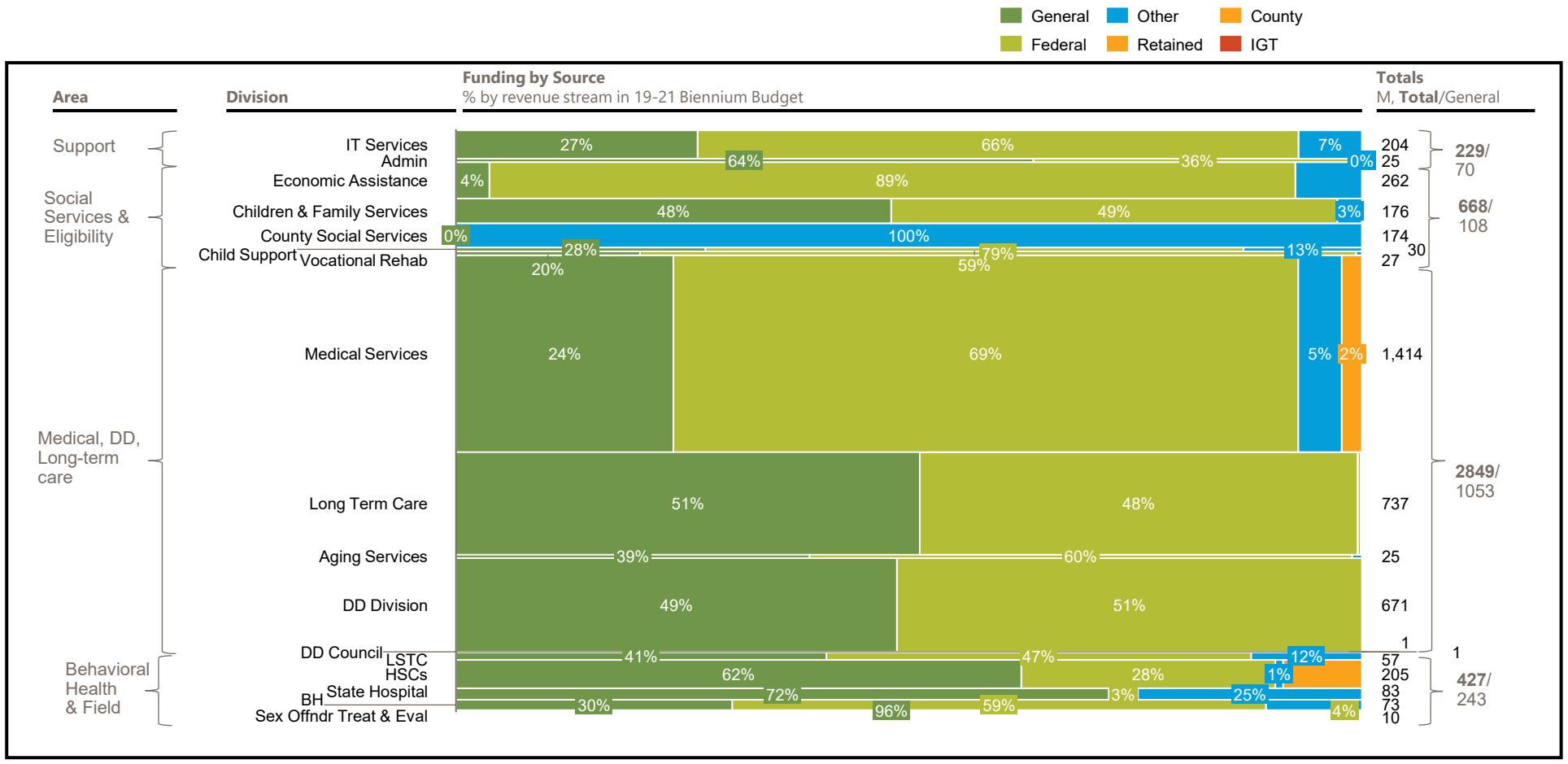
2021-2023 EXECUTIVE BUDGET

Total budget by agency / group



DHS BY FUNCTIONAL AREA

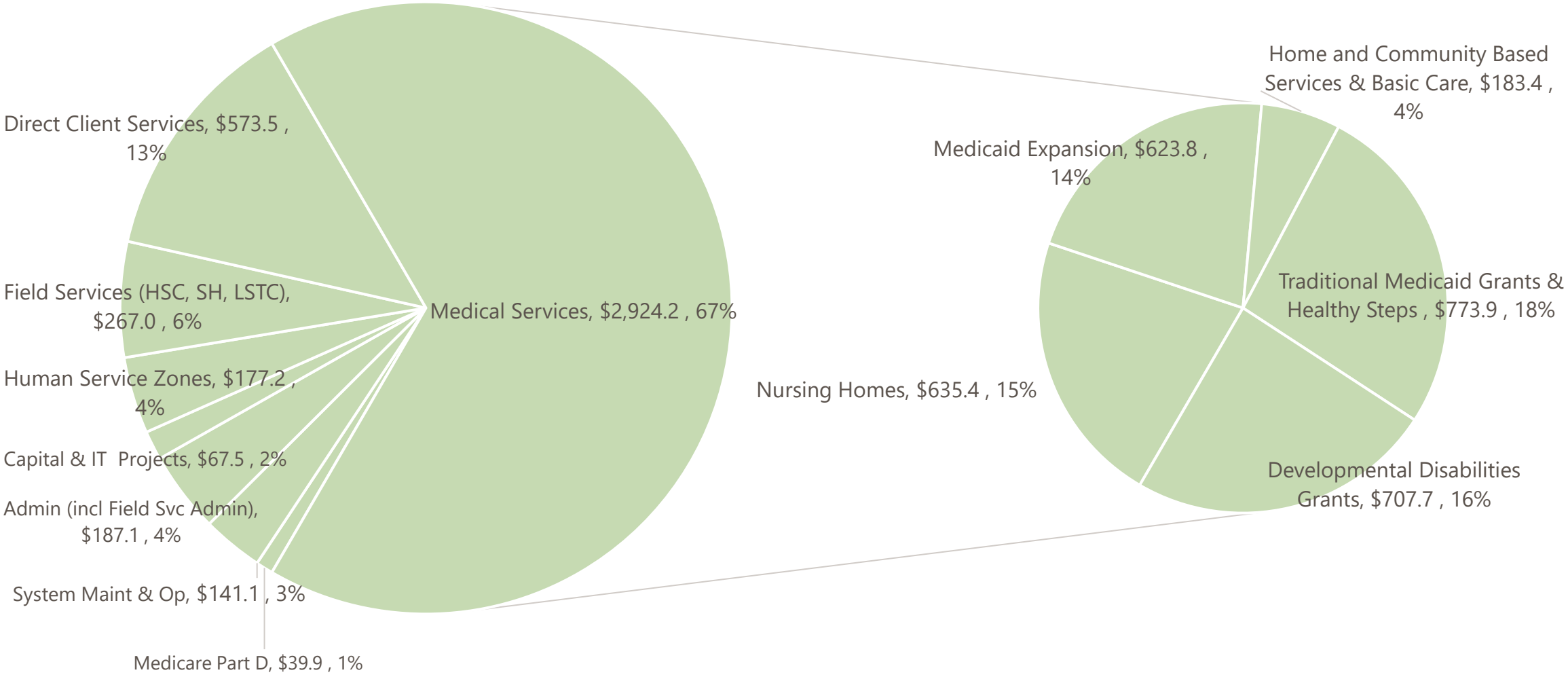
The majority of DHS funds are spent on medical, DD, & long-term care services



March 2020

2021-2023 EXECUTIVE BUDGET DHS

Total budget $4.378 billion, by category of expenditure



Direct Client Services include Economic Assistance Programs, Child Welfare Programs, and grants and service contracts for Aging, Behavioral Health, Vocational Rehabilitation, Medical Services, and Developmental Disability.

#3

Financial Audit findings and corrective actions

SFY19 AUDIT OF DHS
Findings and Programmatic Recommendations

MEDICAID AND SNAP

- Payments After Death. Ensure payments are not made for the benefit of deceased individuals. *New system to be implemented April 2021*
- Child Care Correction Orders Not Resolved. Improve procedures to ensure child care correction orders are resolved at the end of each allowed correction period. *Updated tracking system; new early childhood database to be implemented April 2021*
- Not monitoring child care facilities with MOUs. Perform additional monitoring of child care providers to ensure compliance with memorandum of understanding agreements. *Department no longer uses MOUs*

CHILD PROTECTION SERVICES

- Failure to timely contact suspected victims of child abuse and neglect. Ensure timely face-to-face contact with suspected victims of child abuse and neglect. *Redesign of CPS in process*
- Not performing quality assurance for child protection svc. Ensure consistent and complete quality assurance procedures surrounding reports of child abuse and neglect, investigations, and decisions. *Redesign of QA for CPS implemented Dec 2019; regional field specialists joined QA efforts SFY20*
- Confirmed child abusers not listed on index. Ensure individuals with confirmed child abuse or neglect are properly listed on the Child Abuse and Neglect Index. *Implemented new system reporting March 2019*

OTHER RESULTS

- Financial errors. Strengthen procedures surrounding the CAFR reporting process to ensure accurate amounts are reported to the Office of Management and Budget. *Continued collaboration with OMB and SAO.*
- Medicaid drug rebate system errors. Strengthen controls surrounding the Drug Rebate and Analysis Management System (DRAMS) to ensure receivables balances are properly calculated and interest is properly calculated for overdue drug rebate balances. *System updates in process*

#4

Current Biennium accomplishments and challenges; next biennium goals and plans

DHS 19-21 BIENNIUM ACCOMPLISHMENTS

Optimizing Return on Investment by helping avoid crises

- North Dakotans now receive 50 percent of their behavioral health services from a human service center within a community versus a clinic setting.

Behavioral Health Embedded in Community



- Over the last year, behavioral health clients who received services at a human service center experienced a 53 percent reduction in arrests.

Positive Results from Effective Treatment Delivery



- North Dakotans now have access to 24/7 mobile crisis response. We've provided 5,628 crisis services in the last year, with crisis psychotherapy and triage services doubling in the last three months.

24/7 Crisis Response



- Since updating eligibility criteria for home and community-based services in January 2020, 730 individuals have been able to access services in their home, which is a 25 percent increase from CY2019.

Increased community services to older adults



- We've provided increased access to Medicaid services for pregnant women (increased eligibility from 138 percent to 147 percent of poverty) and children with disabilities (from 225 percent to 250 percent of poverty).

More pregnant women and children with access to health care



- HSC accreditation: The agency's human service centers received four-year national accreditation from the Council on Accreditation for its outpatient behavioral health services.

Accreditation for HSC behavioral health team



- Peer support specialists: DHS provided training to more than 460 individuals, and 30 people are newly certified in delivering behavioral health peer support services.

Peer supports available to more people in more places



DHS 19-21 BIENNIUM ACCOMPLISHMENTS & WORK IN PROGRESS

Improved access to effective services



Process Improvement & Redesign Efforts

- Long term care eligibility team
- Child Protective Service Redesign
- Human Service Zones
- Centralized approach to childcare licensing
- Move to functional teams for child support
- Electronic Visit Verification & case management systems



Treatment & Recovery Supports

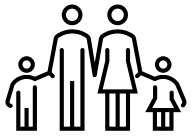
- Medication Assisted Treatment
- Expanded use of SUD voucher
- Behavioral health crisis services



In-Community Services

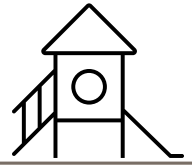
- Peer supports, Companionship, and Adult Foster Care
- Social Determinants of Health via Medicaid (1915i)
- Centralized connection point for home & community-based svc (ADRL)
- Extended Free Through Recovery

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



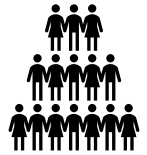
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

#5

Compare agency's request/ recommendation totals, including FTE for next biennium, compared to current biennium

DHS IN THE 21-23 BIENNIUM

Quality services, Proven results, Closer to home

1. Invest resources in **prevention** and **early intervention** resulting in a **reduction in foster care** and facility-based placements of children.

2. Support for new **small-scale settings** for **children and adults** with **complex needs**.

3. Continued investment in **behavioral health** initiatives that **expand access** to vital services.

4. Expansion of **home and community-based services** to older adults and people with disabilities.

5. Focus on **efficiency and effectiveness** in contracting and service delivery.

6. **Expansion** of peer support, supported housing, supported employment, and other **community-based support services**.

7. Across the board **cost savings** related to changes in travel, space utilization, and discretionary grant programs.

DHS OVERVIEW OF BUDGET CHANGES

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	$ 383,915,369	$ 10,643,629	$ 394,558,998
Operating	333,049,456	91,063,140	424,112,596
Capital	2,339,430	25,000	2,364,430
Grants	3,365,450,810	191,077,380	3,556,528,190
Total	**$ 4,084,755,065**	**$ 292,809,150**	**$ 4,377,564,215**
General Fund	$ 1,461,150,884	$ 102,792,973	$ 1,563,943,857
Federal Funds	2,266,624,651	205,560,722	2,472,185,373
Other Funds	356,979,530	(15,544,545)	341,434,985
Total	**$ 4,084,755,065**	**$ 292,809,150**	**$ 4,377,564,215**

DHS STAFFING / FULL TIME EQUIVALENTS

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Management FTE	89.85	8.00	97.85
Program & Policy FTE	640.47	12.00	652.47
Human Service Centers FTE	637.95	-	637.95
Institution FTE	721.96	(31.60)	690.36
County Social Service Financing FTE	140.00	3.00	143.00
Total Regular FTE	**2,230.23**	**(8.60)**	**2,221.63**

HUMAN SERVICE ZONE STAFFING / FTES

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
FTEs approved	1,207	0	1,207
FTEs budgeted	985	0	985

Total FTEs filled as of Dec 20
(fluctuates to meet HSZ needs)
*only filled if within approved budget (attrition, vacancy, etc)

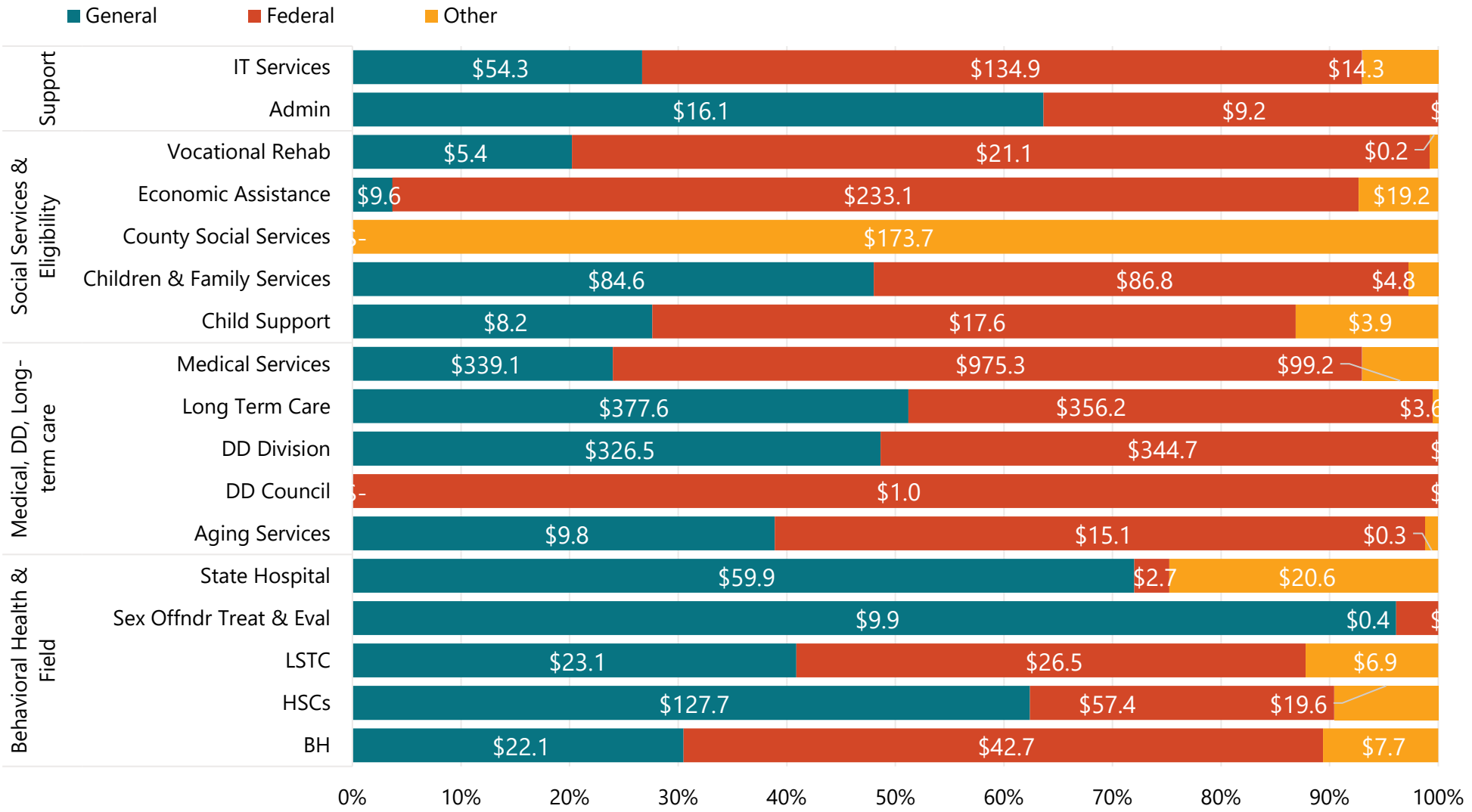
1,030

#6

Explain funding by division including amount in base budget (purpose and use), as well as amount included in request/reco and justification for change from base budget

2019-2021 LEGISLATIVELY APPROVED BUDGET

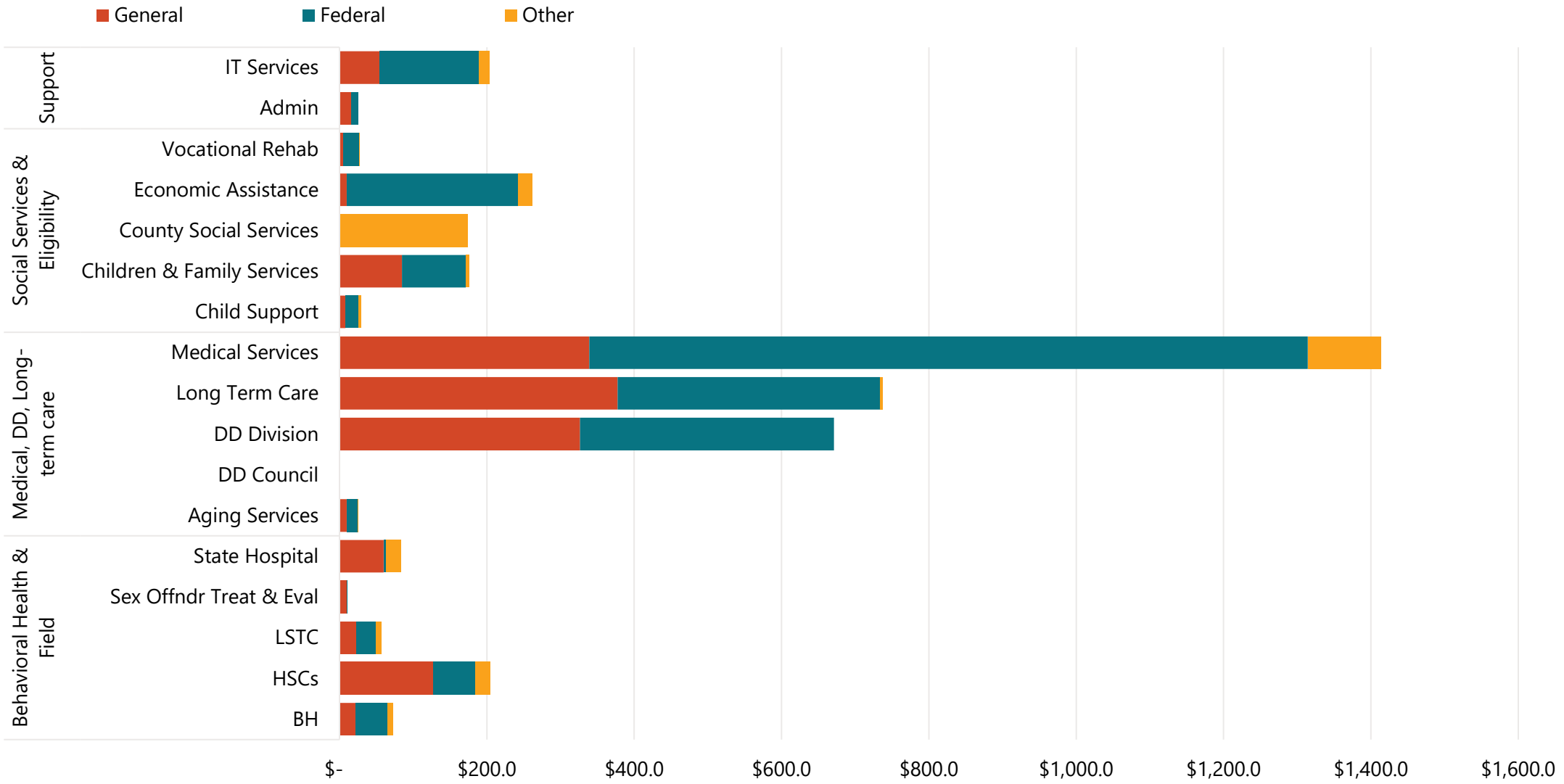
Funding Source, proportional, by division



Budget as of March 30, 2020

2019-2021 LEGISLATIVELY APPROVED BUDGET

Total budget (millions) by division

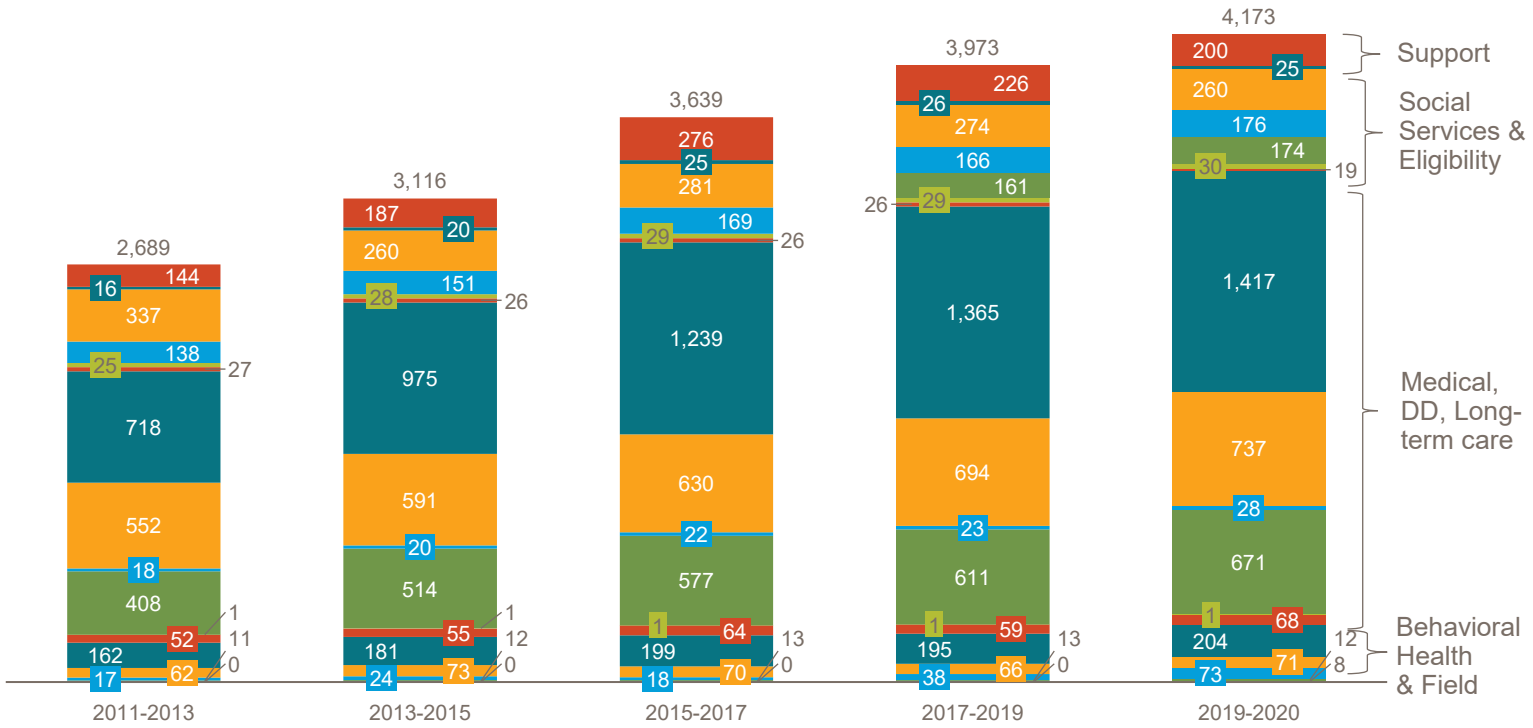


Budget as of March 30, 2020

OVER THE LAST 5 BIENNIA, DD, MEDICAL, AND LONG-TERM CARE HAVE DRIVEN GROWTH IN SPENDING

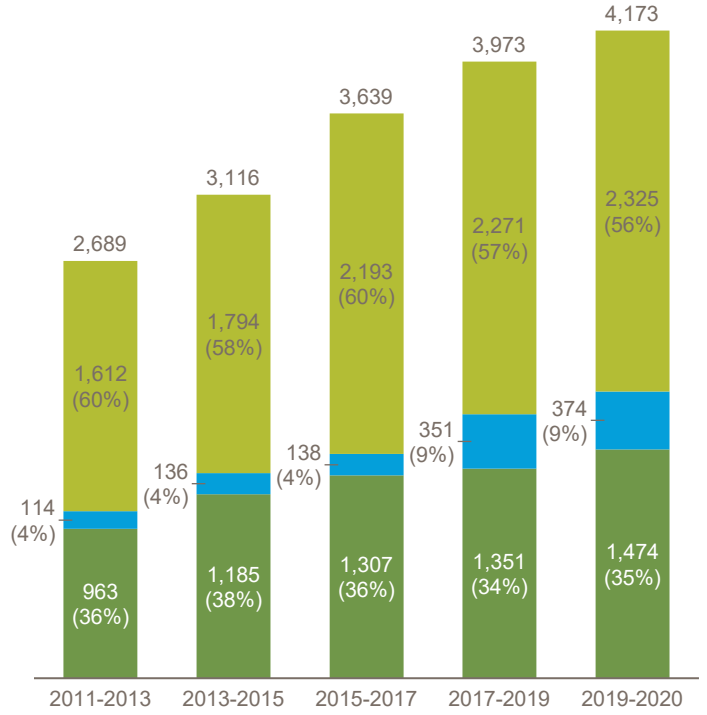
Biennium budget by use division (Compounded Annual Growth Rate (CAGR))
$M for biennium

IT Services (8.97%) | Child Support (1.83%) | DD Division (5.96%) | BH (17.10%)
Admin (5.16%) | Vocational Rehab (-3.37%) | DD Council (-0.02%) | Sex Offndr Treat & Eval (1.39%)
Economic Assistance (-2.70%) | Medical Services (8.91%) | LSTC (2.12%) | Disability Determination
Children & Family Services (2.80%) | Long Term Care (3.29%) | HSCs (3.05%)
HSZs (Cty Social Srvs) | Aging Services (5.18%) | State Hospital (1.42%)



Biennium budget by source (CAGR)
$M for biennium

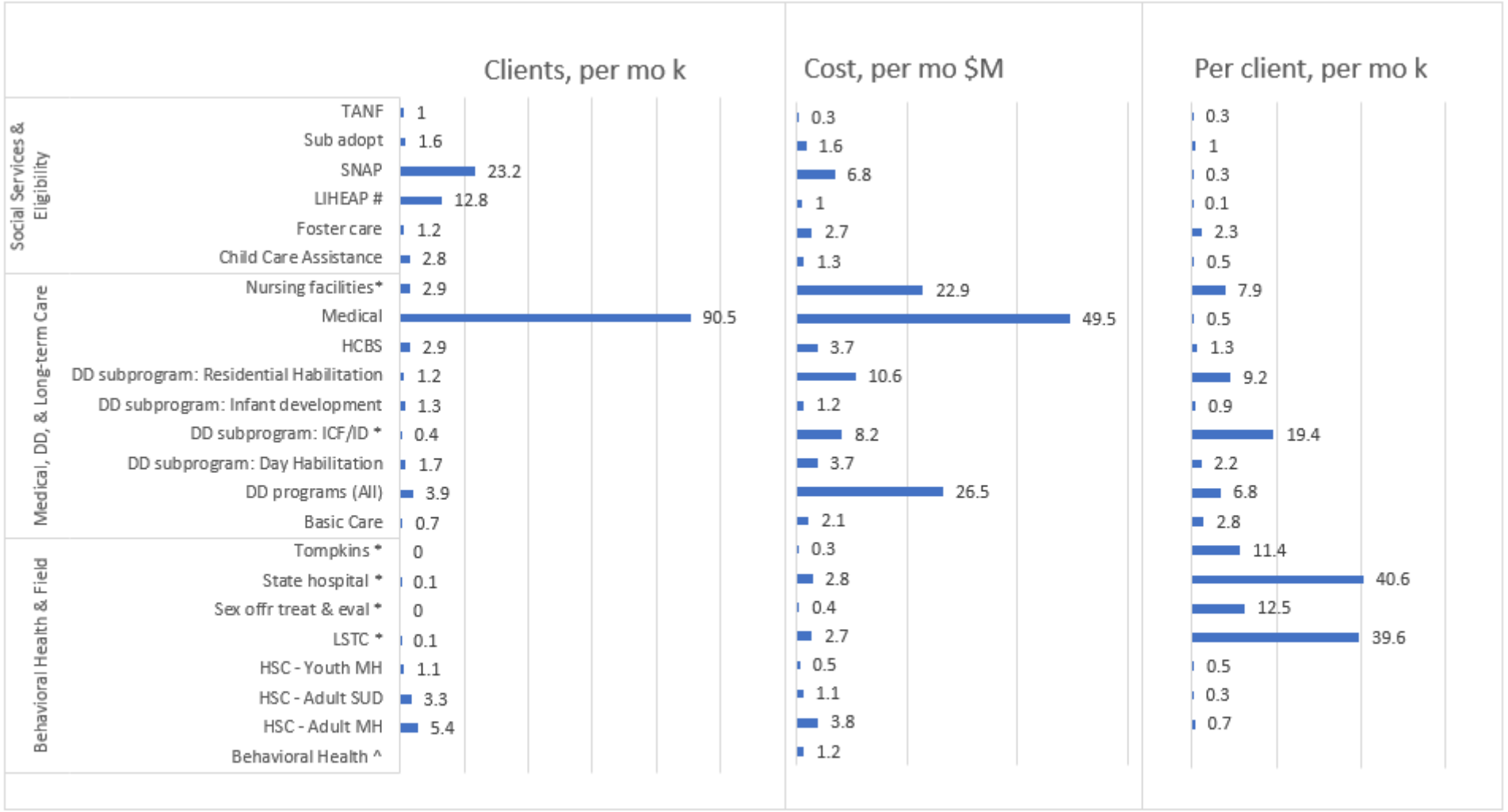
Federal Funds (3.59%)
Other Funds (10.84%)
General Funds (7.66%)



Source: Peoplesoft

HIGHEST PER CLIENT COSTS OCCUR IN INSTITUTIONAL SETTINGS

Expenditures and clients served by program area, SFY20



* Institutional Setting

^ Behavioral Health services are delivered in a manor that does not allow for accurate reporting of clients; reported funds includes administrative dollars.

Based on heating year of October 1 to May 31

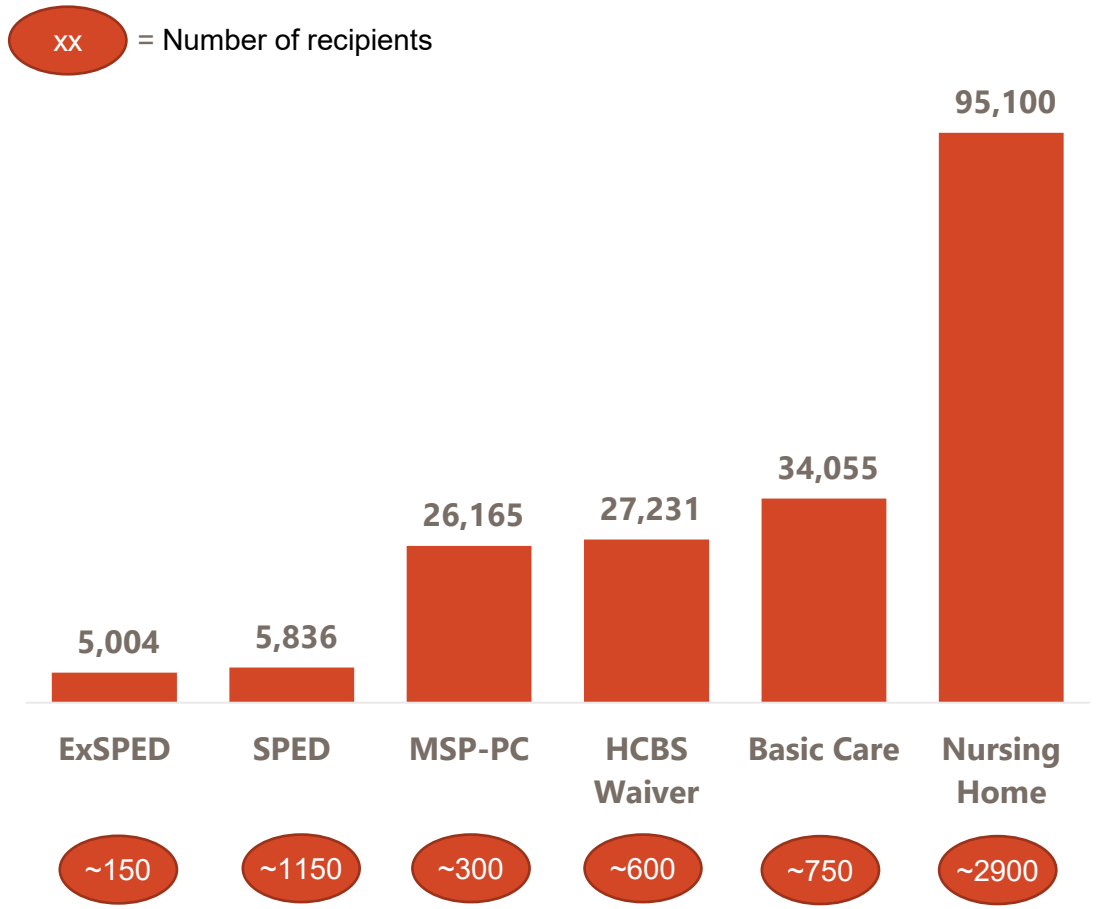
Source: DHS Quarterly Budget Insight, Spend downs, and Institutional Reports

DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

- **Service Payments for the Elderly and Disabled (SPED):** Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- **Expanded SPED (Ex-SPED):** Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- **Home and community-based services (HCBS) waiver:** This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- **Medicaid State Plan personal care (MSP-PC):** Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

MEDICAL SERVICES
Budget Highlights



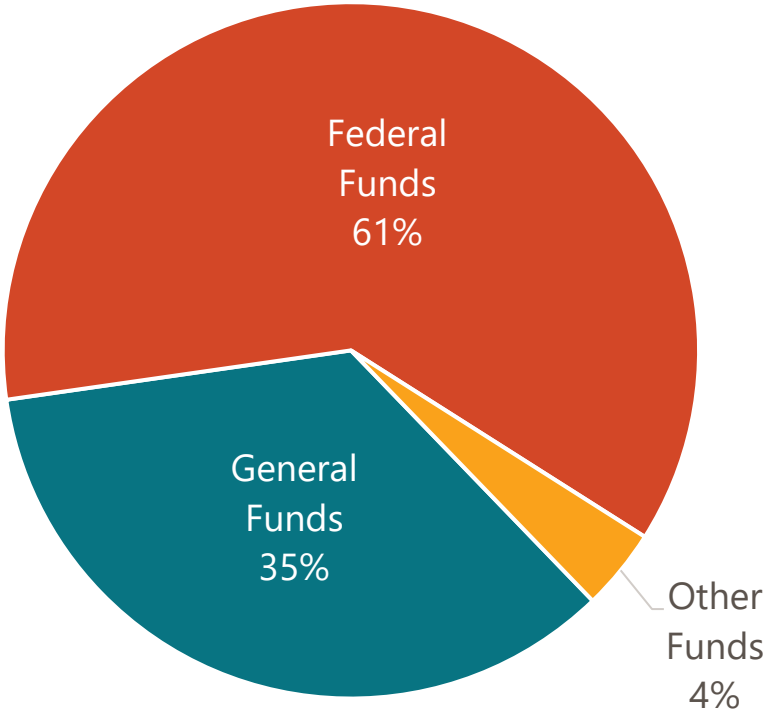
19-21 Budget **$2,155,696,220**

21-23 Budget (exec) **$2,238,065,931**

Includes Traditional, LTC & Expansion

98.5 FTE projected (increase of 12 FTEs); $82.4 million increase in total budget

- Nursing home payment reform and bed buyback
- Reduction in basic care utilization (support study) and increase in HCBS
- Transition administration of Medicaid Expansion to department
- Quality initiative in Medicaid fee for service
- Transition autism voucher to Medicaid program



21-23 Exec Budget

AGING & ADULT SERVICES
Budget Highlights

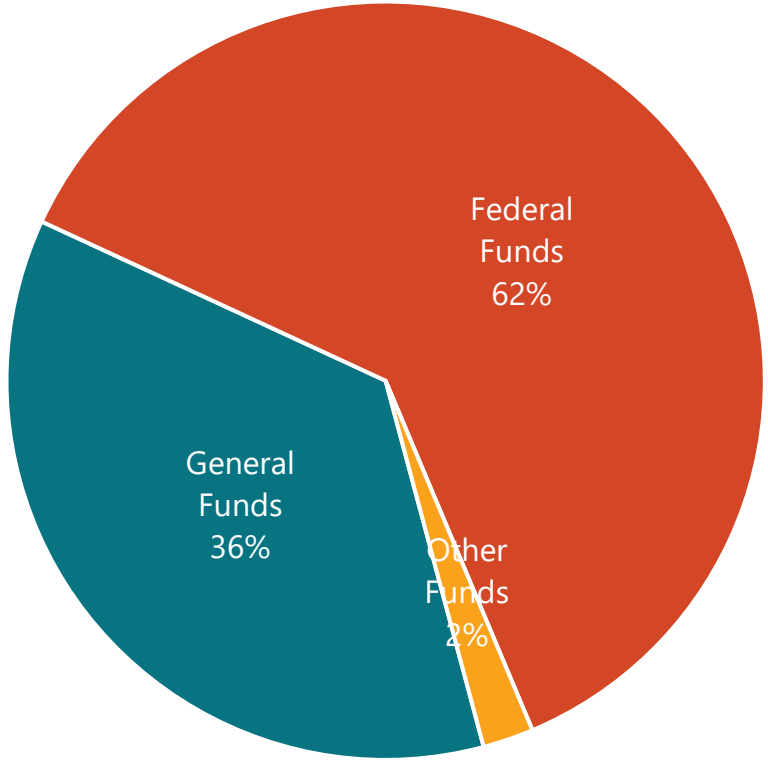


19-21 Budget **$31,214,295**

21-23 Budget (exec) **$34,452,766**

44 FTEs; no change in FTEs projected; $3,238,471 budget increase (98% in federal funds)

- Implementation of in-reach and out-reach and centralized intake for home and community based services
- Continuation of Money Follows the Person
- Eliminate Tech Dependent Waiver
- Various programmatic and operating efficiencies



21-23 Exec Budget

DEVELOPMENTAL DISABILITY SERVICES
Budget Highlights

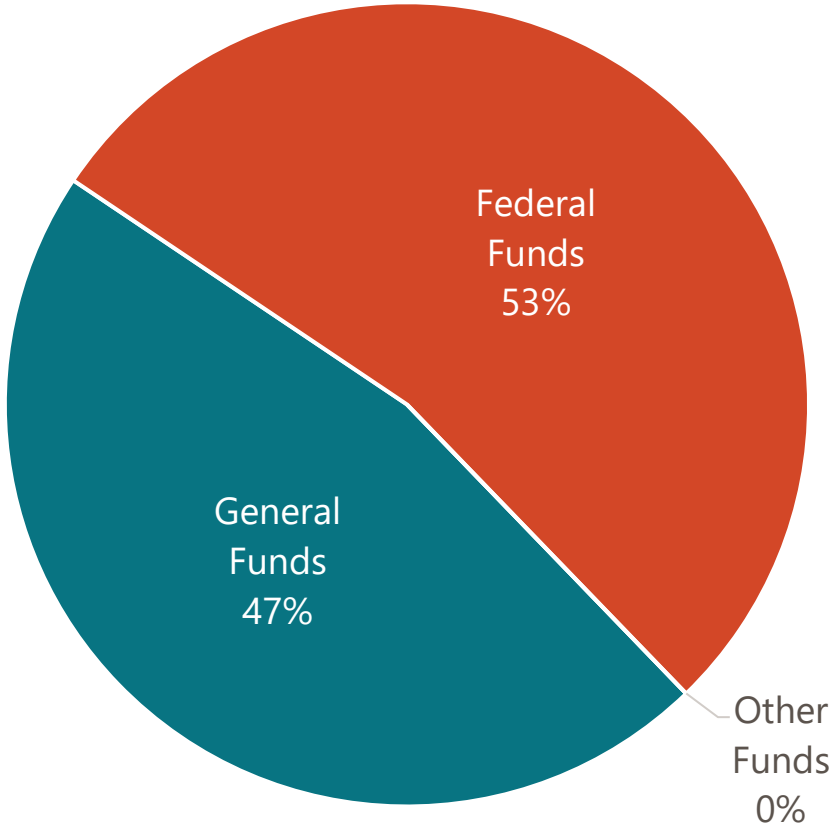


19-21 Budget **$689,016,522**

21-23 Budget (exec) **$739,269,819**

125.87 FTEs; no change in FTEs projected; $50.2 million increase in total budget (83% of increase is from federal funds)

- Diversion/Transition initiative with LSTC
- Payment system adjustments for ICF and Residential Group Homes
- Elimination of recreation and Section 11 grants
- Operating efficiencies related to travel and occupancy



21-23 Exec Budget

LIFE SKILLS TRANSITION CENTER
Budget Highlights

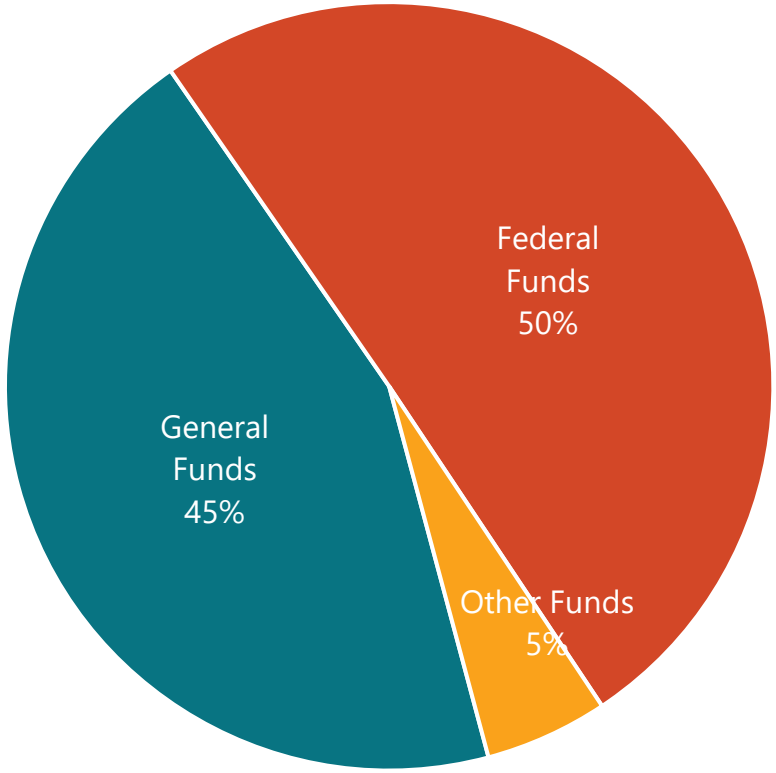


19-21 Budget	**$58,794,948**
21-23 Budget (exec)	**$48,619,605**

308.34 FTEs projected, includes reduction of 14.5 FTEs; $10,175,343 budget reduction (50% in federal funds)

- Reduce census by 26 (16 youth, 10 adults) via both transitions and diversions
- Shift operations to re-orient toward crisis and stabilization service
- Reduce general fund contribution to adaptive equipment service, seeking alternate revenue sources

NOTE: Interconnection between LSTC, CFS, and DD budgets as service models shift



21-23 Exec Budget

CHILDREN & FAMILY SERVICES
Budget Highlights

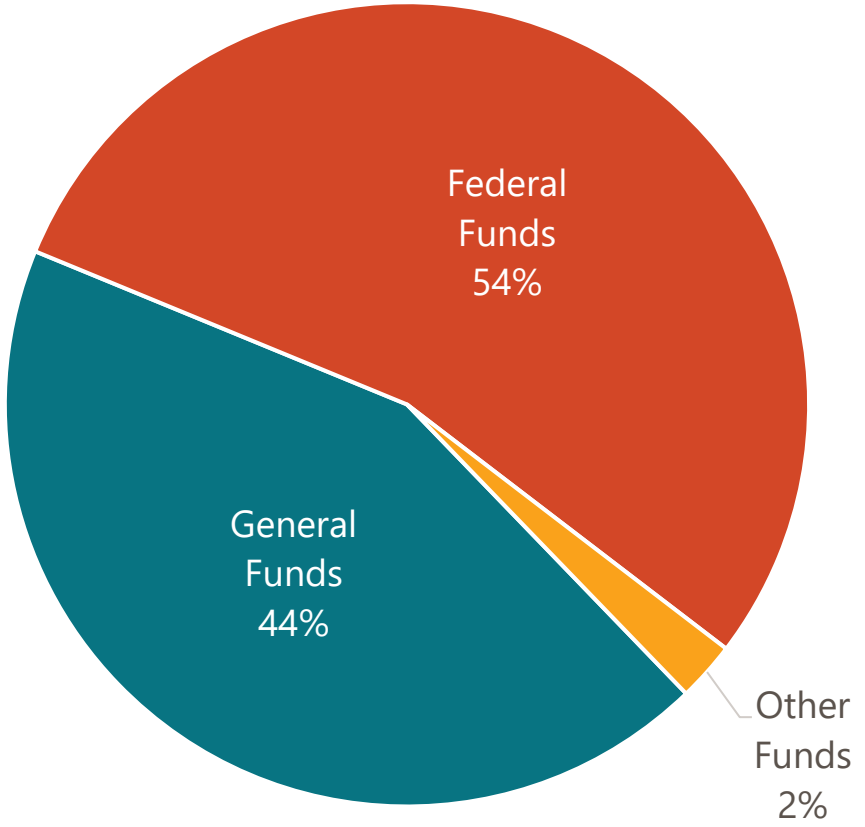


19-21 Budget **$181,171,041**

21-23 Budget (exec) **$165,637,720**

41.6 FTEs; no change in FTEs projected; $15.5 million decrease in total budget (7% of reduction is from federal funds)

- Reduce foster care and residential placements, accomplished in part by investing in evidence-based parent skill building and mental health services to families
- Implement equity in payments for services to families (QRTP, subsidized adoption, targeted case mgmt.)
- Investment in early childhood integrated data system
- Replacement of child welfare technology platform



21-23 Exec Budget

ECONOMIC ASSISTANCE
Budget Highlights

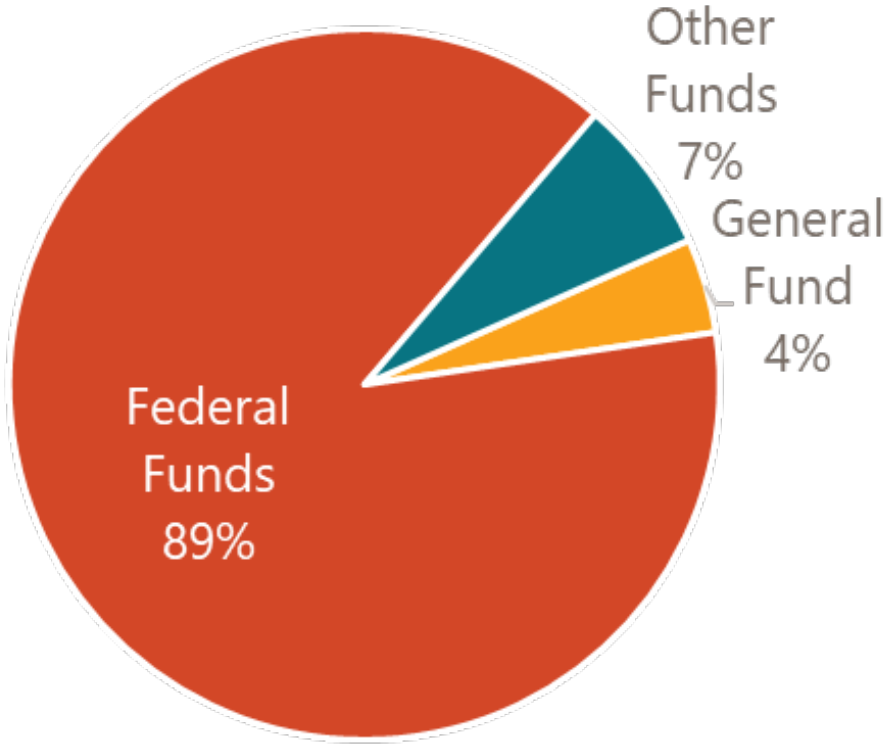


19-21 Budget **$259,846,264**

21-23 Budget (exec) **$274,998,084**

39.8 FTEs; no change in FTEs projected; $15.1 million increase in total budget (77% from federal funding)

- Complete the integration of LIHEAP into integrated eligibility platform
- Finish converting cases from legacy mainframe systems to SPACES
- Administer federal COVID relief funds for low and moderate income households
- Integrate department's housing assistance initiatives into the administration of economic assistance resources



21-23 Exec Budget

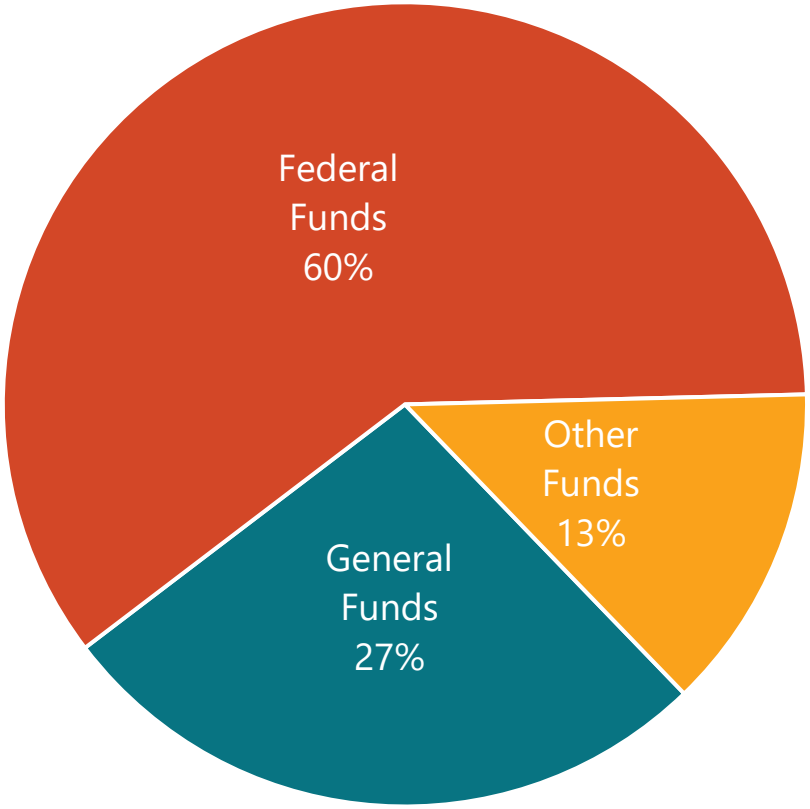
CHILD SUPPORT
Budget Highlights



19-21 Budget	**$29,805,507**
21-23 Budget (exec)	**$30,539,102**

157.7 FTEs; no change in FTEs projected; $733,595 increase in total budget (60% federal funds)

- Operating efficiencies related to travel and occupancy



21-23 Exec Budget

VOCATIONAL REHABILITATION SERVICES
Budget Highlights

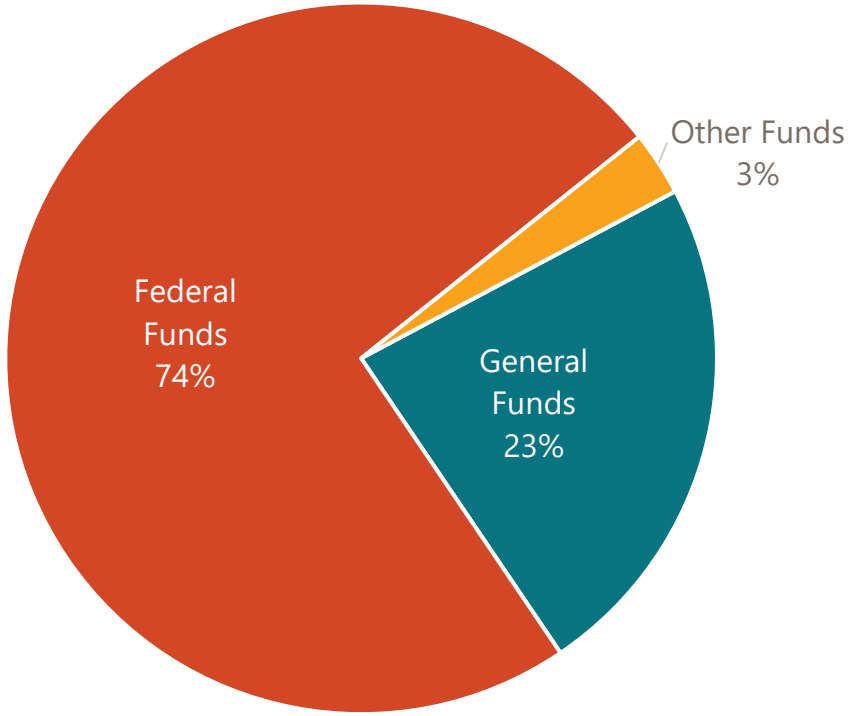


19-21 Budget **$31,853,039**

21-23 Budget (exec) **$30,528,323**

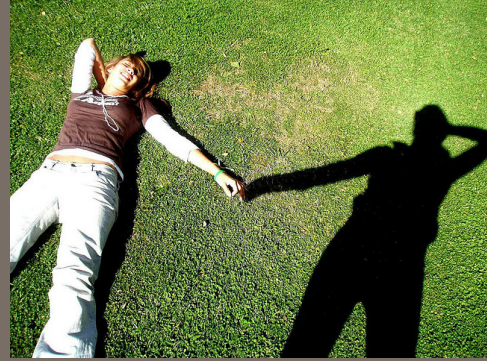
85 FTEs; no change in FTEs projected; $1.3 million decrease in total budget (0% federal funds)

- Operating efficiencies related to travel and occupancy
- Discontinuation of grant to private recreational facility



21-23 Exec Budget

BEHAVIORAL HEALTH
Budget Highlights

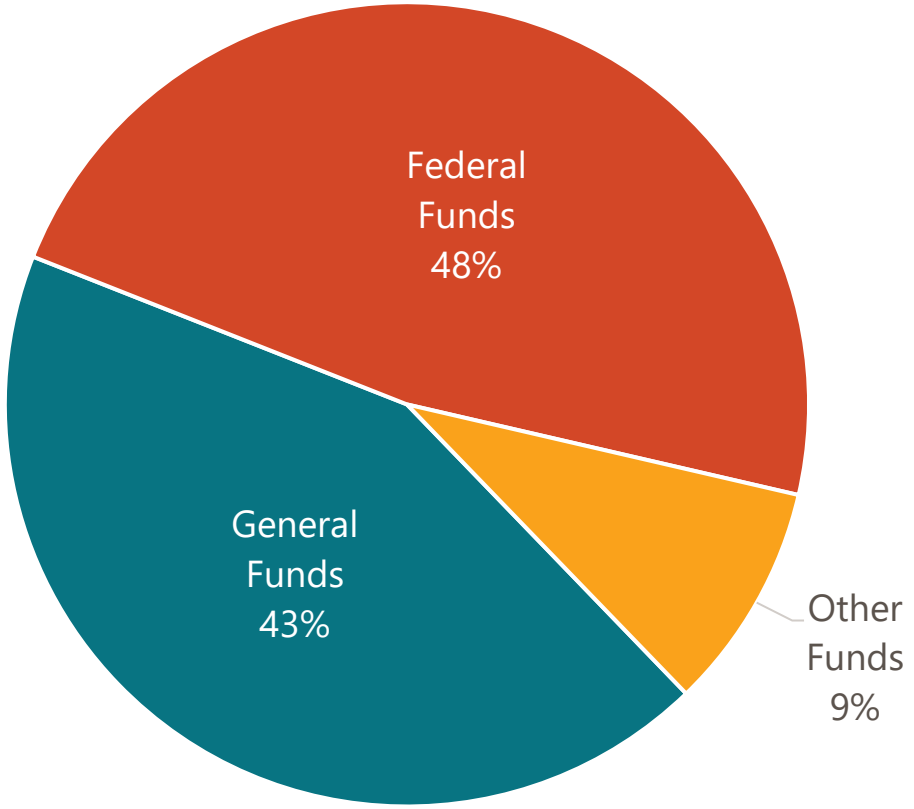


19-21 Budget **$72,069,770**

21-23 Budget (exec) **$85,003,305**

36 FTE; no change in FTEs projected; $12.9 million increase in total budget (0% of reduction from federal funds)

- Substance Use Disorder Voucher
- Expanded Free Through Recovery for non-justice involved families
- Behavioral Health in schools



21-23 Exec Budget

STATE HOSPITAL
Budget Highlights

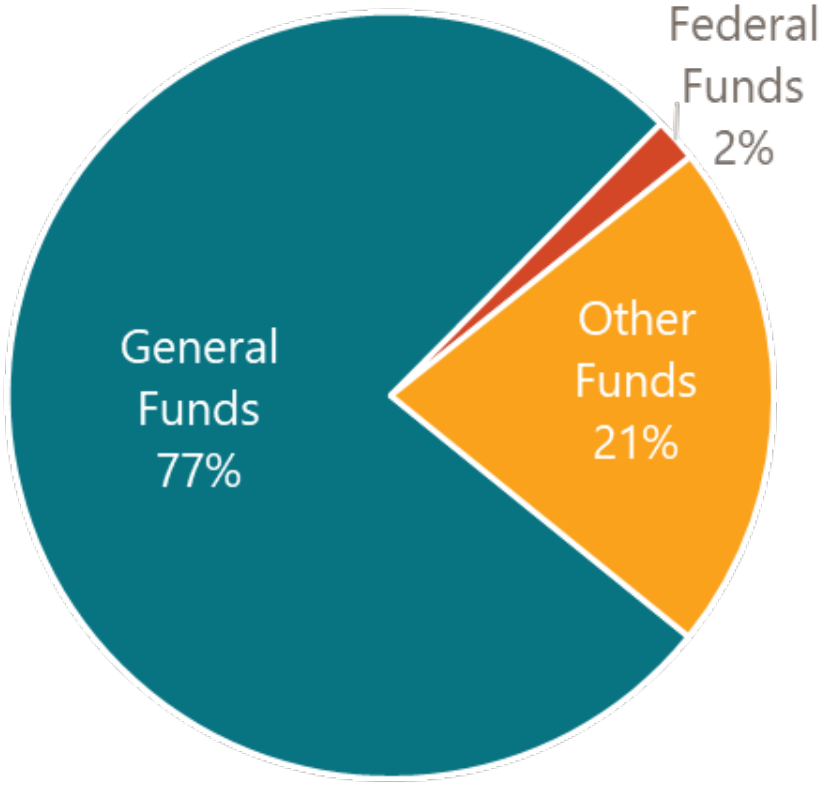


19-21 Budget **$68,801,489**

21-23 Budget (exec) **$65,954,923**

310.52 FTEs; includes reduction of 20.1 FTEs; $2.8 million budget reduction (19% in federal funds)

- Construction of new treatment campus, utilizing operating savings to retire debt service
  - Requires addition of 6-10 hospital beds in western North Dakota
  - Statutory authority to decline admissions when full
  - Reduction of state hospital inpatient services to 75 beds
- Various operating efficiencies at current campus
- Discontinuation of DOCR treatment contract



21-23 Exec Budget

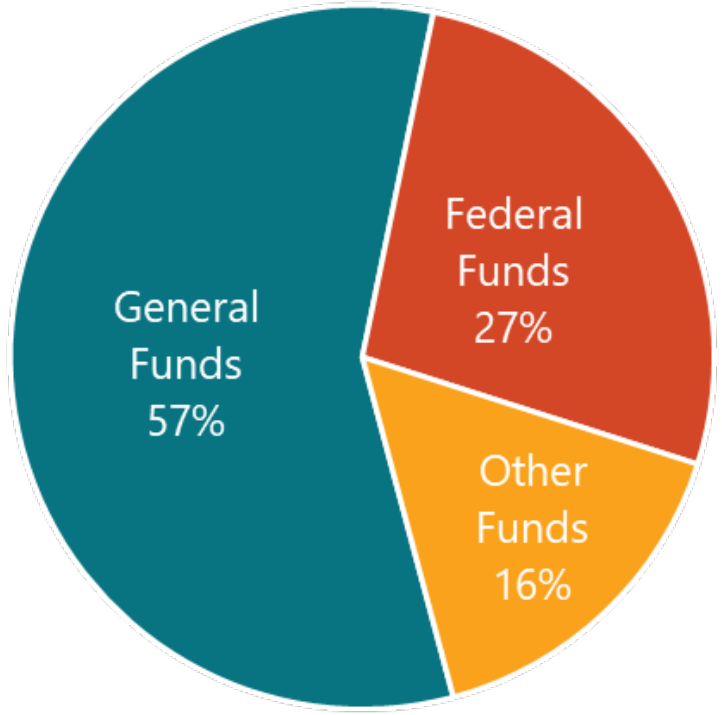
HUMAN SERVICE CENTERS
Budget Highlights



19-21 Budget	**$162,984,547**
21-23 Budget (exec)	**$167,518,311**

637.95 FTEs; no change in FTEs projected; $4.5 million budget increase (27% in federal funds)

- Operating efficiencies across the network of human service centers
- Reduction in various supported housing and employment contracts to facilitate a shift in payment from general fund to 1915i for services delivered to eligible individuals
- Program efficiencies involving transition of case aid and related service contracts



21-23 Exec Budget

HUMAN SERVICE ZONES
Budget Highlights

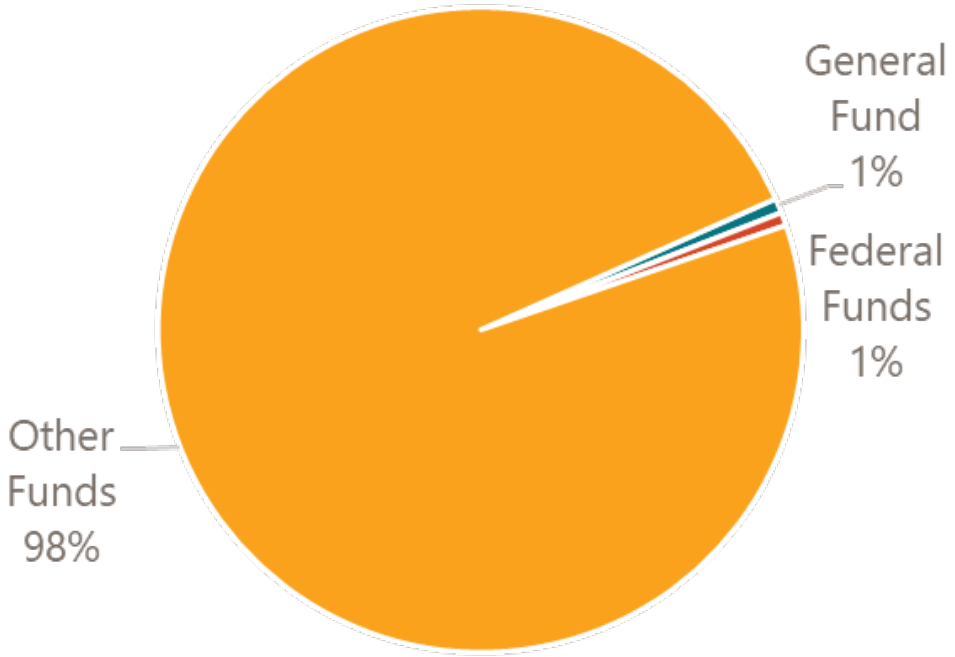


19-21 Budget **$173,700,000**

21-23 Budget (exec) **$177,158,738**

143 FTEs; includes 3 additional FTEs; $3.5 million increase in total budget (34% from federal funding)

- Adding authority to include targeted case management in HSZ budgets
- Redesign eligibility processes to improve customer experience and level workloads



21-23 Exec Budget

#7

Purpose and use of one-time funding items for current biennium

DHS ONE TIME FUNDING

Strategic infrastructure investments support delivery of service

One-Time Funding Description	2019-21	2021-23
Technology Projects	$13,785,658	$ 0
Capital Projects – Life Skills and Transition Center	4,277,165	0
Capital Projects – State Hospital	2,493,500	0
Medically Complex Children Provider Funding Adjustment	977,603	0
Hyperbaric Oxygen Therapy Grant	335,000	0
State Hospital Study	200,000	0
MMIS Modernization	0	35,000,000
Nursing Facility Payment Reform	0	7,200,000
Nursing Home Bed Buy Back	0	3,300,000
Frame/CCIPS Replacement	0	30,000,000
Total All Funds	$22,068,926	$75,500,000
Less Estimated Income	20,556,323	49,525,314
Total General Fund	$1,512,603	$25,974,686

#8

Identify and justify the need for any one time funding being requested / recommended

DHS ONE TIME FUNDING
Replacement of FRAME/CCWIPS

DIVISION
Children & Family Services

BUDGET AMOUNT
$30,000,000
- $15 M general fund
- $15 M federal funds

PURPOSE
Develop and deploy system to manage child protection, foster care, in-home supports to families, and adoption

Supports administrative efficiencies, retirement of mainframe, and requirements for continued federal program compliance



DHS ONE TIME FUNDING

Nursing Home Bed Buyback

DIVISION
Medical Services

BUDGET AMOUNT
$3,300,000
- $3.3 M general fund
- $0 M federal funds

PURPOSE
Right size and support nursing facilities due to COVID and other changes in state regarding HCBS.



DHS ONE TIME FUNDING

Nursing Home Payment Reform

DIVISION
Medical Services

BUDGET AMOUNT
$7,200,000
- $3.35 M general fund
- $3.85 M federal funds

PURPOSE
Modify the nursing home payment system to reward and promote efficiency and support renovation of properties



DHS ONE TIME FUNDING

State Hospital

DIVISION
State Hospital

BUDGET AMOUNT
$0

- $0 M general fund
- $0 M federal funds

PURPOSE
Build new treatment campus is Jamestown to replace aging infrastructure and realize operational savings; finance via public private partnership that applies operational savings to debt service



#9

Agency collections deposited in the general fund or a special fund, and anticipated changes from 2019-21

DHS AGENCY COLLECTIONS

Anticipating increase in fee for service collections at HSCs

2019-21
$20,556,323

2021-23
$26,659,485



$6.1 million

#10

Discuss need for other sections that are included or recommended to be included in agency appropriation bill

SECTIONS IN AGENCY BUDGET BILL

References support quality and efficient service delivery

1. Amendment to section 50-24.1-37 to extend Medicaid expansion and to transition administration of Medicaid expansion to DHS
2. Repeal section 50-24.1-18.1 relating to consumer-directed health maintenance service.
3. Nursing home bed reduction authorization and appropriation
4. Medicaid expansion and nursing home rates expenditures may not exceed appropriation language.
5. Develop a plan to implement health homes and report to legislative management
6. Exemptions to carry-over 2019-23 funds
7. Authorization to convey land at Life Skills and Transition Center and to enter into an agreement to lease state hospital land to the national guard
8. Capital projects and payment language, including authorization to construct a new state hospital
9. Provider process and outcome measures
10. A requirement to the department to establish a new rate setting process and requirements for qualified residential treatment providers

#11

Any other bills being considered by legislative assembly and their potential budgetary impact on agency

OTHER DHS-RELATED BILLS
As of 1-6-21

HB1015 – OMB's appropriation; guardianship grants

HB1034 – Preliminary treatment and involuntary treatment hearings

HB1035 – Juvenile Justice reform bill

HB1048 – Allowance for guardians to be required by Court to furnish a bond

HB1065 – Nursing home operating costs (DHS pre-file)

HB1066 – Accreditation of Human Service Centers (DHS pre-file)

HB1085 - Remedial eye care; Medicaid waivers In-home services (DHS pre-file)

HB1089 – Seclusion, restraint, and prohibition of shock treatment and aversive reinforcement (DHS pre-file)

HB1090 – Nursing home rates (DHS pre-file)

HB1091 – Use of ACH for foster care and shelter care payments (DHS pre-file)

OTHER DHS-RELATED BILLS
As of 1-6-21

SB2004 – Dept of Health appropriation; prevention and behavioral health

SB2015 – DOCR's appropriation; Free Through Recovery / community behavioral health program

SB2082 – Transferring Child Support responsibilities from Court to Department

SB2083 – Child abuse and neglect (DHS pre-file)

SB2084 – Involuntary treatment and emergency detention (DHS pre-file)

SB2085 – Utilization of ACH for medical assistance providers (DHS pre-file)

SB2086 – Operation and financing of Human Service Zones (DHS pre-file)

SB2087 – Medical assistance prior authorization program (DHS pre-file)

SB2088 – Adoption assistance and utilization of ACH for adoptive parents (DHS pre-file)

SB2089 – DHS authority re housing stabilization; autism voucher (DHS pre-file)

OTHER DHS-RELATED BILLS
Un-assigned bills (DHS pre-filed)

None as of 1-6-21

#12

Impact of any budget changes made to meet the Governor’s budget guidelines

2021-2023 Budget Development Framework

DHS asked to provide a 15% reduction in general fund spending

Identified total of $218 million in reductions to achieve targeted general fund savings
- 30% general fund
- 70% federal/other





Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being

21-23 Executive Budget

- Reduced utilization of out-of-home placements, including foster care
- Utilize and support Kinship care for at-risk kids
- Redesign child welfare processes to incorporate improved safety planning practices
- Intensive in-home and evidence-based behavioral health supports for kids and families
- Care coordination for families struggling with mental health and substance abuse
- Optimize opportunity for Title IV-E to become a means to upstream reinvestment
- Substance Use Disorder voucher
- Free Through Recovery



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment

21-23 Executive Budget

- Integrate data sets to facilitate decision making via Early Childhood Integrated Data System
- Evidence based in-home support for young families through Families First Prevention Plan implementation
- Maintenance of state investment in infant development and early intervention services for children with developmental delays
- Maintenance of child care inclusion specialists to support access to child care for children with special needs



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

21-23 Executive Budget

- Connect in-reach/out-reach with timely follow up to connect individuals to services that can be provided outside of institutional settings
- Centralized intake for home and community based services
- Develop non-institutional residential options for behaviorally complex and medically fragile children and adults
- Build HCBS provider capacity for private pay, MA, waivers and SPED
- Streamline provider enrollment processes
- Connect housing and support services to create scattered site supported housing
- Integrate Social Determinants of Health into Medicaid model via 1915i and other Medicaid

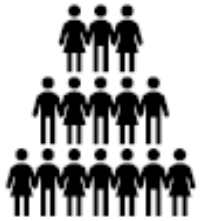


Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service

21-23 Executive Budget

- Re-design eligibility model from policy through determination, focusing on the systemic changes that will improve both access and quality
- Incorporate Tech Dependent and Autism waivers into existing MA framework
- Re-focus HSCs as Community Behavioral Health
- Create focused TANF statewide eligibility team
- Embed HSC behavioral health staff in community settings
- Replace technology platform that supports child welfare and child protective services
- Invest in modernization of MMIS
- Integrate LIHEAP into integrated eligibility platform



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

21-23 Executive Budget

- Reduce our agency's physical footprint
- Integrate person-centered practices into DHS administrative framework
- Increase Leadership Everywhere by 50%,
- Deploy Gallup Employee Engagement Survey and improve scores by .25 in the second year
- Develop DHS Succession plan



Safety Net Services & System Supports

- Operate Medicaid as public health insurance provider
- Deliver behavioral health services to hardest-to-serve populations
- Support service delivery infrastructure
- Administer federal programs, contracts and payment systems

21-23 Executive Budget

- Administer programs that are delivered privately via contract
- Reform Long Term Care payment system to create incentives toward home and community-based services
- Shift contractual services to 1915i
- Transition administration of Medicaid Expansion to DHS
- Reduce extended services contracts
- Rate and payment adjustments for PACE services, telehealth, targeted case management, and I/D Disability services
- Eliminate PCCM provider payment
- Quality Initiative in Medicaid fee for service

#13

One-page itemized listing of changes your agency is requesting the committee make to the executive recommendation

CHANGES FROM EXECUTIVE BUDGET RECOMMENDATION

Adjustments

N/A

We anticipate that there will be adjustments needed as we move through the budget process.

#14

Comparison of agency Optional Adjustment Requests to those recommended in executive budget

OPTIONAL ADJUSTMENT REQUESTS
Comparison of proposed and approved

	To OMB				Executive Budget			
IBARS Description	FTE	General	Federal	Other	FTE	General	Federal	Other
15% Savings		(63,335,882)	(155,923,691)	(467,184)		(55,084,020)	(101,024,656)	(467,184)
5% Other funds reprioritization decrease				(2,429,283)				(2,429,283)
5% Other funds reprioritization increase				2,429,283				2,429,283
Nursing Home Bed Buy Back		6,000,000				3,300,000		
Nursing Facility Payment Reform		3,348,000	3,852,000			3,348,000	3,852,000	
Increase Supervision rate (in State Plan)		566,683	651,991					
Building Maintenance - Heat Pump Replacement		455,000						
Building Maintenance - Base Energy Management System		453,600						
Building Maintenance - Carpet Replacement		269,000						
Building Maintenance - Lighting Retrofit		116,000						
Sex Offender		917,004				917,004		
Duct Cleaning - All Patient Care Buildings		605,000						
Roof - New Horizons Building		575,000						
Door Upgrades/Card Access - LaHaug Building		105,000						
SUD Voucher		9,000,000				9,000,000		
MMIS Module replacement		4,326,686	30,673,314			4,326,686	30,673,314	
New State Hospital		3,366,000						
Early Childhood Integrated Data System (ECIDS)		500,000				500,000		
VAPS Workers from contract to state	6	163,959			(6)			
HCBS Case Management/ ADRL staff	3			498,673	3			498,673
FRAME/CCWIPS Replacement		18,000,000	18,000,000			15,000,000	15,000,000	
Random Moment Time Study (RMTS) system		150,000						
Contract, Payment, and Reporting System		2,000,000						
Inflation for Providers						13,883,837	14,417,097	
Inflation for Employee Compensation		(6,139,260)	2,412,077	12,846,105		2,598,447	4,703,702	13,202,364
Total	9	111,027,839	136,578,541	(39,893,596)	(3)	102,792,972	205,560,725	(15,544,546)

Executive Budget fully supported
Executive Budget partially supported
Executive Budget did not support
Executive Budget supported, adjustment for timing
Fully supported in OMB budget

#15

Amount of federal funding available to agency related to COVID-19 pandemic, actual amount spent and for what purpose

FEDERAL FUNDS AVAILABLE TO DHS FOR COVID RESPONSE

Topical summary of emergency assistance to support basic needs

Child Care

Child Care Em Op Grnt	$48.9 MM (CRF)
Child Care Assistance	$6 MM (CCDBG-CV)

Behavioral Health

Mental Health Grant	$2 MM (SAMHSA)
Crisis Counseling	$1.1MM (SAMHSA)
Community BH	$1.7 MM (CRF)
HSC/Rural	$3.5 MM

Food Assistance

P-EBT	$10 MM (USDA-CV)
P-SNAP	$25.7 MM (USDA FNS)
Sr Meals	$3.6 MM (OAA-CV)
Sr Meals	$1.1 MM (CRF)
Food Bank	$430k (FEMA)

Housing

ERB	$2.9 MM (CRF)
Homeless Coord	$xxx
Rent Assistance	$6.5 MM (CDBG-CV)

Energy Assistance

P-LIHEAP	$5.2 MM (ACF)

Child Welfare

IV-E FMAP	$2.5 MM (ACF)
Violence Prev	$80k
CW Svcs	$76k

Medical Services

FMAP	$85 MM (CMS)
Family caregiver	$500k

Aging Services

Fam Caregiver	$500k
ADRL ACL	$305k
Supportive svc	$1 MM
Ombudsman	$100k
Sr Employ	$889k (SECEP)
SNF Air Pur	$2.6 MM (CRF)

Ops & PPE

Connect Karts	$100k (CRF)
QSP PPE	$50k (CRF)
SNAP Access	$250k (CRF)
Data tools/Ops	$3.5 MM (CRF)

Total Available	**$215,678,868**
Total Spent	**$142,181,611**
(thru 12/21/20)	

DHS COVID RELATED FEDERAL AWARDS & EXPENSE (thru 12-21-20)

Majority of unspent funds as of 12-21-20 related to authorized FMAP

Subdivision	Program	Federal Award/EC Approval	Paid as of 12/21/2020	Notes
Aging Services	Supportive Services	1,000,000	312	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	1,200,000	1,195,618	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	2,400,000	2,385,440	Project period ends 9/30/2021
Aging Services	Family Caregiver Support Program	500,000	460,574	Project period ends 9/30/2021
Aging Services	ADRL ACL Grant	305,454	41,094	Project period ends 9/30/2021
Aging Services	Ombudsman Program	100,000	62,388	Project period ends 9/30/2021
Aging Services	Senior Community Services Employment Program (SCSEP)	889,285	-	Project period ends 12/31/2022
Aging Services	Coronavirus Relief Funds from OMB: Nutrition Services	1,131,800	1,001,729	Coronavirus Relief Funds
Behavioral Health	Emergency Grant to Address Mental & Substance Use Disorders COVID-19 (SAMHSA)	2,000,000	135,136	Project period ends 8/19/2021
Behavioral Health	Crisis, Counseling, and Training Program (SAMHSA)	835,629	-	Project period ends 6/8/2021
Behavioral Health	Crisis Counseling Assistance and Training Program Grant, ISP	251,053	226,738	Project period ends 9/7/2020
Behavioral Health	Coronavirus Relief Funds from OMB: Community-based behavioral health services	1,700,000	-	Coronavirus Relief Funds
Children and Family Services	FMAP IV-E Foster Care & Sub Adopt	2,500,000	1,412,772	Paid is through 9/30/2020 - 6.2% increase
Children and Family Services	Family Violence Prevention and Services Grant	79,837	-	Project period ends 9/30/2021
Children and Family Services	Child Welfare Services State Grant	76,858	-	Project period ends 9/30/2021
Economic Assistance	SNAP - School Meals USDA Replacement	10,058,706	9,543,681	Paid is through Nov. 2020
Economic Assistance	SNAP Increased Benefits	25,752,708	23,795,212	Paid is through Nov. 2020
Economic Assistance	Child Care Development Fund (CCDF)	6,037,905	-	Project period ends 9/30/2023
Economic Assistance	Low Income Home Energy Assistance Program (LIHEAP)	5,176,454	2,144,286	Project period ends 9/30/2021
Economic Assistance	FEMA Share: Great Plains Food Bank pass through	430,200	464,670	FEMA is open ended during the declared emergency
Economic Assistance	Emergency Rent Bridge (Community Development Block Grant)	6,534,942	6,919	Awarded to Department of Commerce
Economic Assistance	Coronavirus Relief Funds from OMB: Childcare Emergency Operating Grant (CEOG)	48,850,000	46,758,287	Coronavirus Relief Funds
Economic Assistance	Coronavirus Relief Funds from OMB: Emergency Rent Bridge (Dept. ID 3080)	2,900,000	2,738,939	Coronavirus Relief Funds
HSC/Institution	Rural Stimulus Payment	3,445,927	1,875	
Management	Coronavirus Relief Funds from OMB: HVAC Air Purification systems for Skilled Nursing Facilities	2,600,000	738,387	Coronavirus Relief Funds
Medicaid Grants	FMAP for Traditional Medicaid, Long-Term Care, and Developmental Disabilities	85,000,000	47,520,244	Paid is through 9/30/2020 - 6.2% increase
Department of Human Services	Coronavirus Relief Funds from OMB: Human Service Zones expenses, agency PPE and telework expenses, temporary staff, Connect Karts, Consultants, LTC portable air purifiers, QSP PPE grants, Grocer EBT Grant, Great Plain Food Bank, Telehealth upgrades	3,922,111	1,477,906	Coronavirus Relief Funds
Department of Human Services	FEMA Share: Agency Expenses	-	69,403	FEMA is open ended during the declared emergency
		215,678,868.99	142,181,611	

Final award different than estimated award approved by Emergency Commission and Budget Section

#16

Additional Information



DHS Invests in People

Human services is the infrastructure of well being.

Human services can help people realize their full potential.

Our communities are stronger when <u>all</u> people can realize their full potential.

NORTH Dakota | Human Services

Be Legendary.™

Appendix

DHS Division Budget Summary Tables

MEDICAL SERVICES – LONG TERM CARE
Budget Summary

Description	Budget 2019-2021	Increase/ (Decrease)	Executive Budget 2021-2023
Grants	853,200	(330,000)	523,200
Medical Grants	736,510,531	85,531,242	822,041,773
Total	**737,363,731**	**85,201,242**	**822,564,973**
General Fund	377,567,931	26,612,730	404,180,661
Federal Funds	356,199,438	61,872,874	418,072,312
Other Funds	3,596,362	(3,284,362)	312,000
Total	**737,363,731**	**85,201,242**	**822,564,973**
Full Time Equivalent (FTE)	0.00	0.00	0.00

MEDICAL SERVICES – TRADITIONAL AND EXPANSION

Budget Summary

Description	2013-2015 Appropriation	2015-2017 Appropriation	2017-2019 Appropriation	2019-2021 Appropriation	Changes	2021-2023 Executive Budget
Salary and Wages	9,361,167	11,006,399	9,217,240	17,631,821	798,183	18,422,004
Operating	39,355,085	44,241,160	53,320,237	48,290,789	8,712,126	57,002,915
Grants						
Medical Grants	806,717,552	1,215,896,867	1,303,690,959	1,352,417,879	(12,341,840)	1,340,076,039
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
General Fund	289,891,636	313,547,595	284,162,440	342,465,788	35,847,622	378,194,515
Federal Funds	514,107,184	914,467,704	962,268,730	977,292,683	(24,294,880)	952,997,802
Other Funds	51,434,984	43,129,127	119,797,266	98,574,018	(14,265,377)	84,308,641
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
Full Time Equivalent (FTE)	**59.50**	**59.50**	**48.00**	**86.50**	**12.00**	**98.50**

AGING & ADULT SERVICES

Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	7,531,996	1,115,342	8,647,338
Operating	20,507,197	1,178,638	21,685,835
Grants	3,175,102	944,491	4,119,593
Total	31,214,295	3,238,471	34,452,766
General Fund	12,128,232	297,546	12,425,778
Federal Funds	18,109,325	3,171,725	21,281,050
Other Funds	976,739	(230,800)	745,938
Total	31,214,295	3,238,471	34,452,766
Full Time Equivalent (FTE)	44.00	0.00	44.00

DEVELOPMENTAL DISABILITIES
Budget Summary

	2019-2021Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	21,041,554	2,147,049	23,188,603
Operating	8,402,117	(562,834)	7,839,283
Capital	10,000	-	10,000
Grants	672,928	(150,000)	522,928
DD Grants	658,889,923	48,819,082	707,709,005
Total	689,016,522	50,253,297	739,269,819
General Fund	336,131,217	8,629,327	344,760,545
Federal Funds	352,885,305	41,623,970	394,509,274
Other Funds	-	-	-
Total	689,016,522	50,253,297	739,269,819
Full Time Equivalent (FTE)	125.87	0.99	125.87

LIFE SKILLS TRANSITION CENTER
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	48,807,542	(8,851,333)	39,956,209
Operating	9,141,275	(1,324,010)	7,817,265
Capital	846,131	0	846,131
Total	58,794,948	(10,175,343)	48,619,605
General Fund	29,426,161	(7,777,688)	21,648,473
Federal Funds	26,880,105	(2,430,575)	24,449,530
Other Funds	2,488,682	32,920	2,521,602
Total	58,794,948	(10,175,343)	48,619,605
Full Time Equivalent (FTE)	322.84	(14.50)	308.34

CHILDREN AND FAMILY SERVICES

Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	8,346,639	153,632	8,500,271
Operating	6,531,727	396,770	6,928,497
Grants	166,292,675	(16,083,723)	150,208,952
Total	181,171,041	(15,533,321)	165,637,720
General Fund	87,651,918	(15,698,254)	71,953,664
Federal Funds	88,707,220	1,028,817	89,736,037
Other Funds	4,811,903	(863,884)	3,948,019
Total	181,171,041	(15,533,321)	165,637,720
Full Time Equivalent (FTE)	41.60	0	41.60

ECONOMIC ASSISTANCE
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	6,777,828	750,224	7,528,052
Operating	10,183,362	(129,940)	10,053,422
Grants	242,885,074	14,531,536	257,416,610
Total	259,846,264	15,151,820	274,998,084
General Fund	8,605,617	3,256,938	11,862,555
Federal Funds	231,997,094	11,701,119	243,698,213
Other Funds	19,243,553	193,764	19,437,317
Total	259,846,264	15,151,820	274,998,084
Full Time Equivalent (FTE)	39.80	0.0	39.80

CHILD SUPPORT
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	25,753,469	1,250,677	27,004,146
Operating	4,052,038	(517,082)	3,534,956
Total	29,805,507	733,595	30,539,102
General Fund	8,088,500	117,317	8,205,817
Federal Funds	17,605,475	704,203	18,309,678
Other Funds	4,111,532	(87,925)	4,023,607
Total	29,805,507	733,595	30,539,102
Full Time Equivalent (FTE)	157.70	0	157.70

VOCATIONAL REHABILITATION
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	14,101,052	687,464	14,788,516
Operating	7,533,223	(144,686)	7,388,537
Grants	10,218,764	(1,867,494)	8,351,270
Total	31,853,039	(1,324,716)	30,528,323
General Fund	9,308,268	(2,024,678)	7,283,590
Federal Funds	22,370,770	678,961	23,049,731
Other Funds	174,001	21,001	195,002
Total	31,853,039	(1,324,716)	30,528,323
Full Time Equivalent (FTE)	85.00	0.00	85.00

BEHAVIORAL HEALTH
Budget Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	6,317,092	745,543	7,062,635
Operating	48,314,144	1,523,449	49,837,593
Grants	17,438,534	10,664,543	28,103,077
Total	72,069,770	12,933,535	85,003,305
General Fund	21,655,789	15,075,517	36,731,306
Federal Funds	42,723,467	(2,236,632)	40,486,835
Other Funds	7,690,514	94,650	7,785,164
Total	72,069,770	12,933,535	85,003,305
Full Time Equivalent (FTE)	36.00	0.00	36.00

STATE HOSPITAL
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries	55,100,672	(1,670,825)	53,429,847
Operating	12,367,468	(1,195,691)	11,171,777
Capital	1,333,349	19,950	1,353,299
Total	68,801,489	(2,846,566)	65,954,923
General Fund	48,936,041	1,594,398	50,530,439
Federal Funds	1,759,125	(543,618)	1,215,507
Other Funds	18,106,323	(3,897,346)	14,208,977
Total	68,801,489	(2,846,566)	65,954,923
Full Time Equivalent (FTE)	330.62	(20.10)	310.52

HUMAN SERVICE CENTERS
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	117,595,353	6,901,854	124,497,207
Operating	16,435,561	(969,915)	15,465,646
Capital	80,000	$0	80,000
Grants	28,873,633	(1,398,175)	27,475,458
Total	162,984,547	4,533,764	167,518,311
General Fund	104,546,617	(8,374,845)	96,171,772
Federal Funds	40,391,387	4,295,666	44,687,053
Other Funds	18,046,543	8,612,944	26,659,487
Total	162,984,547	4,533,764	167,518,311
Full Time Equivalent (FTE)	637.95	0	637.95

HUMAN SERVICE ZONES
Budget Summary

	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries & Benefits	24,186,261	2,934,741	27,121,002
Operating	4,621,303	(432,414)	4,188,889
Grants	144,892,436	956,411	145,848,847
Total	173,700,000	3,458,738	177,158,738
General Fund	0	1,323,223	1,323,223
Federal Funds	0	1,176,874	1,176,874
Other Funds	173,700,000	958,641	174,658,641
Total	173,700,000	3,458,738	177,158,738
Full Time Equivalent (FTE)	140	3	143



House Bill 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

Child Support

Connecting children to resources that improve well-being

NORTH Dakota | Human Services

Be Legendary.℠

CHILD SUPPORT
Program Purpose

The purpose of the Child Support program is to help parents meet the needs of their children by securing appropriate and sustainable child support.



CHILD SUPPORT
What we do – Full Service and Limited Service

- Customer service
- Establishment of paternity
- Establishment of a child support and medical support order
- Income withholding
- Other enforcement actions such as tax refund offset and license suspension
- Employment services
- Periodic review and modification of child support obligation
- Payment processing



CHILD SUPPORT
Opening a Full-Service case

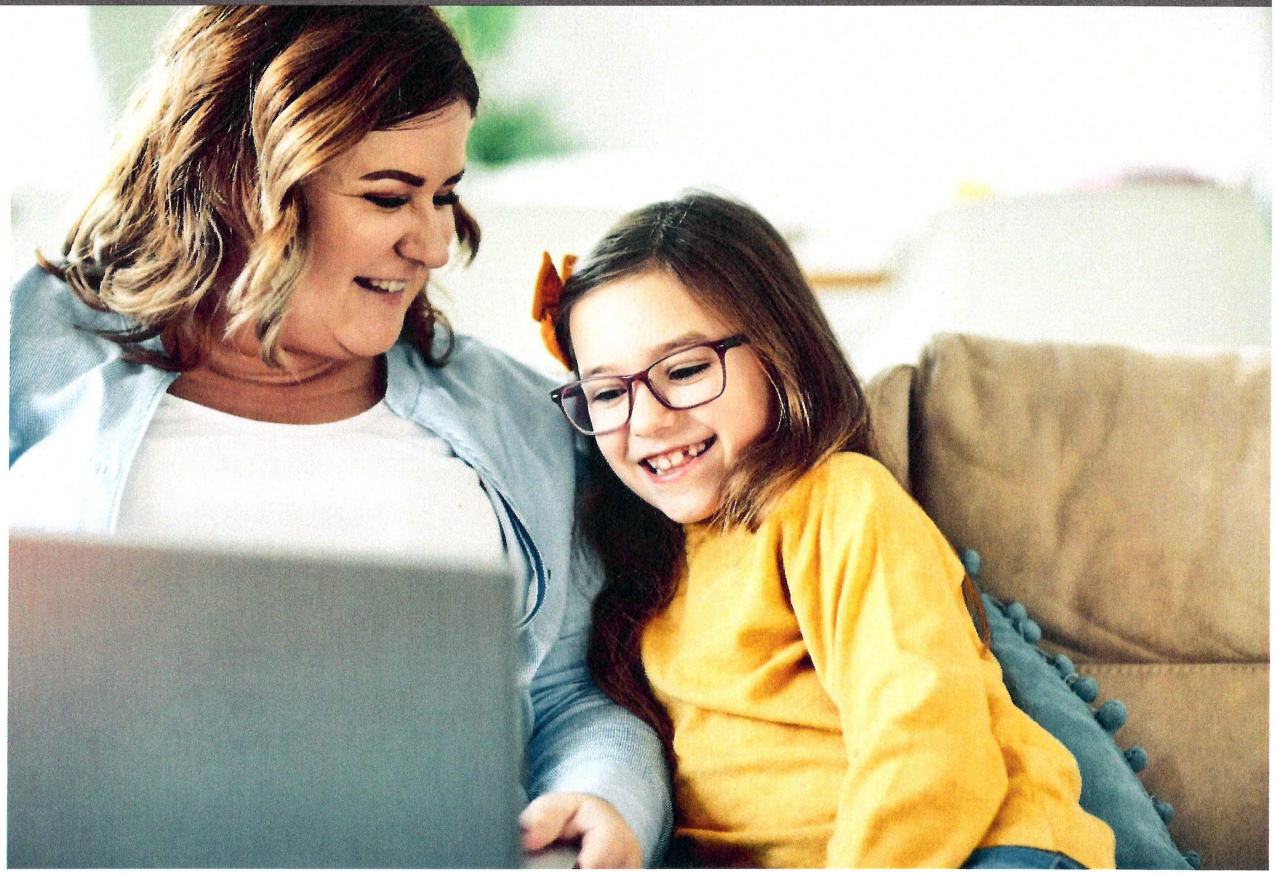
- TANF Referral
- Medicaid Referral
- Foster Care Referral
- Referral from another state or tribal or international child support program
- Application by a parent



CHILD SUPPORT
Return on Investment

Every **$1.00 spent** on Child Support generated **$6.58 for family recipients**

Every **$1.00 in state General Funds spent** on Child Support generates **$20.00 in support for family** recipients



CHILD SUPPORT
Partners



- Employers
- Judges
- Clerks of court
- Sheriffs
- ND state and local government agencies
- Other state and tribal child support programs
- Private attorneys
- Car dealers
- Gaming operators

CHILD SUPPORT
Tribal Partnerships

- Partnership with Three Affiliated Tribes and Standing Rock Sioux Tribe child support programs
- Bring actions in Turtle Mountain and Spirit Lake tribal courts
- Host Tribal Offset Partnership so tribes can access federal offset services
- "Lack of jurisdiction" cases are excluded from federal performance measures



CHILD SUPPORT
Who we serve

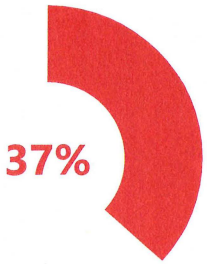
In 2020

- 65,999 children
- 83,721 parents
- 53,243 cases
  - Full service – 34,075
  - Limited service – 19,168



CHILD SUPPORT
Who we serve

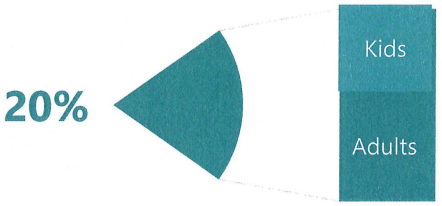
65,999



1 in 3 ND kids

In 2020, 65,999 children received child support services. That is more than 1 of every 3 children under age 18 in the state.

149,720



1 in 5 North Dakotans

149,720 people received child support services in North Dakota in 2020.

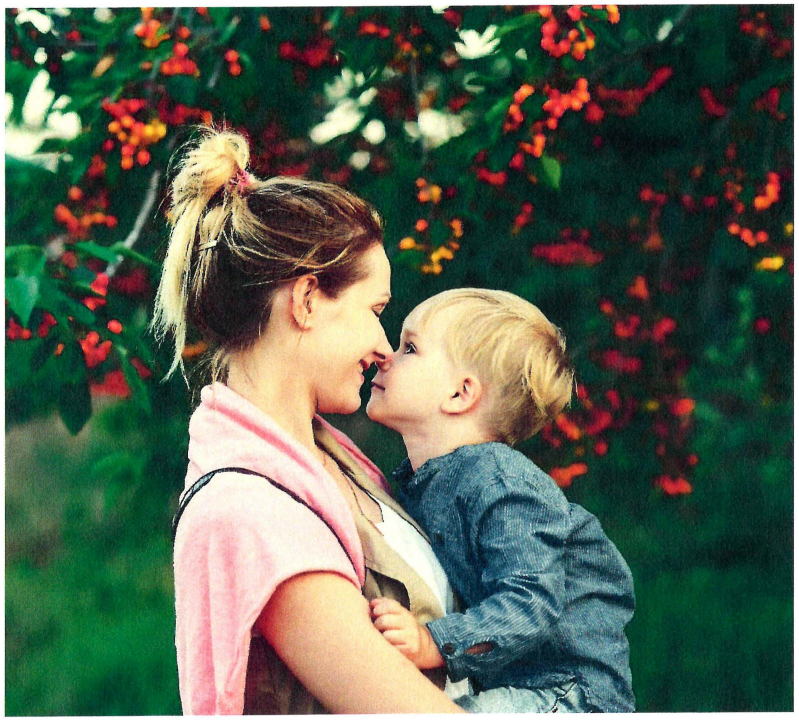
83,721



1 in 7 ND adults

In 2020, 83,721 parents received child support services. That means 1 of every 7 adults (age 18+) in the state has a connection to the child support division.

Meet Bobbi Jo & Tanner



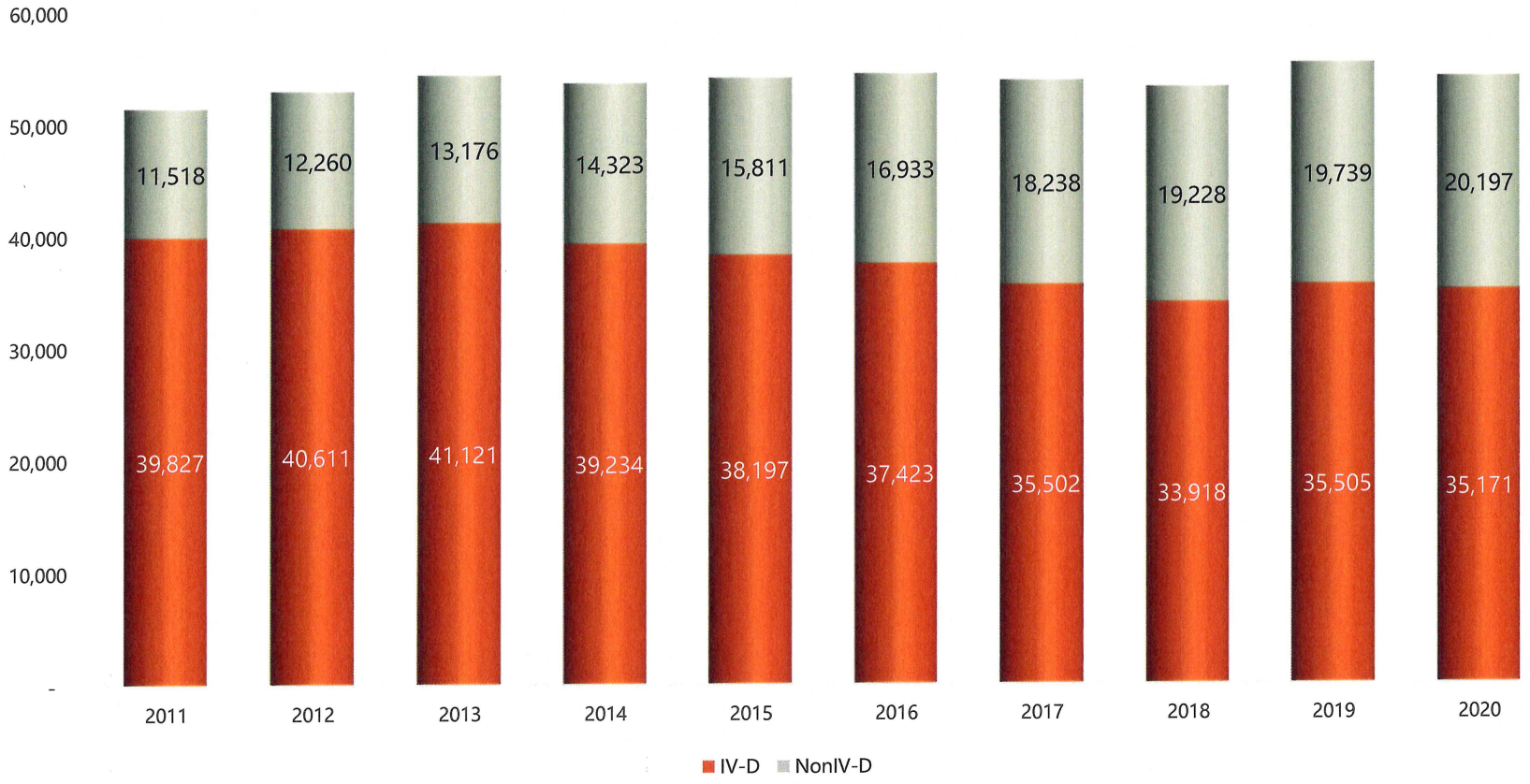
Bobbie Jo is 22 years old and lives in Devils Lake. She used to live with the father of her two-year old son Tanner.

Tanner's father acknowledged his paternity in the hospital when Tanner was born but broke up with Bobbie Jo when Tanner was a baby.

Bobbie Jo has a part-time job at a local convenience store. She is receiving health coverage for herself and Tanner under the Medicaid program.

She is struggling to make ends meet, but currently makes too much income to be eligible for SNAP or TANF.

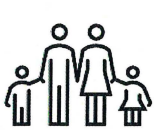
CASELOAD IS STABLE



IV-D case = Full Svc

Non-IV-D case = Limited Svc

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



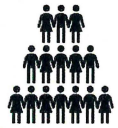
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

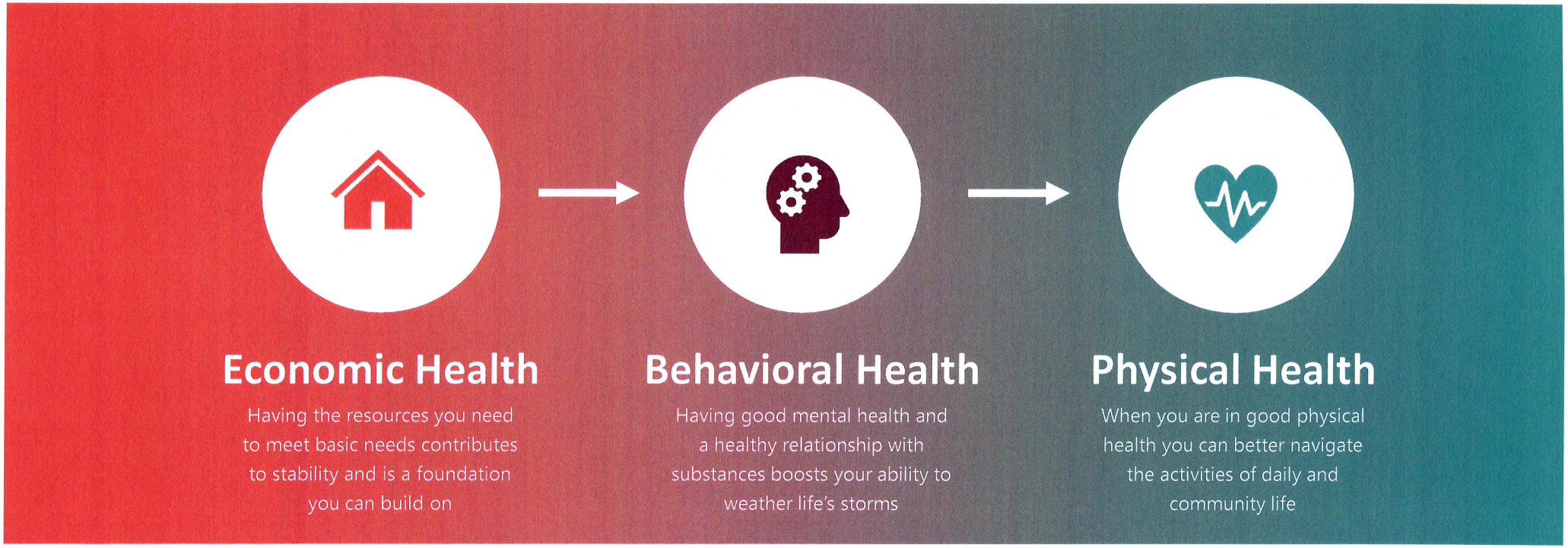
- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

The threads that run through every person's life

Foundations of Wellbeing are Interconnected



The stability that comes from good **economic** health can **improve behavioral** health.
The stability that comes from good **physical** and **behavioral** health **enables economic** health.

CHILD SUPPORT DIVISION
Supporting Family Stability & Economic Health

When child support is received, a child is able to grow up in a more secure and stable environment.



CHILD SUPPORT
Supporting Family Stability & Economic Health

18,000

More than 18,000 families who are owed child support are not receiving the program's services

$25 million

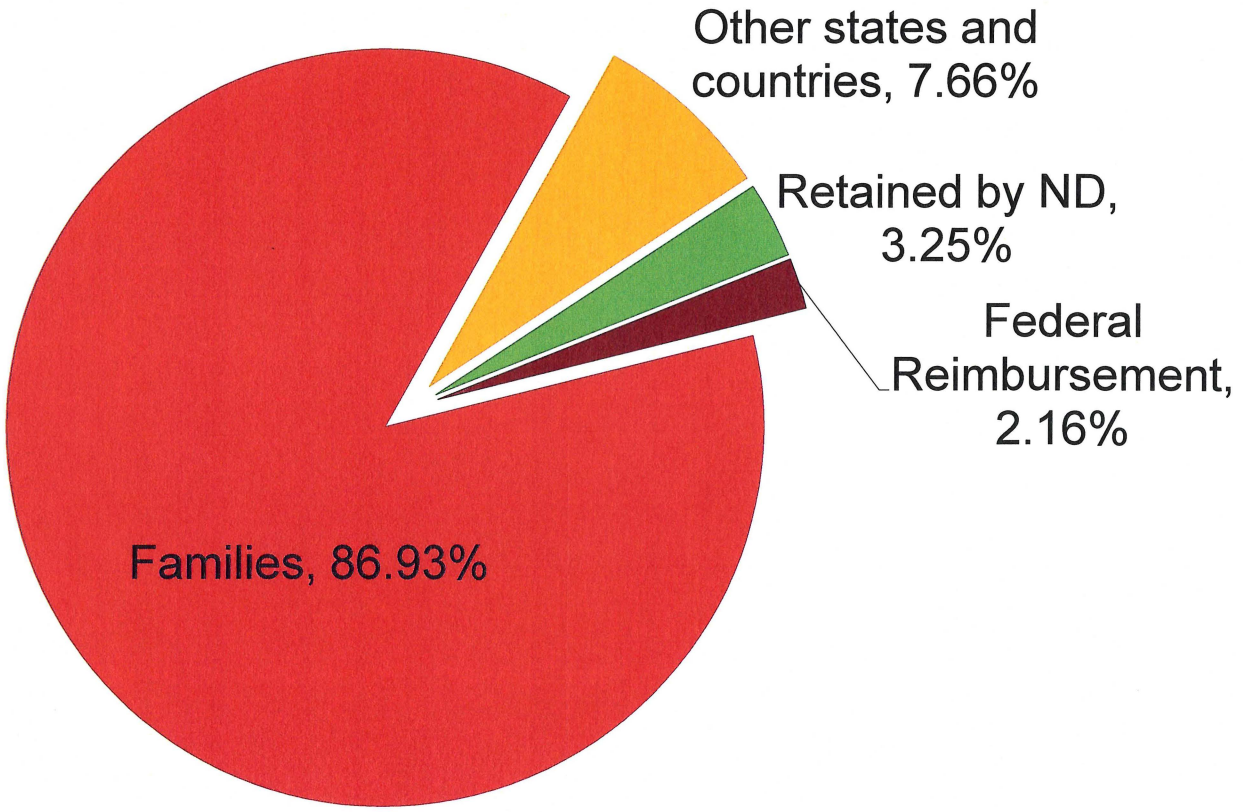
More than $25 million in child support per year is not received in the month when it is due

$250 million

More than $250 million is owed in past-due support in full-service cases and nearly $400 million total in all cases

COLLECTIONS - WHERE THE MONEY GOES

Child support agencies work collaboratively, across state lines, to ensure that families receive the child support they are owed regardless of where they live.



HOW WE MEASURE SUCCESS
Establishing Paternity

If needed, Child Support will help with establishing paternity for the child, using the in-hospital paternity acknowledgment program and court actions.



HOW WE MEASURE SUCCESS
Collection of payments owed

When child support is received, the child is able to grow up in a more secure and stable environment.

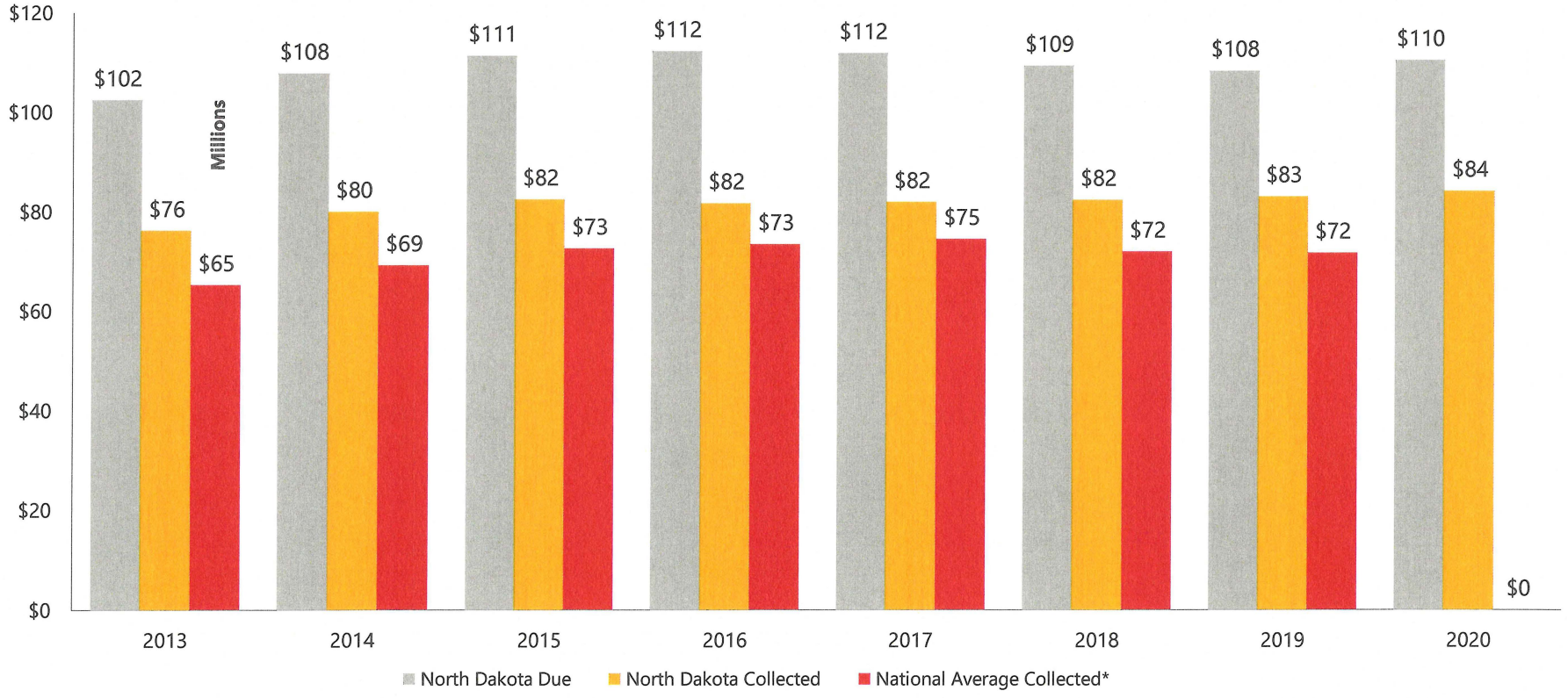
Studies have shown that for every $1 a family receives in child support, $0.19 is saved in reduced need for TANF, SNAP, Medicaid and other programs.



CHILD SUPPORT
Performance Measures

	Orders Established	Paternity Established	Current Support	Cases with Arrears Collection	Cost Benefit
ND FFY 2020	87.31%	110.74%	76.18%	69.84%	$6.58
ND FFY 2019	88.51% (25)	110.47% (5)	76.67% (2)	67.04% (19)	$6.36 (11)
#1 State	95.14%	159.06%	84.23%	84.82%	$11.68
#5 State	93.28%	110.47%	75.09%	72.81%	$7.27
#10 State	91.56%	104.5%	70.06%	69.44%	$6.59

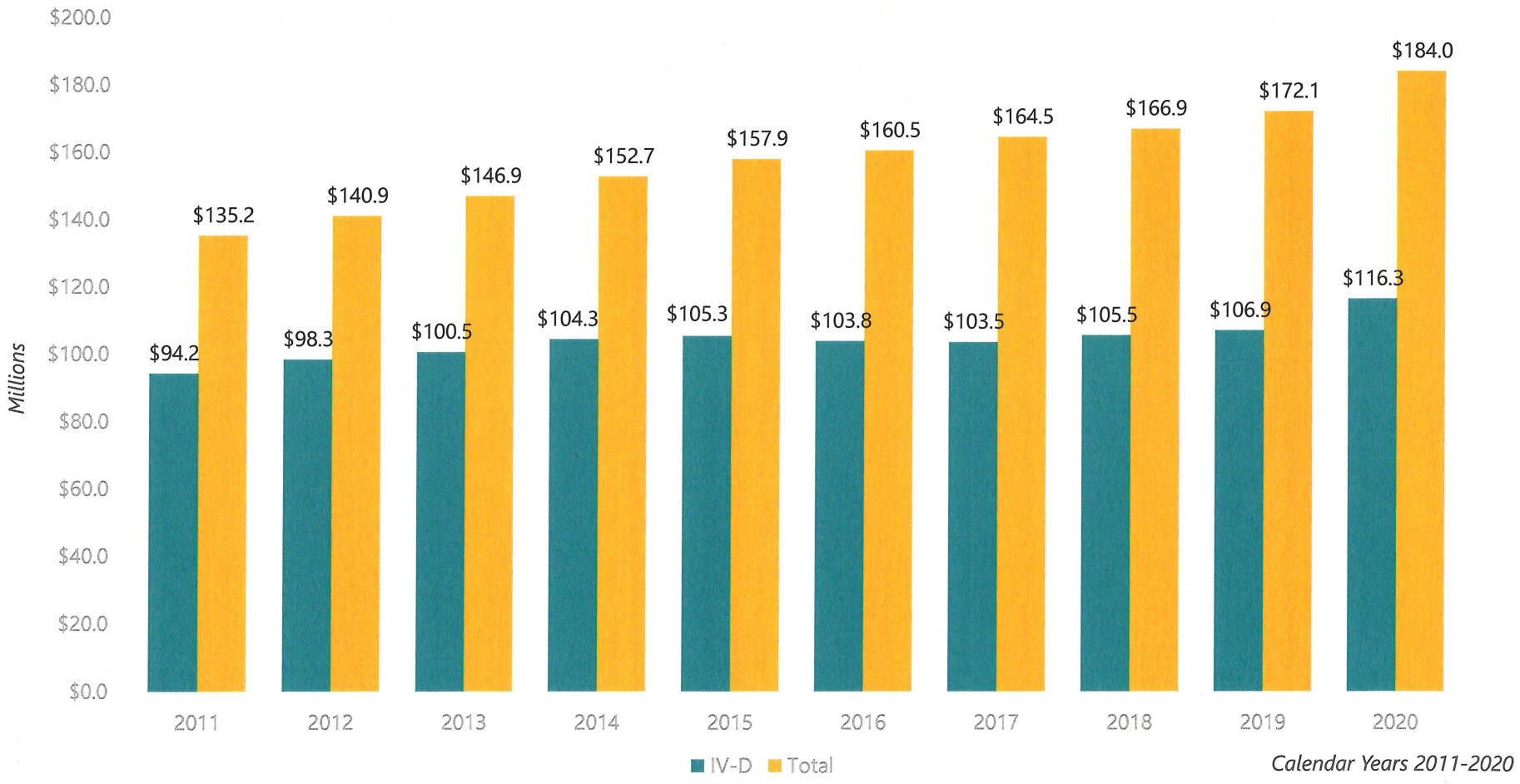
ND CHILD SUPPORT COLLECTIONS TYPICALLY EXCEED NATIONAL AVERAGES BY ABOUT 10%



	2013	2014	2015	2016	2017	2018	2019	2020
North Dakota	74.3%	74.2%	74.1%	72.8%	73.2%	75.3%	76.7%	76.2%
National Average	63.7%	64.2%	65.2%	65.4%	66.6%	65.8%	66.2%	N/A

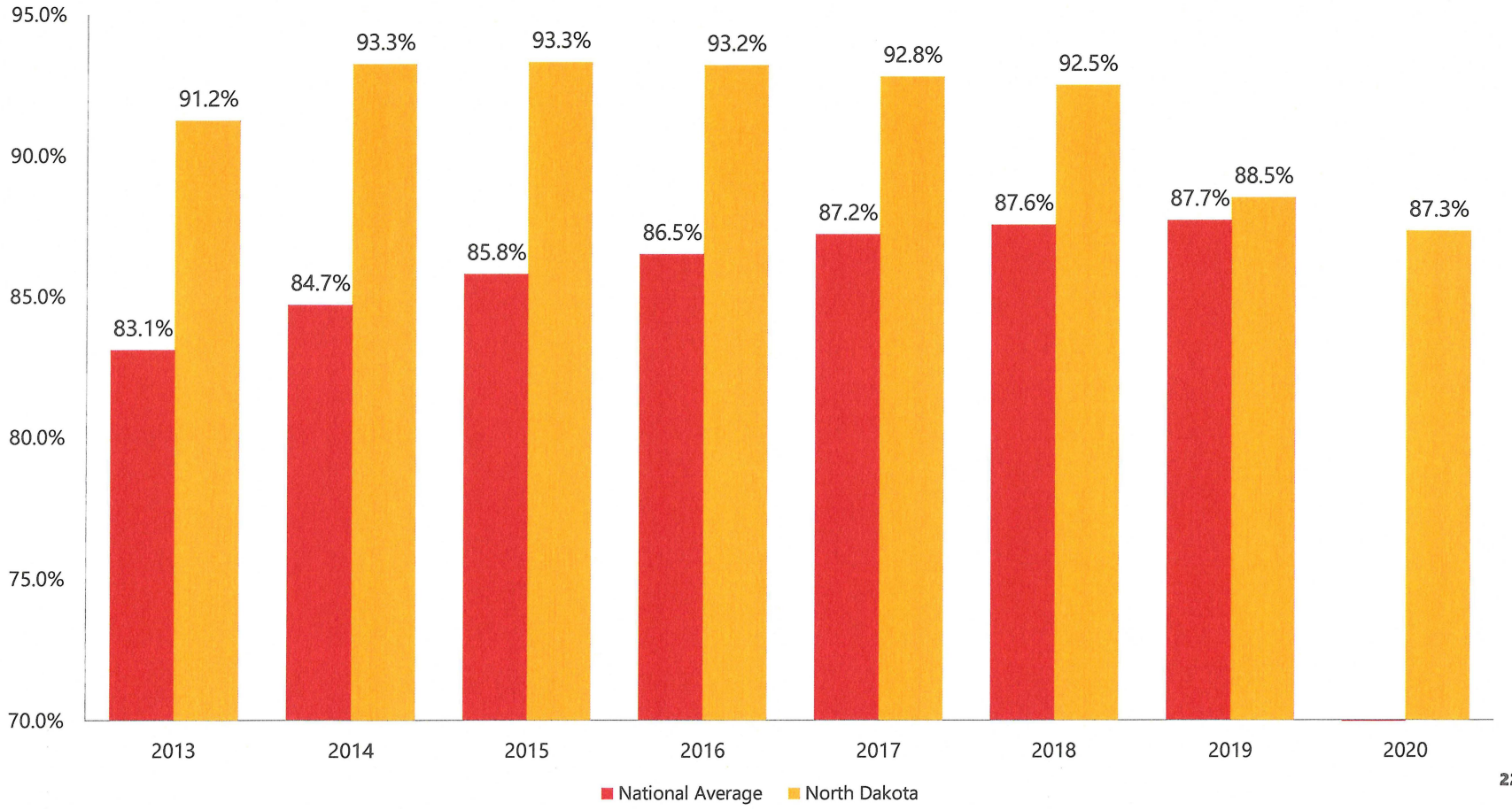
**National average performance applied to North Dakota's current support due.*

COLLECTIONS CONTINUE TO INCREASE

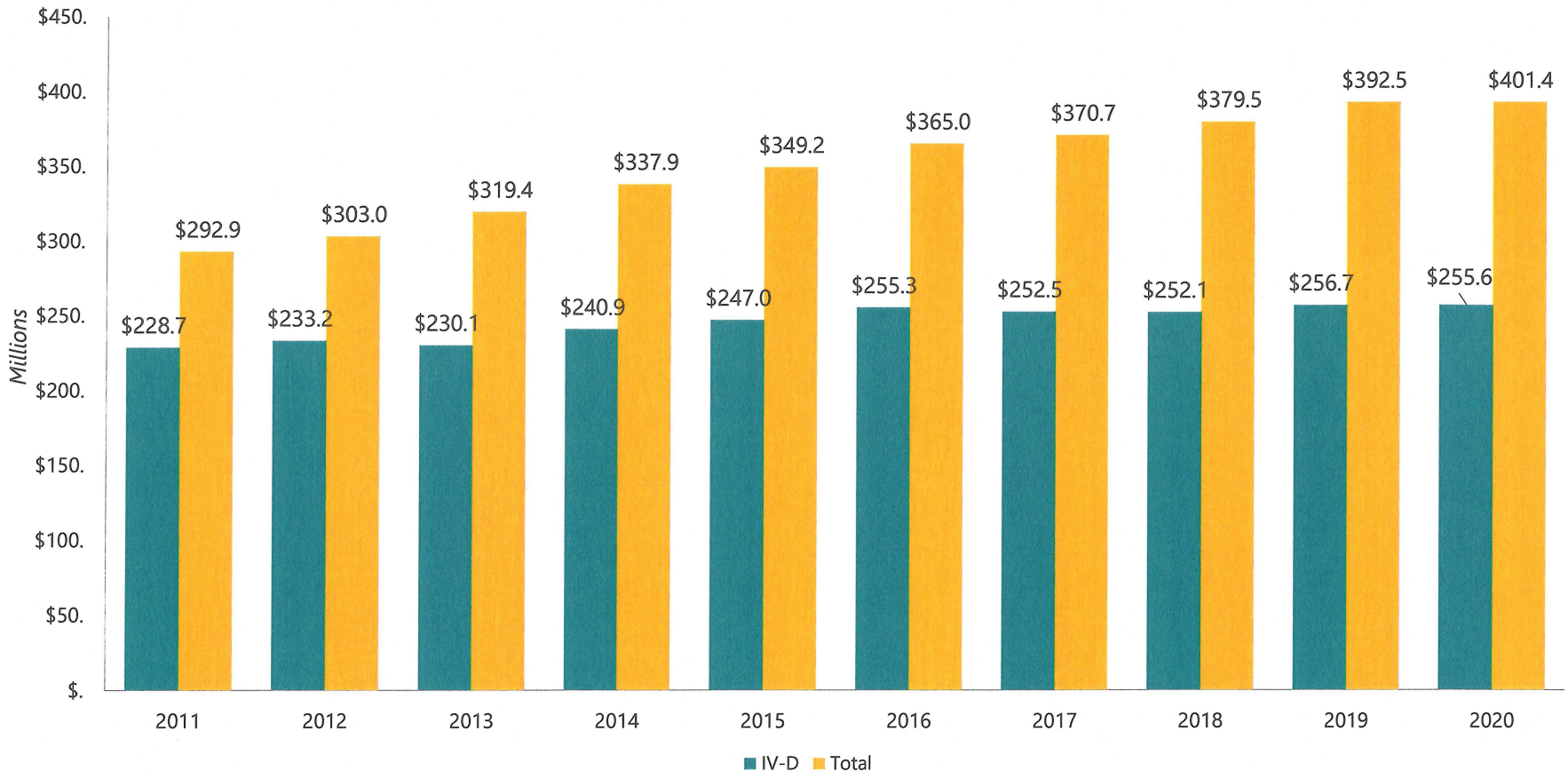


Calendar Years 2011-2020

ORDER ESTABLISHMENT AFFECTED BY COVID-19



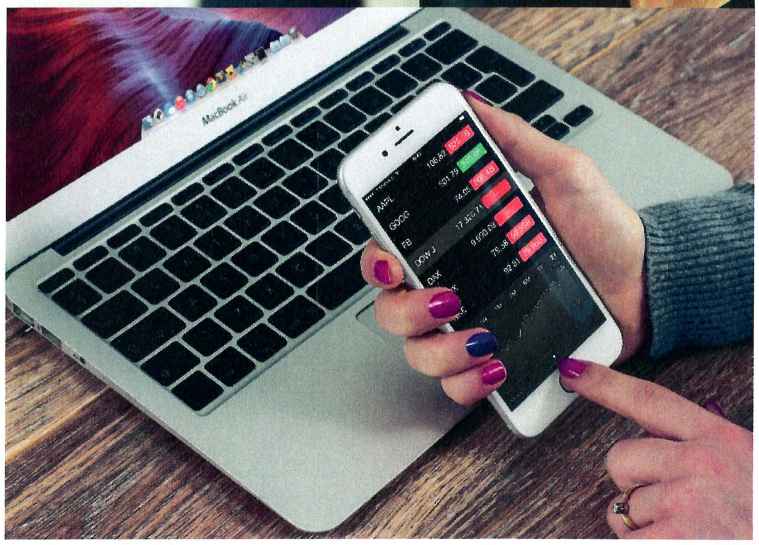
UNPAID SUPPORT IN FULL-SERVICE CASES IS BEING CONTAINED



NEW IN 2019-2021

- Virtual Customer Service
  - Appointment-only in field offices
  - Centralized Call Center
- COVID Response
  - Economic Impact Payments
  - Genetic testing/court actions
- Permanent telework for nearly two-thirds of our team members
- Transforming from regional units to functional units
- Intergovernmental Grant





CHILD SUPPORT
COVID-19 Impacts

- Telework for nearly two-thirds of our team members
- Genetic testing
- Service of Process
- Access to courts
- Increase in unemployment
- $1,200 Economic Impact Payments
  - Injured spouses
  - Incarcerated and deceased

HOW DO CUSTOMERS REACH US?

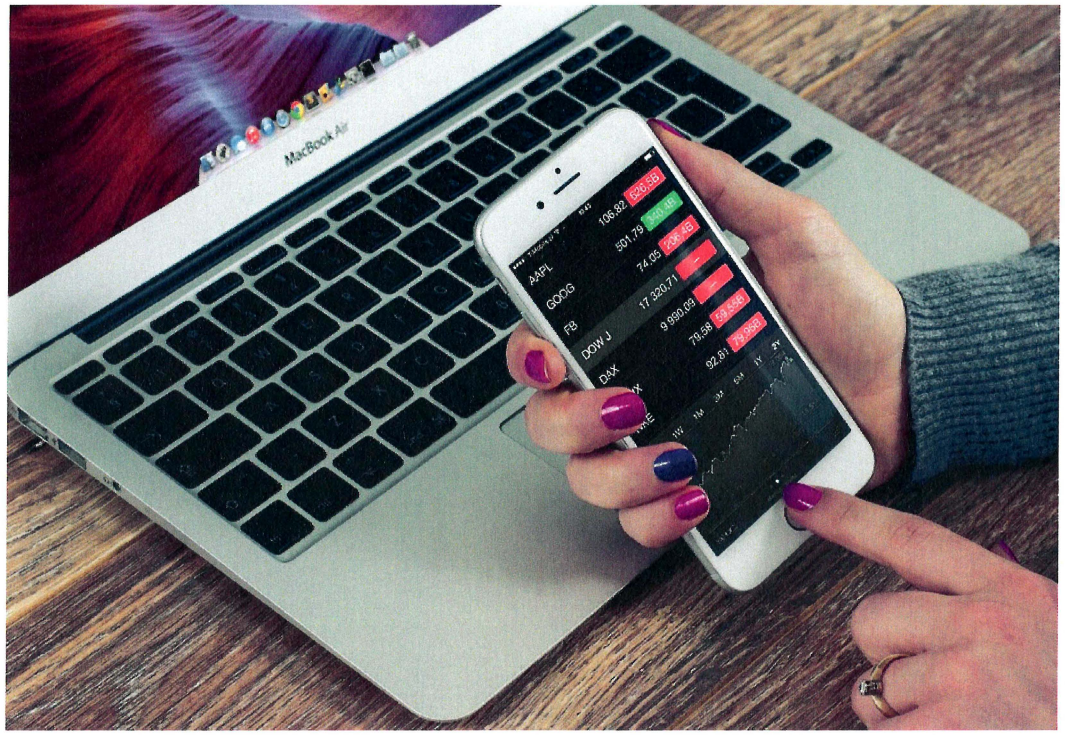


childsupport@nd.gov



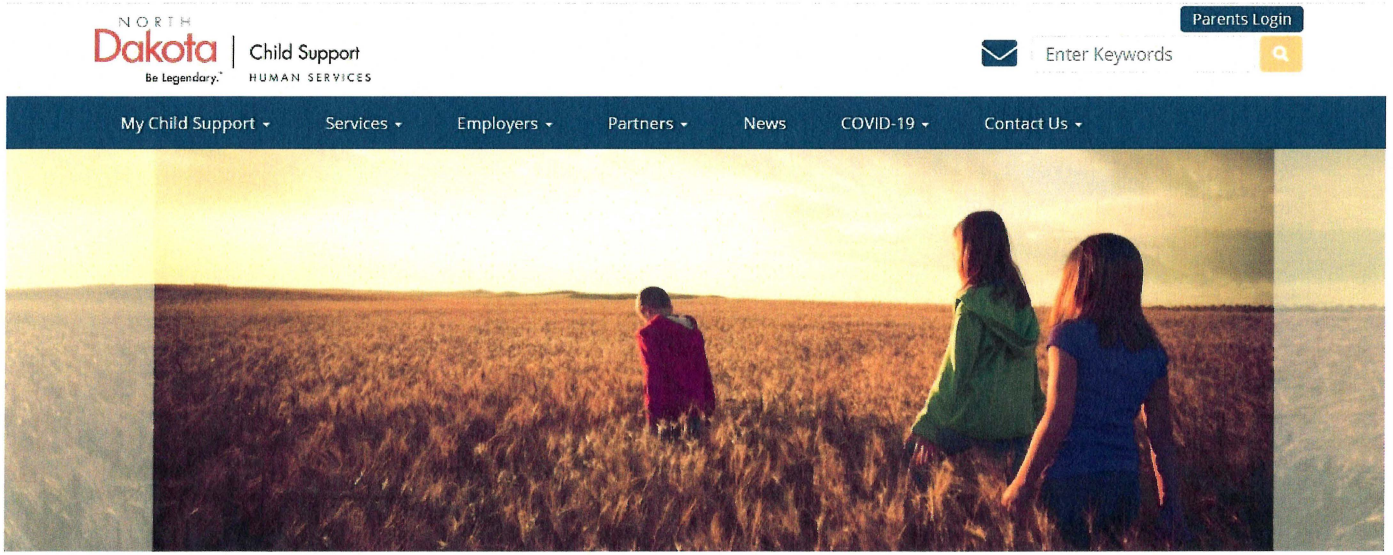
(800) 231-4255

HOW DO CUSTOMERS REACH US?



Anytime, Anywhere

HOW DO CUSTOMERS REACH US?



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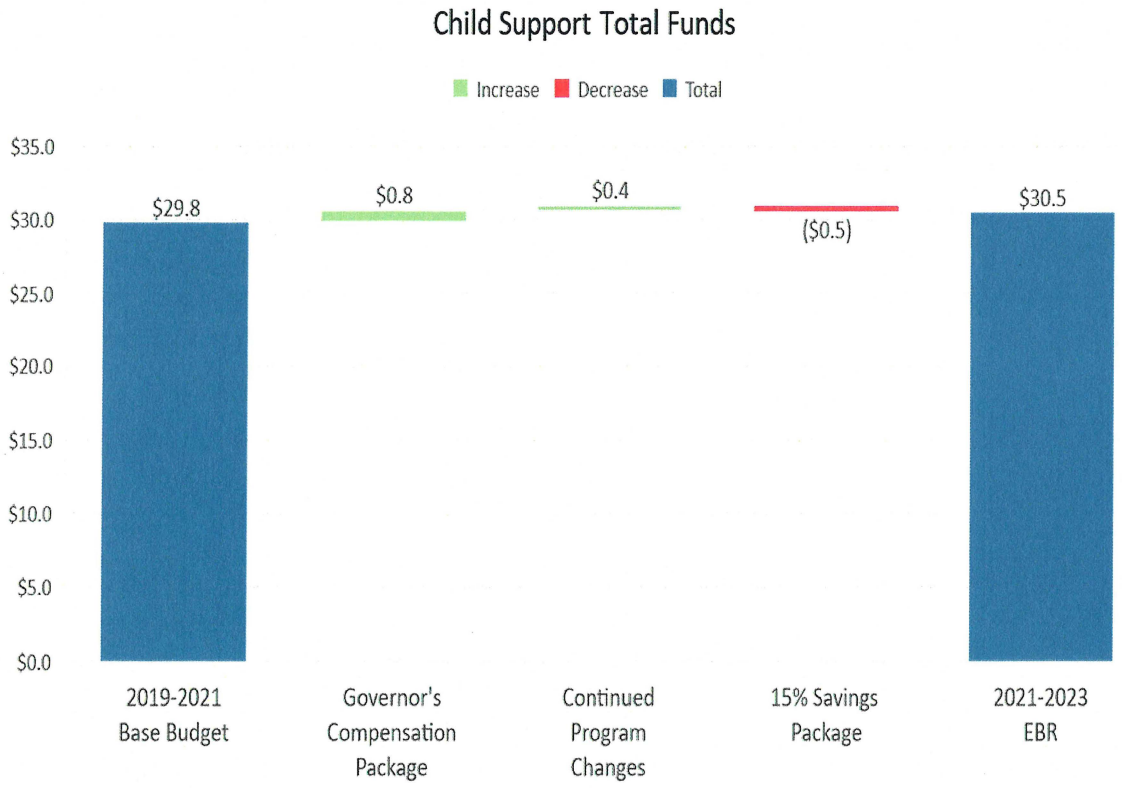
CHILD SUPPORT
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	25,753,469	1,250,677	27,004,146
Operating	4,052,038	(517,082)	3,534,956
Total	29,805,507	733,595	30,539,102
General Fund	8,088,500	117,317	8,205,817
Federal Funds	17,605,475	704,203	18,309,678
Other Funds	4,111,532	(87,925)	4,023,607
Total	29,805,507	733,595	30,539,102
Full Time Equivalent (FTE)	157.70	0	157.70

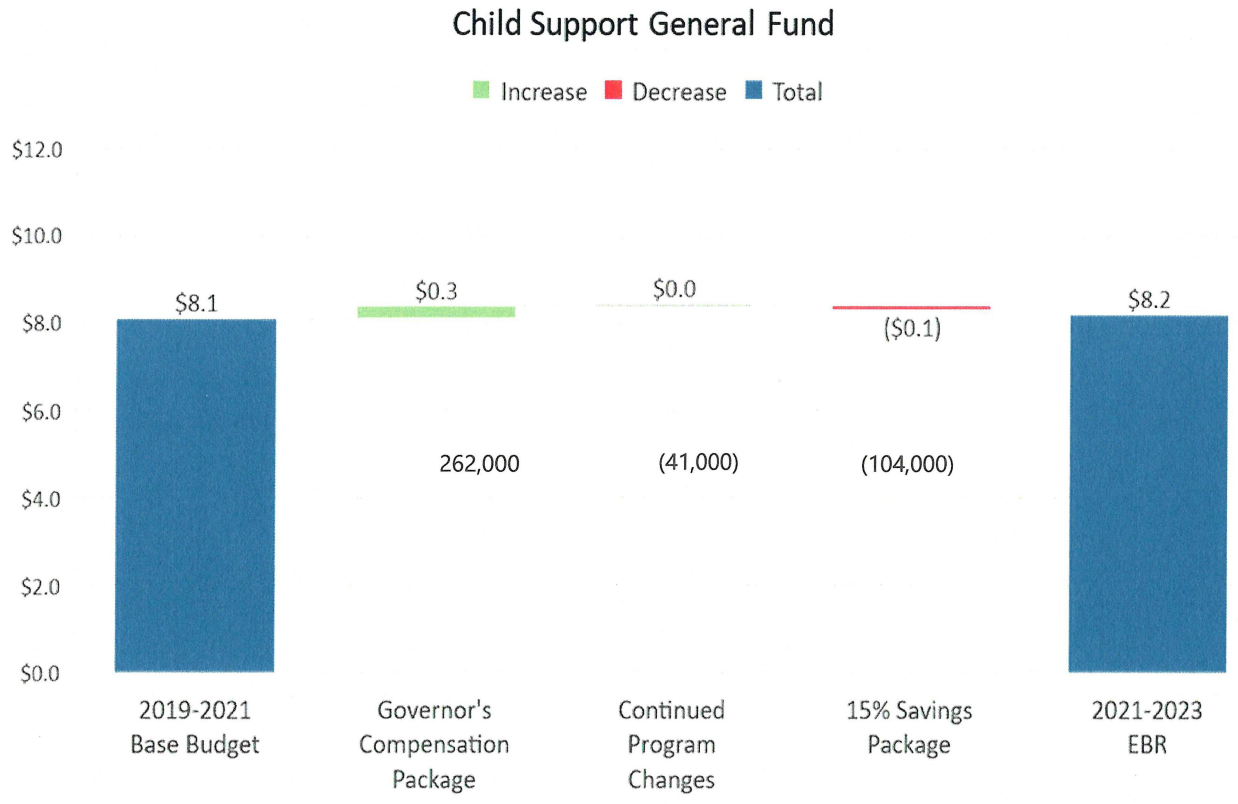
OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



Continued Program Costs
Operational savings related to travel, printing, postage

15% Savings Plan
Reductions related to office space and office equipment leases and maintenance

GENERAL FUND CHANGES (IN MILLIONS)



Continued Program Costs
Operational savings related to travel, printing, postage

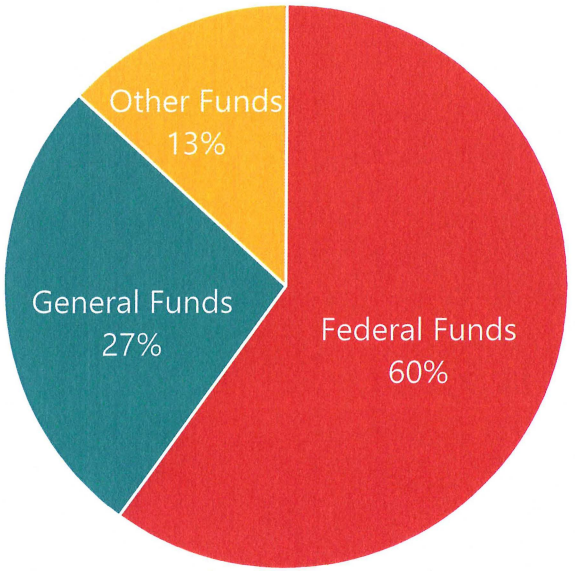
15% Savings Plan
Reductions related to Office Space and office equipment leases and maintenance

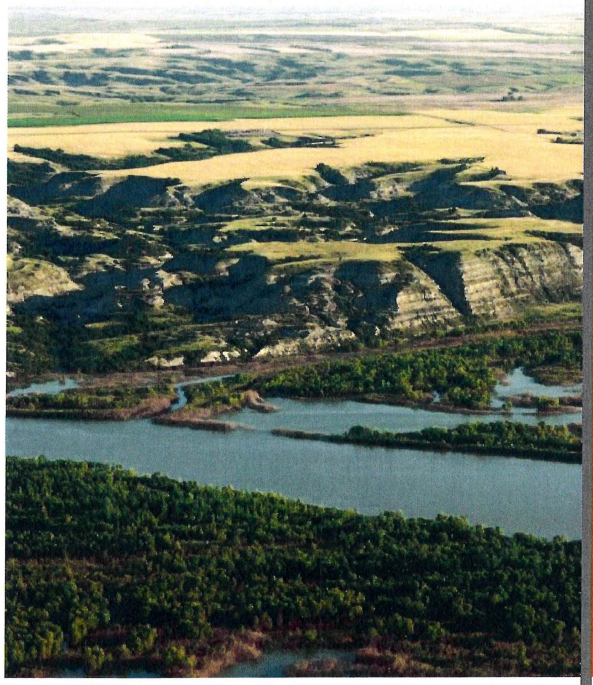


Child Support Budget Summary

No change in FTEs; $733,595 increase in total funding (60% federal funds)

- Operating efficiencies related to travel and occupancy





Contact Information

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Toll Free: 1-800-231-4255
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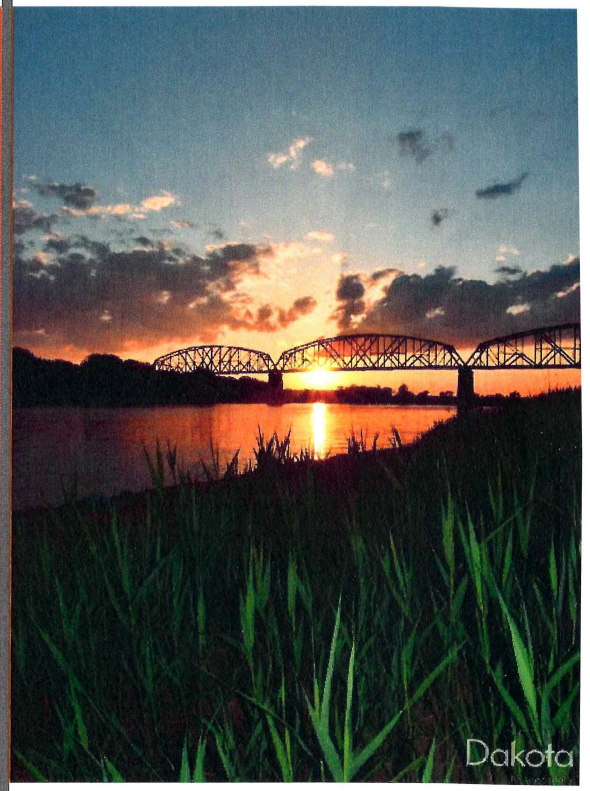




House Bill 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman #1150

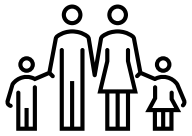
Vocational Rehabilitation

Creating new connections between employees and employers

NORTH Dakota | Human Services

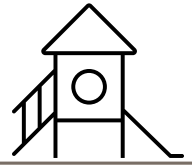
Be Legendary.™

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



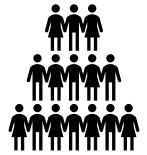
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

The threads that run through every person's life

Foundations of Wellbeing are Interconnected



Economic Health

Having the resources you need to meet basic needs contributes to stability and is a foundation you can build on

Behavioral Health

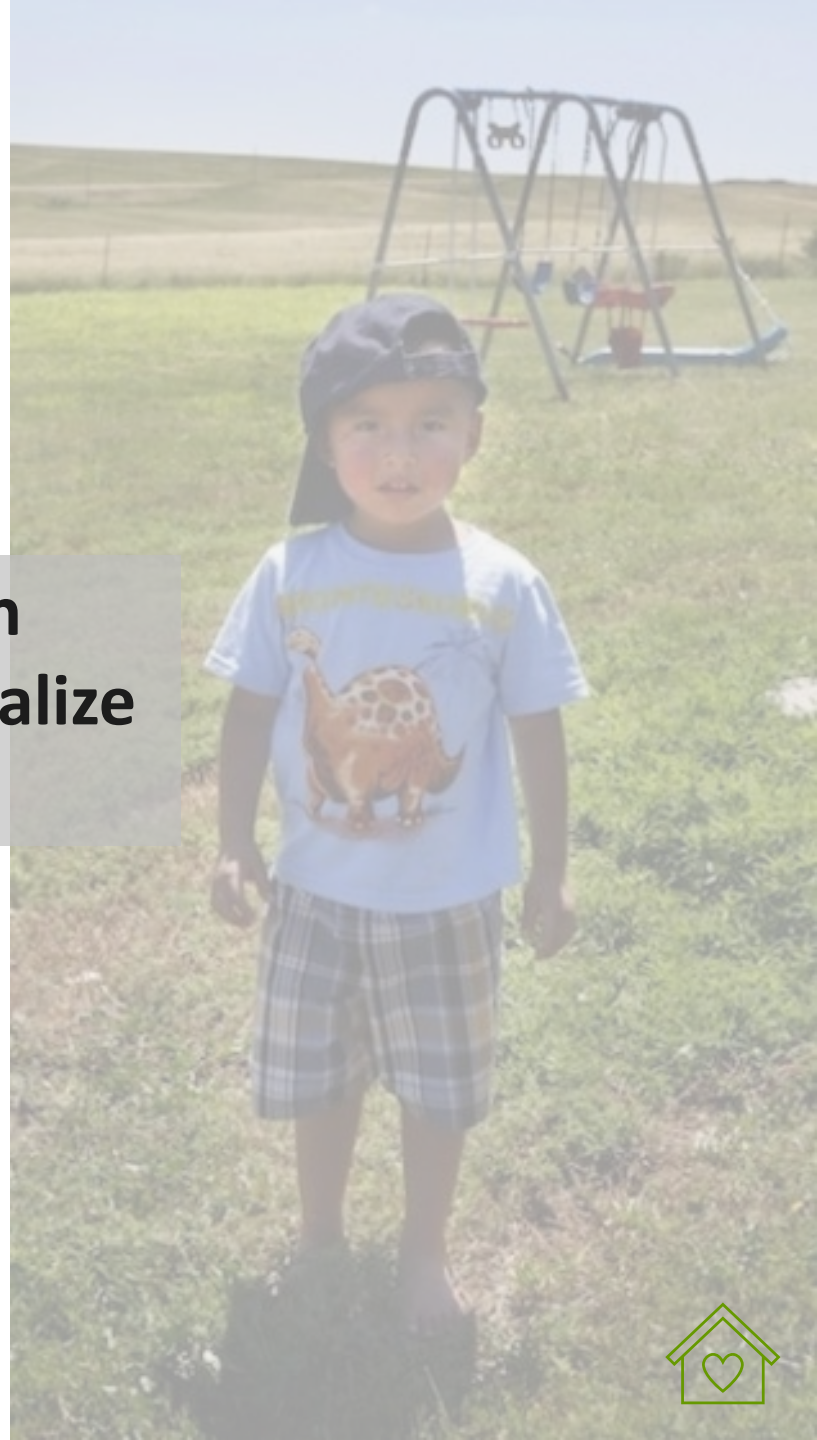
Having good mental health and a healthy relationship with substances boosts your ability to weather life's storms

Physical Health

When you are in good physical health you can better navigate the activities of daily and community life

The stability that comes from good **economic** health can **improve behavioral** health.
The stability that comes from good **physical** and **behavioral** health **enables economic** health.



Communities are stronger when everyone has the opportunity to realize their full potential

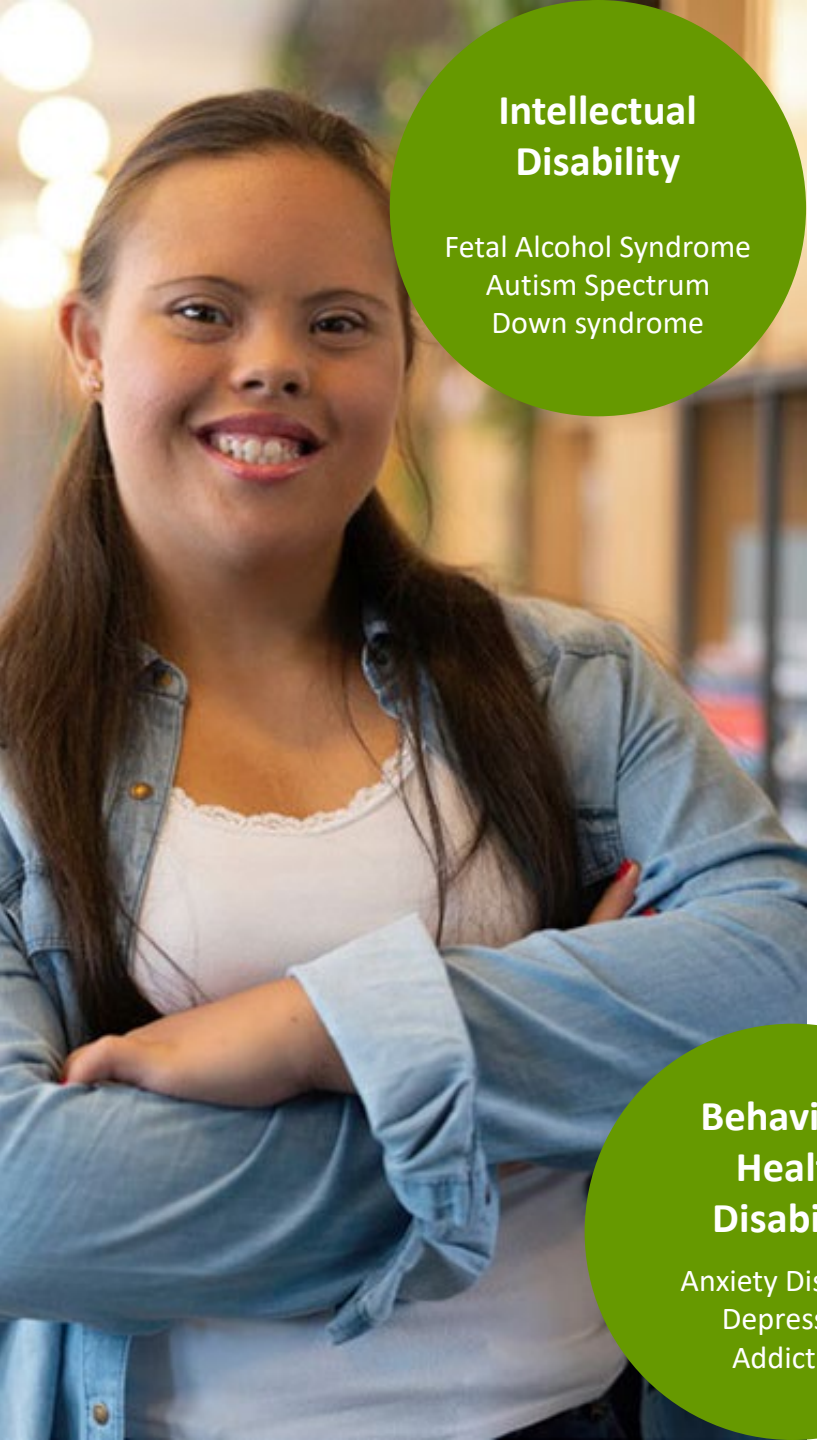
VOCATIONAL REHABILITATION DIVISION
Program Purpose

Assists North Dakotans with disabilities to enter or re-enter the workforce through individualized services

- Assess skills and abilities
- Identify a vocational goal
- Develop an individualized plan to achieve employment
- Provide services that result in competitive integrated employment

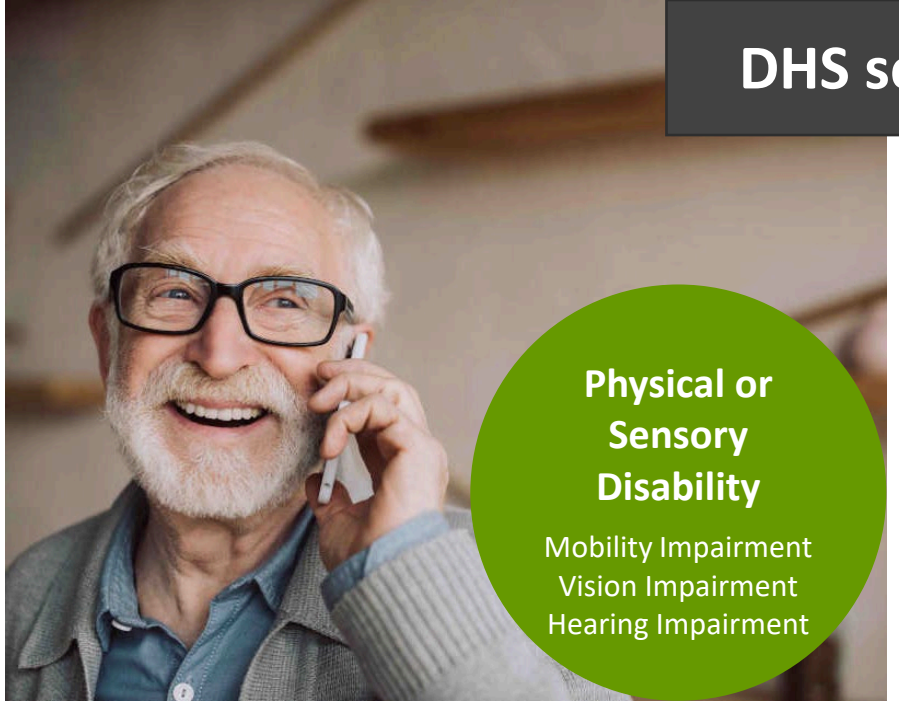


DHS serves people with Disabilities



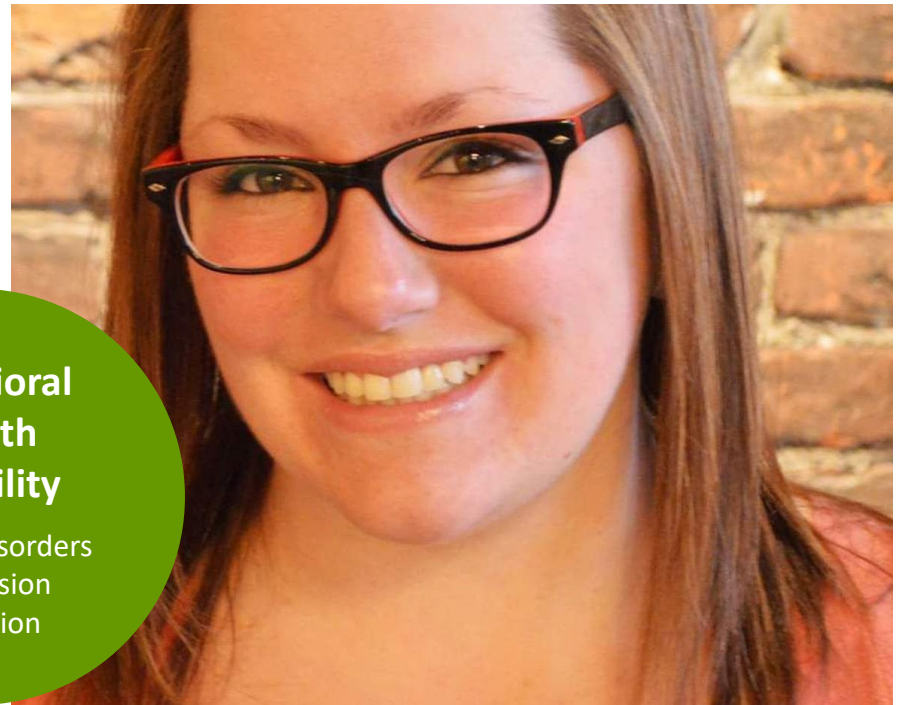
Intellectual Disability

Fetal Alcohol Syndrome
Autism Spectrum
Down syndrome



Physical or Sensory Disability

Mobility Impairment
Vision Impairment
Hearing Impairment



Behavioral Health Disability

Anxiety Disorders
Depression
Addication



Cognitive or Neurological Disability

Learning Disability
Acquired Brain Injury
Multiple Sclerosis

VOCATIONAL REHABILITATION DIVISION
Eligibility

- Physical or mental disability
- Barrier to seeking, maintaining, or advancing in employment due to disability
- Individual requires and will benefit from VR services



VOCATIONAL REHABILITATION DIVISION
Services

- Vocational Counseling and Guidance
- Pre-employment Transition Services to Students with Disabilities
- Vocational Training
- Assistive Technology
- Hearing and Vision Services
- ADA Consultation to Businesses
- Placement Site Recruitment
- Job Placement



CONNECTING IN SCHOOL: PRE-EMPLOYMENT TRANSITION SERVICES (PRE-ETS)

Assists students with disabilities in making the transition from high school to post secondary education programs and/or competitive integrated employment

(age 21 or younger and 9th grade or above)

2019-2020

Served students in 62 ND schools



CONNECTING WITH EMPLOYERS: SERVICES TO BUSINESSES

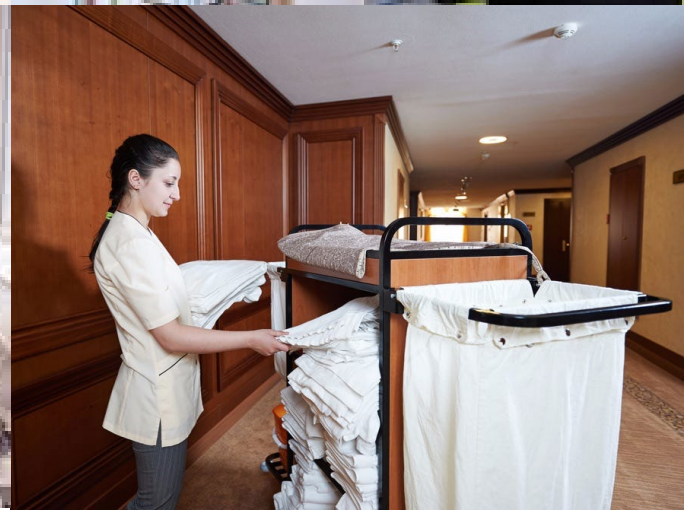
Any ND employer is eligible for VR services (non-profit or for-profit business or government agency)

- Assist employers in connecting to an untapped labor pool of people with disabilities
- Retaining existing, well-trained and productive workers who may have developed or have a worsening disability
- Providing education on disability awareness, tax incentives and the Americans with Disabilities Act



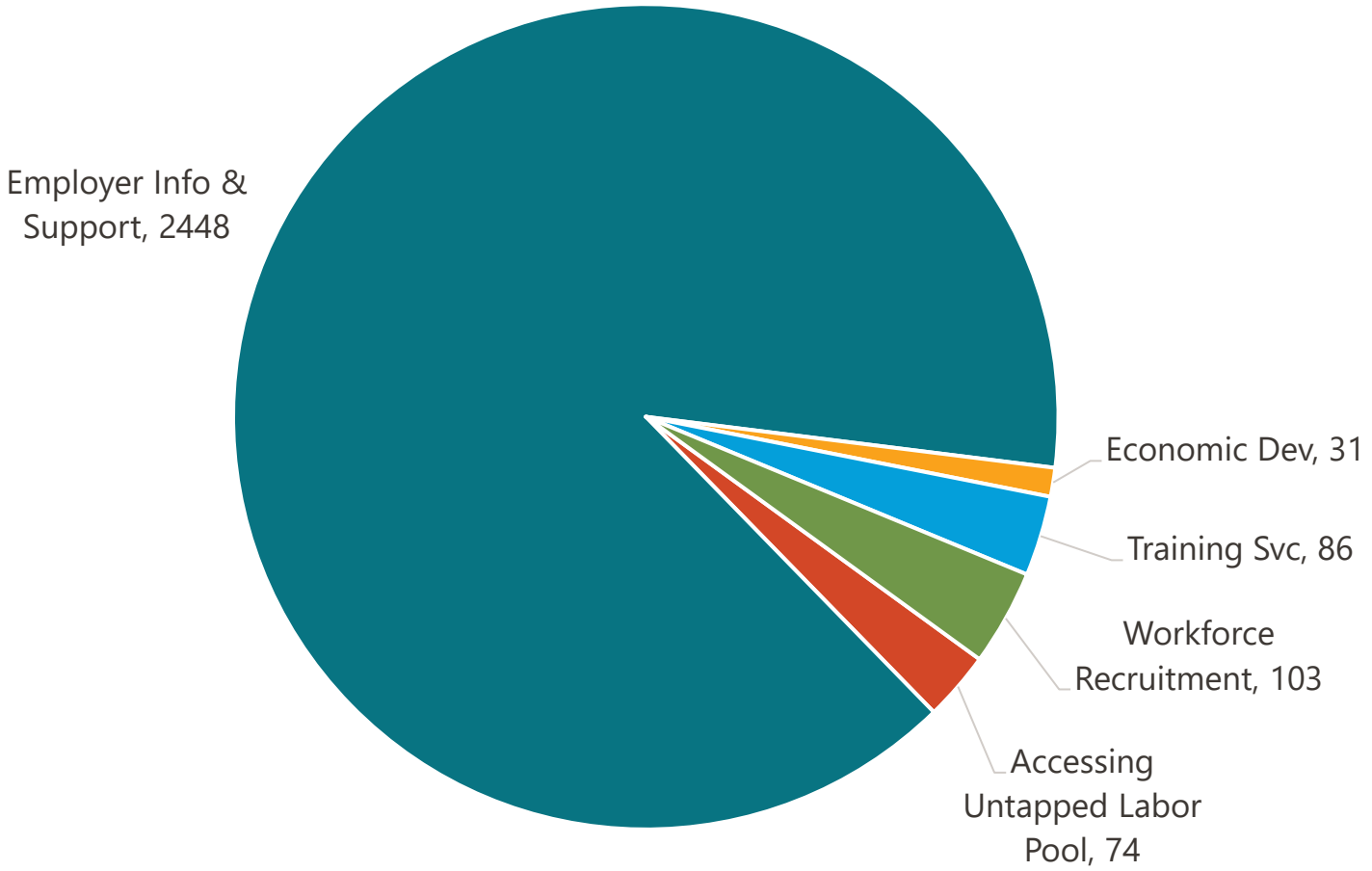






CONNECTING WITH EMPLOYERS: SERVICES TO BUSINESSES

In 2020, VR staff provided 2,742 services to 1,498 different businesses



CONNECTING AT HOME:
OLDER INDIVIDUALS WHO ARE BLIND OR VISION IMPAIRED

Assessment of need for home modifications and equipment

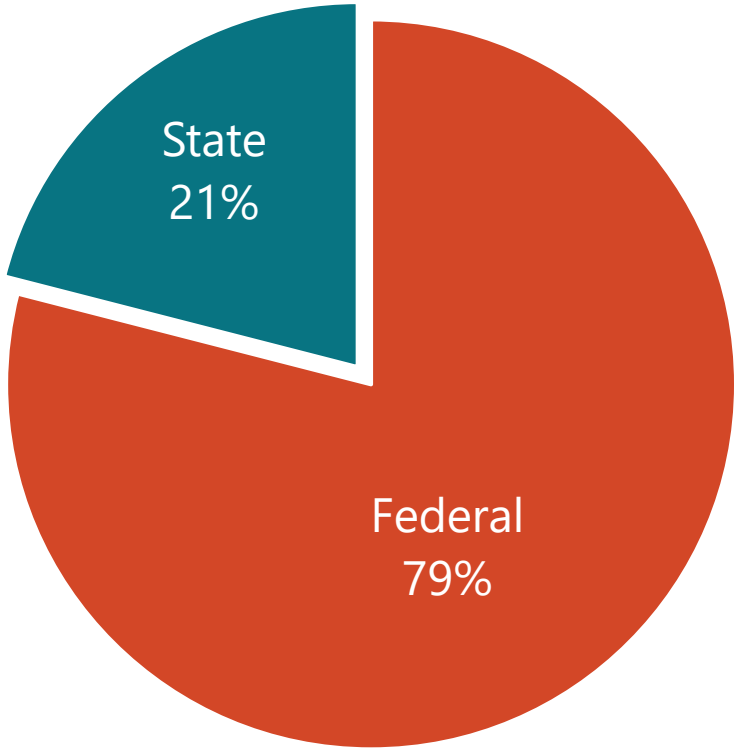
- Assistive Technology Devices and Training – magnifiers, lighting, etc.
- Communication Skills
- Independent Living Skills
- Home or environmental modifications/equipment
- Counseling, Advocacy, Training, and Support



VOCATIONAL REHABILITATION DIVISION
Return on Investment

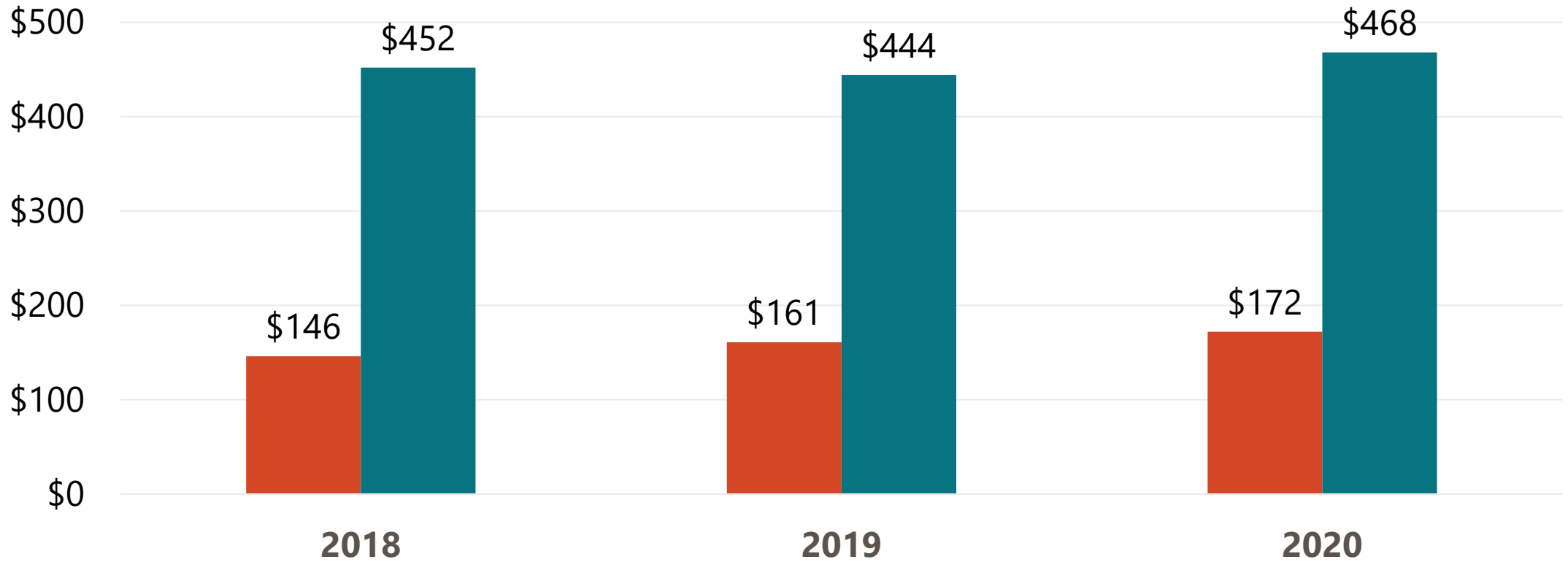
For every **one dollar spent** on Vocational Rehab services Clients **earnings increase by $9.12/hour**

For every **one dollar spent** on Vocational Rehab services Clients **pay $1.82 in taxes**

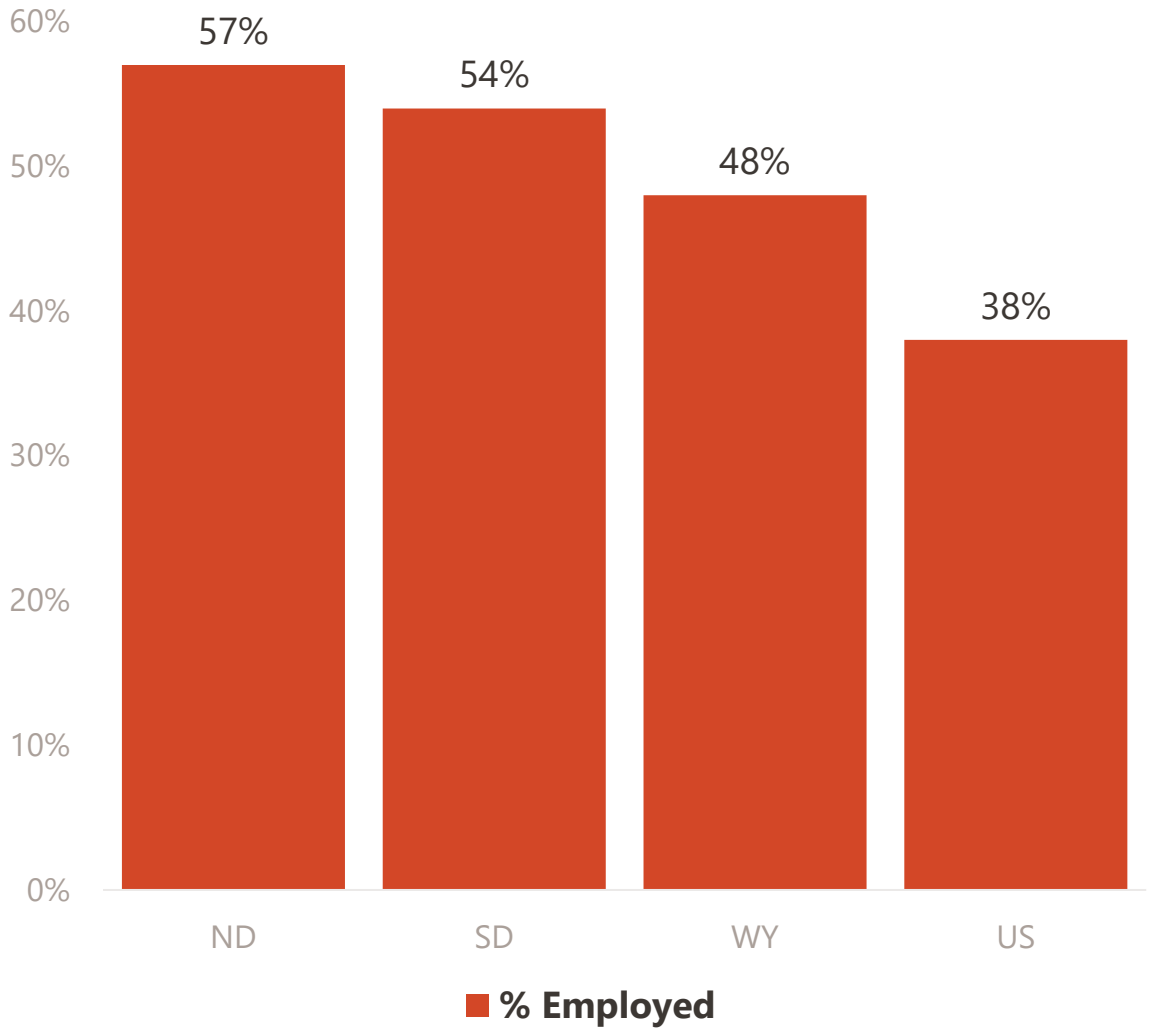


FFY 2020 STATS

Average Weekly Wage of VR Clients at Application vs. Placement

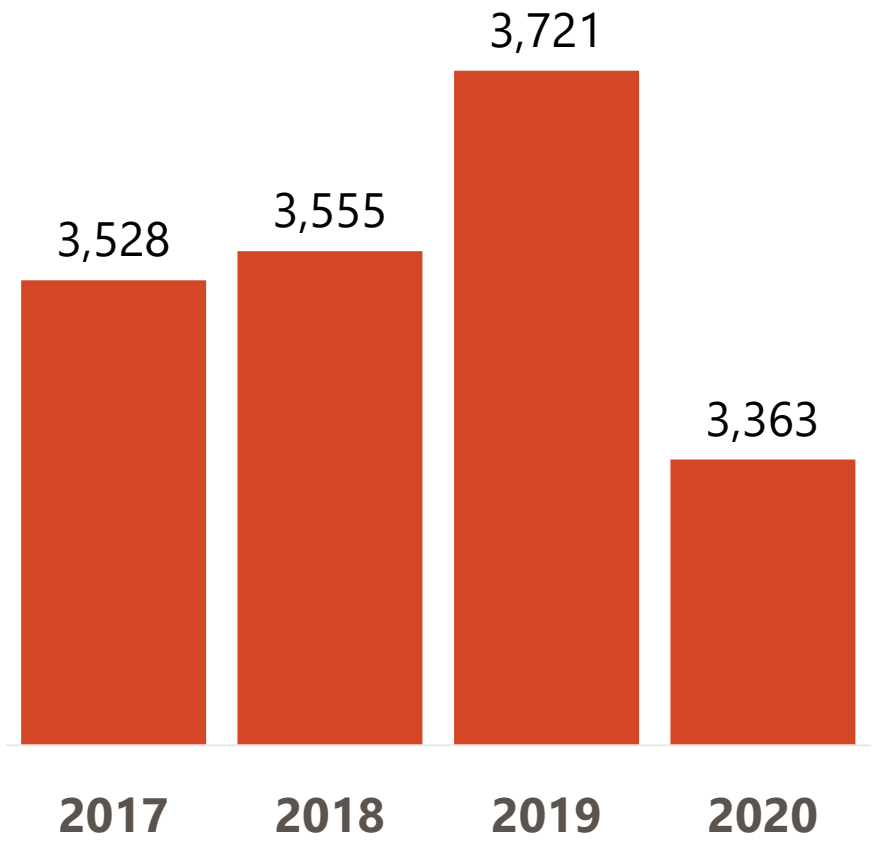


ND IS 1ST IN THE U.S. IN TERMS OF % OF PEOPLE WITH DISABILITIES WHO ARE EMPLOYED



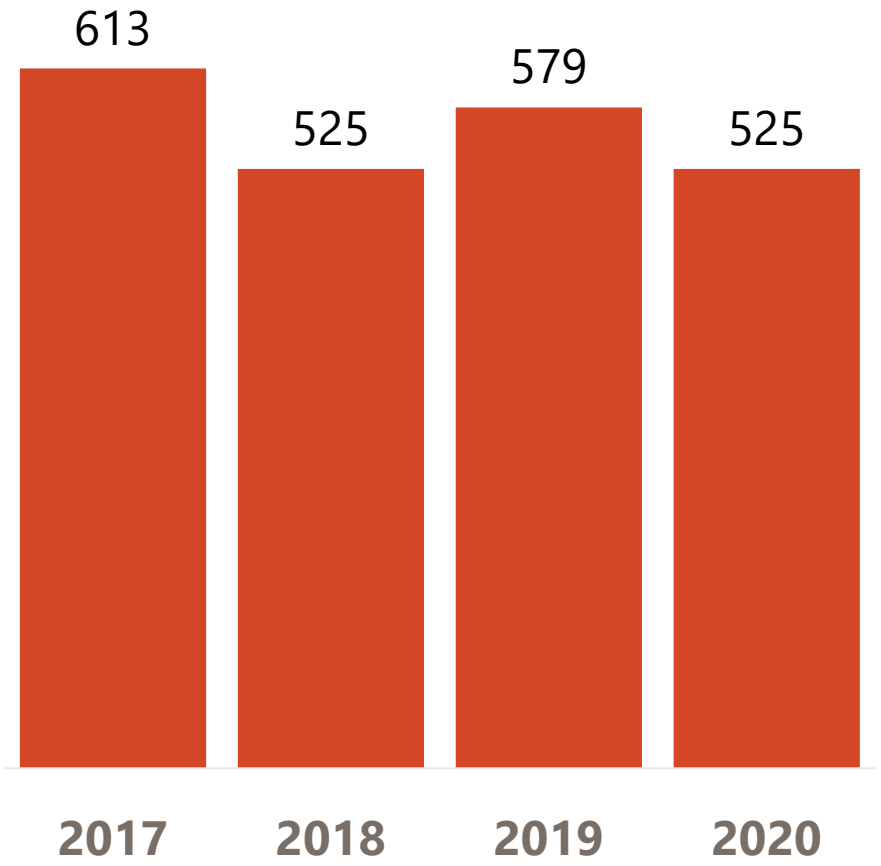
FFY 2020 STATS

VR Clients Enrolled/In Process



FFY 2020 STATS

VR Clients Successfully Placed



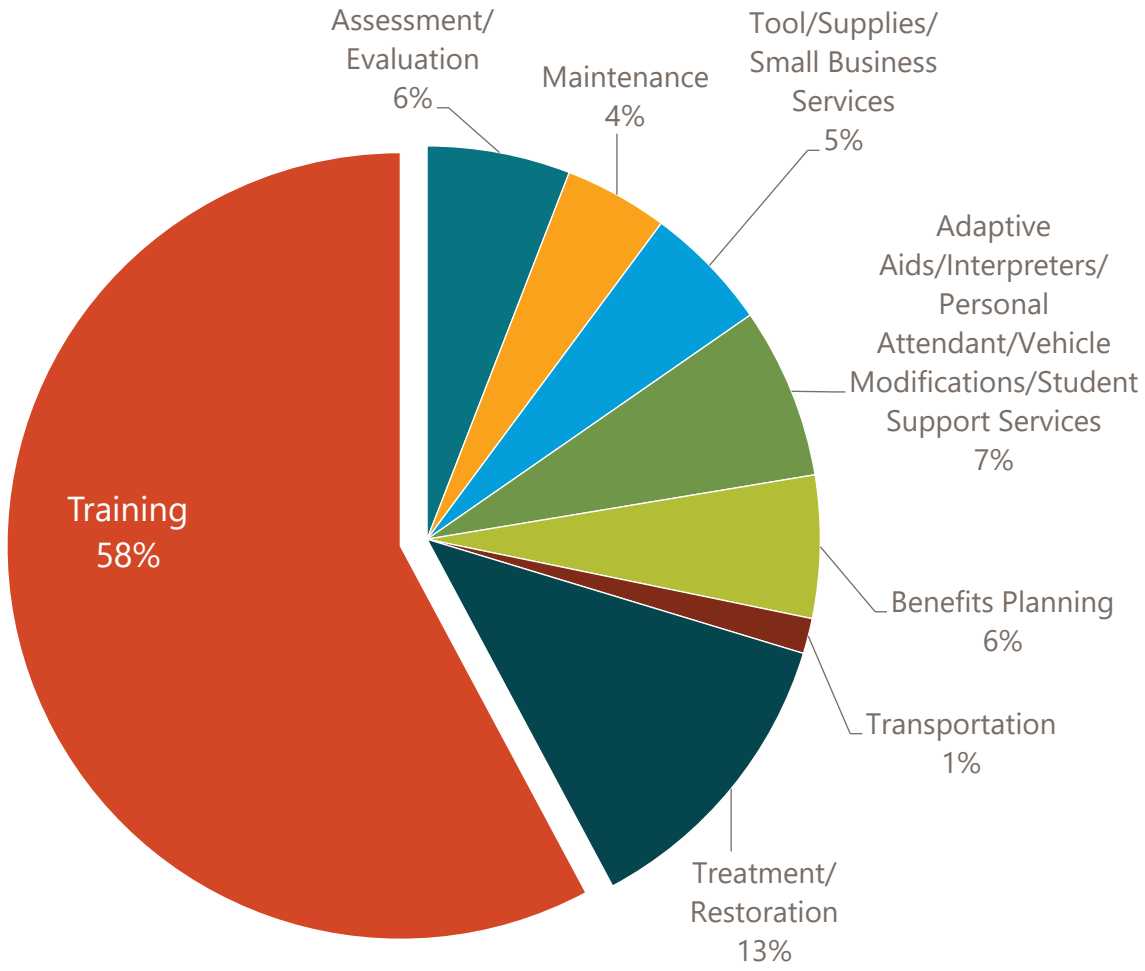
CASE SERVICE EXPENDITURES FFY 2020 - $2,339,231

58% of NDVR's Case Service Expenditures are used to provide training individuals with disabilities, which includes:

- On-the-Job Training
- Work Experience
- Job Development
- Customized Employment
- Supported Employment
- Post-secondary Tuition

Treatment/Restoration includes:

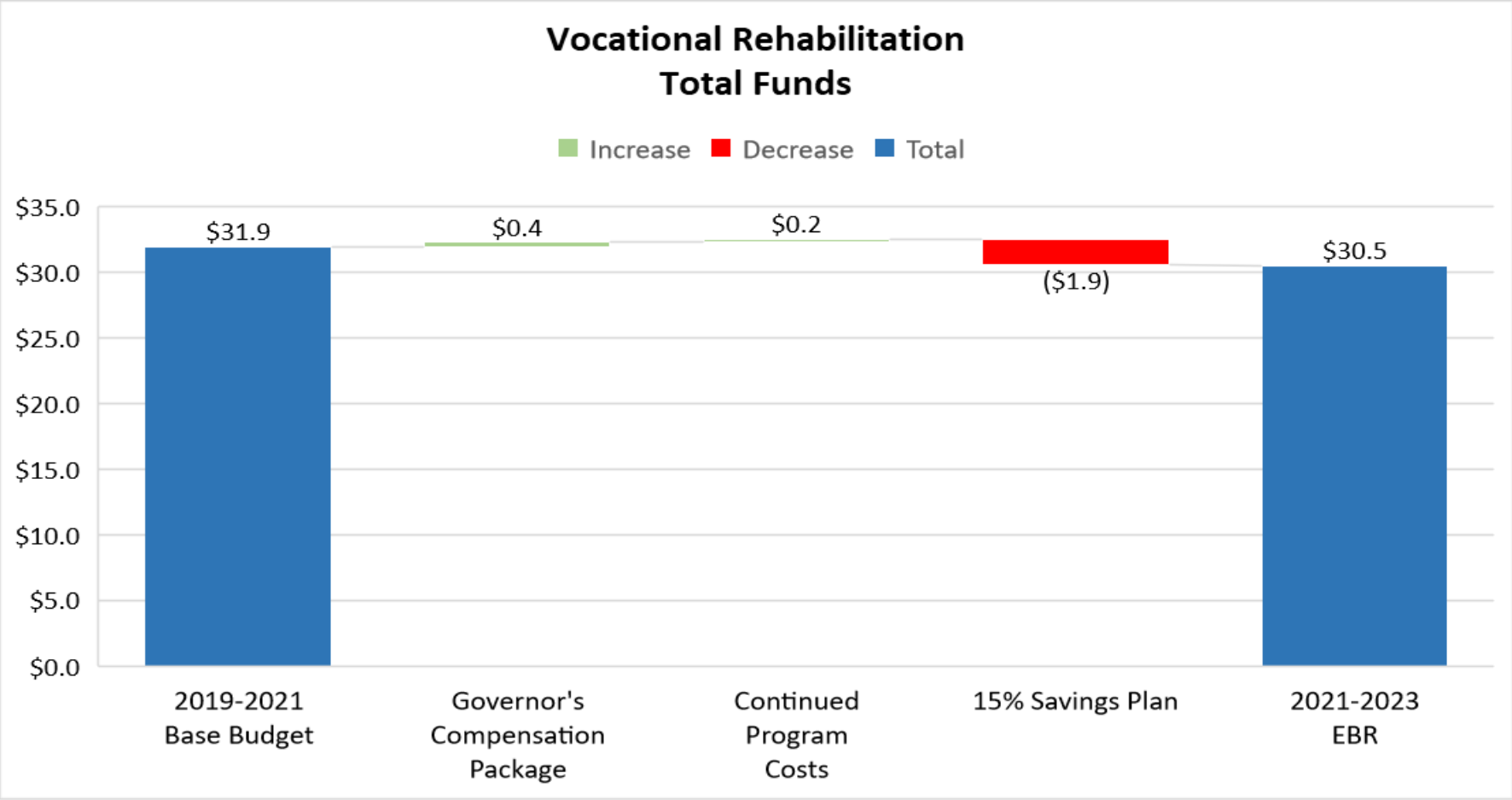
- Therapy/Medical visits (PT, OT, behavioral health)
- Hearing and vision aids



OVERVIEW OF BUDGET CHANGES

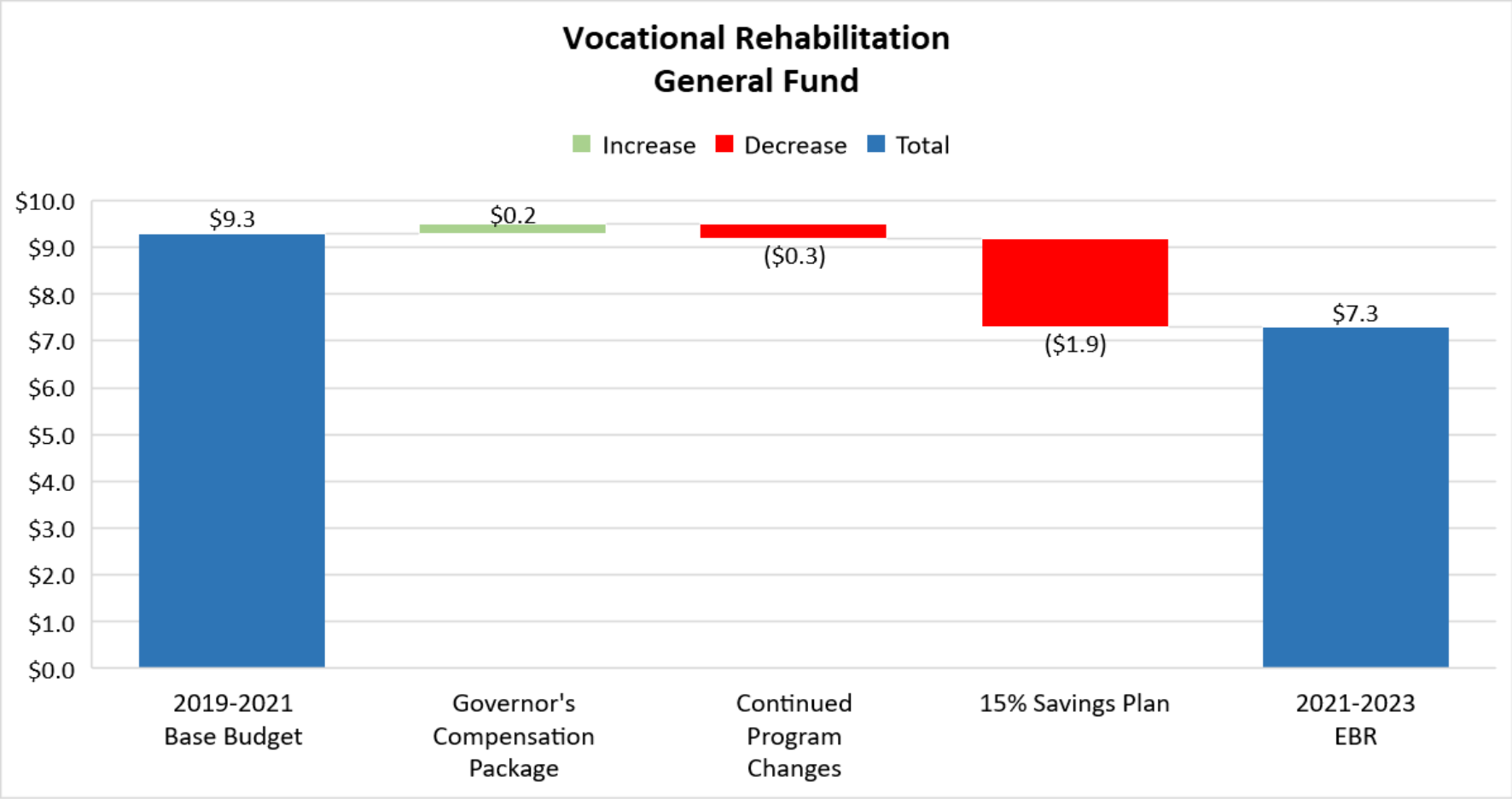
Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	14,101,052	687,464	14,788,516
Operating	7,533,223	(144,686)	7,388,537
Grants	10,218,764	(1,867,494)	8,351,270
Total	31,853,039	(1,324,716)	30,528,323
General Fund	9,308,268	(2,024,678)	7,283,590
Federal Funds	22,370,770	678,961	23,049,731
Other Funds	174,001	21,001	195,002
Total	31,853,039	(1,324,716)	30,528,323
Full Time Equivalent (FTE)	85.00	0.00	85.00

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



- Overall decrease of ($1.3M) from 2019-2021 Base Budget
  - Continued Program Costs of $0.2M:
    - Annual salary adjustments of $0.3M
    - Reduction of contracted costs of ($0.2M)
    - Increase in Job Service building rent of $0.051M
  - 15% Savings Plan of ($1.9M):
    - Elimination of contracted costs for Centers for Independent Living of ($1.7M)
    - Elimination of contracted costs for Bottineau Winter Park of ($0.2M)

GENERAL FUND CHANGES (IN MILLIONS)



- Overall reduction of ($2.0M) from 2019-2021 Base Budget
  - Continued Program Changes of ($0.3M):
    - Decrease for Basic Support Case Services
  - 15% Savings Plan of ($1.9M):
    - Elimination of contracted costs for Centers for Independent Living of ($1.7M)
    - Elimination of contracted costs for Bottineau Winter Park of ($0.2M)

ADDITIONAL PROGRAMS

Federal Plan Responsibility

- WIOA Unified State Plan for Workforce – DOL (partial, with JSND and DPI)
- State Plan for Independent Living – Admin for Comm Living/HHS

Councils and Commissions

- Statewide Rehabilitation Council
- State Independent Living Council

Designated State Entity for Centers for Independent Living

- Independent living skills training
- Information and referrals for orientation and mobility
- Transition services – from institutions to home/community based; also youth transition to independent living
- Peer mentoring
- Advocacy

STATE PLAN FOR INDEPENDENT LIVING

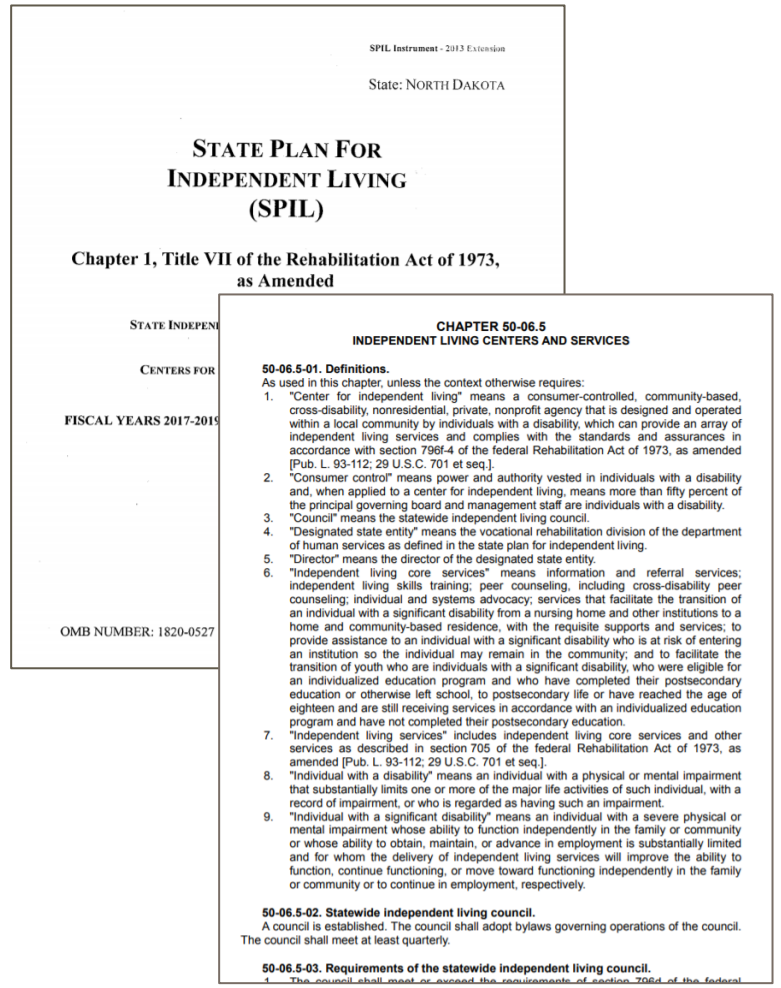
- ND receives approx. $663,808 from the federal Administration for Community Living (ACL) to support independent living services each biennium
- In the past, ND appropriated the $73,756 required match plus $1,675,406 of general funds for a total of approximately $1,749,162 each biennium
- Title VII Funds go directly to Centers for Independent Living
- Outcomes defined in SPIL (3-year renewal)

Dakota
Center for Independent Living

Freedom
Resource Center for Independent Living

Independence, Inc.
A Resource Center for Independent Living

Options
Resource Center for Independent Living



SPIL Instrument - 2013 Extension

State: NORTH DAKOTA

STATE PLAN FOR INDEPENDENT LIVING (SPIL)

Chapter 1, Title VII of the Rehabilitation Act of 1973, as Amended

STATE INDEPEN

CENTERS FOR

FISCAL YEARS 2017-2019

OMB NUMBER: 1820-0527

CHAPTER 50-06.5
INDEPENDENT LIVING CENTERS AND SERVICES

50-06.5-01. Definitions.
As used in this chapter, unless the context otherwise requires:

1. "Center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential, private, nonprofit agency that is designed and operated within a local community by individuals with a disability, which can provide an array of independent living services and complies with the standards and assurances in accordance with section 796f-4 of the federal Rehabilitation Act of 1973, as amended [Pub. L. 93-112; 29 U.S.C. 701 et seq.].
2. "Consumer control" means power and authority vested in individuals with a disability and, when applied to a center for independent living, means more than fifty percent of the principal governing board and management staff are individuals with a disability.
3. "Council" means the statewide independent living council.
4. "Designated state entity" means the vocational rehabilitation division of the department of human services as defined in the state plan for independent living.
5. "Director" means the director of the designated state entity.
6. "Independent living core services" means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; individual and systems advocacy; services that facilitate the transition of an individual with a significant disability from a nursing home and other institutions to a home and community-based residence, with the requisite supports and services; to provide assistance to an individual with a significant disability who is at risk of entering an institution so the individual may remain in the community; and to facilitate the transition of youth who are individuals with a significant disability, who were eligible for an individualized education program and who have completed their postsecondary education or otherwise left school, to postsecondary life or have reached the age of eighteen and are still receiving services in accordance with an individualized education program and have not completed their postsecondary education.
7. "Independent living services" includes independent living core services and other services as described in section 705 of the federal Rehabilitation Act of 1973, as amended [Pub. L. 93-112; 29 U.S.C. 701 et seq.].
8. "Individual with a disability" means an individual with a physical or mental impairment that substantially limits one or more of the major life activities of such individual, with a record of impairment, or who is regarded as having such an impairment.
9. "Individual with a significant disability" means an individual with a severe physical or mental impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment, respectively.

50-06.5-02. Statewide independent living council.
A council is established. The council shall adopt bylaws governing operations of the council. The council shall meet at least quarterly.

50-06.5-03. Requirements of the statewide independent living council.

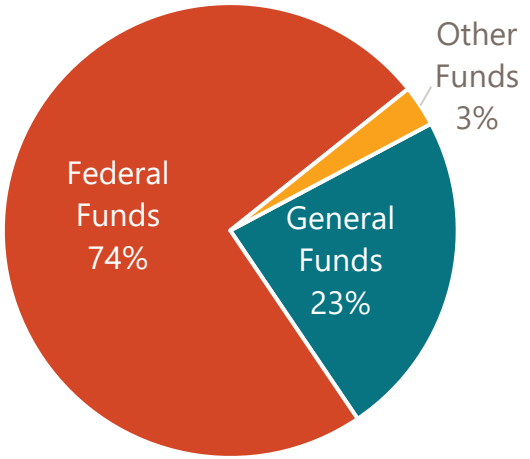


VR Budget Summary

19-21 Budget	**$31,853,039**
21-23 Budget (exec)	**$30,528,323**

85 FTEs; no change in FTEs projected; $1.3 million decrease in total budget (0% federal funds)

- Operating efficiencies related to travel and occupancy
- Discontinuation of grant to private recreational facility
- Exec budget included reduction in state match to Title VII federal funds allocated to Centers for Independent Living; DHS requests restoration of these funds to preserve state's access to federal funds to support independent living





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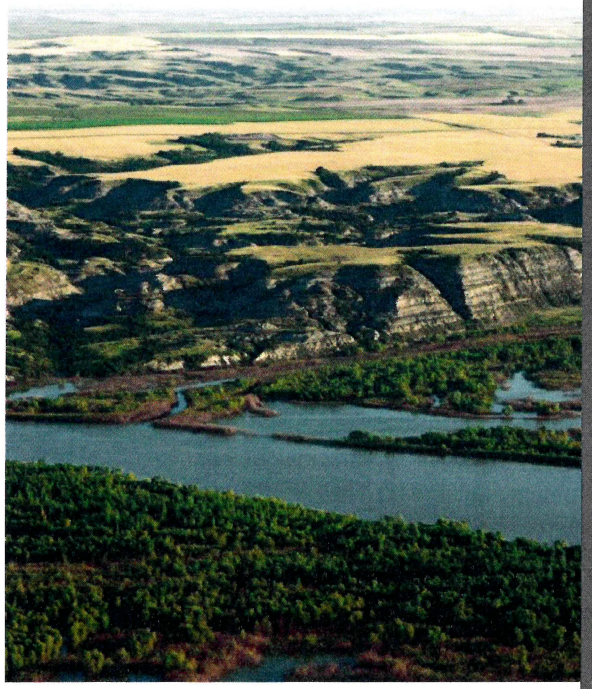
ND Relay TTY: 7-800-366-6888
E-mail: daschlinger@nd.gov





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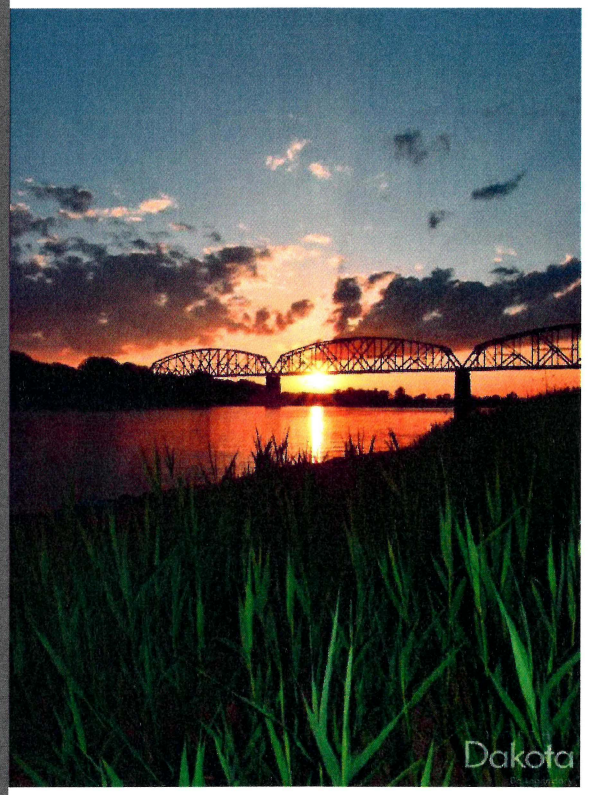
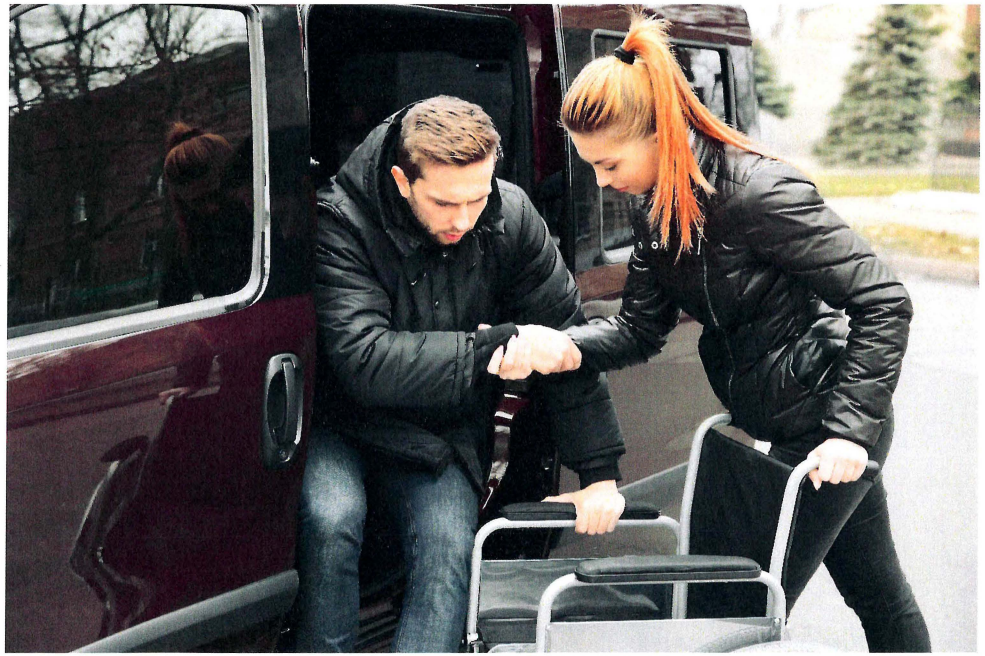


DDS MISSION

To improve the quality of life for North Dakotans with disabilities who apply for or receive Social Security Administration disability benefits, by making timely, consistent and accurate disability determinations.



THE DISABILITY DETERMINATION SERVICES (DDS) PROGRAM



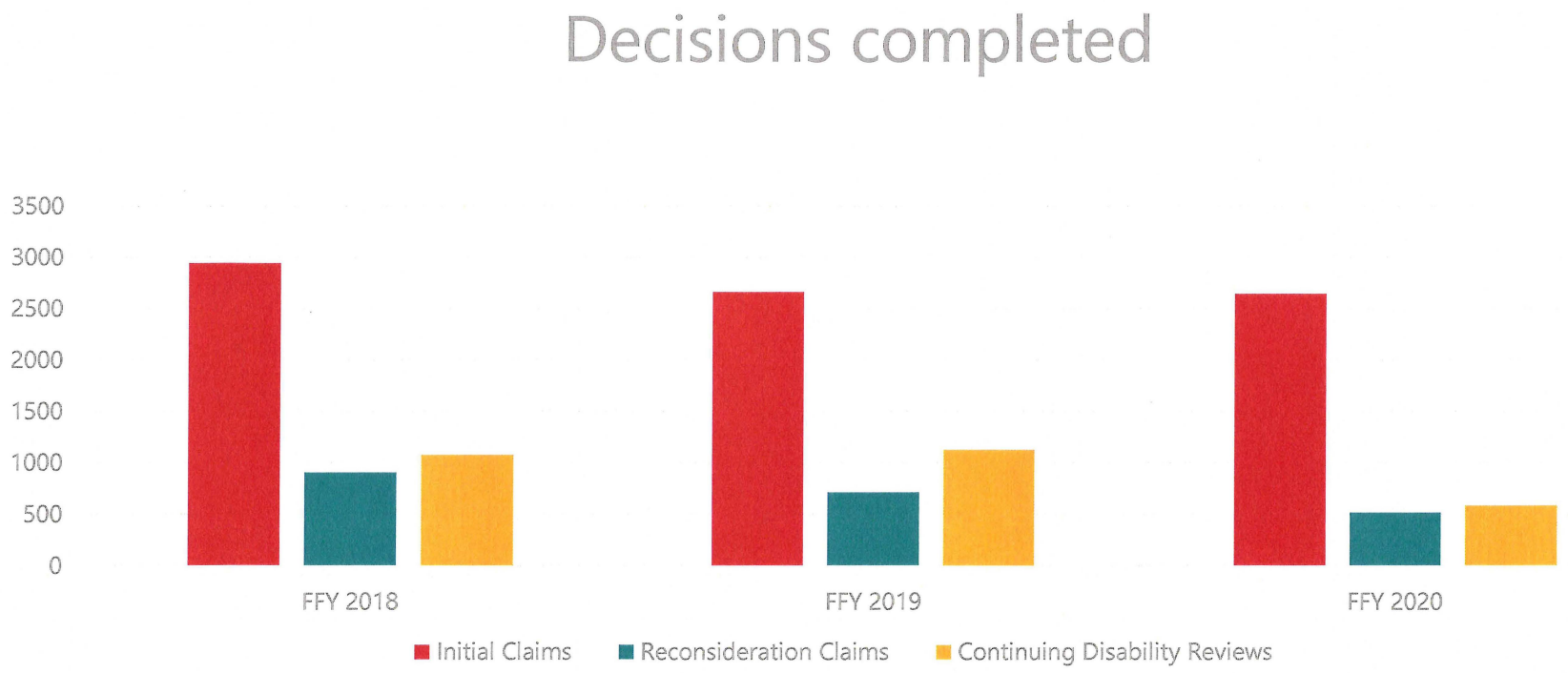
- 100% federally funded
- DDS staff make medical disability determinations using Social Security Administration (SSA) guidelines
- The Social Security disability program provides Social Security Disability Insurance (SSDI) and/ or Supplemental Security Income (SSI) benefits to persons with disabilities who are unable to work

DISABILITY DECISIONS



- The DDS processes disability determinations for the Social Security Administration for 3 main claim levels:
  - Initial claims
  - Reconsideration claims
  - Continuing Disability Reviews (CDR)
- The number of disability decisions that the DDS makes each year is determined by the Social Security Administration

DISABILITY DECISION STATISTICS



COVID-19 IMPACTS

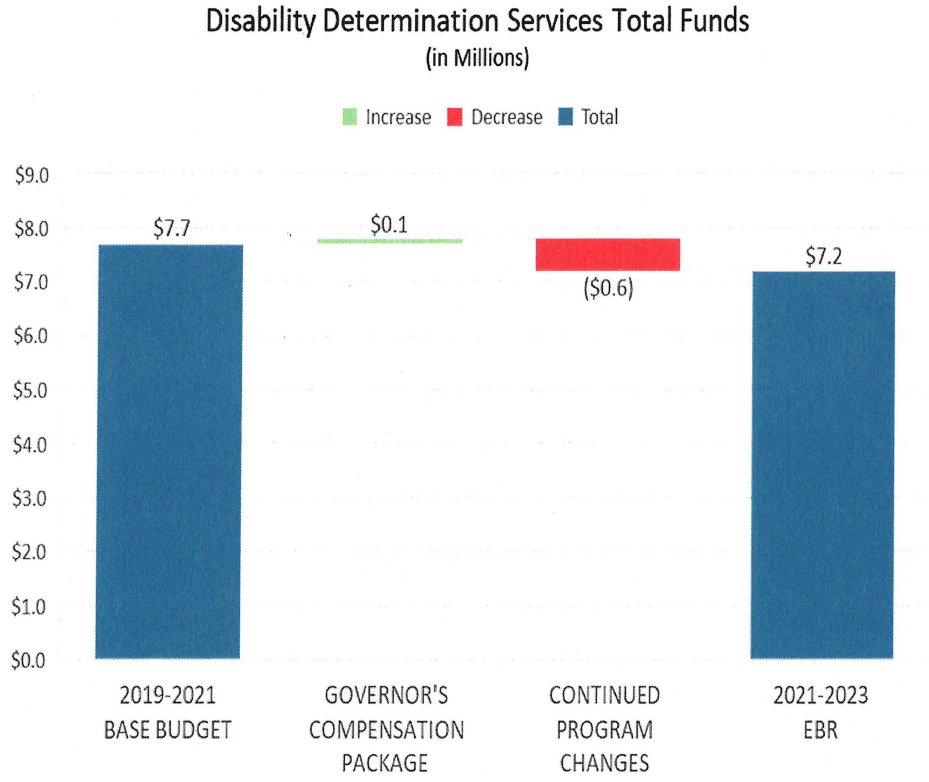
- The DDS was directed by the SSA to temporarily suspend some service delivery activities due to the pandemic
- Those activities were focused on avoiding certain adverse actions that would result in a reduction, suspension or termination of Social Security or Supplemental Security Income benefits.
- Safety considerations were also of chief concern, so we did not:
  - Schedule consultative examinations
  - Schedule in-person disability hearings



OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries	3,983,988	164,425	4,148,413
Operating	1,728,174	(360,148)	1,368,026
Grants	1,970,000	(320,000)	1,650,000
Total	7,682,162	(515,723)	7,166,439
General Fund	0	0	0
Federal Funds	7,682,162	(515,723)	7,166,439
Other Funds	0	0	0
Total	7,682,162	(515,723)	7,166,439
Full Time Equivalent (FTE)	23.00	0	23.00

DDS TOTAL FUNDS (IN MILLIONS)



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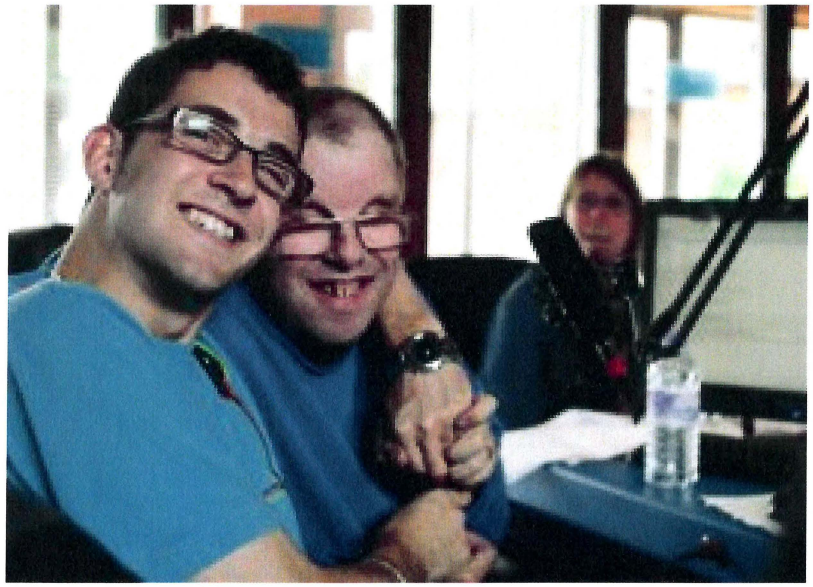
  - $.034 for Medical Consultants related to new claims system
  - ($.033) for travel costs
  - ($.320) for Medical evidence
  - ($.375) for Cooperative Disability Investigations (CDI) Unit

SSA DISABILITY PAYMENTS TO ND CITIZENS



Data from September 2020

Social Security Disability payments (SSDI)

Amount of Benefits Paid:
$17.5 million paid monthly in disability benefits

Supplemental Security Income (SSI)

Amount of Benefits Paid:
$4.1 million paid monthly to blind/disabled residents



House Bill 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTH Dakota | Human Services

Be Legendary.™

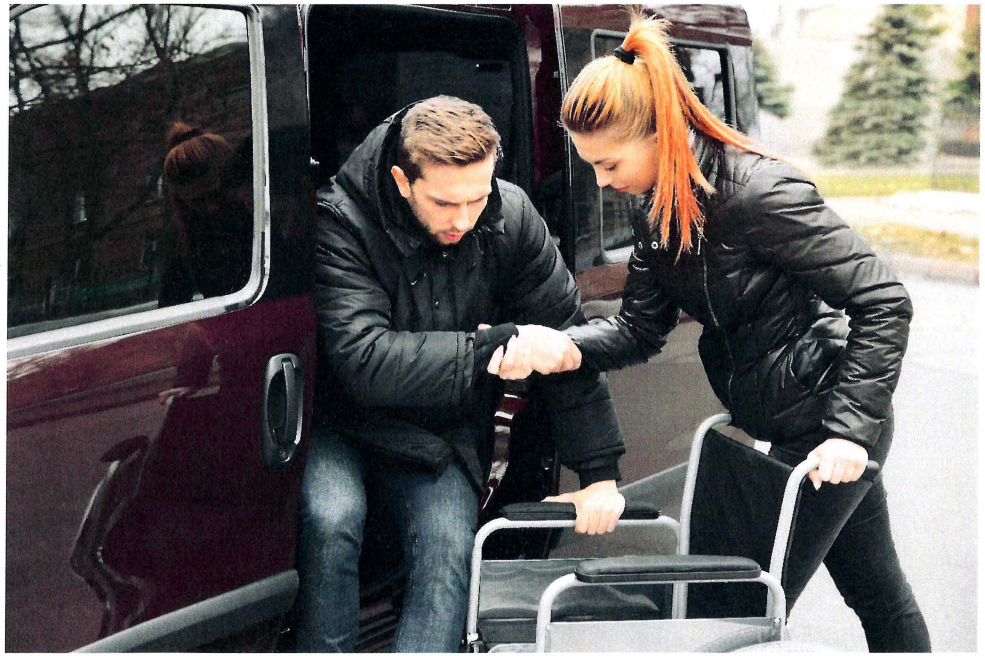
Disability Determination Services

DDS MISSION

To improve the quality of life for North Dakotans with disabilities who apply for or receive Social Security Administration disability benefits, by making timely, consistent and accurate disability determinations.



THE DISABILITY DETERMINATION SERVICES (DDS) PROGRAM



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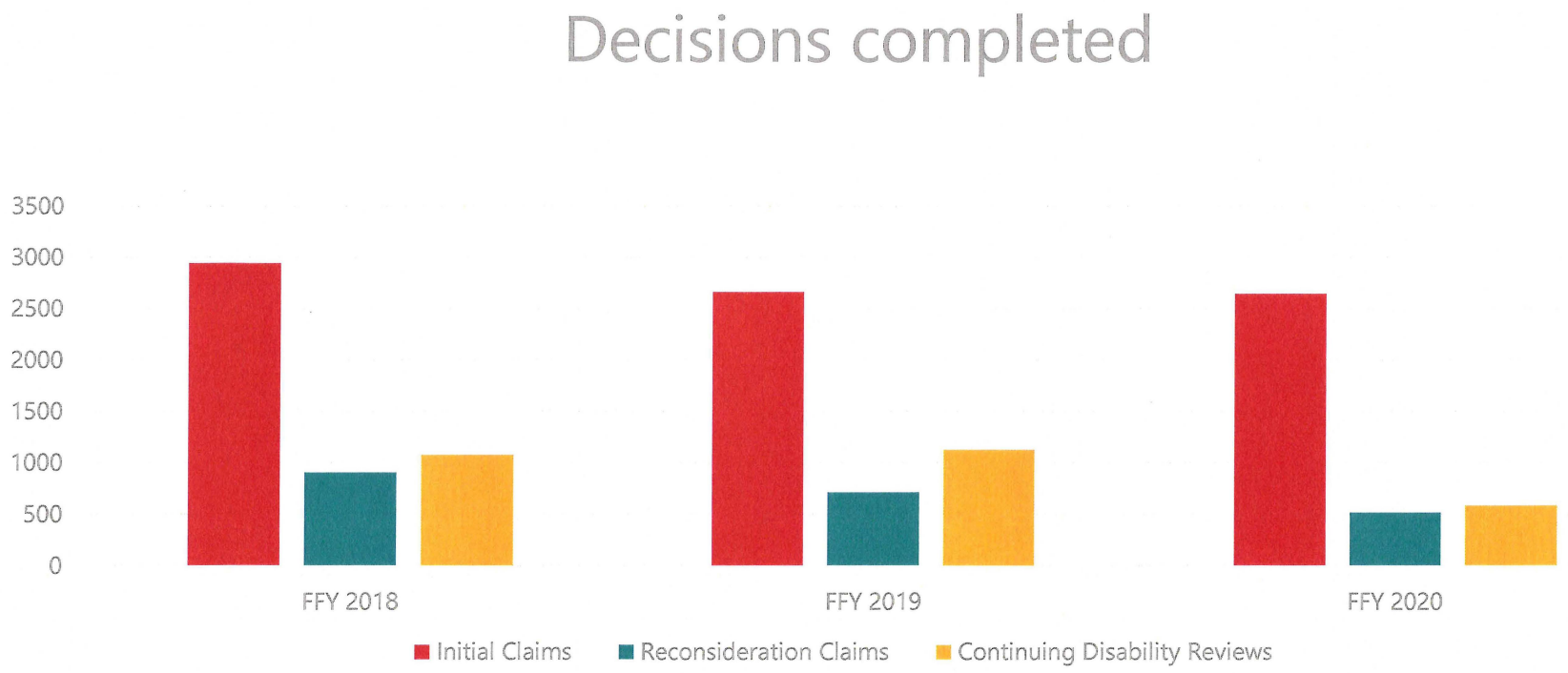

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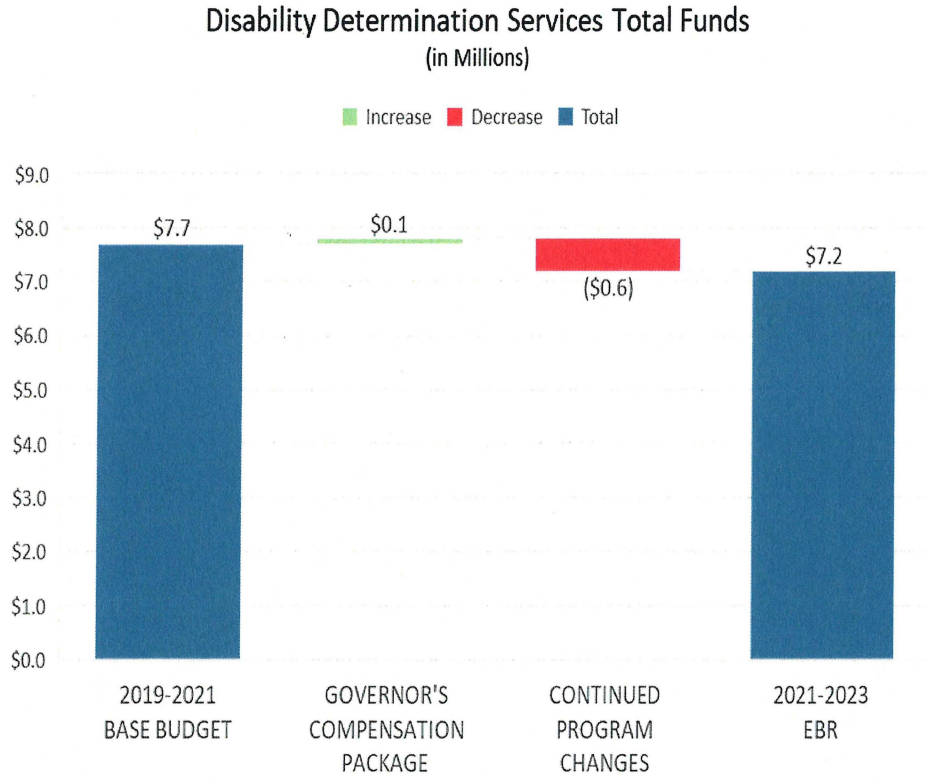

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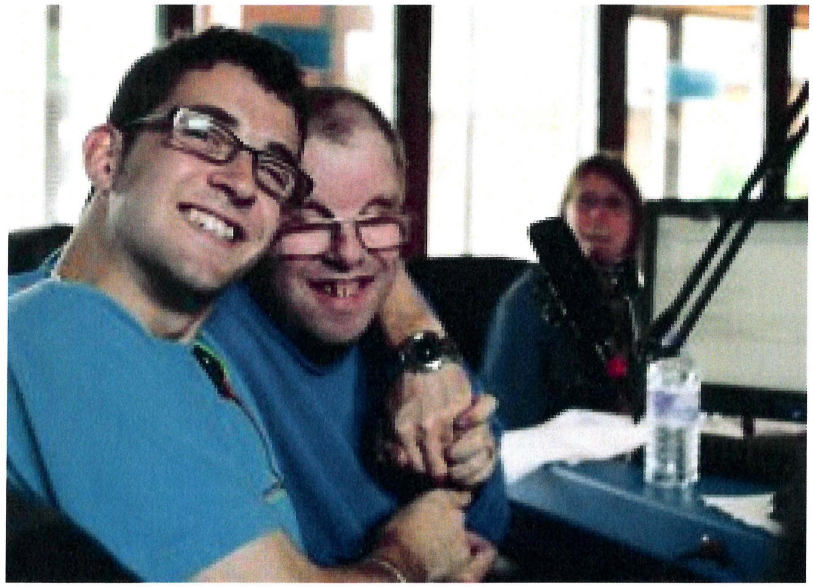

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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/11/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 2:07 p.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

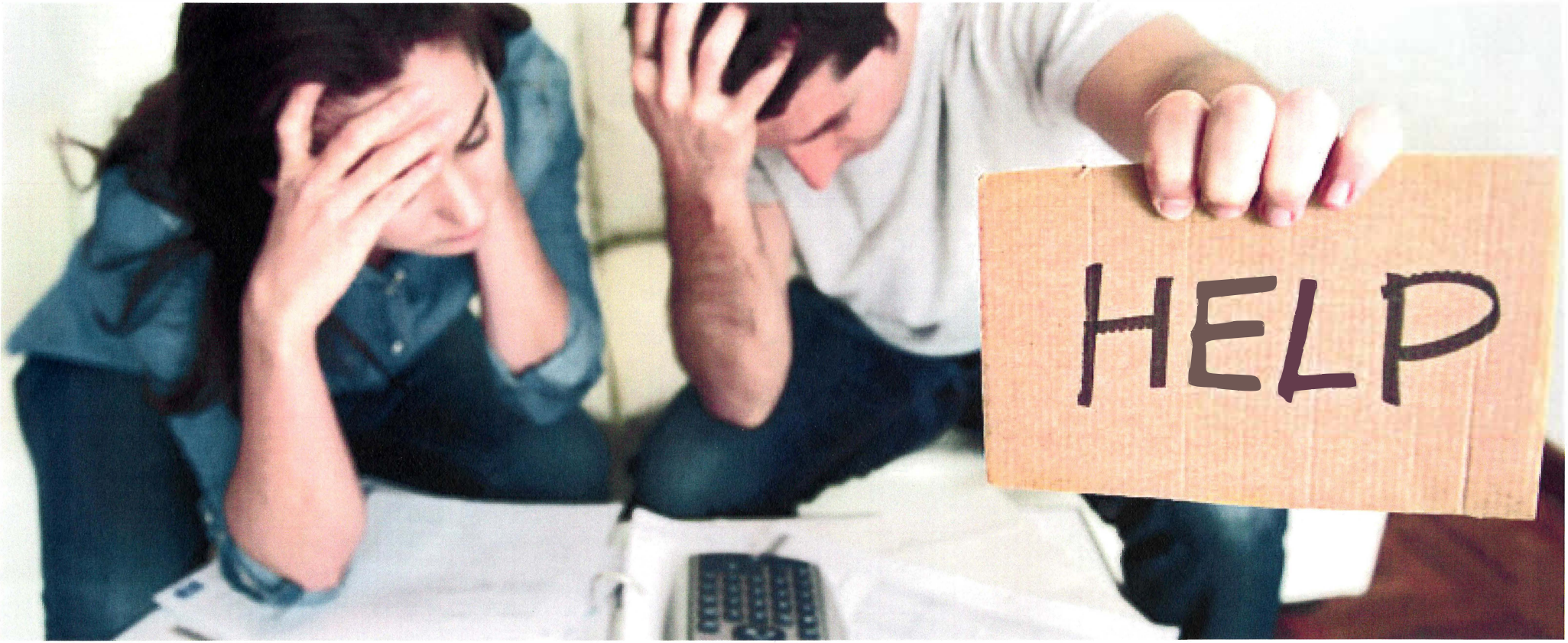
- Economic Assistance
- Traditional Medicaid
- Medical Services
- Medical Services Funding Request

Michelle Gee, Dir. of Human Services (2:10 pm) testified about economic assistance #1148

Caprice Knapp, Medical Serv. Director (3:03 pm) testified about Traditional Medicaid #1157

Chair Nelson closed the hearing at 3:59 p.m.

Cole Fleck, Committee Clerk



House Bill 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

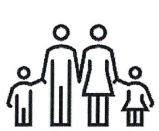
Economic Assistance

Connecting people to resources that help meet basic needs

NORTH Dakota | Human Services

Be Legendary.™

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



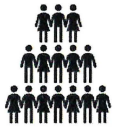
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

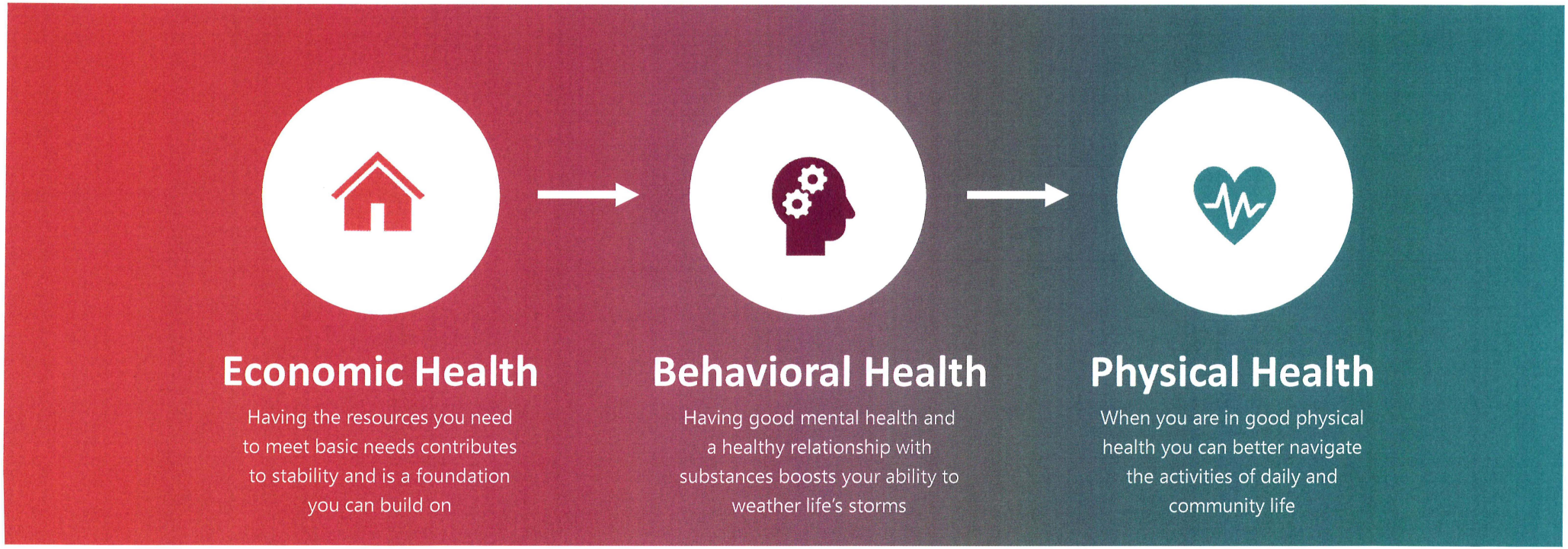
- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

They are thread running through every person's life

Foundations of Wellbeing are Interconnected



The stability that comes from good **economic** health can **improve behavioral** health.
The stability that comes from good **physical** and **behavioral** health **enables economic** health.

ECONOMIC ASSISTANCE
Program Purpose

The Economic Assistance team **helps** lower income **North Dakotans when they are struggling to make ends meet** by **connecting** them **to resources** that can **help meet** their **basic needs**, **preventing** greater and more damaging **crises.**



ECONOMIC ASSISTANCE
Federal Programs



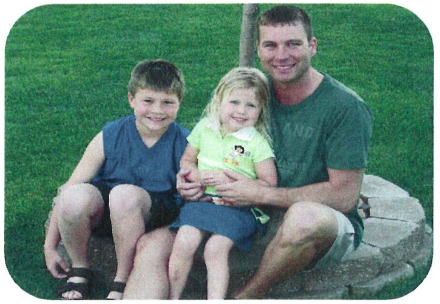
Child Care Assistance Program (CCAP)



Low-Income Home Energy Assistance Program (LIHEAP)



Supplemental Nutrition Assistance Program (SNAP)



Temporary Assistance for Needy Families (TANF) Program

ECONOMIC ASSISTANCE
What We Do

Program Administration

- Federal Compliance
- State Plan
- State Law & Administrative Rules
- Federal Reporting
- Federal & State Agreements

Eligibility System Support

- Program and Policy Support
- Training
- Benefit Issuance
- Integrated Eligibility System Development and Maintenance

Program Integrity and Performance

- Program Monitoring
- Federal and State Quality Reviews
- Federal and State Audits
- Performance Improvement

Connecting North Dakotans to economic assistance is a partnership

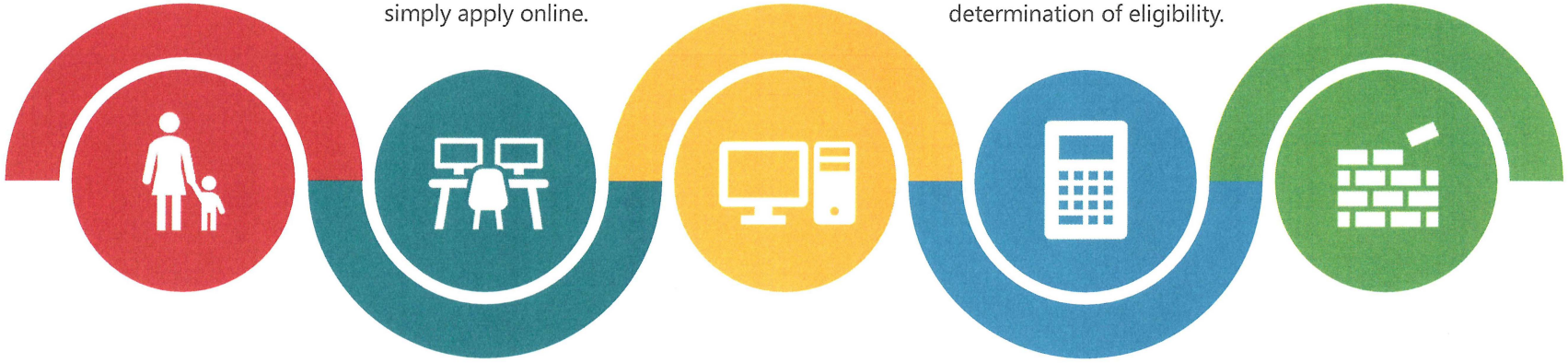
The state and Human Service Zones work together to deliver help to low and moderate-income families

Contact Human Service Zone

The local applicant can contact their human service zone directly or they can simply apply online.

Determine eligibility

An eligibility worker will review the information, reach out if needed, and make a determination of eligibility.



Person decides to apply

Making ends meet is getting more difficult every month so the applicant makes the decision to reach out for help.

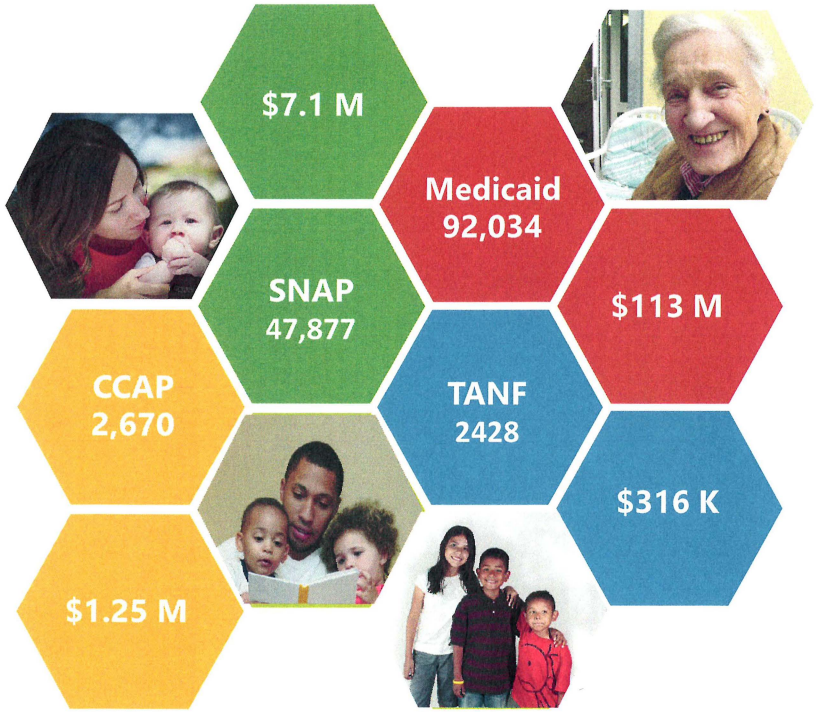
Gather information

The applicant can enter as much info as they can in the SPACES self-service portal.

Issue benefits

If the applicant is eligible to receive assistance, the state will issue the benefit in the appropriate manner.

140,000 - 150,000 North Dakotans utilize SPACES to access economic assistance in North Dakota each year



Average Monthly Individuals/Benefits (FY20)

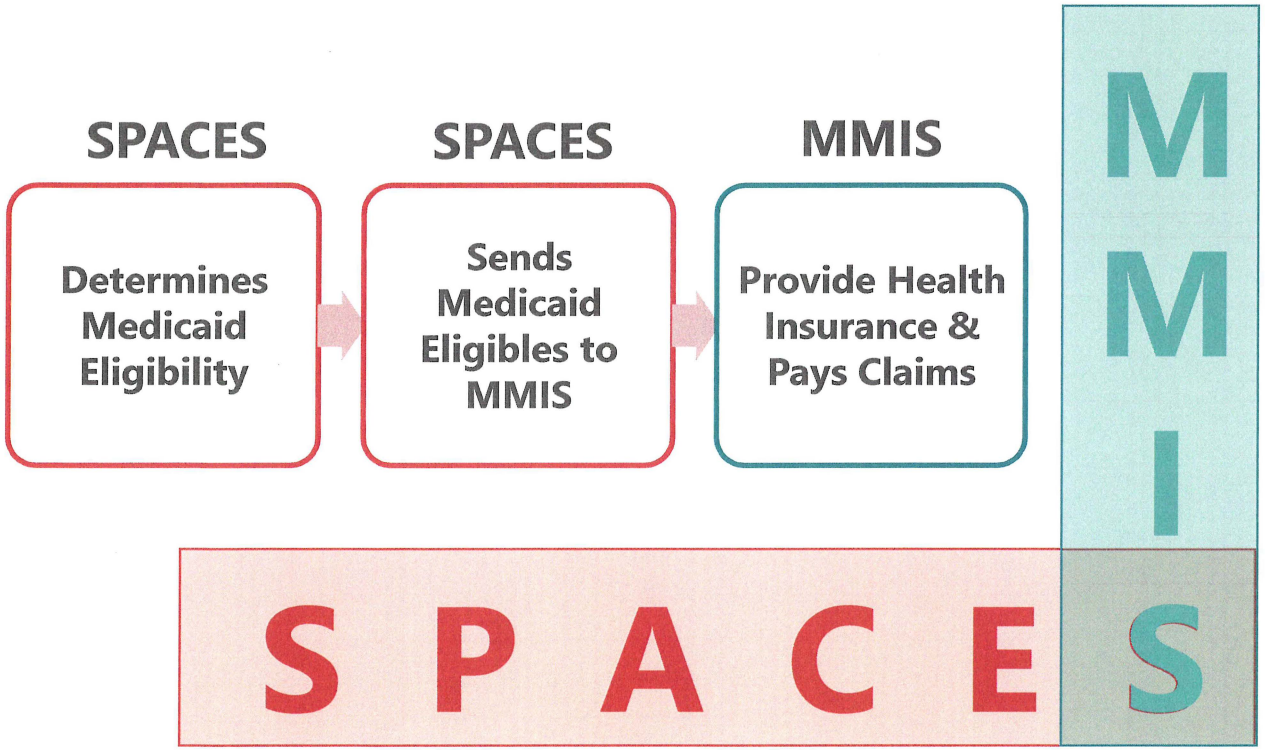
M — 119,763 people in 68,287 households have a Medicaid record in SPACES

S — 73,262 people in 34,795 households have a SNAP record in SPACES

T — 5,124 people in 1,981 households have a TANF record in SPACES

C — 4,946 people in 2,960 households have a CCAP record in SPACES

Two major technology platforms work together to connect low-income North Dakotans to resources



SPACES **interfaces with more than 50 systems**, including:

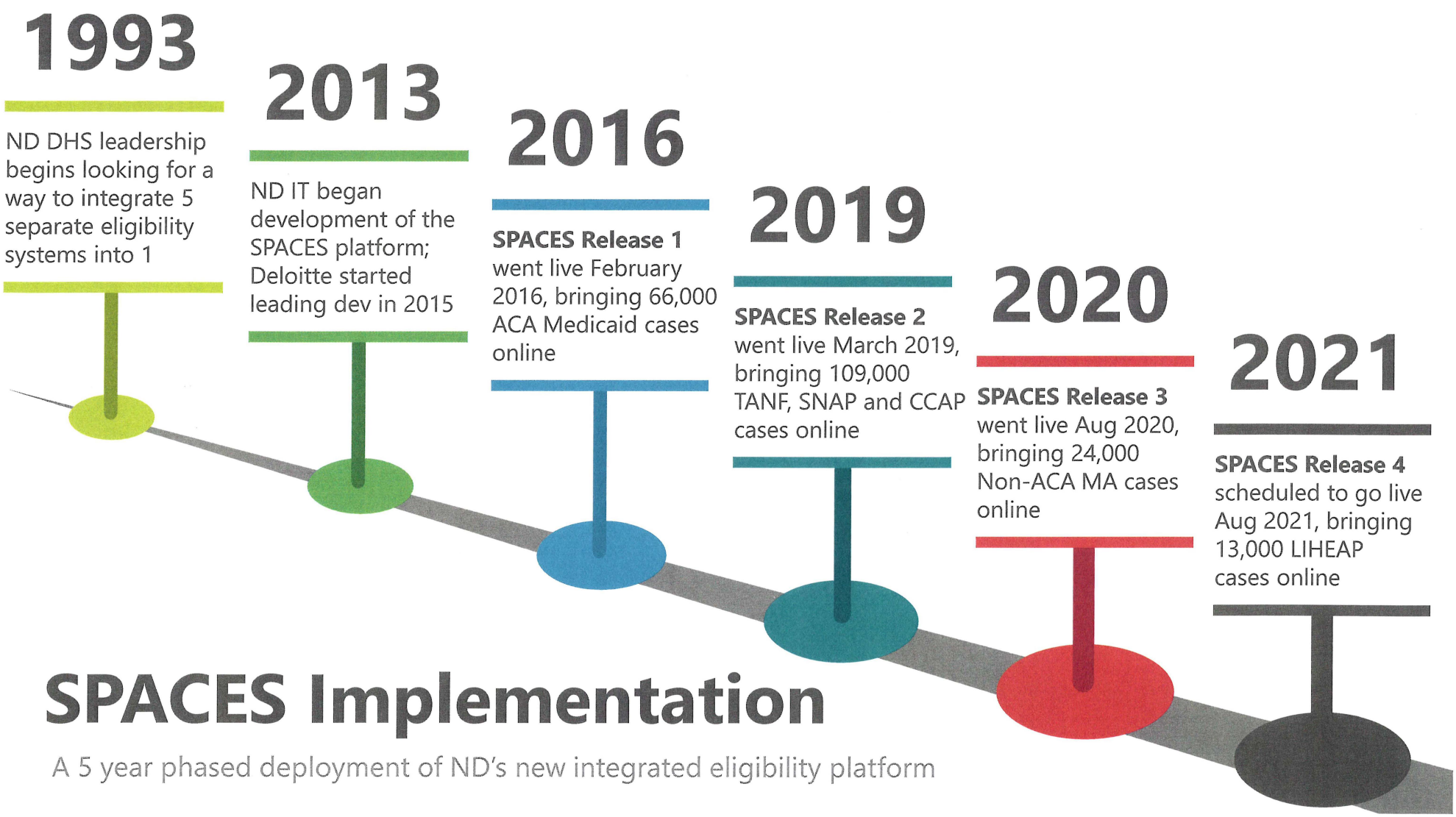
- Child Support
- Social Security
- Vital Records
- IRS
- EBT & EPC Systems
- ND PeopleSoft

145,000

North Dakotans

$1,472,000,000

Economic Assistance



SPACES Implementation

A 5 year phased deployment of ND's new integrated eligibility platform

ECONOMIC ASSISTANCE

State Median Income for ND households 2020

Many federal assistance programs are designed to help individuals and families who earn less than 60% of State median income (SMI).

60% SMI is roughly equivalent to 200% of the federal poverty level.

	30% SMI		60% SMI		100% SMI	
Household Size	Annual Income	Hourly Wage	Annual Income	Hourly Wage	Annual Income	Hourly Wage
1	$ 15,720	$ 7.56	$ 31,440	$ 15.12	$ 52,400	$ 25.19
2	$ 20,562	$ 9.89	$ 41,124	$ 19.77	$ 68,540	$ 32.95
3	$ 25,398	$ 12.21	$ 50,796	$ 24.42	$ 84,660	$ 40.70
4	$ 30,234	$ 14.54	$ 60,468	$ 29.07	$ 100,780	$ 48.45
5	$ 35,070	$ 16.86	$ 70,140	$ 33.72	$ 116,900	$ 56.20
6	$ 39,912	$ 19.19	$ 79,824	$ 38.38	$ 133,040	$ 63.96
7	$ 40,818	$ 19.62	$ 81,636	$ 39.25	$ 136,060	$ 65.41
8	$ 41,724	$ 20.06	$ 83,448	$ 40.12	$ 139,080	$ 66.87

Hourly wage based on assumption of 2,080 hours of work / year (full time equivalent)

EVERY OCCUPATION HAS A DIFFERENT EARNING PROFILE, WHICH HELPS US UNDERSTAND WHO MAY BE ELIGIBLE FOR ASSISTANCE

Sampling of occupations by average wage (2019)







Less than $12 / hr	$12 - $20 / hour	$20 - $28 / hour	$28 - $35 / hour
Waiter/Waitress	Pharmacy tech	Carpenter	School counselor
Child care worker	Home health	Loan processor	Rotary drill oper
Dishwasher	PT assistant	Legal secretary	HR specialist
Bartender	Hair stylist	Correctional officers	Accountant
Cafeteria worker	Retail	Auto service tech	Real Estate Sales
Short order cook	Farmworker	Surgical tech	PR specialist
Cashiers	Restaurant cook	Roofer	Counselor
Clerical assistant	Data entry	Lic Practical Nurse	Registered Nurse
Personal care aide	EMTs & paramedics	Dental assistant	Computer network specialist
	Carpet installers	Firefighter	Construction supervisor
	Maintenance workers	Surgical assistant	Dental hygienist
	Nursing assistant	Clergy	Architecture occ
	Laborer	Social worker	Speech pathologist
	Substitute teacher	Police	
	Office/accounting clerk	Hotel manager	
	Light truck driver	Roustabout	
	Extraction helper	Heavy truck driver	

ECONOMIC ASSISTANCE

Child Care Assistance Program (CCAP)

CCAP helps pay a portion of the **cost of childcare** for working families or families in training or education programs.

Families can earn up to **60% of state median income** and be eligible for assistance.



ECONOMIC ASSISTANCE
Child Care Assistance Program (CCAP)

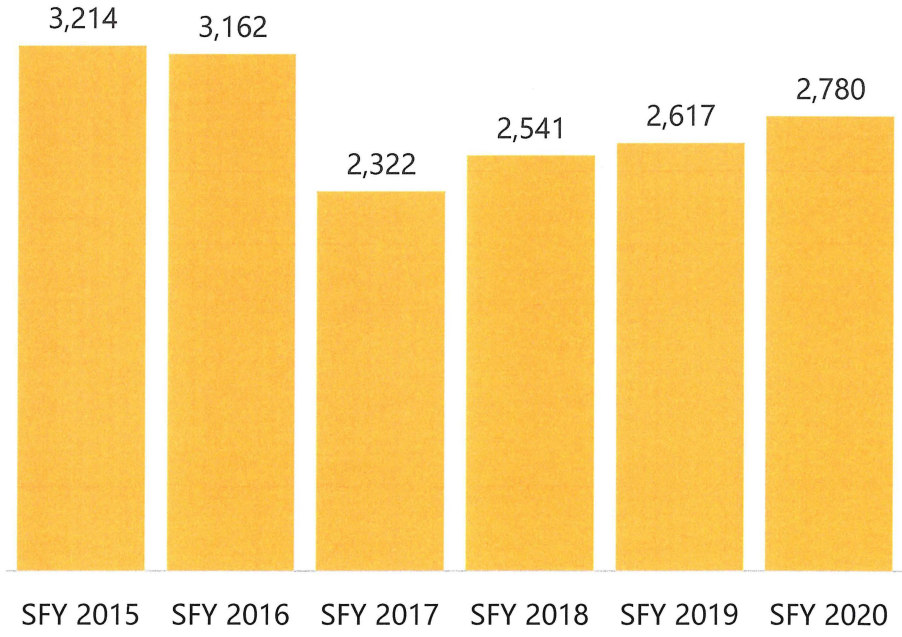
2,780
Average number of children served per month

$15.6 million
Support to families

$466
Average payment per child per month

SFY2020

Average number of children served per month

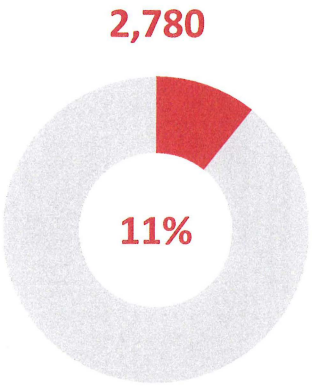


ECONOMIC ASSISTANCE
Child Care Assistance

73%

Parents in workforce

73% of the 44,237 North Dakota households who have children younger than age 5 likely have at least some need for child care as all available parents are in the workforce



1 in 10 eligible children

26,000 ND children age 13 or younger live in households where parent earnings are less than 200% of the federal poverty level. 2,780 children (**11% of** potentially **eligible**) are **currently served** by CCAP in our state.

40,769

7% receive CCAP

1,500+ approved child care providers are licensed to serve 40,769 children each year. In 2020, an average of 2,780 of those licensed slots served children who received assistance

ECONOMIC ASSISTANCE

Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP helps households with **home heating costs** by paying a portion of their heating bills, **and** with **improving** their home's overall **energy efficiency**.

Families can earn up to **60% of state median income** and be eligible for assistance.



ECONOMIC ASSISTANCE
Low Income Home Energy Assistance Program (LIHEAP)

12,785

Households served last heating season

$12 million

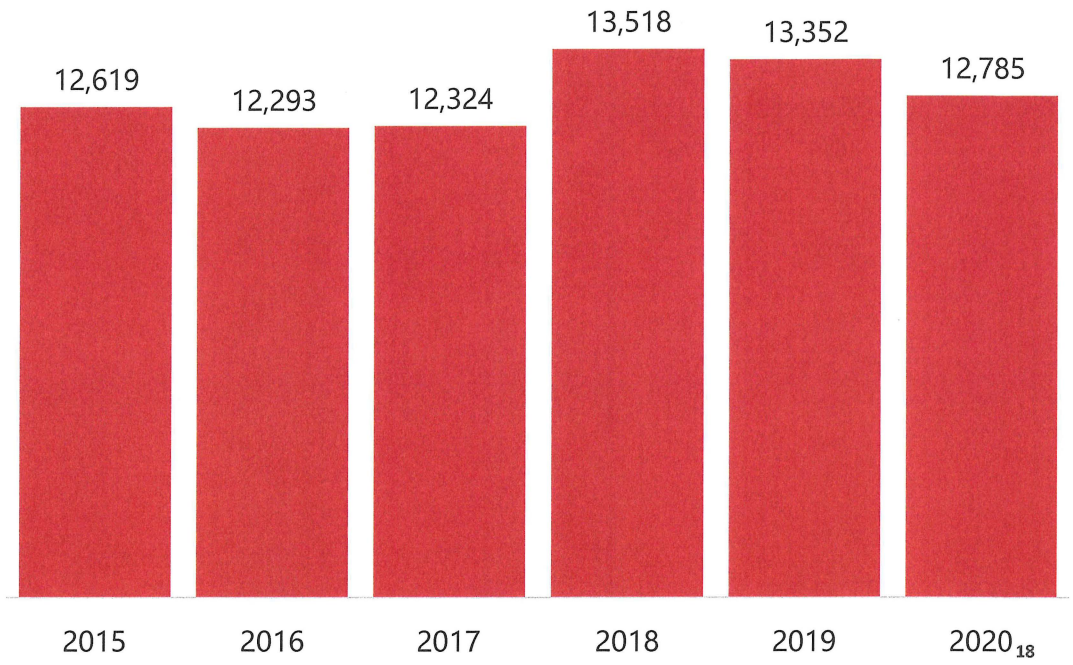
Support to households

$930

Average payment per household per heating season

SFY2020

Average Households served per Heating Season (Oct-May)



ECONOMIC ASSISTANCE

Supplemental Nutrition Assistance Program (SNAP)

Provides nutrition benefits to supplement the food budget of lower income families so they can purchase healthy food and move towards self-sufficiency

Families can earn up to **60% of state median income** and be eligible for assistance.



ECONOMIC ASSISTANCE
Supplemental Nutrition Assistance Program (SNAP)

520

SNAP is a partnership

520 retailers in North Dakota are authorized to accept SNAP payments from eligible households

$1.00→$1.54

Local economies benefit

Beyond helping families gain access to nutritious food, SNAP offers local economic benefits as well. Each $1.00 in SNAP generates $1.54 in local economic activity.

1/3

Boosting family food budgets

SNAP provides nutrition assistance to people of all ages and circumstances.

36% - children under 18

35% - aged or disabled

35% - have earned income

ECONOMIC ASSISTANCE
Supplemental Nutrition Assistance Program (SNAP)

48,323

Average number of individuals in served in 23,178 households

$78 million

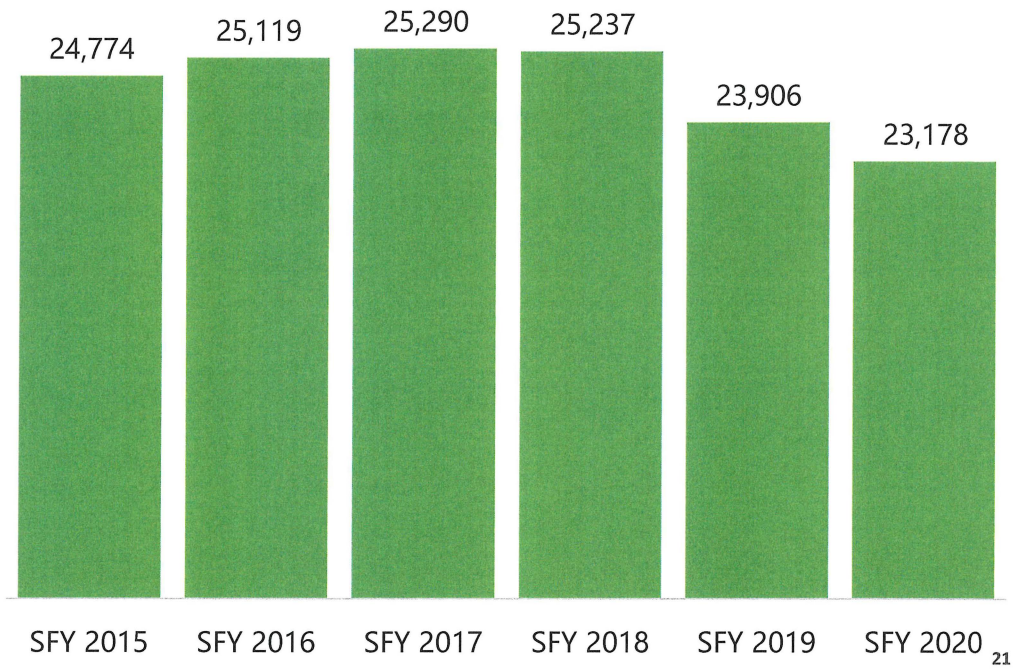
Support to households

$280

Average payment per household per month

SFY2020

Average households served per month



Sample Menus for USDA Food Plans which serve as the basis for SNAP benefits

Food Plan / Meal	Avg Cost / month	Breakfast	Lunch	Dinner
Thrifty	Family of 2: $398.70 Family of 4: $668.50	Orange Juice Cereal Milk Toast	Peanut butter sandwich Carrot/celery sticks Applesauce	Baked beans and frankfurters Hash browns Carrots Bread Cookies
Low-Cost	Family of 2: $511.70 Family of 4: $880.40	Orange Juice Cereal Milk Coffee Cake	Grilled cheese sandwich Green beans Peaches Cookies	Roast beef Quartered potatoes Onions, Carrots, Spinach Roll Ice cream
Moderate-Cost	Family of 2: $634.70 Family of 4: $1,100.30	Orange Juice Scrambled eggs English muffin Jam	Bologna/cheese sandwich Assorted relish tray Pickles Applies Cookies	Baked ham Scalloped potatoes Green beans Lettuce salad Hot roll Cake
Liberal	Family of 2: $792.80 Family of 4: $1,332.40	Grapefruit halves Bacon French Toast Syrup	Assorted cold cuts & sliced cheeses Relish tray Buttered bread Potato chips, French onion dip Pickles	Baked ham Potatoes au gratin Broccoli Tomatoes & mixed green salad Assorted fresh fruits Hot biscuits Cake with ice cream

ECONOMIC ASSISTANCE

Temporary Assistance to Needy Families (TANF)

TANF provides assistance to needy families with children who are deprived of parental support or care.

Which means that a parent is absent due to divorce, separation, death or one or both parents are aged or disabled.



ECONOMIC ASSISTANCE
Temporary Assistance to Needy Families (TANF)

945

Average number of families served per month

81%

Of beneficiaries are children

52%

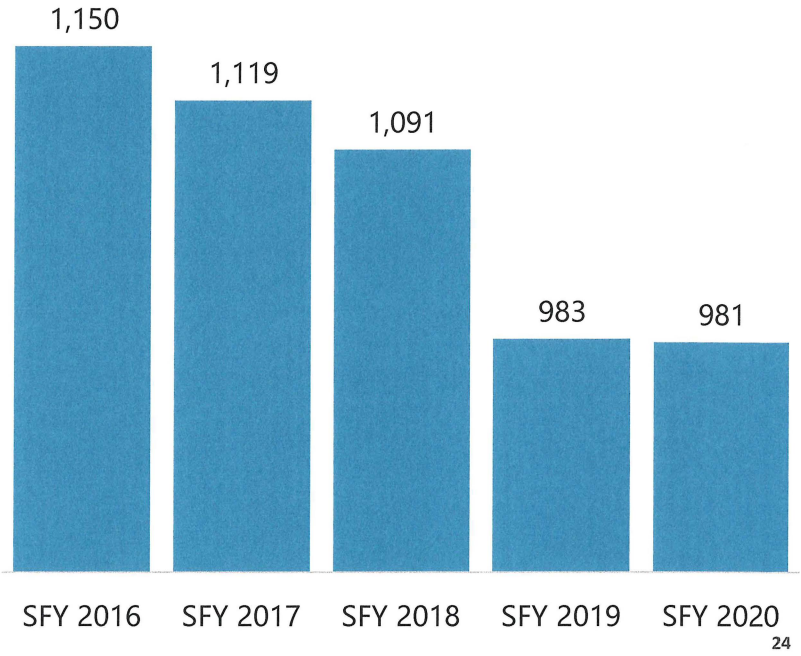
Of ND TANF cases are child only cases (children in the care of a non legally responsible caretaker)

$297

Average benefit per family per month

SFY2020

Average households served per month



ECONOMIC ASSISTANCE

Temporary Assistance to Needy Families (TANF)

TANF Funded Programs

Alternatives to Abortion

Reimbursements to organizations that deliver alternative services and education to the public.

Crossroads

Case management and support service payments to qualified teen parents who are pursuing an education.

Kinship Care

Alternative to foster care for children living with a relative and in the care, custody and control of a Human Service Zone, Division of Juvenile Services, or a tribal agency within ND.

Parental Responsibility Initiative for the Development of Employment (PRIDE)

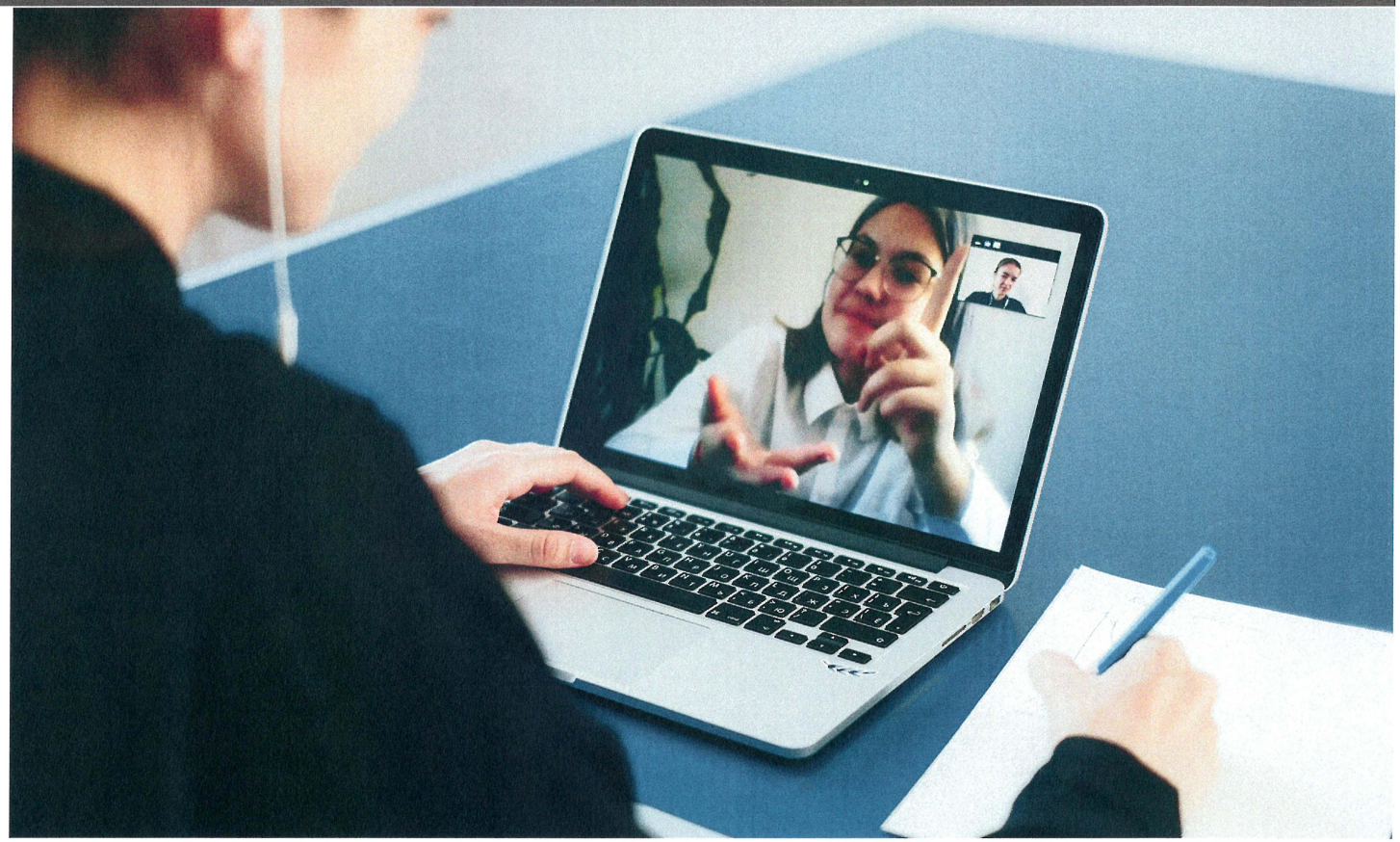
Case management and support service payments to address nonpayment of child support by noncustodial parents.

ECONOMIC ASSISTANCE

COVID 19 Program Administration and Service Delivery

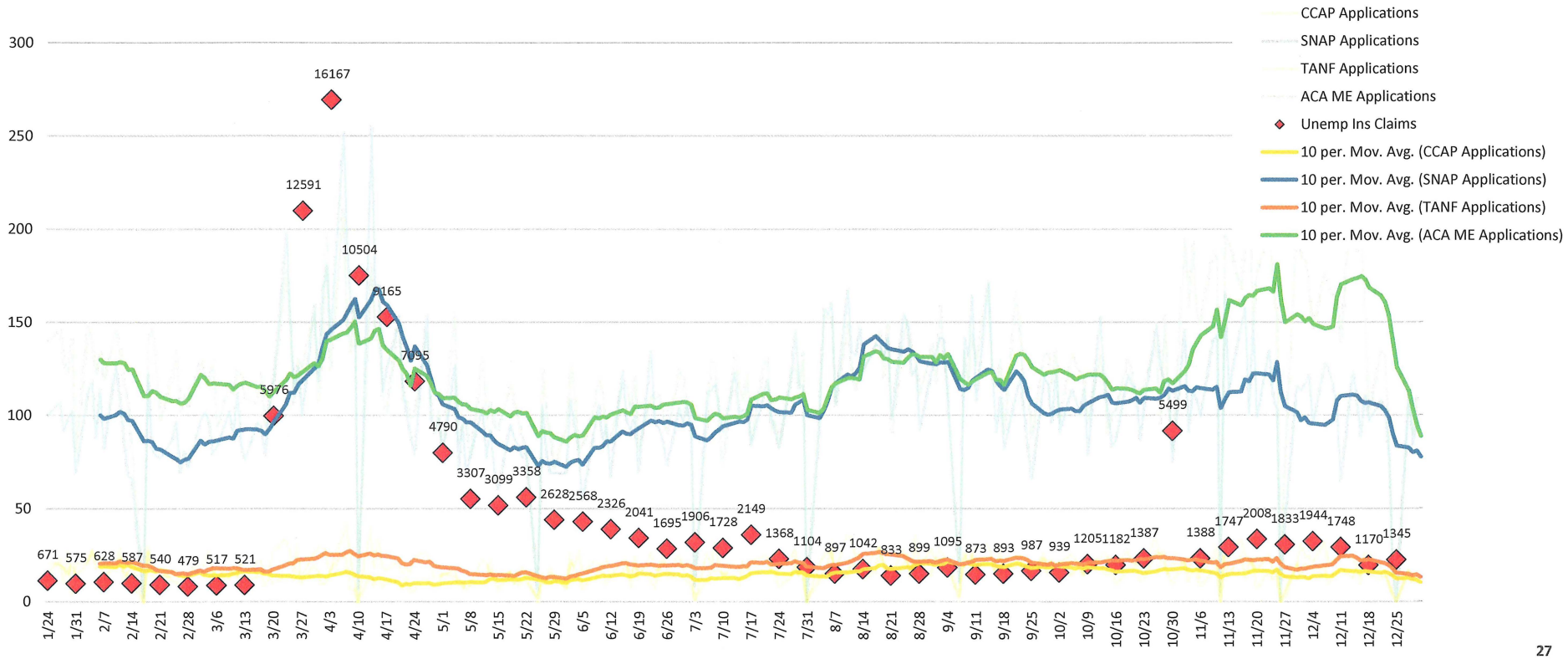
To ensure the health and safety of the individuals we serve along with Human Service Zone staff the following measures were implemented:

- Waiver of face-to-face interview requirement
- Mail issuance of EBT Cards
- Waived mandatory work requirements



ECONOMIC ASSISTANCE APPLICATIONS DURING 2020

Daily applications remained above pre-COVID levels throughout 2020 with peaks in April, August and November/December



ECONOMIC ASSISTANCE

COVID 19 - Emergency Food and Energy Assistance

Pandemic EBT (P-EBT)

- Issued SNAP benefits to children eligible for free or reduced-price school meals who did not receive those meals due to school closure.
- Delivered info to families in partnership with DPI.
- Approximately 36,750 children received $9.5 million in SNAP benefits due to COVID school closure March-May 2020.

$9.5 million

SNAP Emergency Assistance

- Provides the maximum SNAP benefit to all SNAP eligible household starting in March 2020.
- An average of 15,000 households receive $2.6 million in additional benefits per month.
- Optional program benefit is authorized each month by USDA FNS.

$26 million

Pandemic LIHEAP (P-LIHEAP)

- Provided one-time help with the cost of electric utility bills for qualifying households.
- Payments were issued directly to participants' electric utility providers.
- Assistance available to households eligible in 2019-20 heating season
- Assisted 6,500 households as of 12-31-20

$3 million

ECONOMIC ASSISTANCE

COVID 19 - Child Care Assistance Program (CCAP)

- Allowed for more than 40 absence hours per month due to illness, quarantine and provider closures
- Allowed families to maintain eligibility as they were seeking employment (both at application and re-review)
- Extended payment request deadlines and aligned with Child Care Emergency Operating Grant (CEOG)



ECONOMIC ASSISTANCE

COVID 19 - SNAP Enhancement Grants

Grant program to help ND grocers update their point-of-sale systems and websites to enable online and by-phone ordering and delivery, improving access to food for both SNAP beneficiaries and community residents

Through Dec 2020 assisted grocery stores with system upgrades in:

- Minot
- Ruthville
- Mohall
- Newtown
- Michigan
- Scranton



ECONOMIC ASSISTANCE

COVID 19 - Emergency Rent Bridge (ERB)

1,410

Rental assistance to 1,500 households in 33 counties

$520

Average amount of rental assistance per household per month

$2.9 million

Total CRF funds distributed through 12-31 for ERB, paid to 486 housing providers



FEDERAL FUNDS TO BECOME AVAILABLE FOR COVID RESPONSE

Pandemic Relief Bill signed 12-30-21

Child Care
Child Care Assistance Program through (CCDBG via ACF/HHS)

Housing
Rental Assistance (US Treasury)
Low Income Water Utility Assistance (ACF/HHS)

Food Assistance
P-EBT (for families eligible for free or reduced lunch in school) (SNAP via FNS/USDA)
Enhanced SNAP benefit eligibility (SNAP via FNS/USDA)
Senior Meals (OAA via ACL/HHS)

Behavioral Health
Mental Health Grants (SAMHSA)

Aging Services
Supportive services (OAA via ACL/HHS)

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	6,777,828	750,224	7,528,052
Operating	10,183,362	(129,940)	10,053,422
Grants	242,885,074	14,531,536	257,416,610
Total	259,846,264	15,151,820	274,998,084
General Fund	8,605,617	3,256,938	11,862,555
Federal Funds	231,997,094	11,701,119	243,698,213
Other Funds	19,243,553	193,764	19,437,317
Total	259,846,264	15,151,820	274,998,084
Full Time Equivalent (FTE)	39.80	0.0	39.80

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



Continued Program Costs

- Emergency Rent Bridge $3.5 million (Dept of Commerce / DCS HUD funds)
- Other cost changes $0.1 million

GENERAL FUND CHANGES (IN MILLIONS)



GRANT CHANGES

North Dakota Department of Human Services

Changes in Economic Assistance (EA) Program Grants from 2019-2021 Appropriation to 2021-2023 Executive Budget To House

Description	**2019-2021 Appropriation**	Continued Program Changes	Costs to Continue	Total Changes	Executive Budget Changes	**2021-2023 Budget to House**
Temporary Assistance for Needy Families (TANF)	$7,623,000		($7,800)	($7,800)		$7,615,200
Child Care Assistance	$27,787,643		$6,923,232	$6,923,232		$34,710,875
Kinship Care	$2,990,000		($200)	($200)		$2,989,800
Supplemental Nutrition Assistance Program (SNAP) - Benefits	$165,240,000		$2,760,000	$2,760,000		$168,000,000
Low Income Home Energy Assistance Program (LIHEAP)	$25,728,145		$1,660,010	$1,660,010		$27,388,155
Total EA Program	$229,368,788		$11,335,242	$11,335,242	$0	$240,704,030
General Fund	$5,655,480	$0	$2,952,453	$2,952,453	$0	$8,607,933

Also included in the grants line are other Economic Assistance Program grants for which cost and caseload data is not computed. These grants include:

TANF Transportation and Support Services	$2,224,400	($613,170)		($613,170)		$1,611,230
SNAP Training, Outreach, and Nutrition Education Grants	$2,504,114	$369,464		$369,464		$2,873,578
LIHEAP Weatherization, Outreach, and Case Management	$8,787,772	($60,000)		($60,000)		$8,727,772
Emergency Rent Bridge		$3,500,000		$3,500,000		$3,500,000
Total Other Grants	$13,516,286	$3,196,294		$3,196,294		$16,712,580
General Fund	$56,239	($22,639)		($22,639)		$33,600

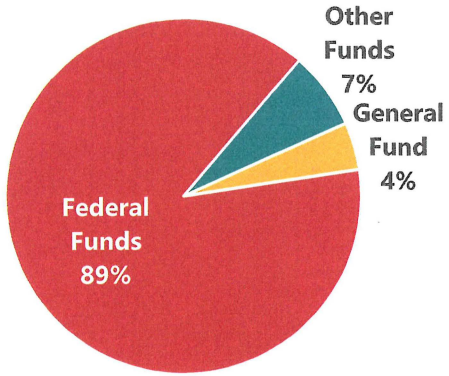
Total EA Grants	$242,885,074	$3,196,294	$11,335,242	$14,531,536	$0	$257,416,610
General Fund	$5,711,719	($22,639)	$2,952,453	$2,929,814	$0	$8,641,533

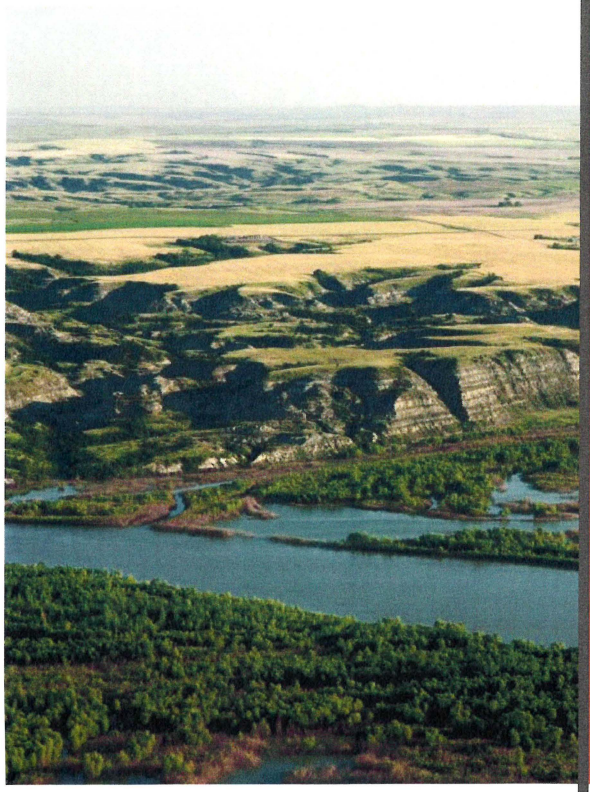


EA Budget Summary

No change in FTEs; $15.1 million increase in total budget (77% from federal funding)

- Complete the integration of LIHEAP into integrated eligibility platform
- Finish converting cases from legacy mainframe systems to SPACES
- Administer federal COVID relief funds for low and moderate-income households
- Integrate department's housing assistance initiatives into the administration of economic assistance resources





Contact Information

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Phone: 701-328-1633
Toll Free: 800-755-2716
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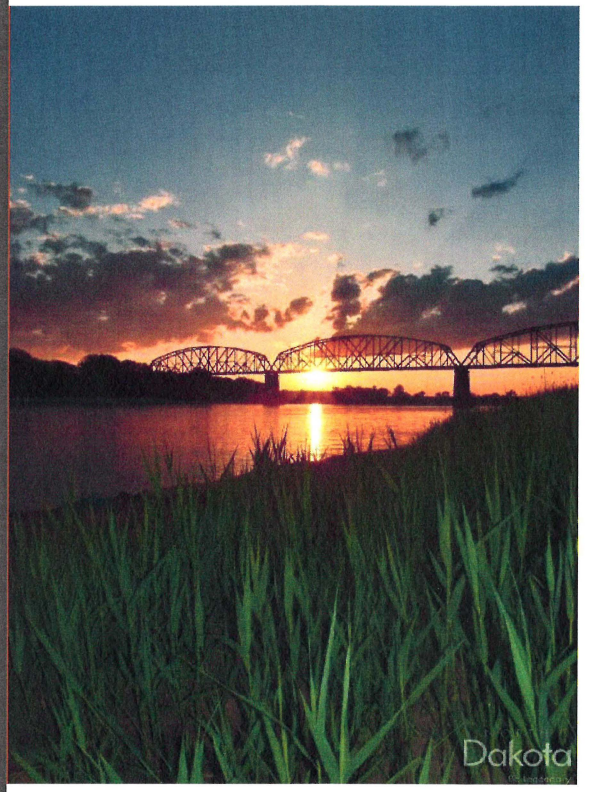

#1157



Medical Services Budget- House Bill 1012
Traditional Medicaid

House Appropriations, Chairman Nelson

Caprice Knapp, PhD Medical Services Director

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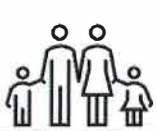
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Overview of Medical Services



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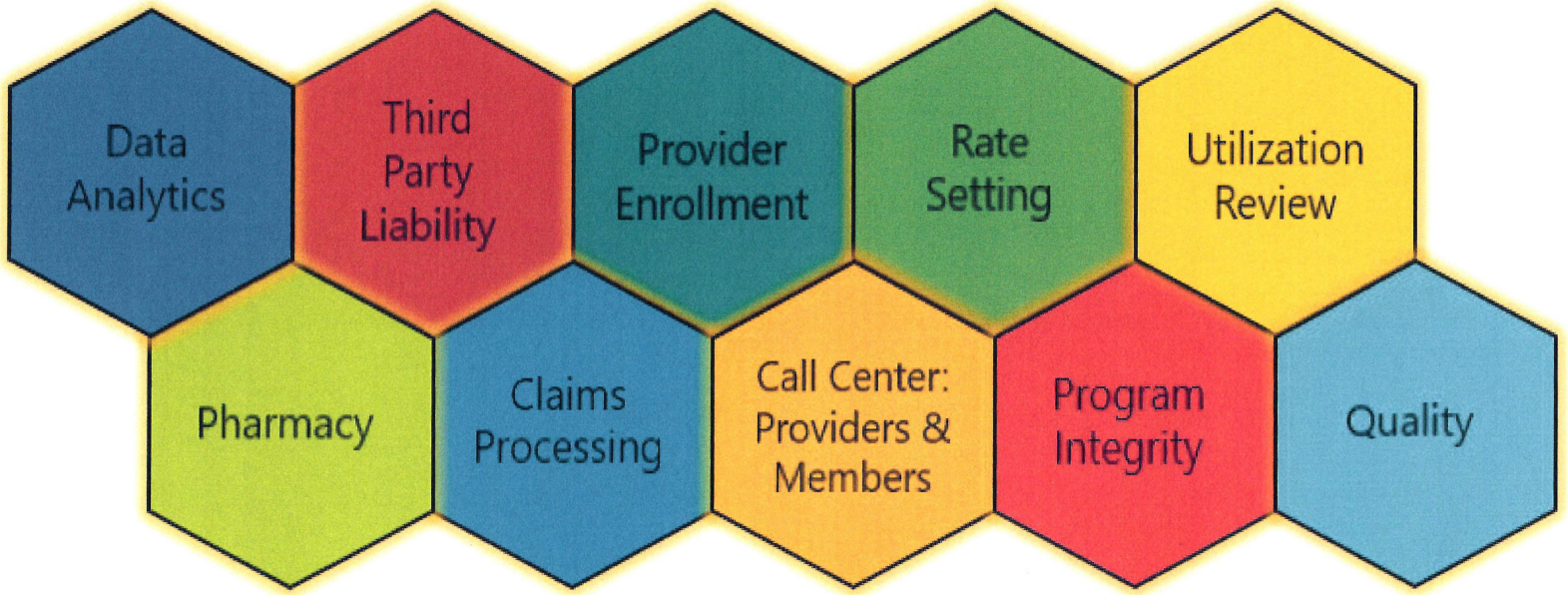
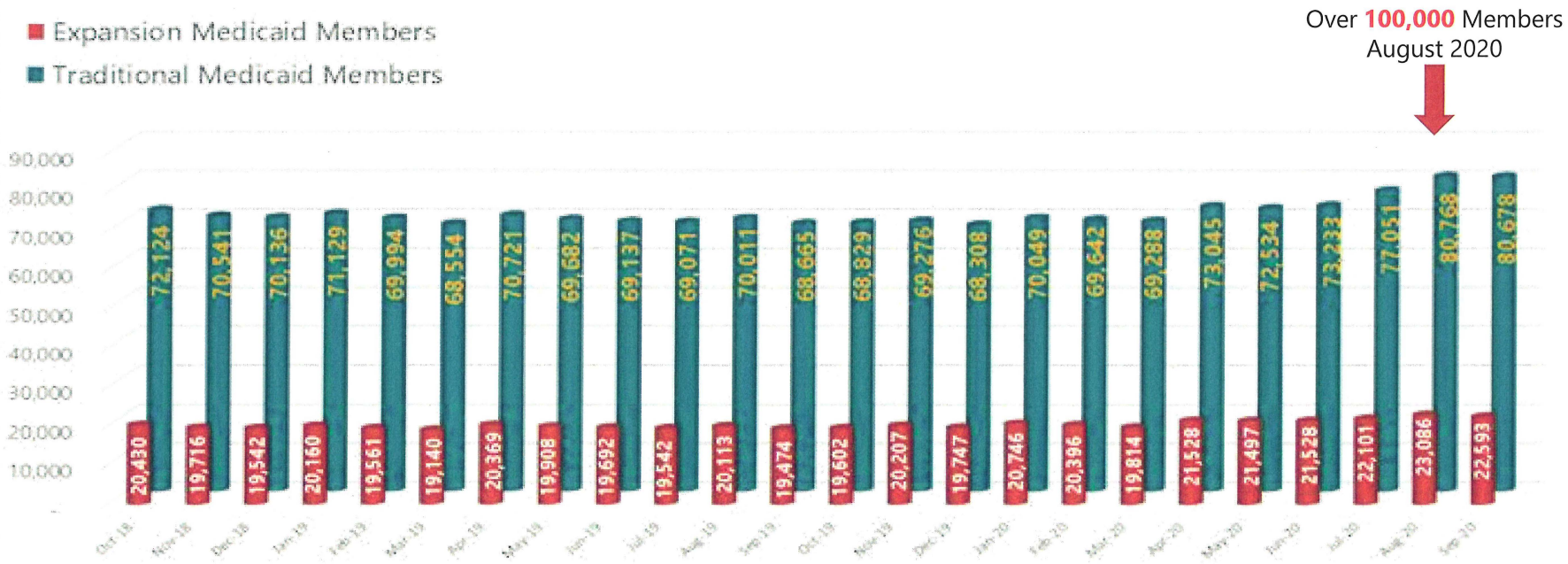
MEDICAL SERVICES DIVISION

What We Do



MEDICAL SERVICES DIVISION
Who We Serve

Traditional and Expansion Medicaid Members
24 Month Period
October 2018 - September 2020



Note: Numbers include Children's Health Insurance Program members

MEDICAL SERVICES DIVISION
Traditional Medicaid

Traditional Medicaid

Payments:

- Fee-For-Service
- Payment rate is about 100% of Medicare's reimbursement
- Some providers are paid according to their cost like nursing homes, critical access hospitals, and Human Service Centers
- Some provider payment rules are set by the feds IHS, FQHC

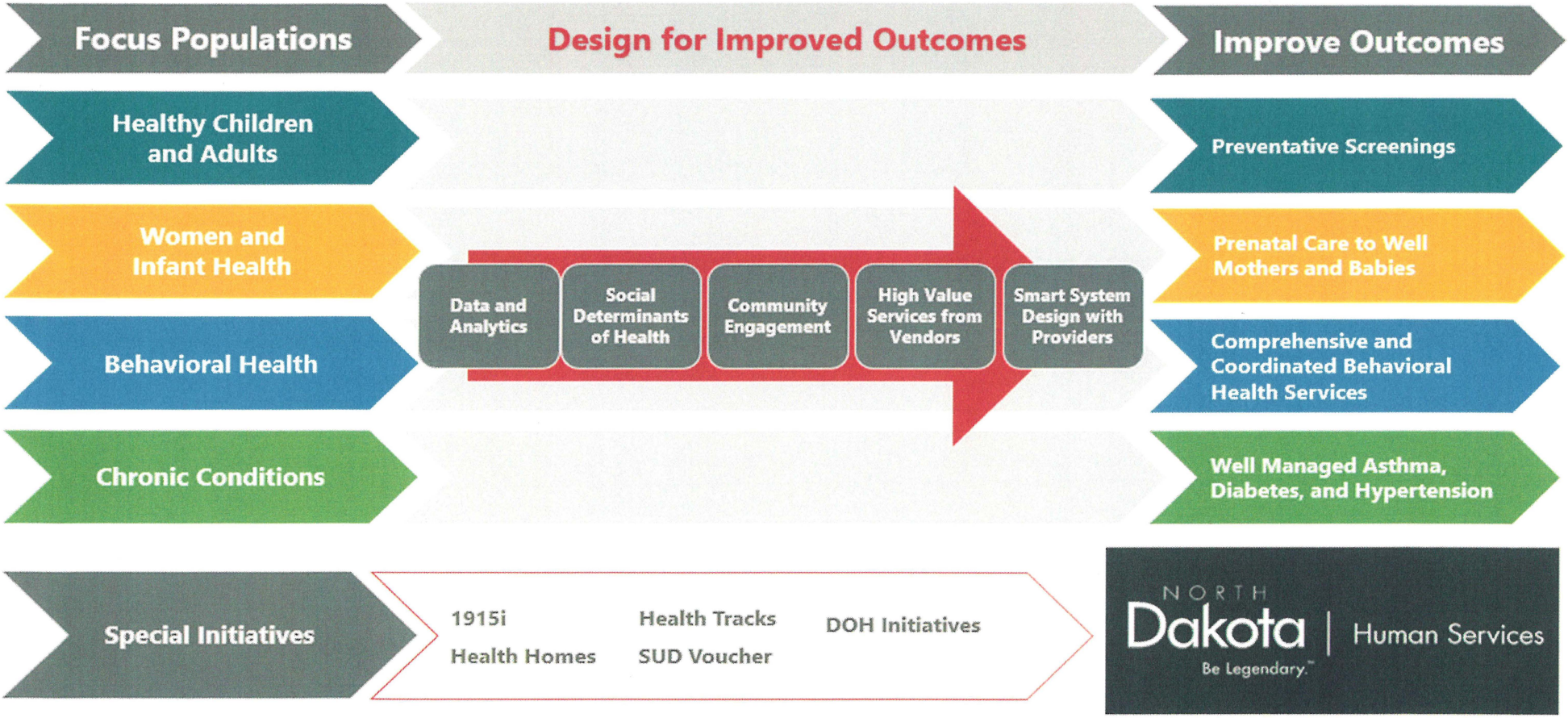
Fee Schedules:
http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html

Other Programs in Traditional Medicaid

Health Tracks: Early & Periodic Screening, Diagnosis & Treatment

MEDICAL SERVICES DIVISION Quality

North Dakota Medicaid Quality Strategy



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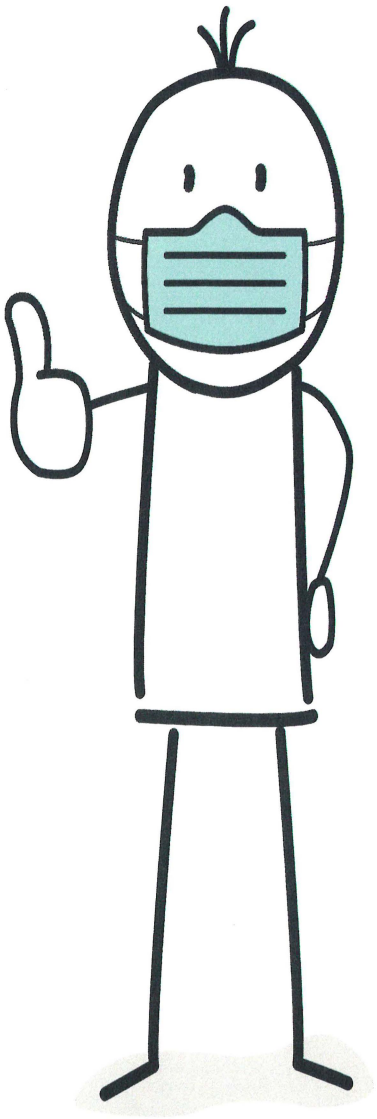
COVID-19: **FMAP 6.2% IMPACT**

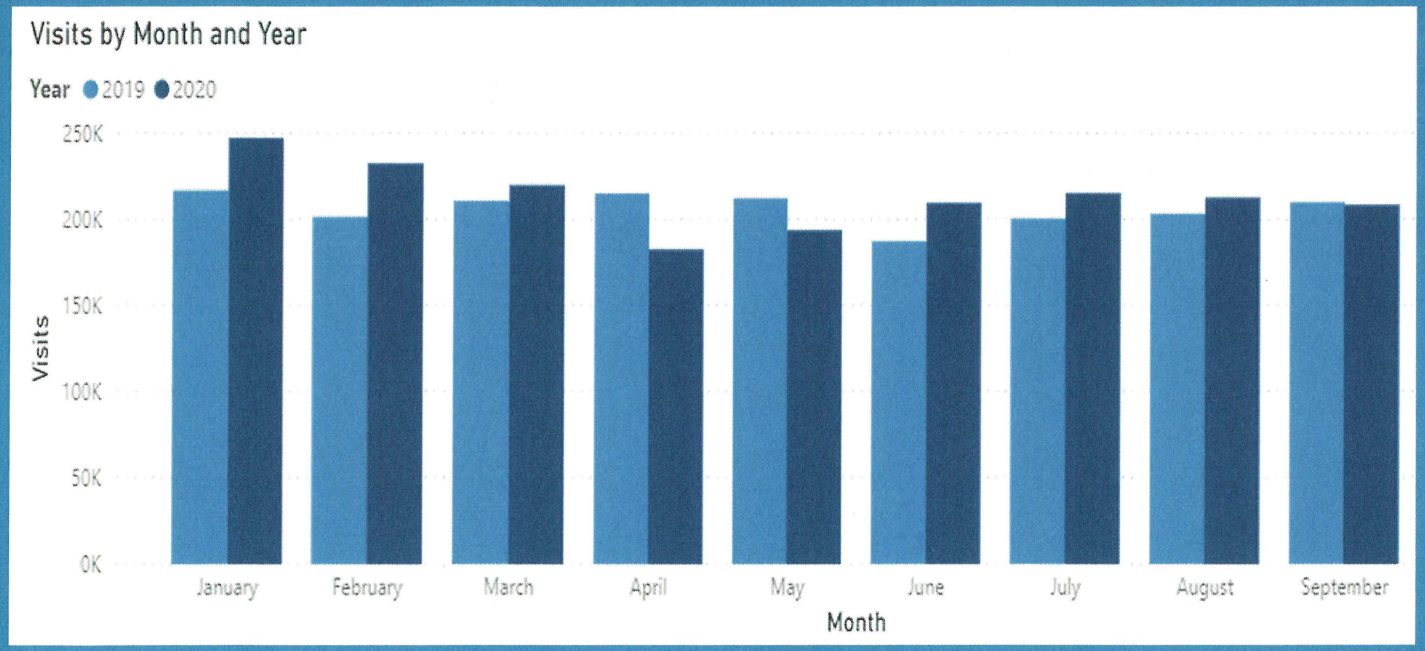
Average General Fund Expenditures

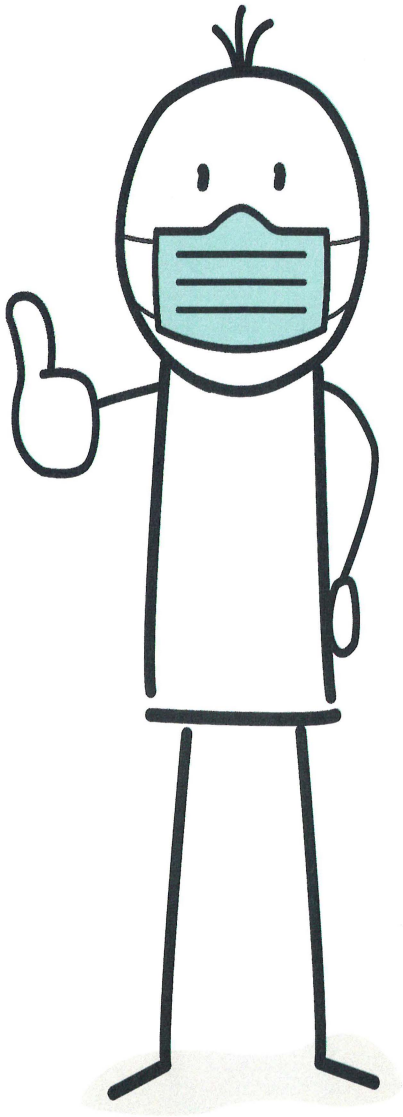
	DD	LTC	Traditional	Expansion
August 2019 - March 2020	$13,315,738.78	$15,054,484.62	$11,719,483.00	$2,775,323.00
April 2020 - September 2020	$10,541,758.98	$12,856,855.67	$10,801,010.83	$3,285,486.83
Difference of Average	**-$2,773,979.80**	**-$2,197,628.95**	**-$918,472.17**	**$510,163.83**
Total Average Difference	**-$5,379,917.09**	Less using average than months August 2019 - March 2020		



COVID-19: **TRADITIONAL MEDICAID UTILIZATION**

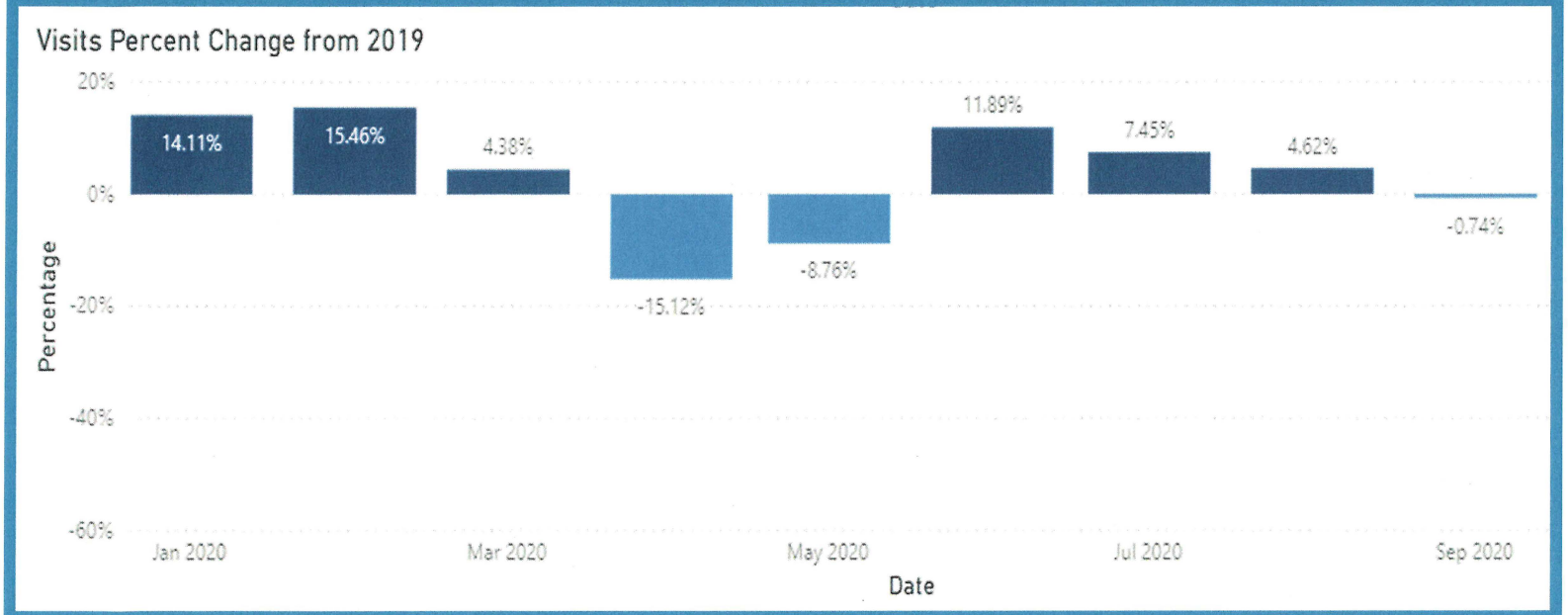
Utilization Comparison 2019 v. 2020

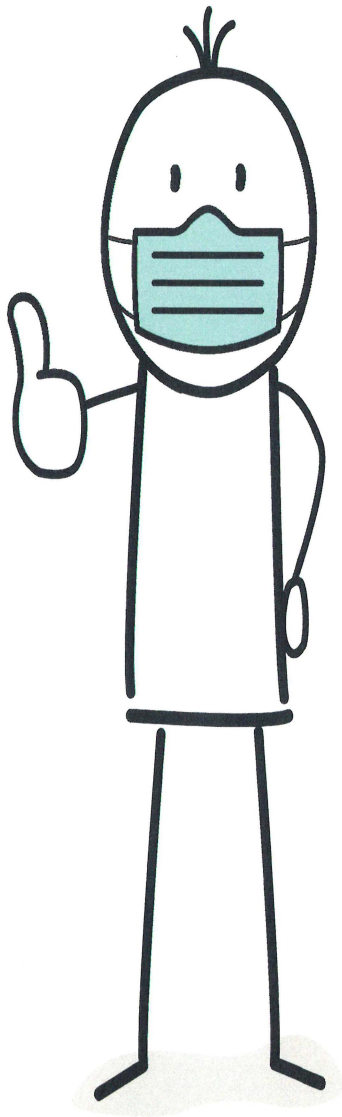




COVID-19: **UTILIZATION PERCENTAGE CHANGES IN TRADITIONAL MEDICAID**

Utilization changes shown in percentages from 2019 to 2020





COVID-19: **ENROLLMENT TREND v. 6.2% FMAP BUMP**

2020 Events: In 2020 the State received 6.2% **more** federal funds (lowering the General Fund need). To receive those funds Medicaid **cannot disenroll anyone** from coverage. Medicaid saw new applicants and the churn rate was 0%. As a result, enrollment reached 100,000 in August and continues to grow. However, decreases in utilization in April and May **provided a buffer**.

2021 Scenario 1: In 2021, HHS extended the public health emergency to April. This continues to lower the General Fund need by 6.2% and our churn rate continues to be 0 with a few exceptions. However, utilization is generally back up to pre-COVID levels. **The buffer will no longer exist.**

2021 Scenario 2: Sometime in the biennium the Biden Administration will end the public health emergency and the 6.2% increase in federal funds will go away. DHS will have 6 months to work through the backlog of redeterminations. There are **no funds** being provided by CMS for this work.

OVERVIEW OF BUDGET

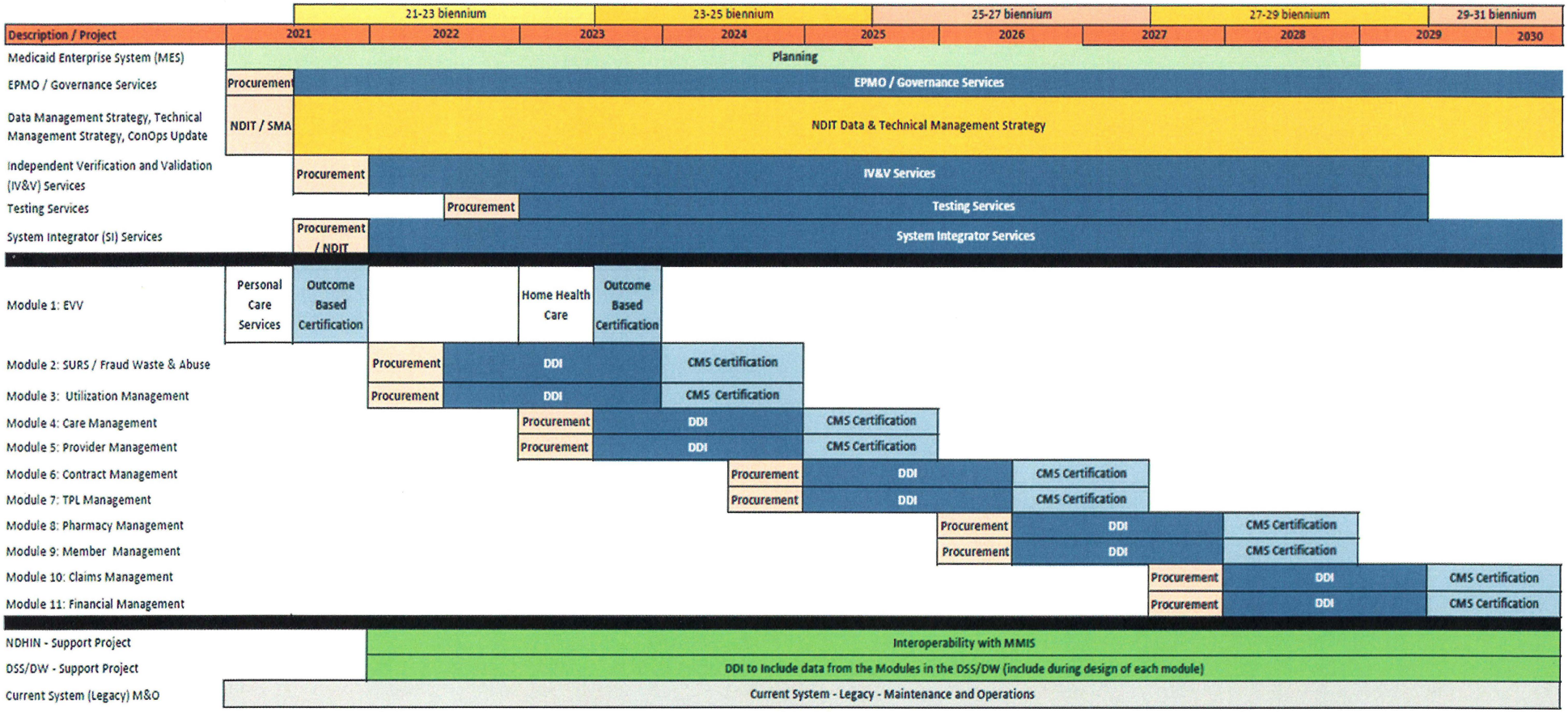
Description	2013-2015 Appropriation	2015-2017 Appropriation	2017-2019 Appropriation	2019-2021 Appropriation	Changes	2021-2023 Executive Budget
Salary and Wages	9,361,167	11,006,399	9,217,240	17,631,821	798,183	18,422,004
Operating	39,355,085	44,241,160	53,320,237	48,290,789	8,712,126	57,002,915
Grants						
Medical Grants	806,717,552	1,215,896,867	1,303,690,959	1,352,417,879	(12,341,840)	1,340,076,039
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
General Fund	289,891,636	313,547,595	284,162,440	342,465,788	35,847,622	378,194,515
Federal Funds	514,107,184	914,467,704	962,268,730	977,292,683	(24,294,880)	952,997,802
Other Funds	51,434,984	43,129,127	119,797,266	98,574,018	(14,265,377)	84,308,641
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**(2,831,531)**	**1,415,500,958**
Full Time Equivalent (FTE)	**59.50**	**59.50**	**48.00**	**86.50**	**12.00**	**98.50**

MMIS MODERNIZATION – THE ROAD AHEAD




MMIS -
ASSESSMENTS
Medicaid Information Technology Architecture
State Self-Assessment (MITA SS-A)
Ernst & Young Feasibility Assessment

HIGH LEVEL PROJECT SCHEDULE



BENEFITS OF MODERNIZATION

- CMS Directive & 90/10 enhanced funding
- System upgrades are more manageable
- Enhanced & specialized system functionality
- Potential to leverage NASPO ValuePoint
- One Vendor does not control the system
- Modularity enhances Interoperability
- Leverage cloud based or SaaS solutions
- As technology changes, modules are easier to replace

- State and Federal Mandates, Business Changes, and Technology changes are easier to accomplish
- Provide benefits to members and providers working toward the goal of interoperability that will result in more value-based care
- To reduce operational costs; increase flexibility and responsiveness to rapidly changing healthcare, legislative, business, and technical needs; and advance partnerships with intrastate and interstate agencies

POTENTIAL ROADBLOCKS

- Modernization of MMIS will require a transition of legacy platforms to modules and at times the maintenance and operations of those will overlap.
- Costs as related to multiple procurements
- NDIT and DHS staff availability

MMIS PROGRESS IN OTHER STATES

Montana

Montana Program for Automating and Transforming HealthCare Project **(MPATH)** 6-year plan ($99 Million)

- Data Analytics (Multi-release March 2018-November 2019)
- Provider Services (Multi-release August 2019-April 2020)
- System Integration Services(Implemented July 1 ,2019)
- Care Management (Multi-release June 2020-February 2022)
- Claims Module-Planned Implementation (Late 2022/Early 2023)
- Additional RFP Releases (October 2019-December 2022)
  - Fraud, Waste & Abuse Analytics
  - TPL Recoveries
  - Customer Care
  - Pharmacy Benefit Management System
  - Drug Rebate Management
  - Electronic Visit Verification

Wyoming

The Wyoming Department of Health, Division of HealthCare Financing, MMIS Replacement Project Team for the Wyoming Integrated Next Generation System **(WINGS)**

- $75 million proposal
- Four Modules have been implemented and are live:
- Pharmacy Benefit Management System(PBMS)
- System Integrator
- Data Warehouse
- Fraud, Waste and Abuse Case Tracking
- Two Modules are in the implementation phase
- Benefit Management System-Claims Processing with Third Party Liability
- Electronic Visit Verification(EVV)
- Care/Case Management System Module RFP through procurement July 2020

BUDGET SAVINGS

Equity
PCCM $2 PMPM Elimination



Equity
Remedial Eye Program, PRTF



Quality
Value-Based Purchasing



PCCM $2 PMPM ELIMINATION



Estimated Total Potential Savings **$1,652,240**

Elimination of PCCM PMPM Payments

	Total	Federal	State
Primary Care Case Management	$ (1,652,240)	$ (882,371)	$ (769,869)

REMEDIAL EYE PROGRAM, PRTF

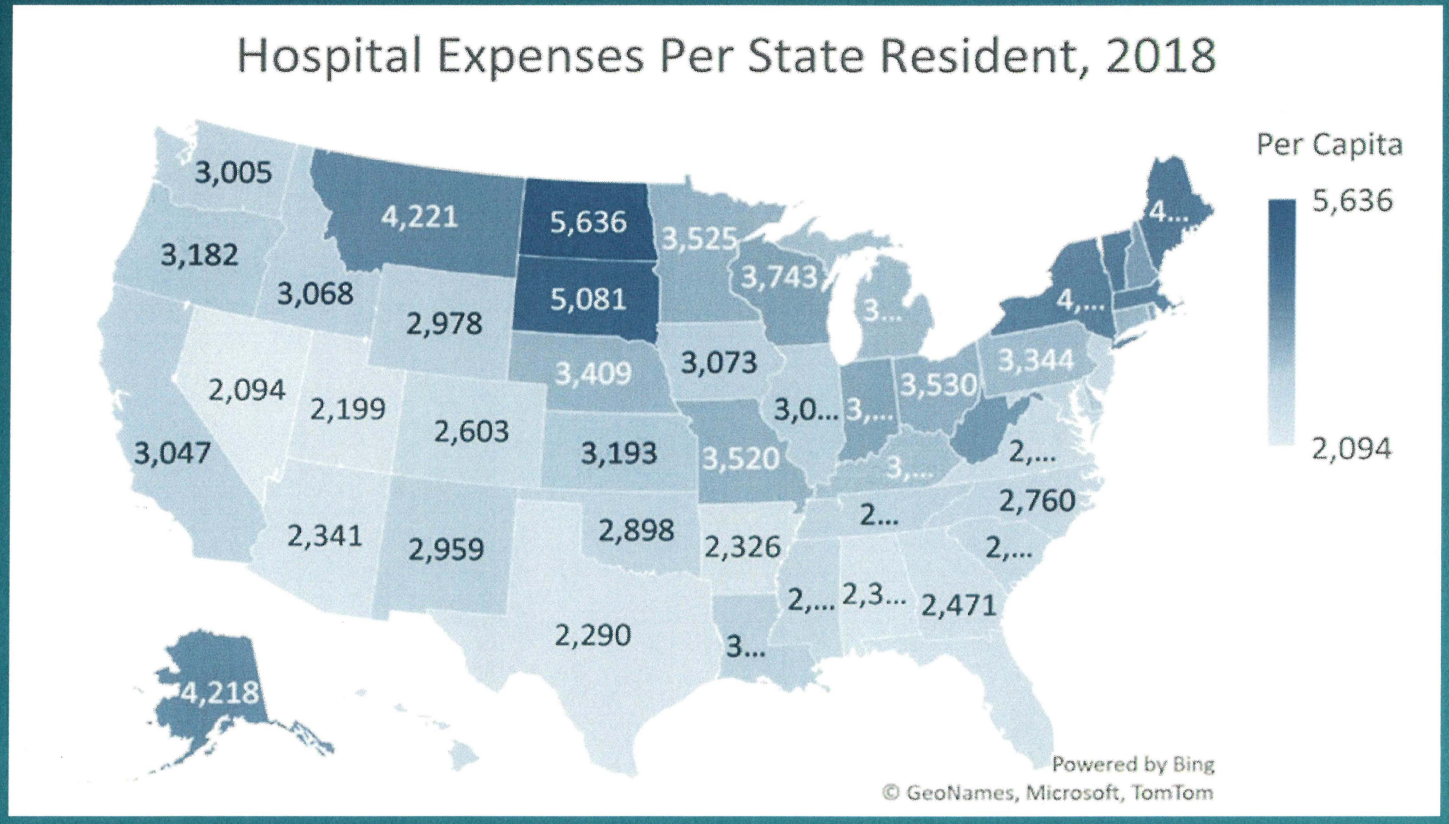
Estimated Total Potential Savings **$1,401,399**

Elimination of Remedial Eye, PRTF Payments

	Total	Federal	State
Remedial Eye Program	$ (5,000)	$ (0)	$ (5,000)
PRTF Technical Correction	$ (1,396,398)	$ (745,834)	$ (650,565)

VALUE BASED PURCHASING

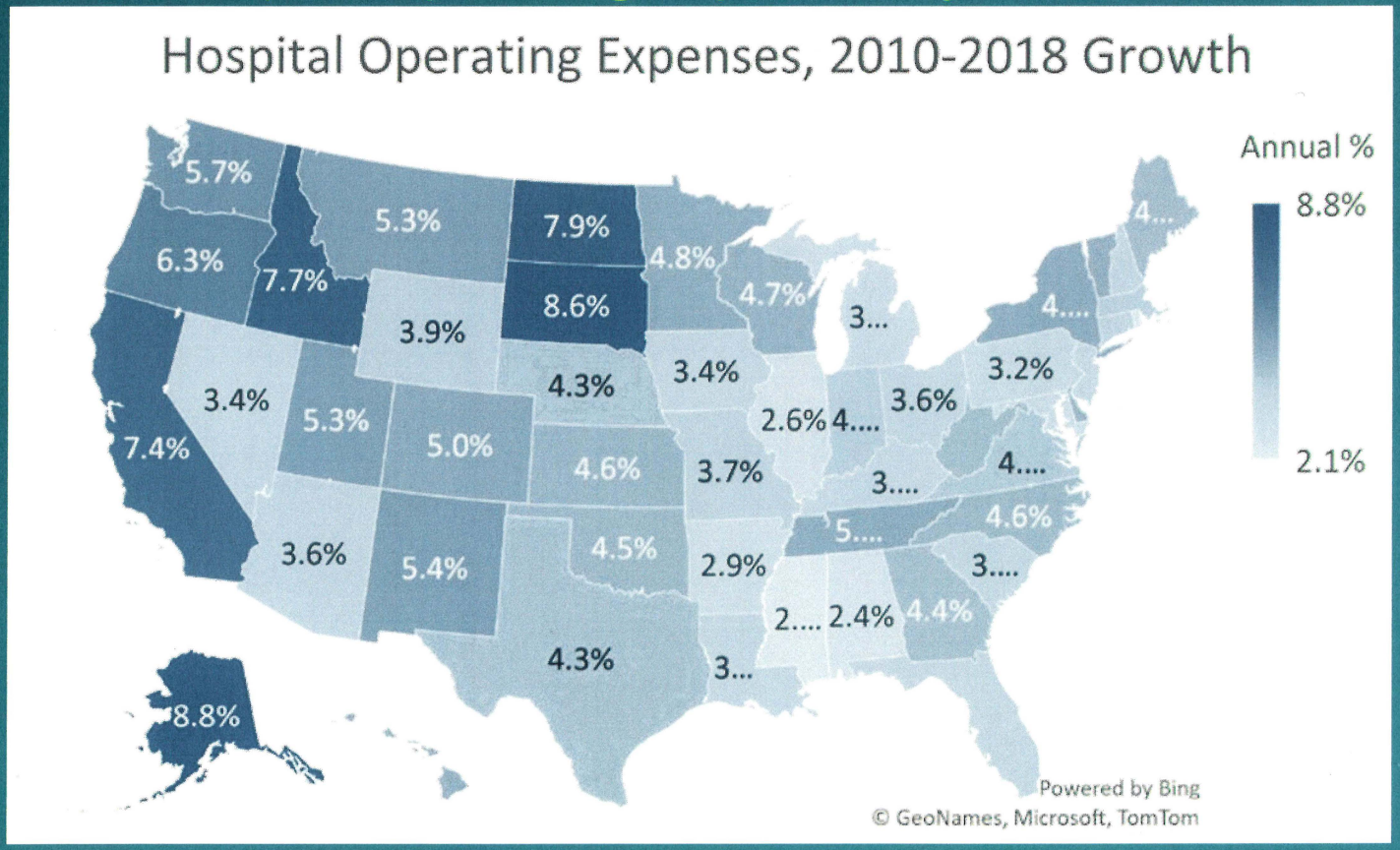
Hospital expenses by State



Source: https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/20200910%20North%20Dakota%20Legislative%20Management%20Interim%20Health%20Care%20Study.pdf

VALUE BASED PURCHASING

Hospital operating expenses by State



Source: https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/20200910%20North%20Dakota%20Legislative%20Management%20Interim%20Health%20Care%20Study.pdf

VALUE BASED PURCHASING

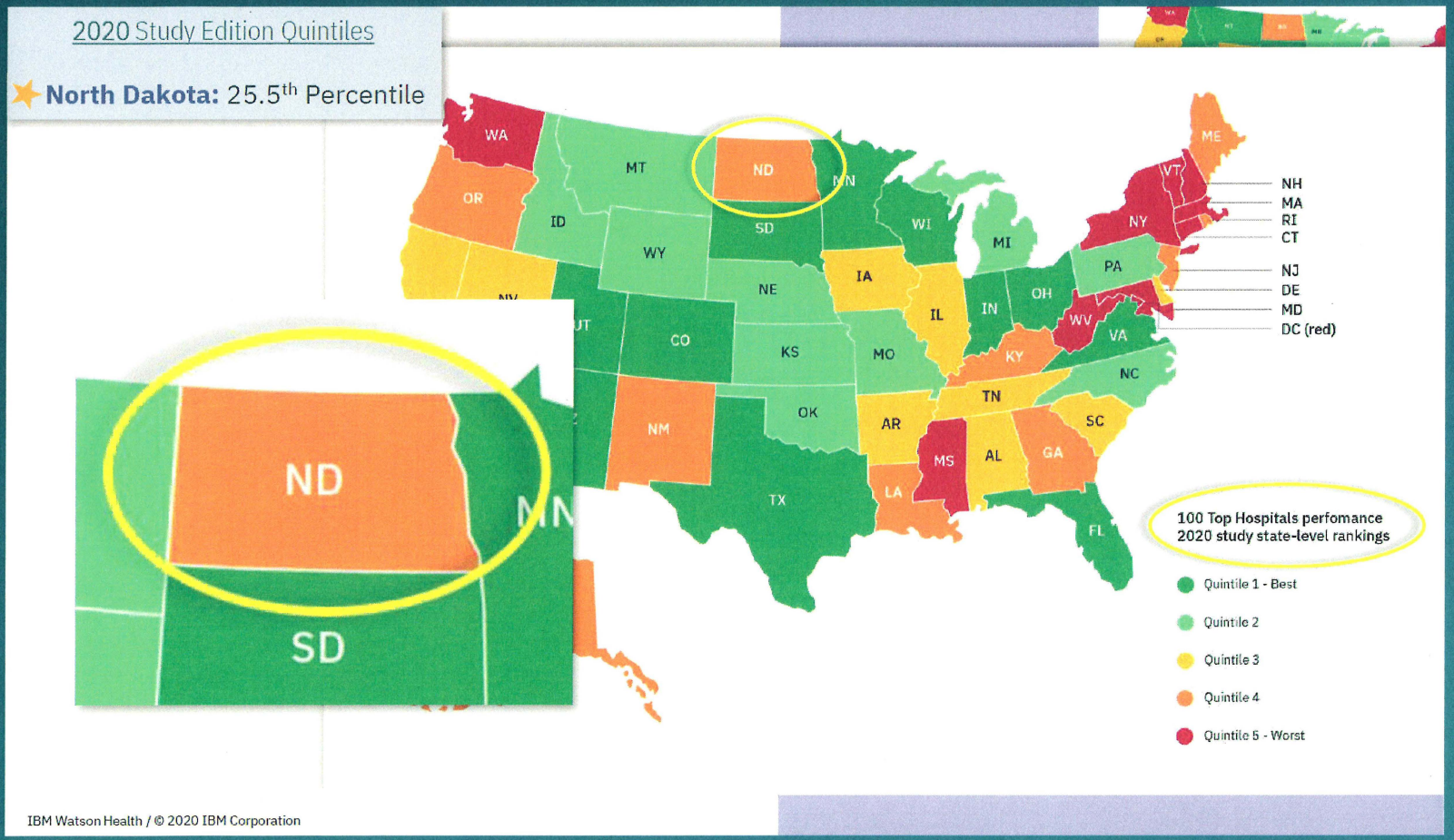


North Dakota Hospital Quality: Compare Star Ratings

Star Rating	Hospital
★★★★	CHI St. Alexius Health Bismarck
★★★★	Essentia Health Fargo
★★	Altru Hospital Grand Forks
★★	Sanford Medical Center Bismarck
★★	Sanford Medical Center Fargo
★★	Trinity Hospital Minot

**Rating based on current data collection periods from Hospital Compare, last updated on July 22, 2020*

VALUE BASED PURCHASING



VALUE BASED PURCHASING

North Dakota

Measure-by-measure

These are 2018 values for the entire "state as a hospital," set against the median values of winners and all other non-winners in our primary 100 Top Hospitals® study (all five peer comparison groups, combined)

*(*This table represents all hospitals who were eligible for inclusion in the 2020 100 Top Hospitals study edition, which does **not** include Critical Access Hospitals or specialty care facilities since they often have no publicly reported values for several of the metrics to the right, especially extended outcomes.)*

National Performance Comparison*

Domain	Performance Measures	North Dakota	Medians	
			Benchmark Hospitals (Winners)	Peer Hospitals (Nonwinners)
Clinical Outcomes	Inpatient Mortality Index[1]	1.45	0.79	1.01
	Complications Index[1]	1.22	0.77	0.94
	HAI Index[2]	0.89	0.59	0.76
	Influenza Immunization Rate[3]	90.7	99.0	97.0
Extended Outcomes	30-Day Mortality Rate[4]	12.6	11.8	12.5
	30-Day Hosp-Wide Readmission Rate[5]	14.8	14.9	15.3
Operational Efficiency	Average Length of Stay[1]	4.46	4.2	4.7
	ED Throughput Measure[6]	122	190.0	217.0
	Inpatient Expense per Discharge[7]	$6,638	$6,163	$6,994
Financial Health	Operating Profit Margin[6]	-0.1	15.2	3.7
Patient Experience	HCAHPS Top Box Percent[6]	68.2	76.5	71.0

IBM Watson Health / © 2020 IBM Corporation

VALUE BASED PURCHASING

DHS met with members of the North Dakota Hospital Association

- 6 Prospective Payment System Hospitals
- 3 large Critical Access Hospitals

Meeting Dates

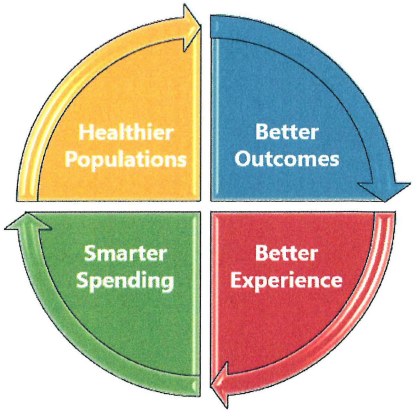
- **11/13/20** – Episodes of Care
- **12/3/20** – Pay-For-Performance
- **12/10/20** – Accountable Care Organizations

The 3 VBP Models presented by experts from other states

- Tennessee presented on Episodes of Care
- Wisconsin presented on Pay-For- Performance
- Caravan Health presented on Accountable Care Organization

VBP Models align with Quality

Quadruple Aim for ND Medicaid



VALUE BASED PURCHASING



1. States that incorporate VBP model into their Medicaid program can **increase quality** and **bend the cost curve**.
2. DHS sent a survey to call participants to understand their preferred VBP model. All PPS hospitals **except** Sanford completed the survey.
3. DHS will present the survey results to committee members and describe options for VBP models.

VALUE BASED PURCHASING FOR HOSPITALS



Estimated Total Potential Savings **$6,250,000**

Value Based Purchasing for Hospitals			
	Total	**Federal**	**State**
Value-Based Purchasing	$ (6,250,000)	$ (4,687,500)	$ (1,562,500)

FUNDING REQUEST
2021-2023



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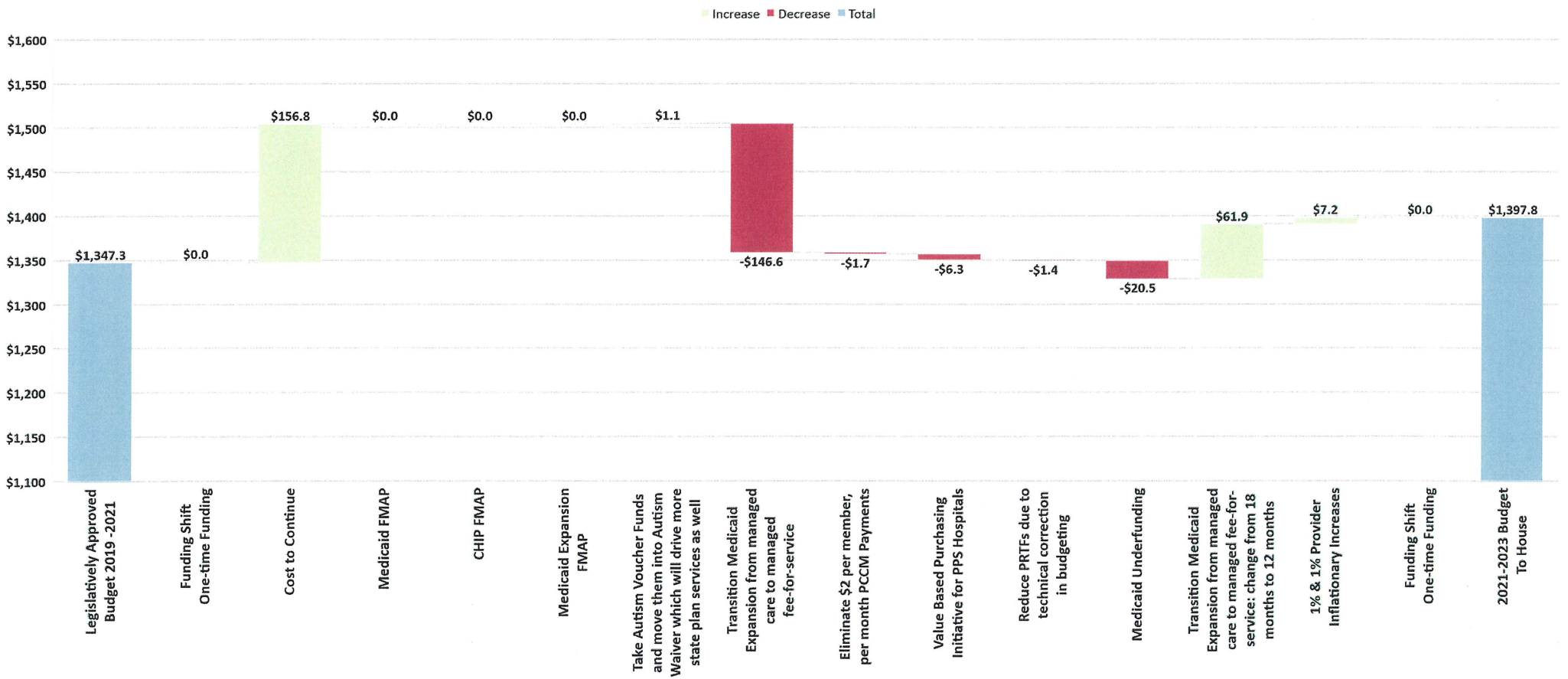
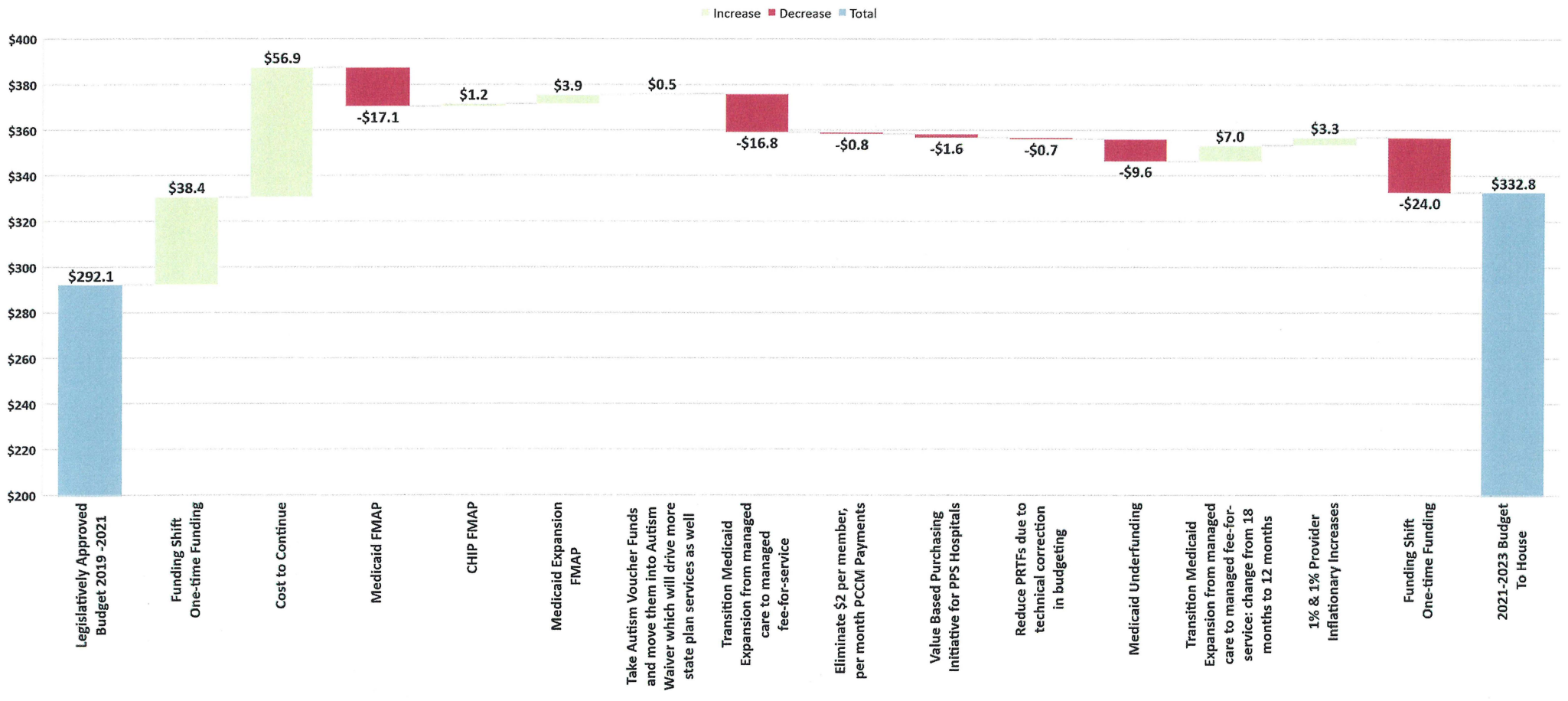
MEDICAL TOTAL FUND CHANGE (IN MILLIONS)



MEDICAL GENERAL FUND CHANGE (IN MILLIONS)



Thank you!

North Dakota Medicaid



Caprice Knapp, PhD
Division Director

Phone: (701) 328-1603
E-Mail: cknapp@nd.gov

NORTH Dakota | Human Services
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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/12/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 10:08 a.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Children and Family Services
- Parental Substance Abuse and child behavior
- Children and Family Services Budget
- Behavioral Health in ND

Cody Pederson, Dir. of Children & Family Services (10:09 am) testified about Children & Family services #1103

Pamela Sagness, Dir. Behavioral Health Division (11:05 am) testified about behavioral health overview #1101

Chair Nelson closed the meeting at 12:04 p.m.

Cole Fleck, Committee Clerk



House Bill 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman #1103

Children and Family Services

Rethinking Child Welfare in North Dakota

NORTH Dakota | Human Services

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CHILDREN AND FAMILY SERVICES
Program Purpose

The purpose of the Children and Family Services division is to help families who are struggling avoid disruption by having access to the help they need to build stability and well-being together.



CHILDREN AND FAMILY SERVICES
What we do

Safety

- Child protective services
- Child fatality review panel
- State Child protection team
- Parent Resource Centers
- Alliance for Children's Justice

Permanency

- Foster Care
- Adoption
- Guardianships
- Interstate compacts for the placement of children
- Unaccompanied minor services
- Independent living services
- Licensing for QRTPs and LCPAs

Well-being

- Family preservation services
- Intensive In-home therapy
- Nurturing Parent programs
- Healthy Families
- Parent aides
- In-home case management
- Respite care
- Family centered engagement
- Early childhood services
- Child care licensing

CHILDREN AND FAMILY SERVICES

In ND child welfare services are delivered by local, state, tribal and private providers using both federal and state funds

Dept of Human Services

- **Human Service Centers**
  - Crisis teams
  - Intensive In-home services (therapy & treatment, skills training, behavior mod)
  - Targeted case management
- **Children & Family Services**
  - Training and coaching of field staff
  - Oversee quality service delivery
  - Administration of policy

Private Human Service Providers

- Safe shelter for crisis
- Human trafficking supports and safe beds
- Unaccompanied minor services
- Foster homes, including therapeutic
- Targeted case management

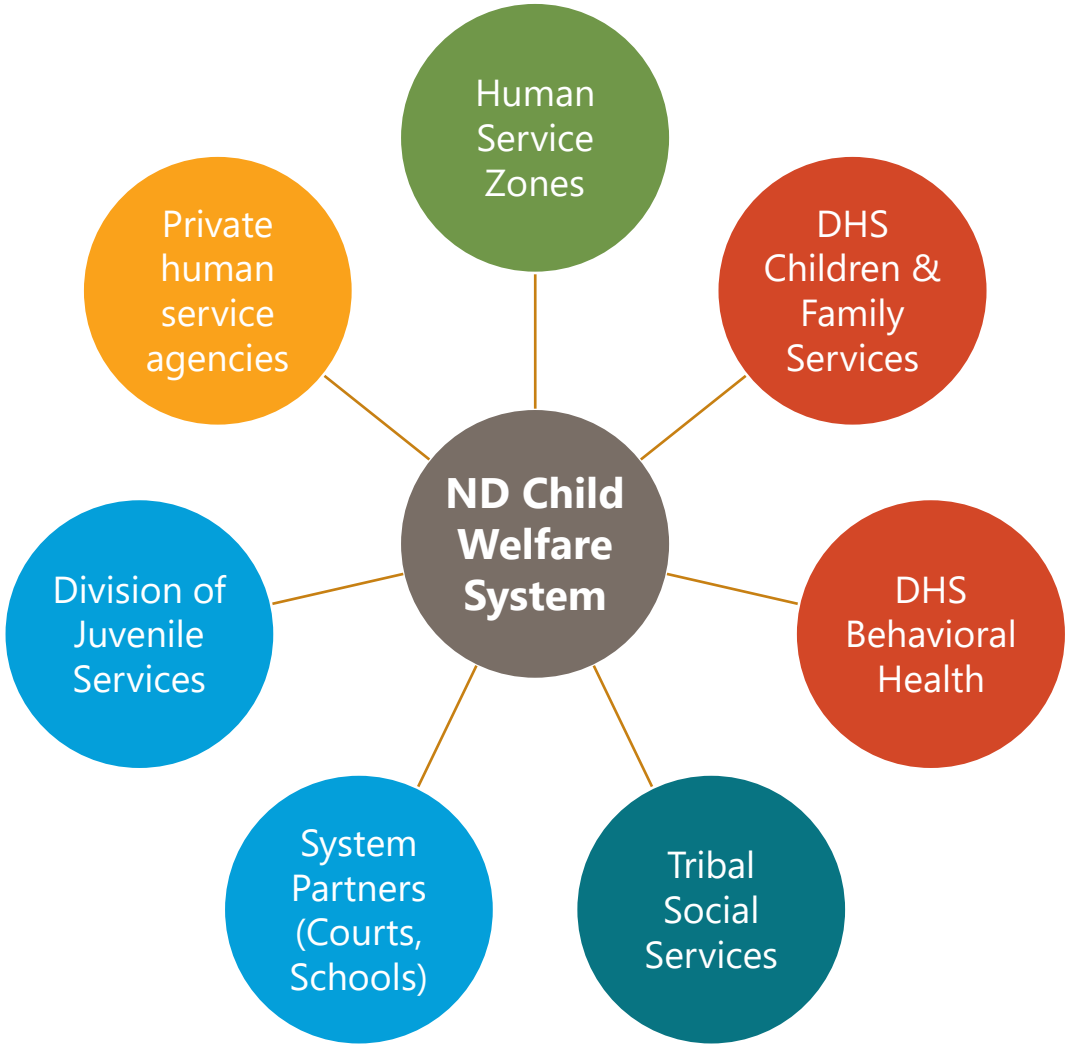
Tribal Social Services

- FRAME entry and foster eligibility determinations
- Joint practice model and ICWA training
- Native American Training Institute supports (training, billing, svc delivery)
- New FMAP service contracting
- IV-E agreements boost access to funding

Human Service Zones

- Assess present and impending danger
- Safety planning
- Case management
- Assess and build parent capacities
- Provide safe supports for children and families
- Refer and broker services needed for families
- In home supports
- Parent aides
- License foster homes
- Intake for child abuse and neglect reports

The Child Welfare System in North Dakota includes both public and private sector partners



The mission of the child welfare system in North Dakota

Safe Children
Strong Families



What’s driving us

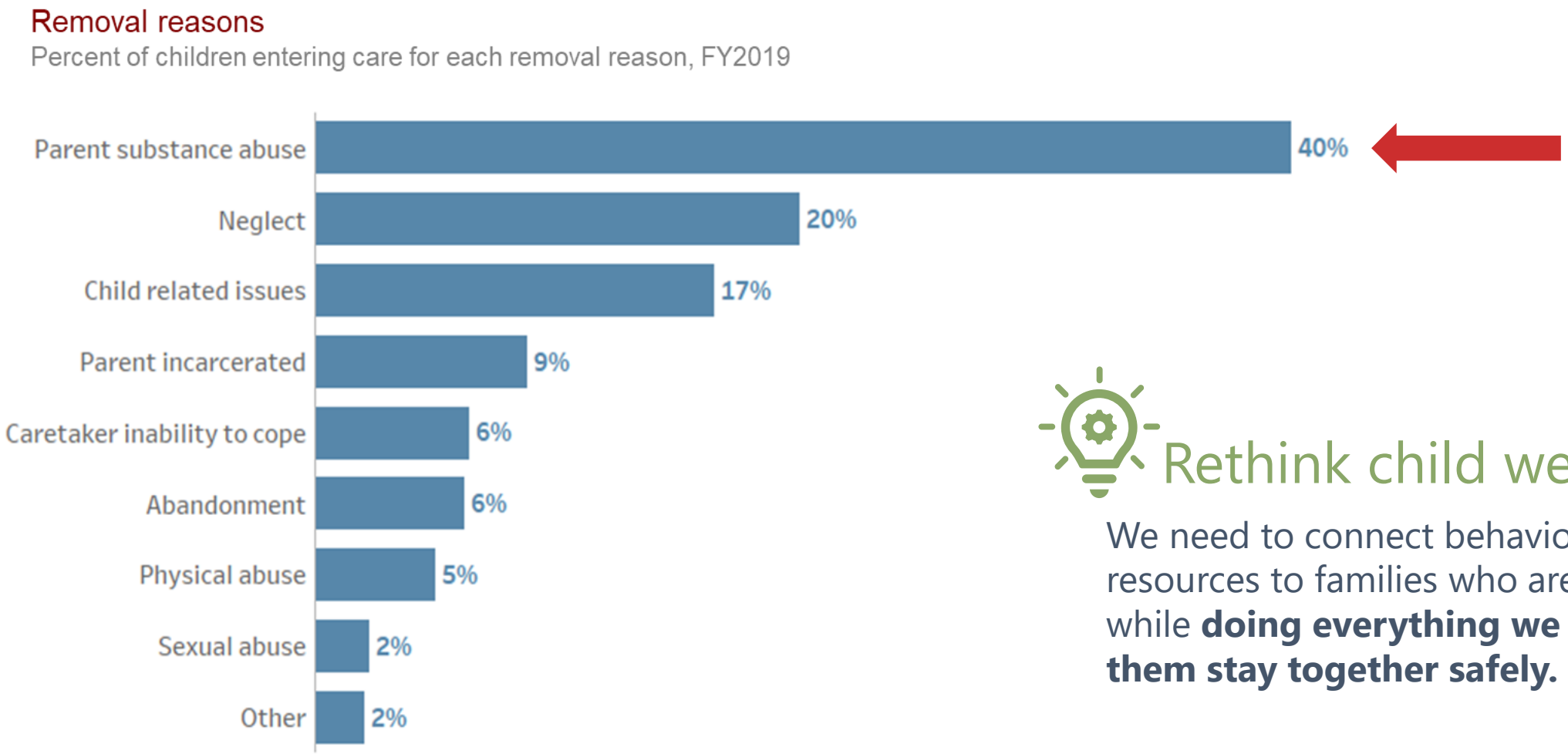
- Abuse and neglect related to substance abuse in families
- Increasing challenging behaviors in K-3
- Adolescent suicides
- Inconsistencies in child protection practices
- Delays in completion of child safety assessments
- Clear return on investments made early



"Everyone would agree that children should not be exposed to abuse or neglect.

"The process of being removed from one's home and placed in foster care has consequences as well and can have negative effects that last a lifetime."

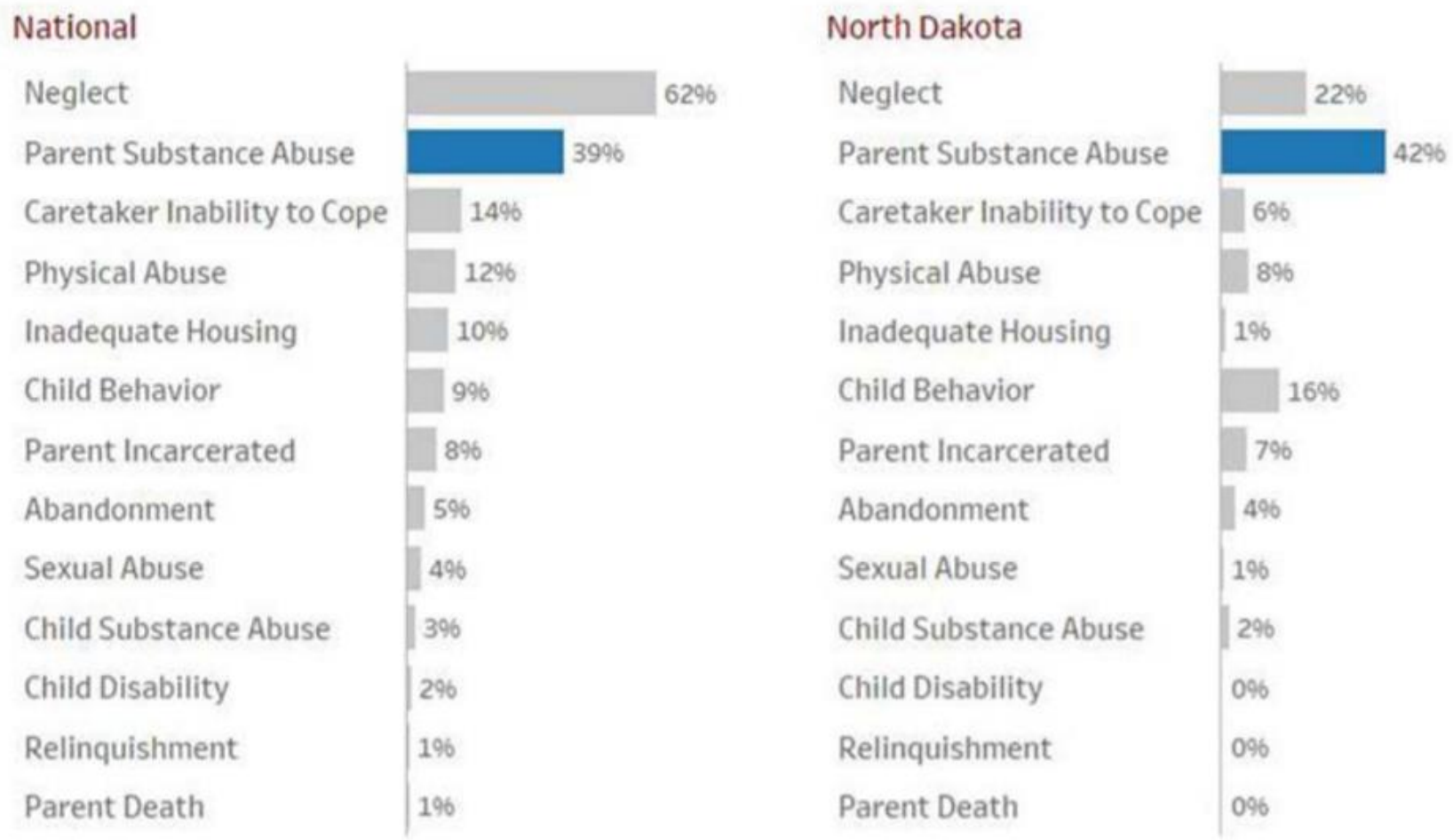
Substance abuse and unaddressed mental health needs are major de-stabilizing forces in families



Rethink child welfare

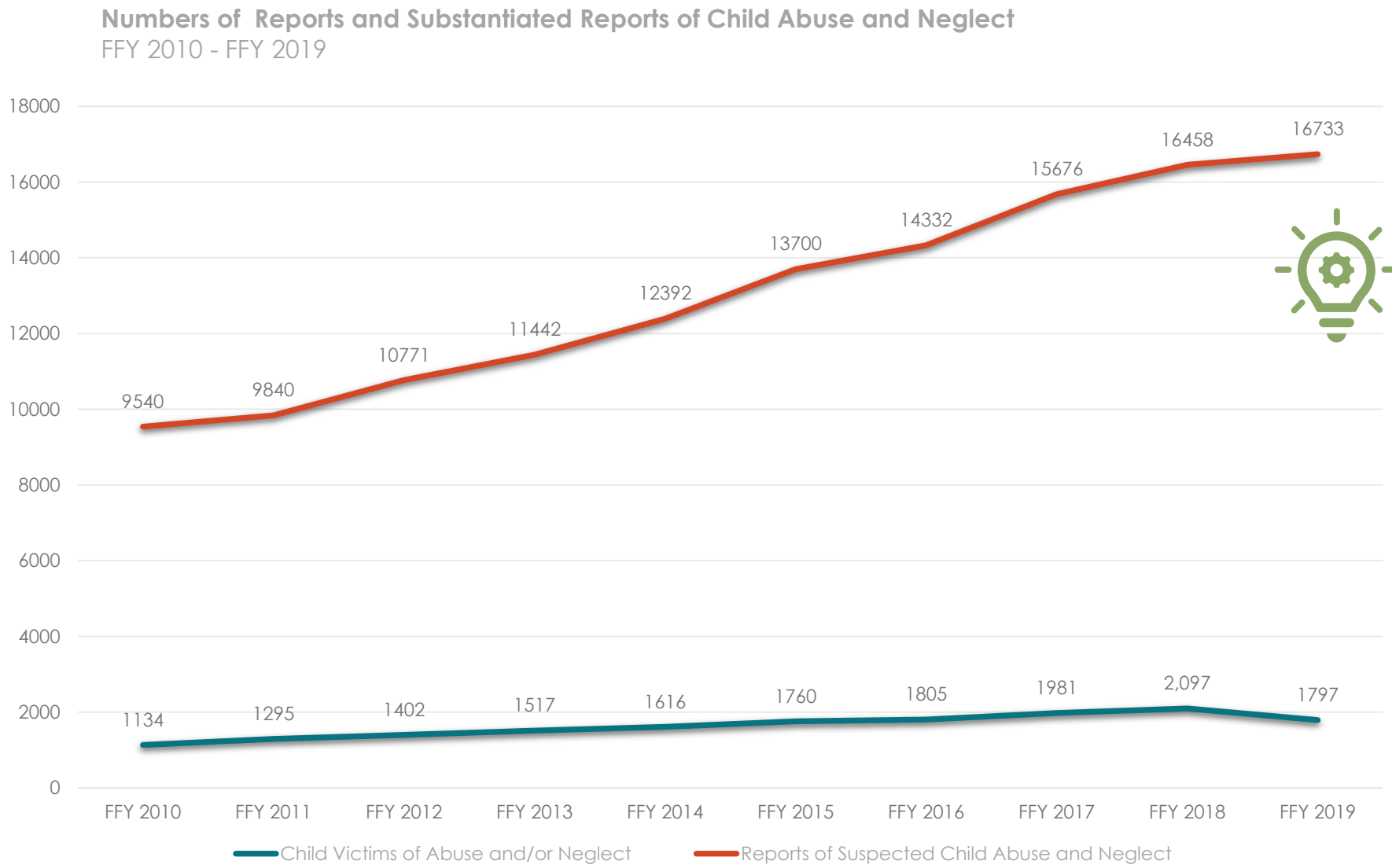
We need to connect behavioral health resources to families who are struggling while **doing everything we can to help them stay together safely.**

Parental Substance Abuse and Child Behavior are cited more often as reasons for removal in North Dakota than in the U.S.



Data source: FFY 2017 state-submitted AFCARS data. Denotes percent of children entering foster care for each removal reason; multiple reasons may be selected for a single child.

10-12 percent of child abuse/neglect calls are ultimately substantiated as abuse/neglect

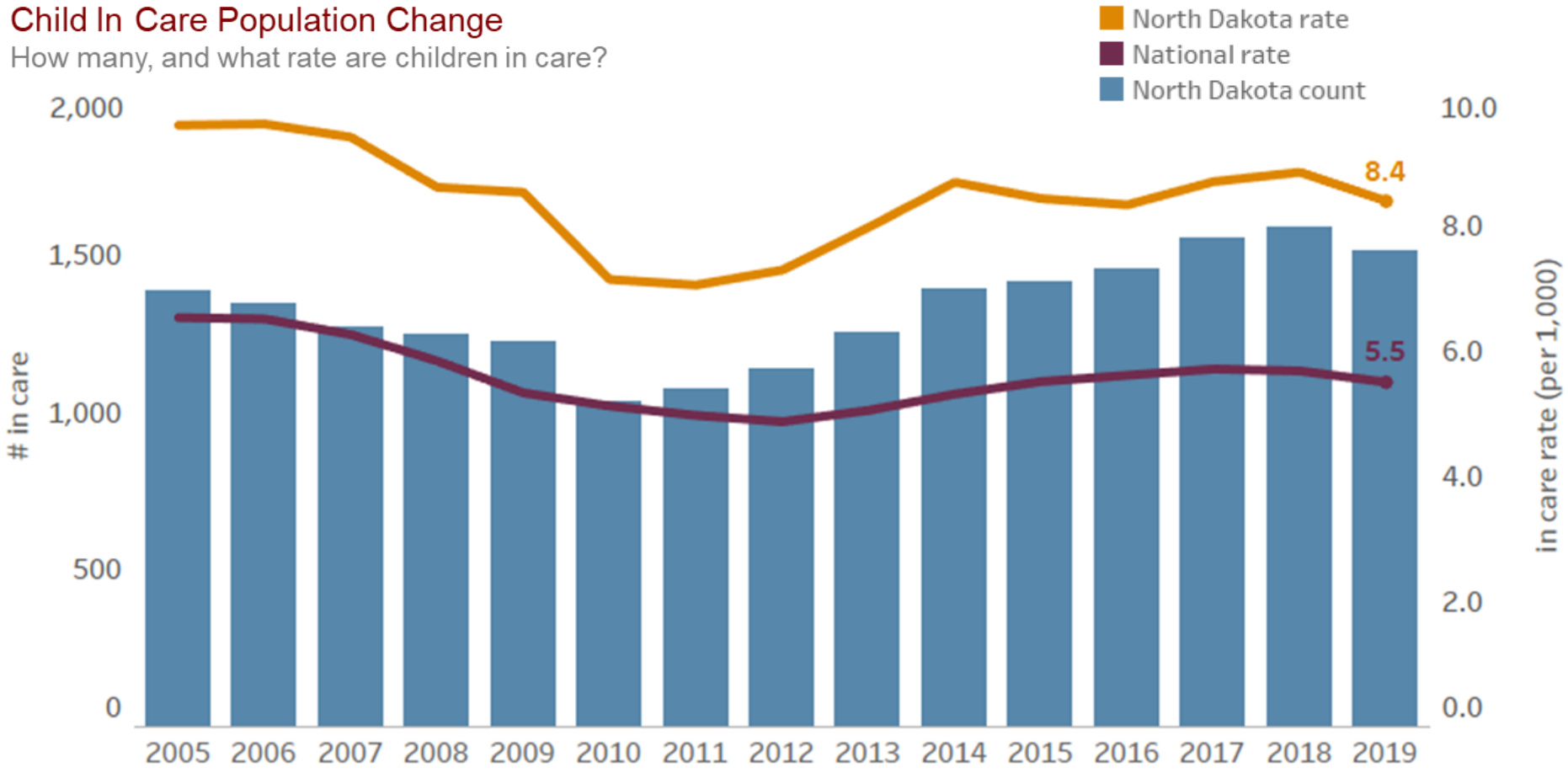


Rethink child welfare

People who call to report a suspicion of abuse or neglect are seeing something that causes them to be concerned about a child's (and their family's) well-being.

We need a different response for those often valid concerns.

The rates at which children are placed in foster care is 52 percent higher in North Dakota than in the U.S. overall



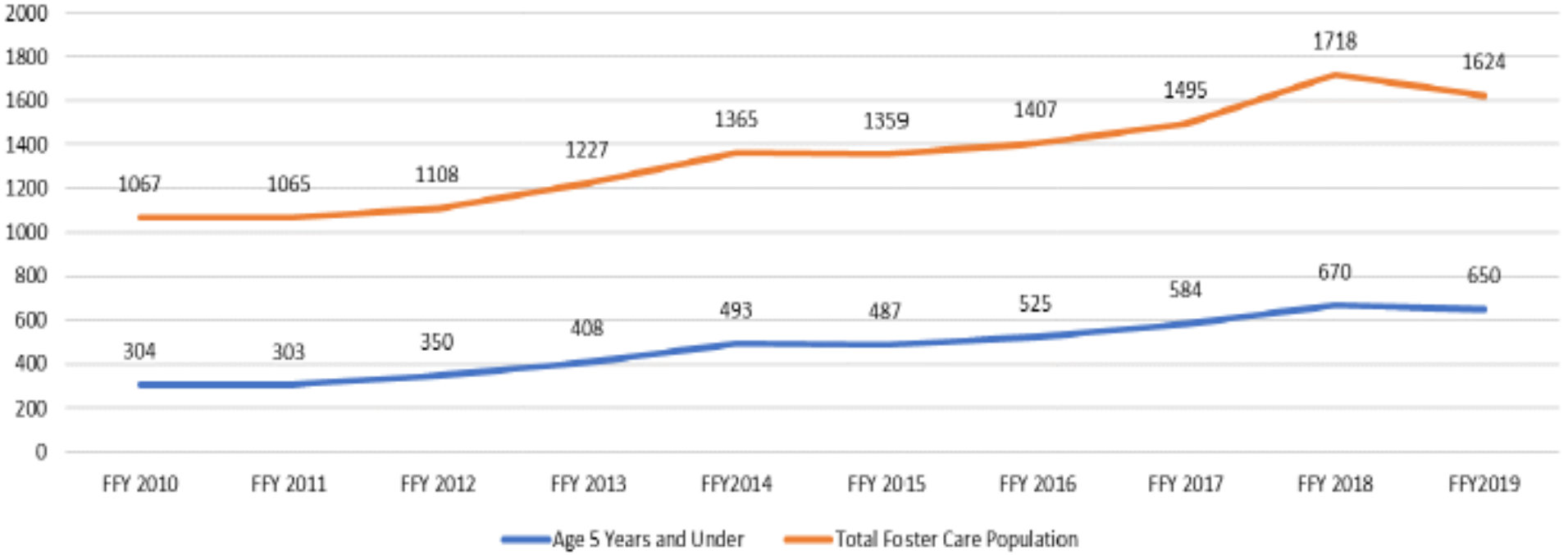
Rethink child welfare

We need to shift resources from removal to family strengthening and preservation.

The percentage of children in foster care under age 5 has risen steadily from 28% to 40% since 2010

The number of children in foster care in ND has risen by 52% over the last 10 years

ND Foster Care census and those age 54 years and under, FFY 2010-2019

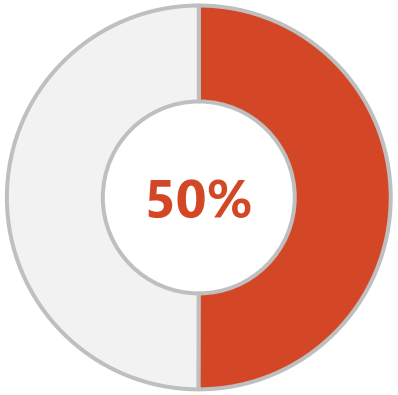


Rethink child welfare

Early interventions with young families are they key to reducing foster care placement for the youngest children.

CHILDREN & FAMILY SERVICES
Foster Care in ND – 2020 Snapshot

796



1 in 2 age 0-7

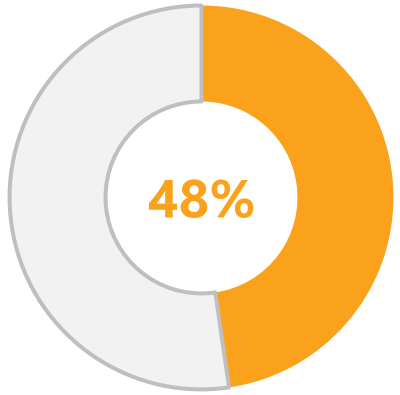
Half of the 1,591 children in foster care in North Dakota are age 7 or younger. (2020)

34%

Intense level of care

Of the 189 kids receiving therapeutic foster care in 2020, 65 (34%) were younger than 7 years old.

759



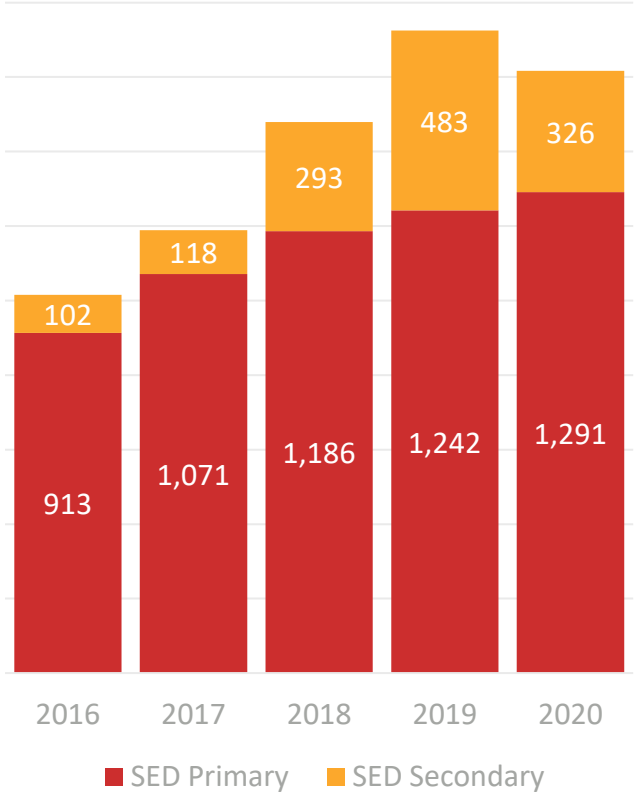
5x more likely

Native American children make up 48% of the total number of children in foster care in ND (759 of 1,591).

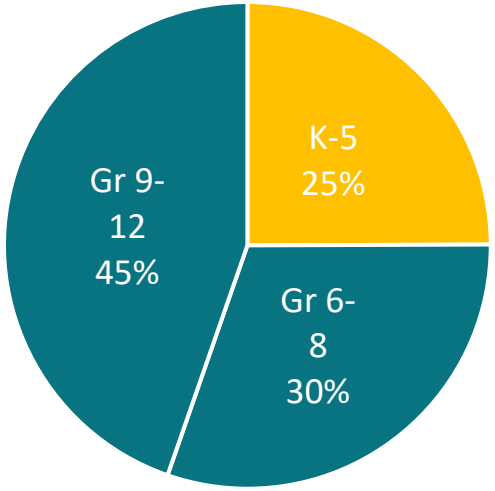
Native American children make up 8.7% of kids under age 18 in ND.

Trends in services for emotional disturbance, age of incidents and rates of chronic absence point to increasing behavioral health needs for kids and families

Students receiving services for "emotional disturbance" in Grades K-12



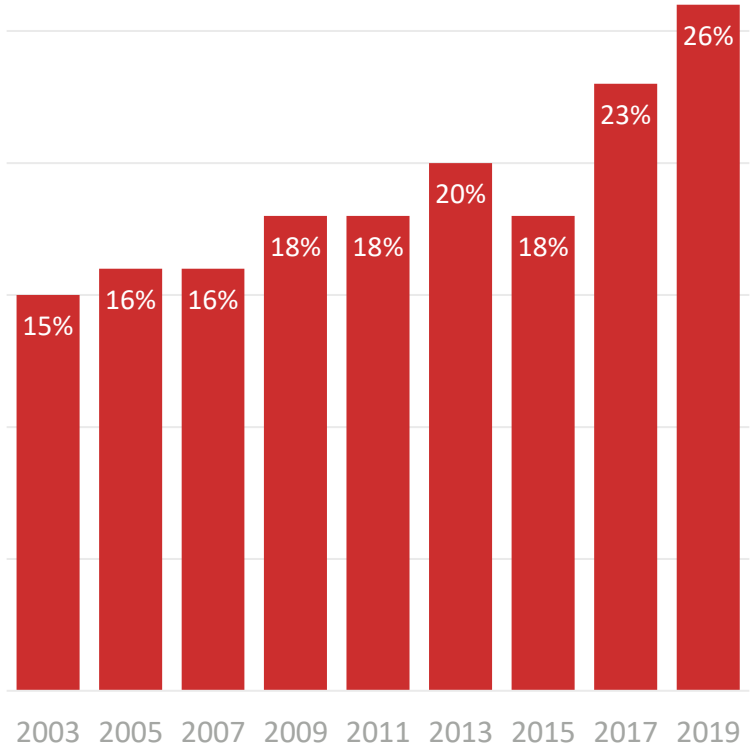
"Incidents" in school setting by grade level (2019-20 school year)



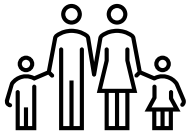
Rethink child welfare

Supporting behavioral health needs in families will can prevent disruptions at home and in school.

4th graders counted as chronically absent by academic year

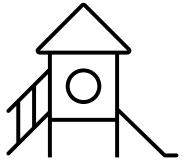


DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



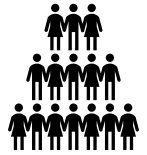
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

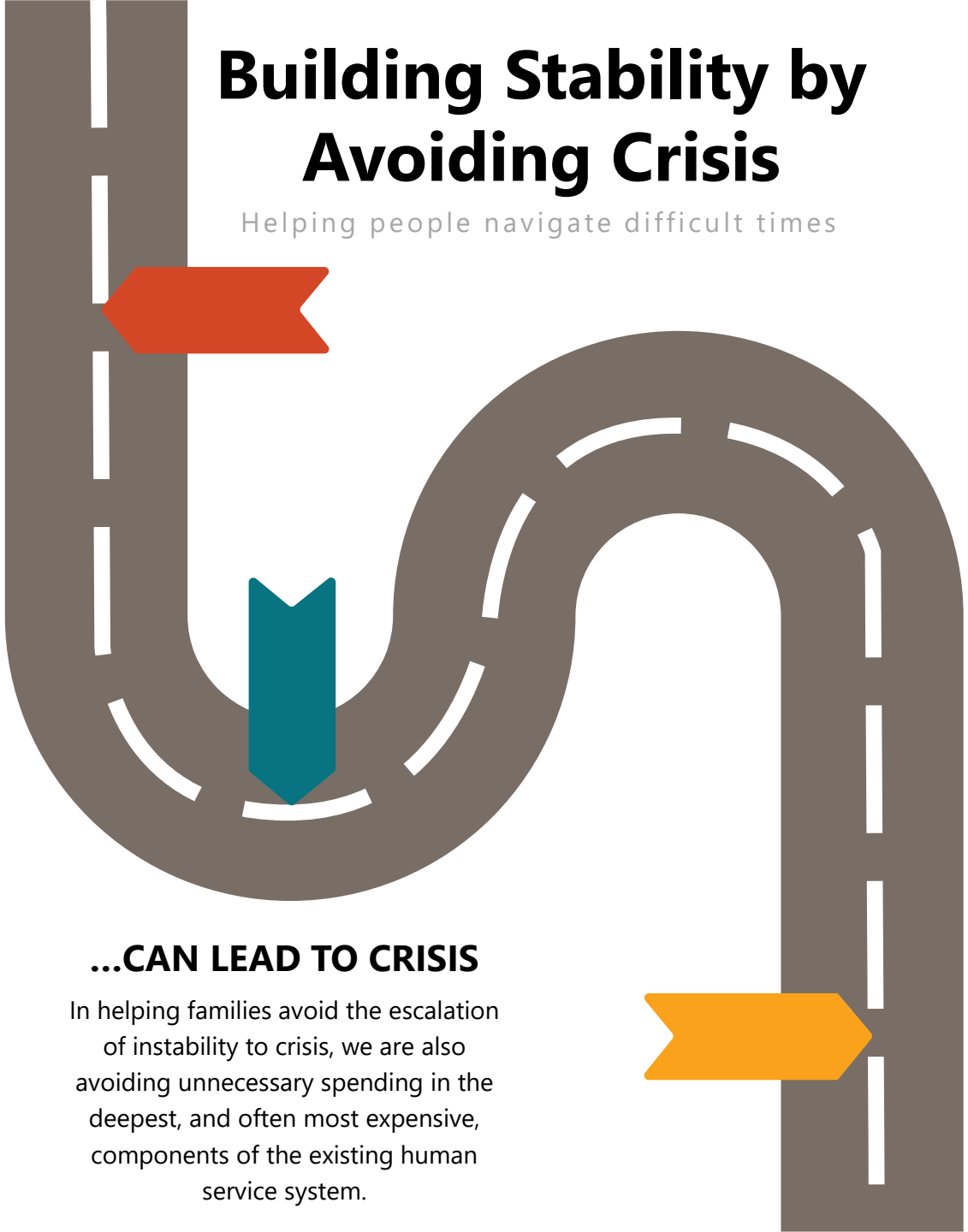
Economic Health | Behavioral Health | Physical Health

Building Stability by Avoiding Crisis

Helping people navigate difficult times

DISRUPTION

When families experience disruption, their ability to be a fully engaged, productive member of the community and the workforce is compromised.



...CAN LEAD TO CRISIS

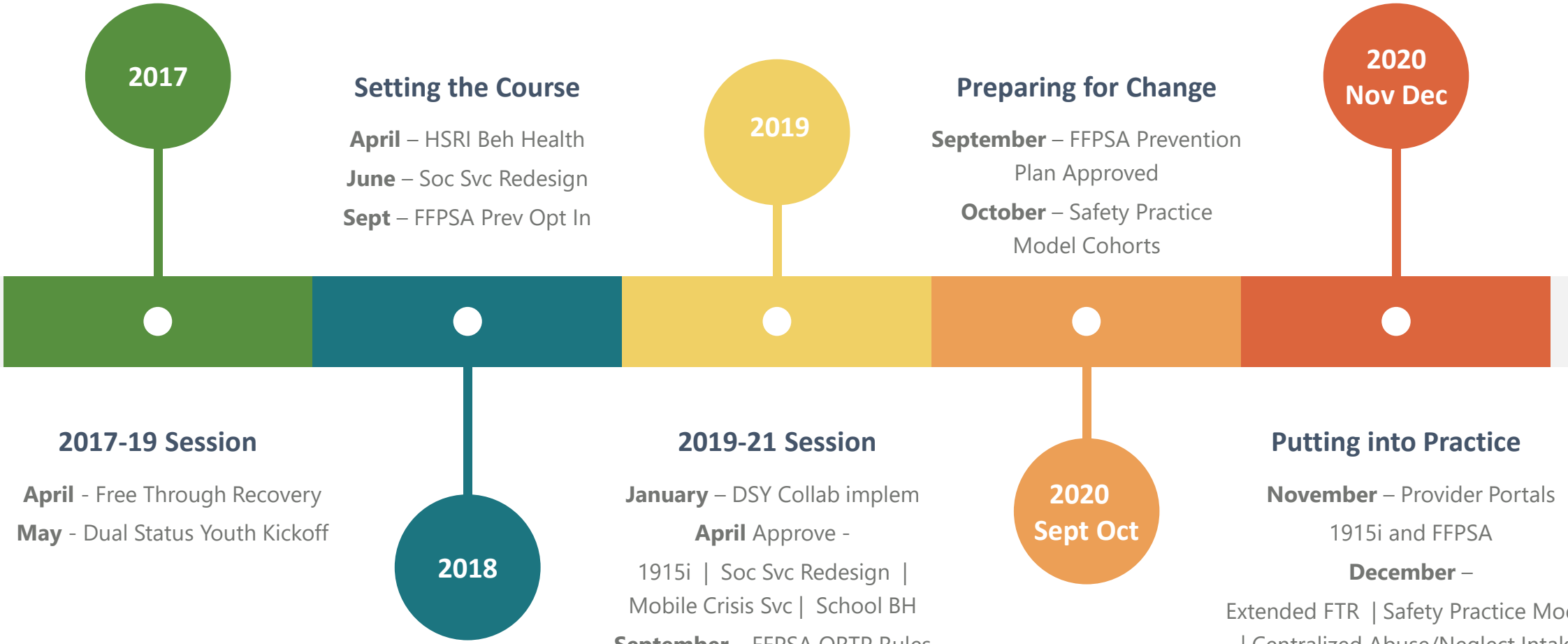
In helping families avoid the escalation of instability to crisis, we are also avoiding unnecessary spending in the deepest, and often most expensive, components of the existing human service system.

SERVICES SUPPORT STABILITY

Intervening early will both save money and strengthen families. It will allow us to reserve deep end services for the times when they are truly needed, and help people avoid deepening their journey into crisis by diverting from institutions, keeping families together, and helping and sure that people have a place to call home.

Our Journey Toward Building Stronger Families

Redefining Child Safety and Wellbeing through a Two-Gen Lens



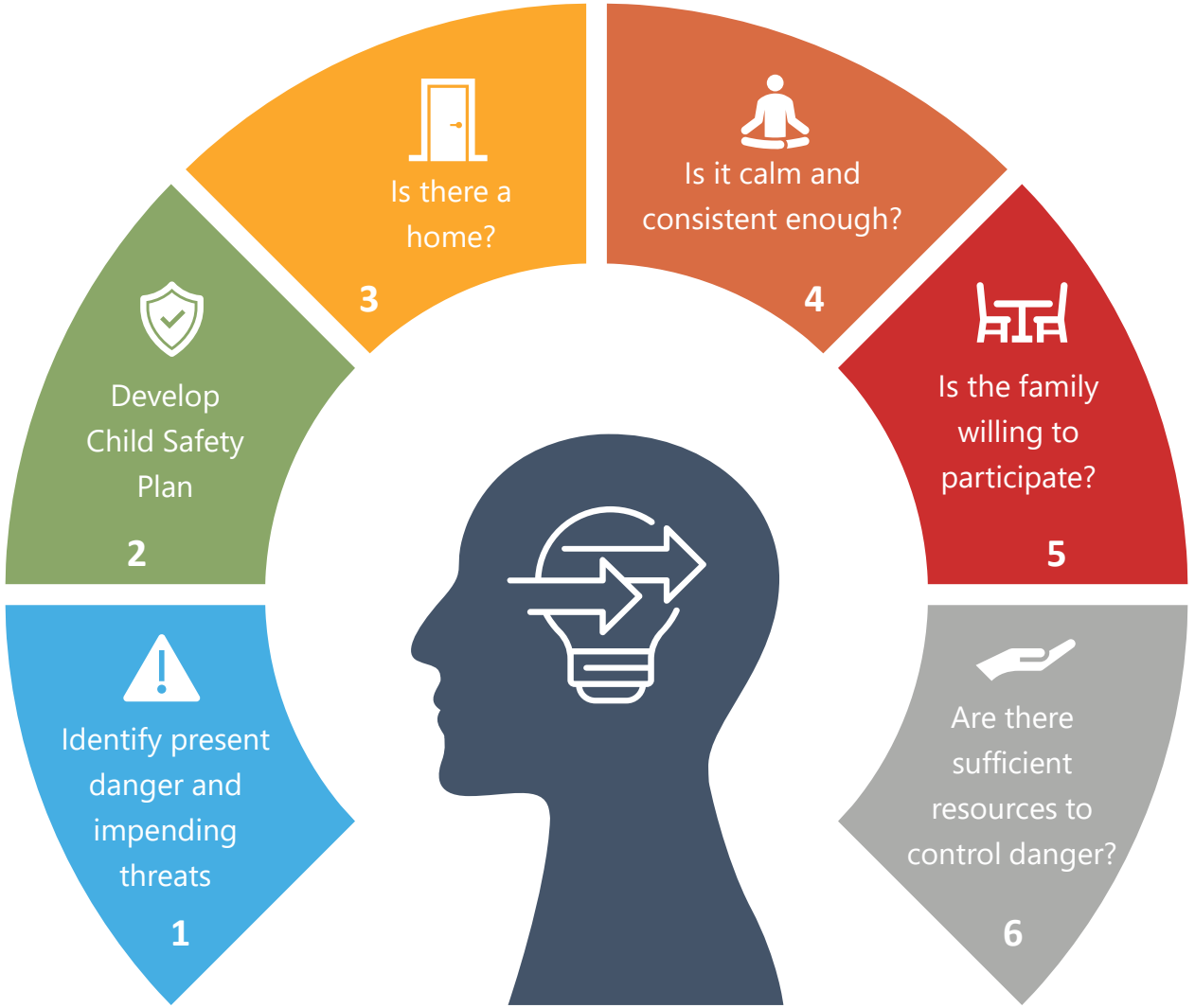
Understanding Child Safety

When can a child remain safely at home and when is removal necessary

Safety Plan Determination looks at 3, 4, 5, and 6

If ALL YES
Child can remain in home with necessary supports in place

If any are NO
Child safety is not assured, so removal is necessary



Safety ≠ A Place

Safe Child

A child is safe if:

- ✓ No threats of danger exists within the family, **or**
- ✓ The parent/caregivers possess sufficient protective capacity to manage any threats, **or**
- ✓ The child is not vulnerable to the existing danger.

ND Safety Framework Practice Model Resource Guide, November 2020

Vulnerability

Refers to a child's capacity for self-protection. Factors include assessment of several aspects of a child's capacity:

- ✓ Age
- ✓ Physical or Mental Disability
- ✓ Provocative Behaviors
- ✓ Powerless, defenseless, non-assertive
- ✓ Illness
- ✓ Invisible to other adults

Safety is an issue only when there is a vulnerable child in a family.

ND Safety Framework Practice Model Resource Guide, November 2020



"North Dakota's Child Welfare System is focusing on efforts to **ensure availability and access** to a broad, flexible array of **effective community-based services and supports**

for children and their families

that address their emotional, social, educational and physical needs,

including traditional and nontraditional services as well as natural and informal supports."

ND 2020-2024 Title IV-E Prevention Services and Programs Plan

Children considered a "Candidate for Foster Care"

Under 18 years of age	Significant interference or limitations of the child's functioning in home, school or community	Child is pregnant or parenting a child(ren)	Siblings in foster care
Inadequate supervision based on family and youth circumstances	Currently involved in 2 or more community services or agencies	DSM diagnosis for emotional, behavioral, or mental health disorder	Child whose adoption or guardianship arrangement is at risk of disruption
Prior out of home placement	Reunification has occurred	Difficulties are interfering or limiting achievement or maintenance in 1 or more developmentally appropriate skills	Parent/custodian/guardian has limited capacity to meet educational, medical, safety or basic needs of child due to parental need*

Have access to



Evidence-based Prevention Services

In home parent skill-based programs

Mental health programs

Substance abuse prevention and treatment

*Parental inability to meet needs of child could be due to parent(s)' behavioral health, incarceration, physical or intellectual disability, debilitating or life-threatening medical needs, homelessness or substandard living conditions, verbalization of no longer wanting their child, or substance exposed newborns.

Meet Jayce.



Meet Jayce's family.

Age 9

Mom noticed Jayce wasn't himself. His teachers noticed too.

Acting out in school. Aggressive. Defiant. Sullen. Tipped over a desk in the classroom.

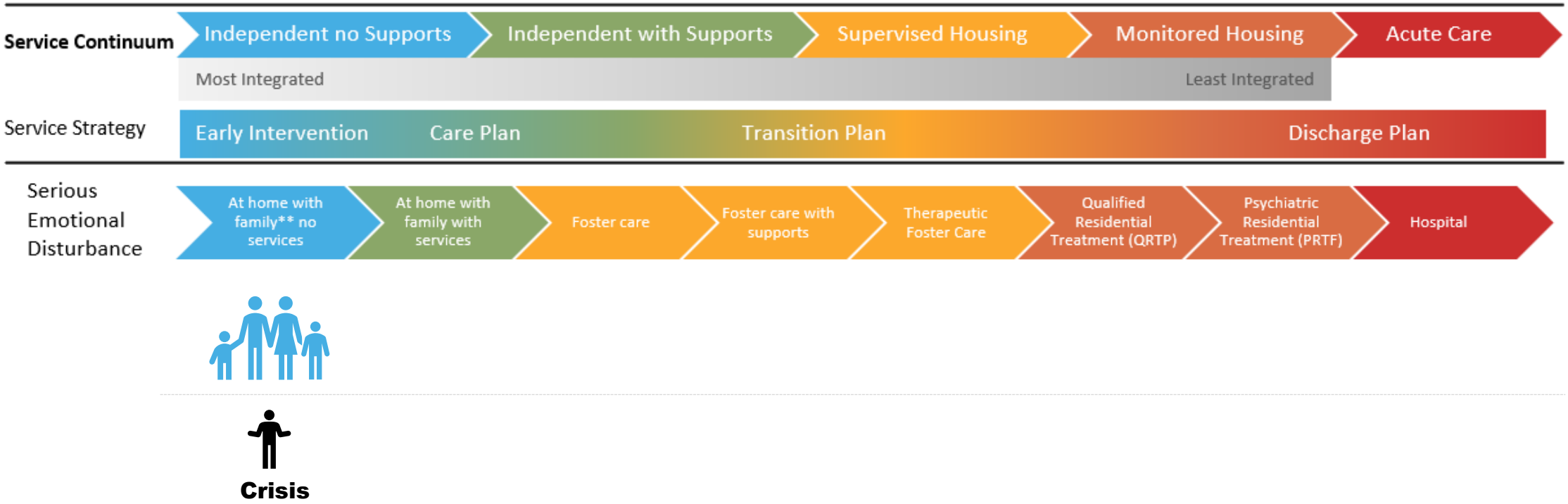
He lives at home with his mom, dad and little brother.

Jayce's school called in an abuse/neglect report.

- Mom, dad and brother (age 4)
- Both mom and dad work full time. Mom is a cashier. Dad works for a farmer.
- They don't qualify for Medicaid. They have a basic insurance package through the exchange.
- Tensions at home are escalating. Jayce's dad is becoming increasingly frustrated and has turned to alcohol in an unhealthy way to cope with Jayce's behavior.

What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions



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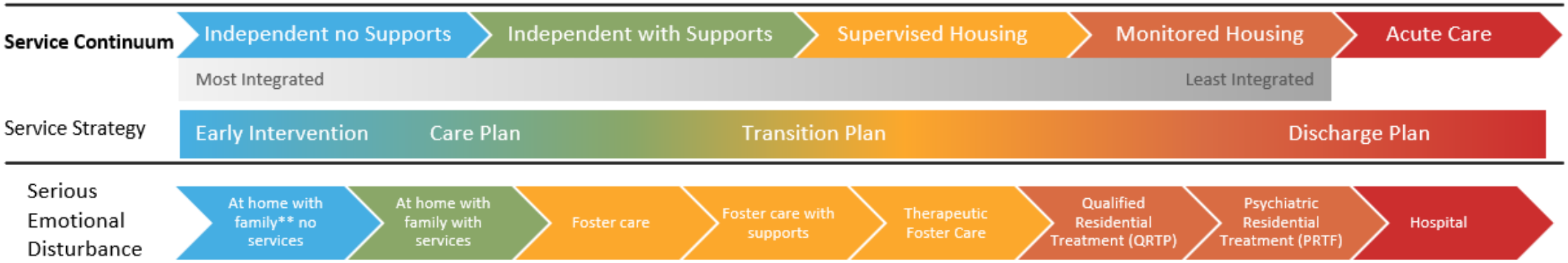
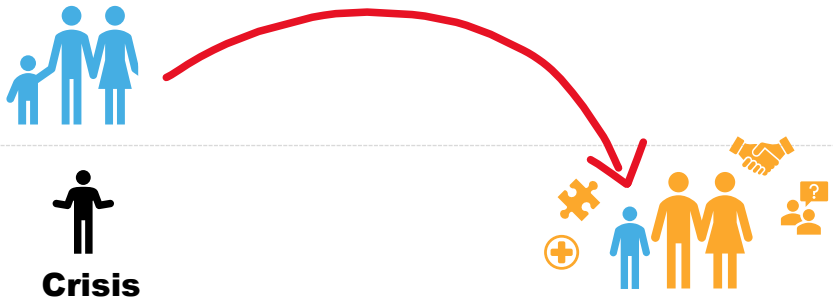
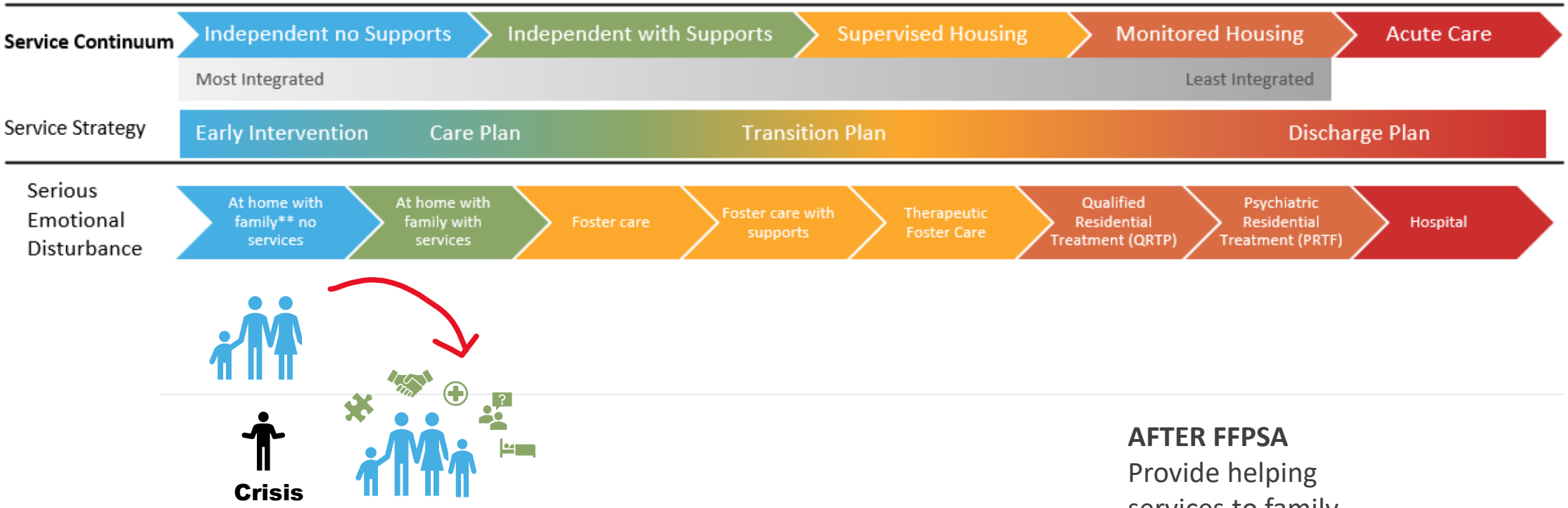




BEFORE FFPSA
Provide helping services to child while in foster care using federal IV-E funds

What does it mean to serve a family together rather than apart?

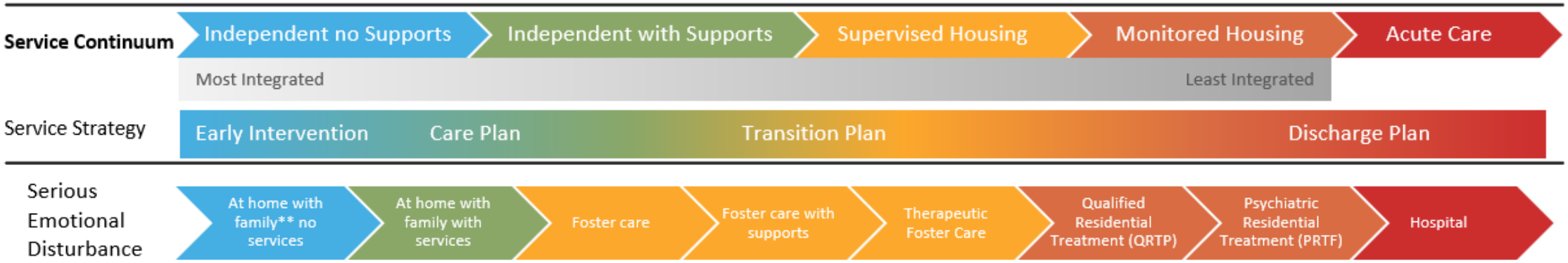
Understanding how systems can help children and families avoid crisis-level disruptions



AFTER FFPSA
Provide helping services to family <u>while they are together</u>, using federal IV-E funds

What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions





ALTERNATE - AFTER FFPSA

Provide helping services to child while in foster care AND to family using federal IV-E funds, shortening the time the family is apart

Meet Kevin, Brenda & Brandon



Kevin (43) and Brenda (42) live in a small home in Rolla with their son Brandon (6)

Kevin works for a local builder full time. Brenda is a paraprofessional at the elementary school.

Kevin suffers from depression and has been drinking a lot. Brenda has been diagnosed with an anxiety disorder.

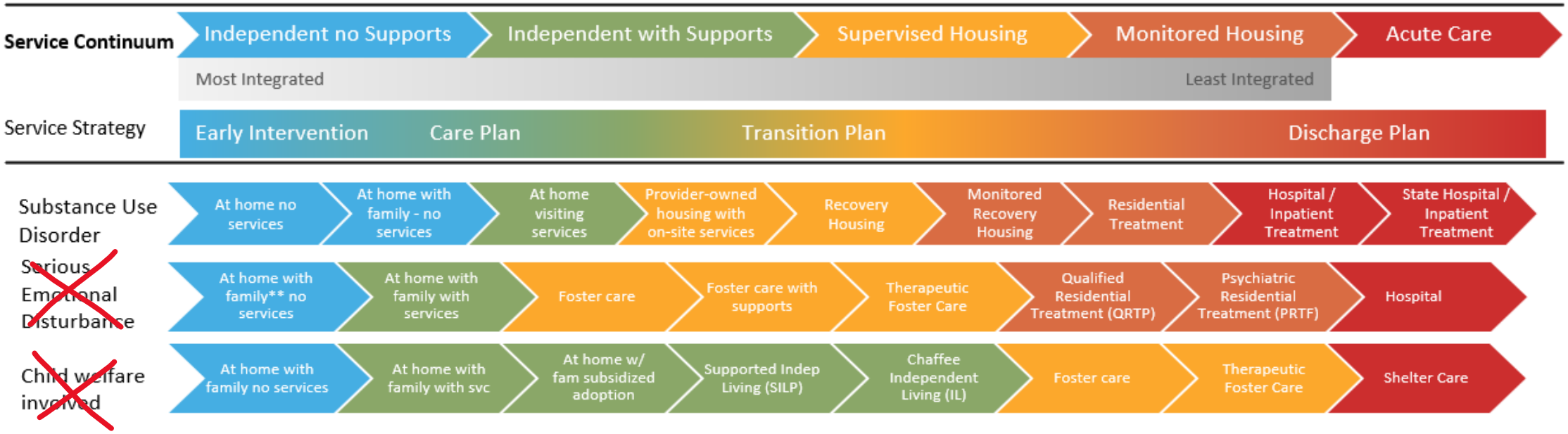
Brandon attends first grade. The year started off well but he's been more withdrawn in class as the year has gone on.

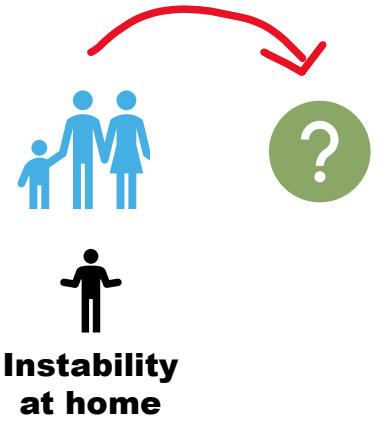
When they're getting hours at work, they can usually make ends meet. Money has been tight lately.

Tensions at home are rising.

What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions



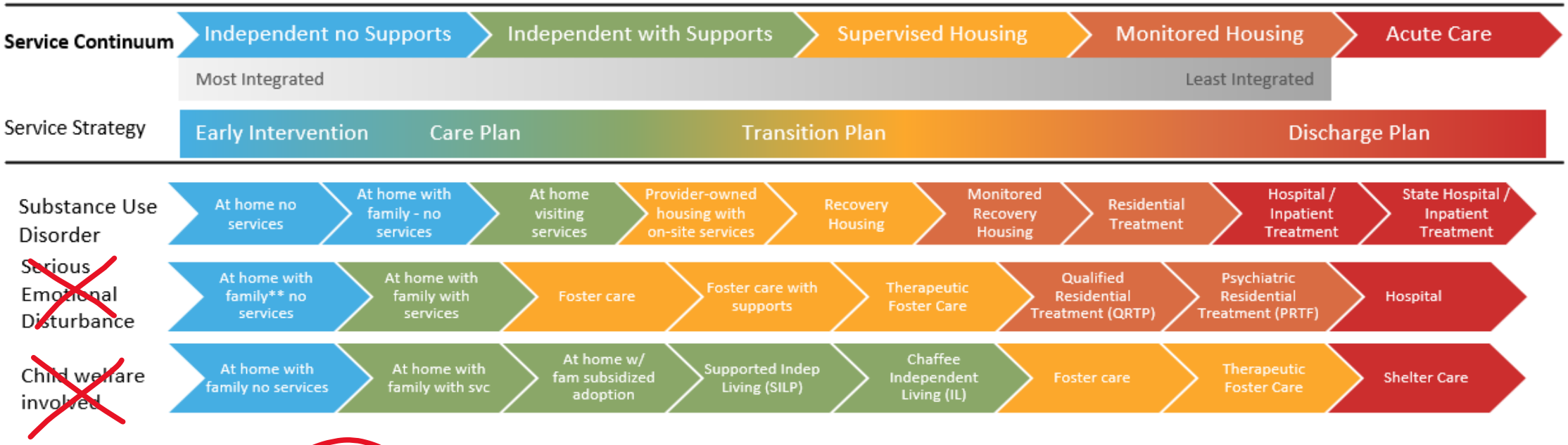


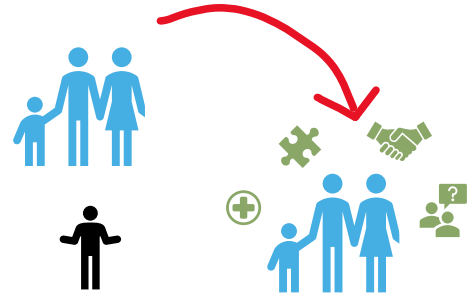
BEFORE FFPSA

Parents could access mental health or substance abuse services through their **insurance** or their **own resources**; **no** intervention with child welfare (Title IV-E) **resources UNTIL** a report of **abuse or neglect** is filed

What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions





Instability at home

AFTER FFPSA

Family can **access** mental health and substance abuse services for mom and dad **through Title IV-E**

Why? Parents' mental health and substance abuse issues are causing instability in the home, which means the child could be a candidate for foster care if things escalate further

Meet Sarah & Leah



Sarah (19) and her daughter Leah (1) live in a small efficiency apartment in Grand Forks.

She works part-time as a front desk receptionist for a local hair salon.

She received a scholarship to take classes online at night to earn her associate degree in medical transcription.

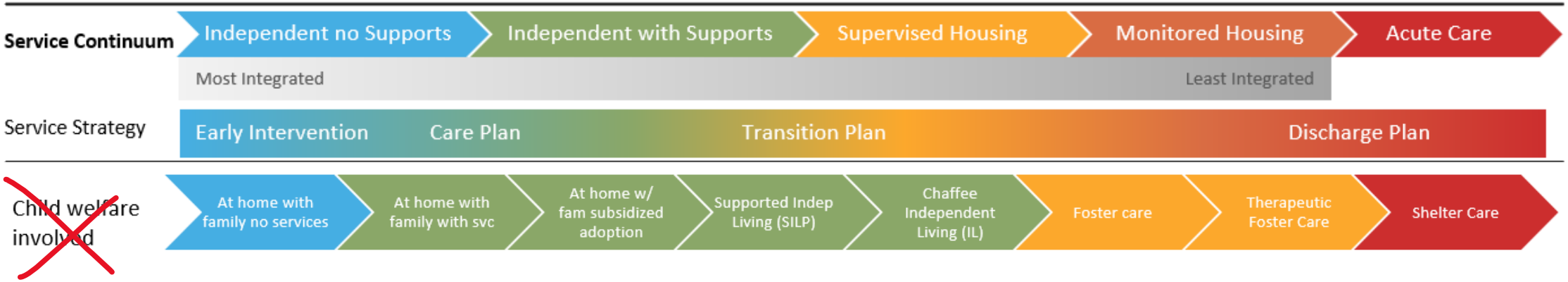
Sarah is almost always late with rent. Her hours at work went down. She hasn't been able to pay the last two months.

Sarah's neighbor watches Leah while she's at work.

Sarah doesn't have a car. She receives SNAP and Leah has health coverage through CHIP. Sarah has coverage through Medicaid Expansion.

How can we help stabilize a family?

Understanding how systems can help children and families avoid crisis-level disruptions







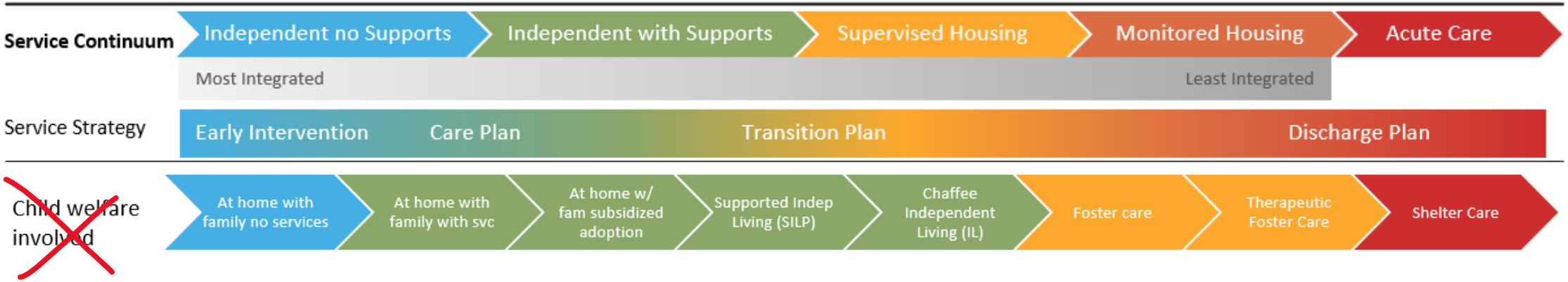
Crisis

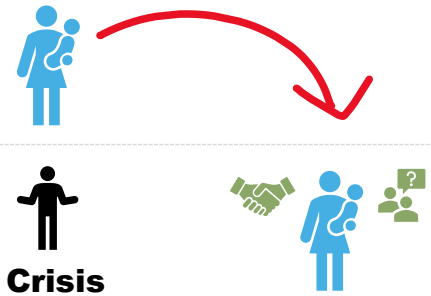
BEFORE FFPSA

Sarah would be eligible to participate in a parent skill-building program if a privately funded slot is available in her community.

How can we help stabilize a family?

Understanding how systems can help children and families avoid crisis-level disruptions





AFTER FFPSA

Because Sarah is at risk of losing her housing, she would be eligible to receive parent skill-building services from a IV-E funded provider.

Meet Taylor.



Taylor is 15.
She lives with a foster family.
She has been in the custody of a Human Service Zone for 15 months.

Taylor's behavior has been erratic and risky. She is drinking, smoking marijuana, has run away from school and home, and has been cited by the police 3 times.

Taylor has been hospitalized twice in the last 3 months for suicidal ideation.

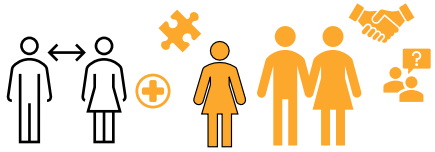
She's not doing well at school or at home.

Her guardian requested an emergency placement at a Qualified Residential Treatment Program (QRTP).

What does it mean to deliver services closer to home?

Understanding how systems can help children and families avoid crisis-level disruptions

Service Continuum	Independent no Supports	Independent with Supports	Supervised Housing	Monitored Housing	Acute Care			
	Most Integrated				Least Integrated			
Service Strategy	Early Intervention	Care Plan	Transition Plan			Discharge Plan		
Serious Emotional Disturbance	At home with family** no services	At home with family with services	Foster care	Foster care with supports	Therapeutic Foster Care	Qualified Residential Treatment (QRTP)	Psychiatric Residential Treatment (PRTF)	Hospital
Child welfare involved	At home with family no services	At home with family with svc	At home w/ fam subsidized adoption	Supported Indep Living (SILP)	Chaffee Independent Living (IL)	Foster care	Therapeutic Foster Care	Shelter Care
Juvenile Justice involved	At home no services	At home with family no services	At home alone - with services	At home with family - with services	Therapeutic Foster Care	Host Home	Monitored Recovery Housing	Juvenile Detention



Crisis

CRISIS

Taylor has been removed from her birth home, has mental health and substance use issues, and has been involved with law enforcement. She is in crisis.

What does it mean to deliver services in most integrated setting?

Understanding how systems can help children and families avoid crisis-level disruptions

Service Continuum	Independent no Supports	Independent with Supports	Supervised Housing	Monitored Housing	Acute Care			
	Most Integrated				Least Integrated			
Service Strategy	Early Intervention	Care Plan	Transition Plan		Discharge Plan			
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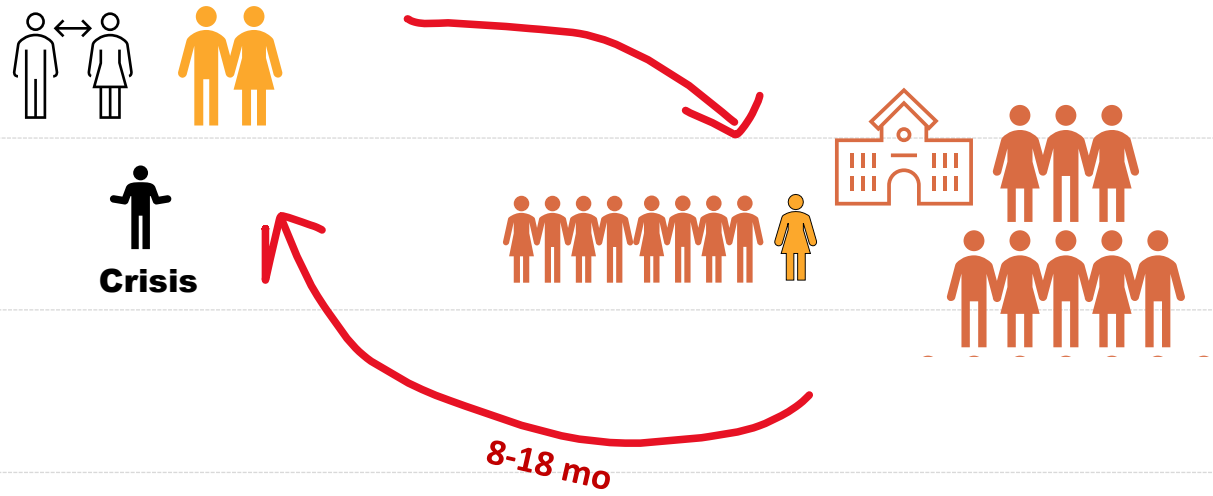
Juvenile Justice involved	At home no services	At home with family no services	At home alone - with services	At home with family - with services	Therapeutic Foster Care	Host Home	Monitored Recovery Housing	Juvenile Detention

BEFORE FFPSA

Taylor's emergency placement at the QRTP would end when the QRTP indicated that treatment was complete, at which point she would be sent back to her foster home.



What does it mean to deliver services in most integrated setting?

Understanding how systems can help children and families avoid crisis-level disruptions

Service Continuum	Independent no Supports	Independent with Supports	Supervised Housing	Monitored Housing	Acute Care			
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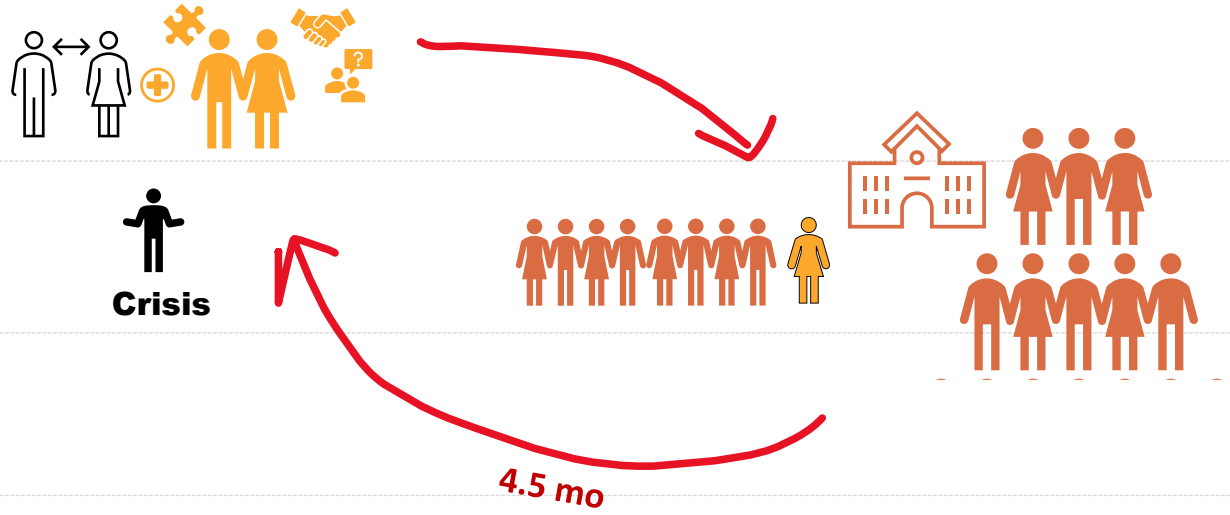
Juvenile Justice involved	At home no services	At home with family no services	At home alone - with services	At home with family - with services	Therapeutic Foster Care	Host Home	Monitored Recovery Housing	Juvenile Detention

AFTER FFPSA

An independent assessor evaluates the level of care Taylor needs at placement and every 3 months after. Once it is determined that she doesn't need an institutional level of care, she will return home to complete treatment.



What does it mean to deliver services in most integrated setting?

Understanding how systems can help children and families avoid crisis-level disruptions

Service Continuum	Independent no Supports	Independent with Supports	Supervised Housing	Monitored Housing	Acute Care			
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Juvenile Justice involved	At home no services	At home with family no services	At home alone - with services	At home with family - with services	Therapeutic Foster Care	Host Home	Monitored Recovery Housing	Juvenile Detention



PERMANENCY

Taylor's case manager does a family search. Her aunt steps in and provides kin care. They pursue formal guardianship through the courts and Taylor moves out of foster care and out of "systems" involvement. If they need help to get through tough times, they will still be eligible under FFPSA.

Meet Samuel.



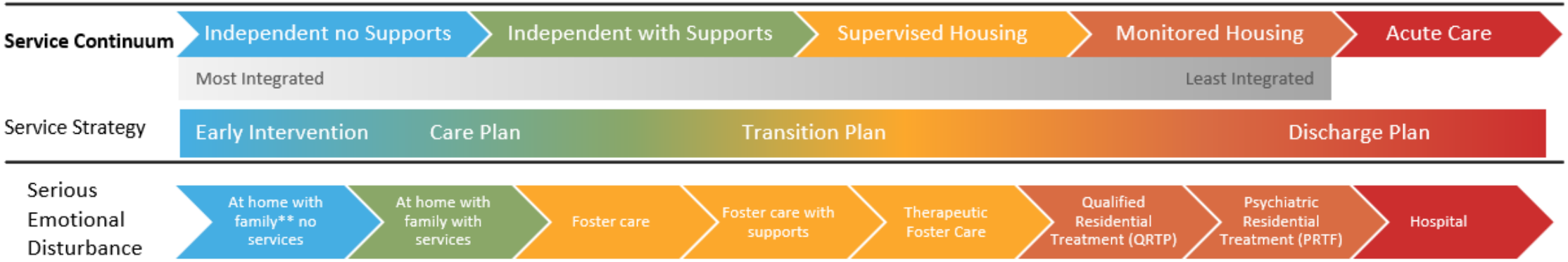
Samuel is 13.

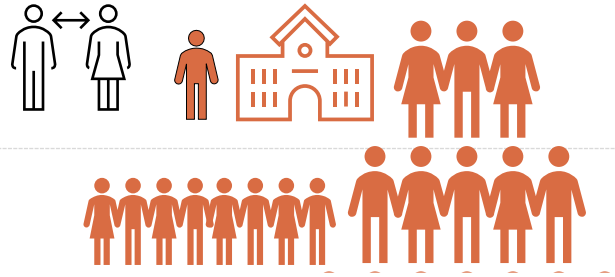
Samuel was removed from his parental home because of sexual abuse and was placed in a QRTP as an emergency placement.

He is legally in the custody of the Human Service Zone.

What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions





BEFORE FFPSA

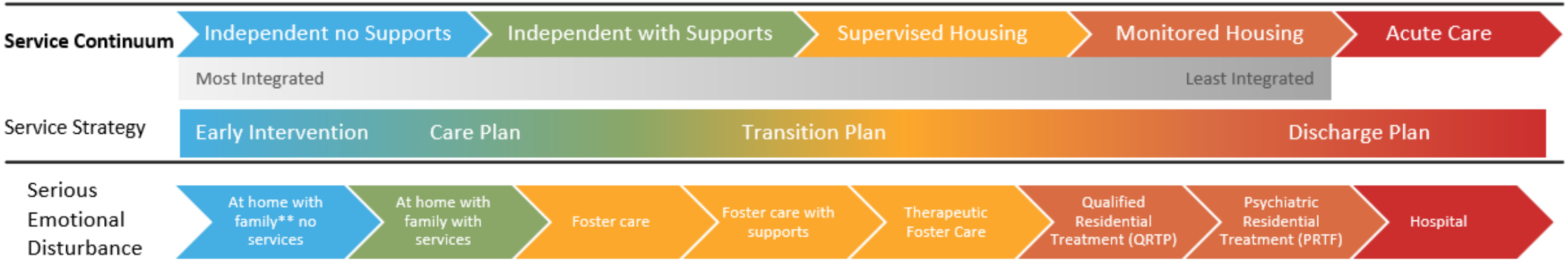
Samuel's emergency placement at the QRTP would end when the QRTP indicated that treatment was complete, at which point he would be sent to a foster home identified by the custodian.



Crisis

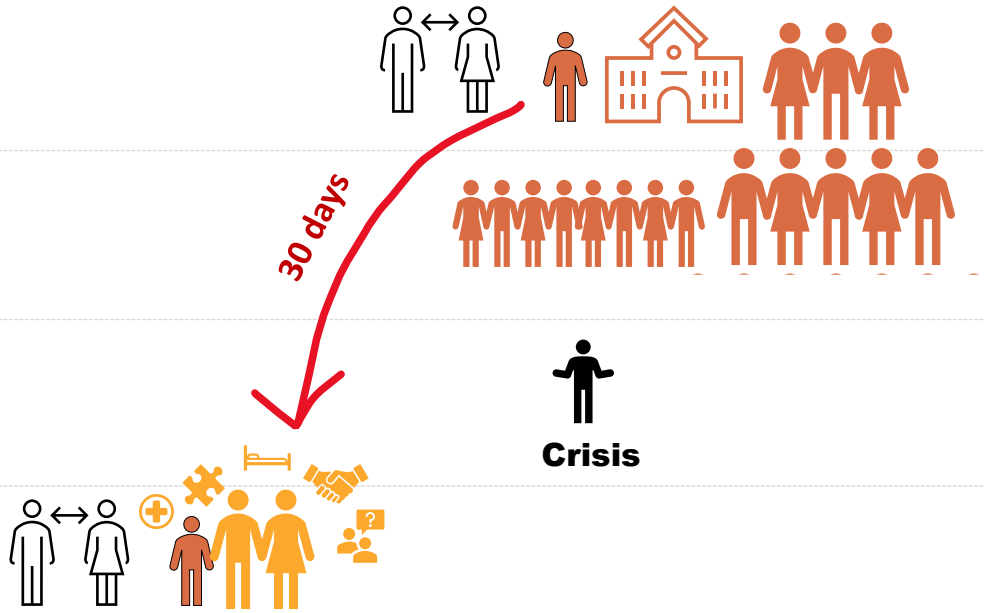
What does it mean to serve a family together rather than apart?

Understanding how systems can help children and families avoid crisis-level disruptions



AFTER FFPSA

After having an assessment of level of care needed, it was determined that Samuel's emergency placement at the QRTP would end after 30 days. Custodian identified foster family to facilitate transition after emergency stabilization.





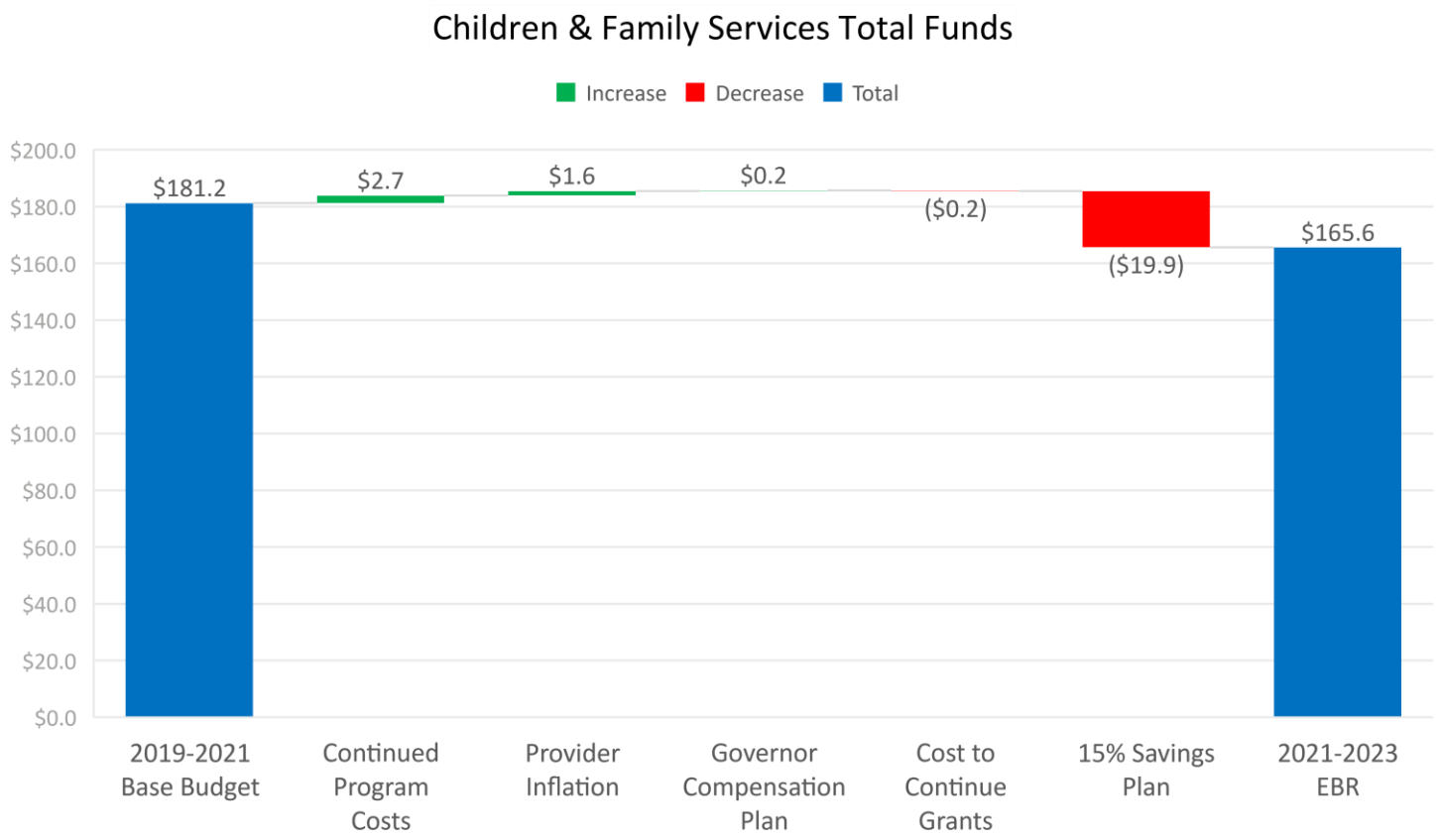
Our goals

- Reduce Foster Care Numbers
- Reduce Institutional Placements
- Reduce Out of State Placements
- Reduce Substance Abuse as Abuse/Neglect factor
- Increase Kids receiving evidence-based supports
- Reduce severity of school-based behaviors

CHILDREN AND FAMILY SERVICES
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	8,346,639	153,632	8,500,271
Operating	6,531,727	396,770	6,928,497
Grants	166,292,675	(16,083,723)	150,208,952
Total	181,171,041	(15,533,321)	165,637,720
General Fund	87,651,918	(15,698,254)	71,953,664
Federal Funds	88,707,220	1,028,817	89,736,037
Other Funds	4,811,903	(863,884)	3,948,019
Total	181,171,041	(15,533,321)	165,637,720
Full Time Equivalent (FTE)	41.60	0	41.60

CHILDREN AND FAMILY SERVICES
Overview of Budget Changes – Total Budget



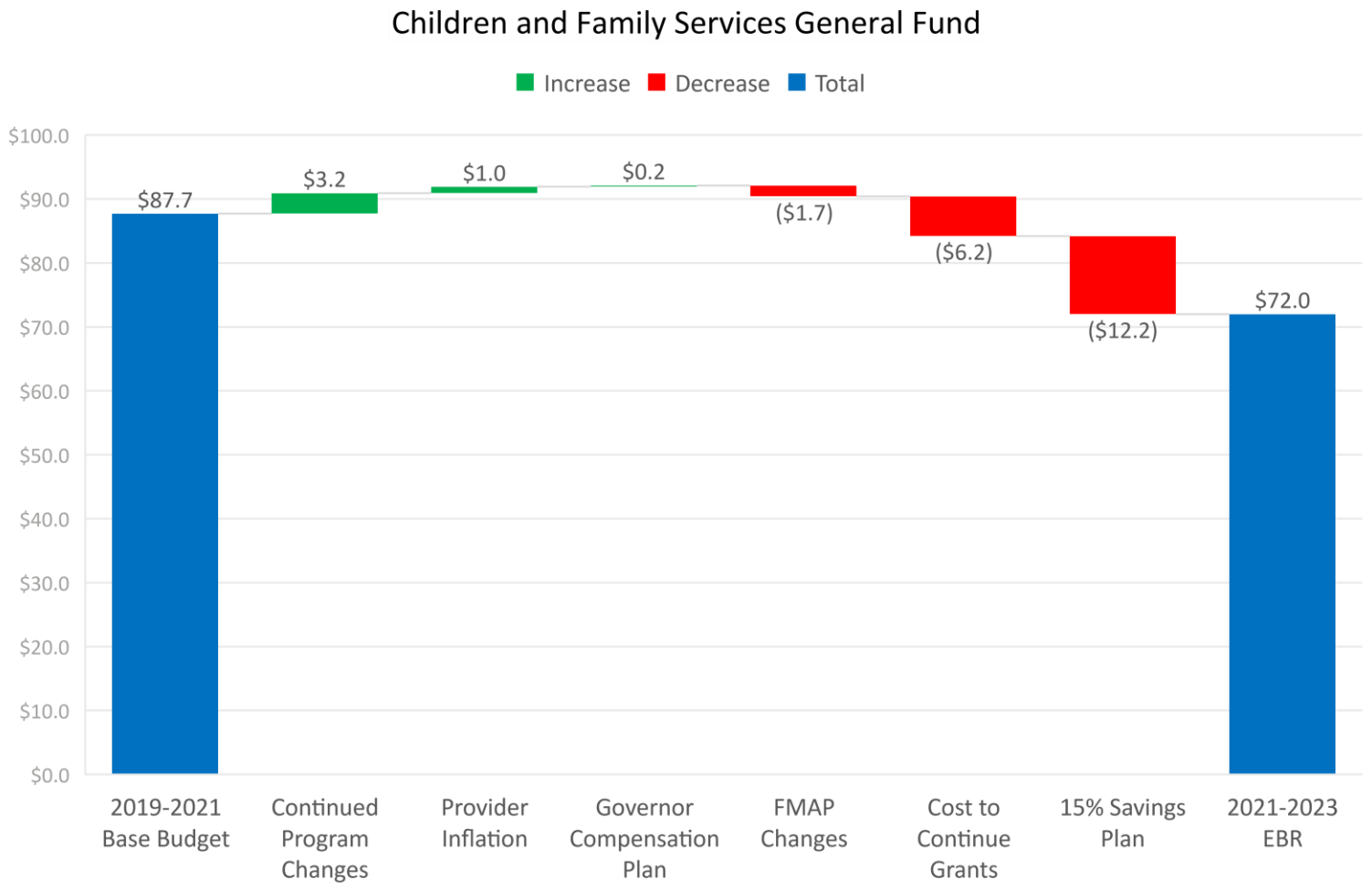
15% Savings Plan

- Foster Care ($14.9) million
- Uniform TCM Rates ($2.4) million
- Eligibility Efficiencies ($2.2) million
- Contract Adjustments ($0.4) million

Continued Program Costs

- Tribal Agreements $2.6 million
- Special Needs Adoption $0.7 million
- Other cost changes ($0.6) million

CHILDREN AND FAMILY SERVICES
Overview of Budget Changes – General Fund



15% Savings Plan

- Foster Care ($9.7) million
- Uniform TCM Rates ($1.1) million
- Eligibility Efficiencies ($1.1) million
- Contract Adjustments ($0.3) million

Continued Program Costs

- Tribal Agreements $2.6 million
- Other cost changes $0.6 million

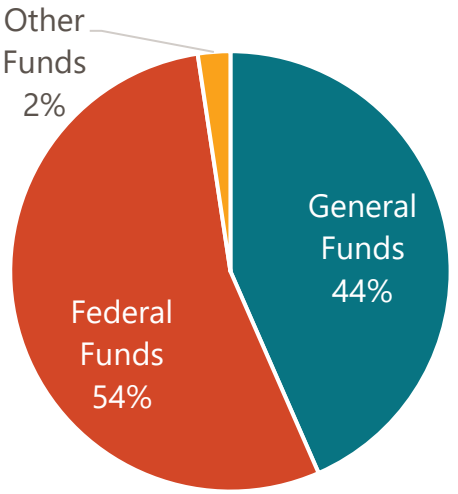


CFS 21/23 Budget Summary

19-21 Budget	**$181,171,041**
21-23 Budget (exec)	**$165,637,720**

41.6 FTEs; no change in FTEs projected; $15.5 million decrease in total budget (7% of reduction is from federal funds)

- Reduce foster care and residential placements, accomplished in part by investing in evidence-based parent skill building and mental health services to families
- Implement equity in payments for services to families (QRTP, subsidized adoption, targeted case mgmt.)
- Investment in early childhood integrated data system
- Replacement of child welfare technology platform



DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

CHILDREN AND FAMILY SERVICES

Replacement of FRAME/CCWIPS

BUDGET AMOUNT

$30,000,000

- $15 M general fund
- $15 M federal funds

PURPOSE

Develop and deploy system to manage child protection, foster care, in-home supports to families, and adoption

Supports administrative efficiencies, retirement of mainframe, and requirements for continued federal program compliance





Contact Information

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Children & Family Services Division
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3rd Floor, Judicial Wing
Bismarck, ND 58505

Phone: 701-328-3587
E-mail: ctpedersen@nd.gov



NORTH Dakota | Behavioral Health
Be Legendary.™ HUMAN SERVICES



House Bill 1012 #1101
House Appropriations
Representative Nelson, Chairman

Behavioral Health Division
Pamela Sagness, Director

What is Behavioral Health?

A state of mental/emotional being and/or choices and actions that affect **WELLNESS**.



BEHAVIORAL HEALTH IS HEALTH



Why is Behavioral Health Important?

Persons with behavioral health disorders die, on average, about *5 years earlier* than persons without these disorders.

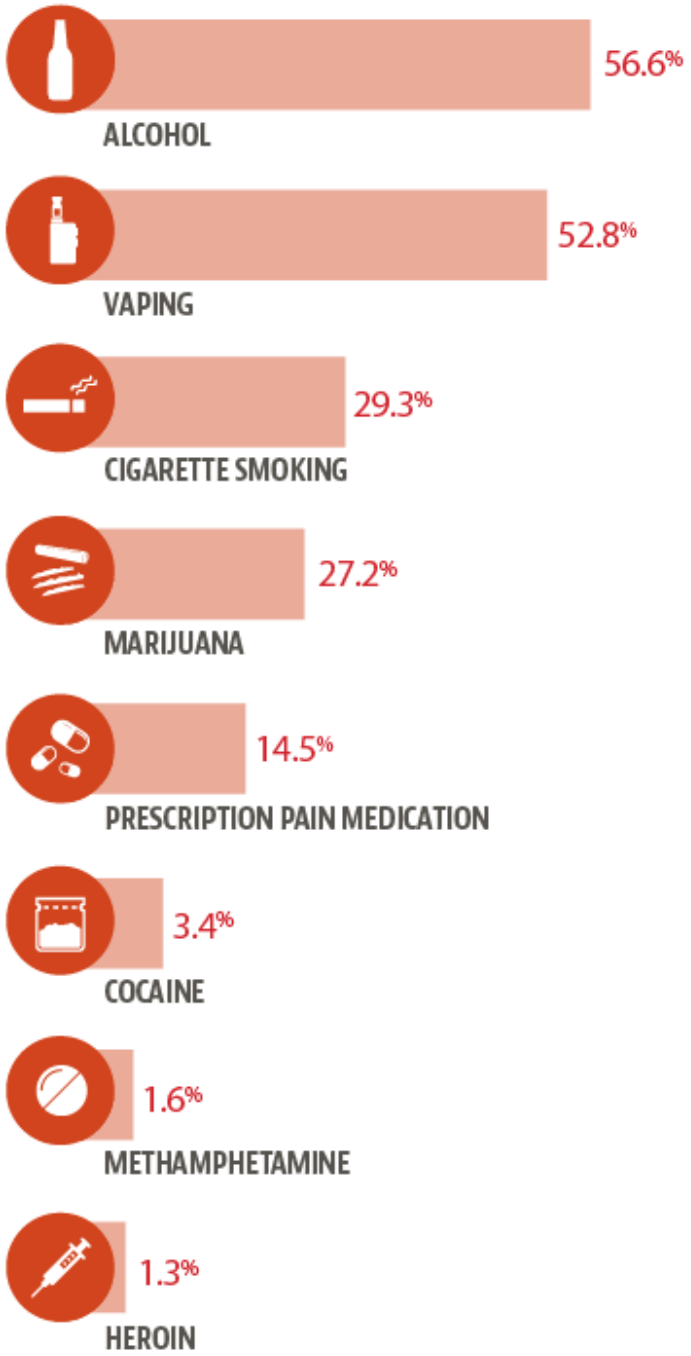
Persons with serious mental illness (SMI) are now dying *25 years earlier* than the general population



(Druss BG, et al. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. Medical Care 2011; 49(6), 599–604.)

ND Youth Lifetime Substance Use
(High School Students)

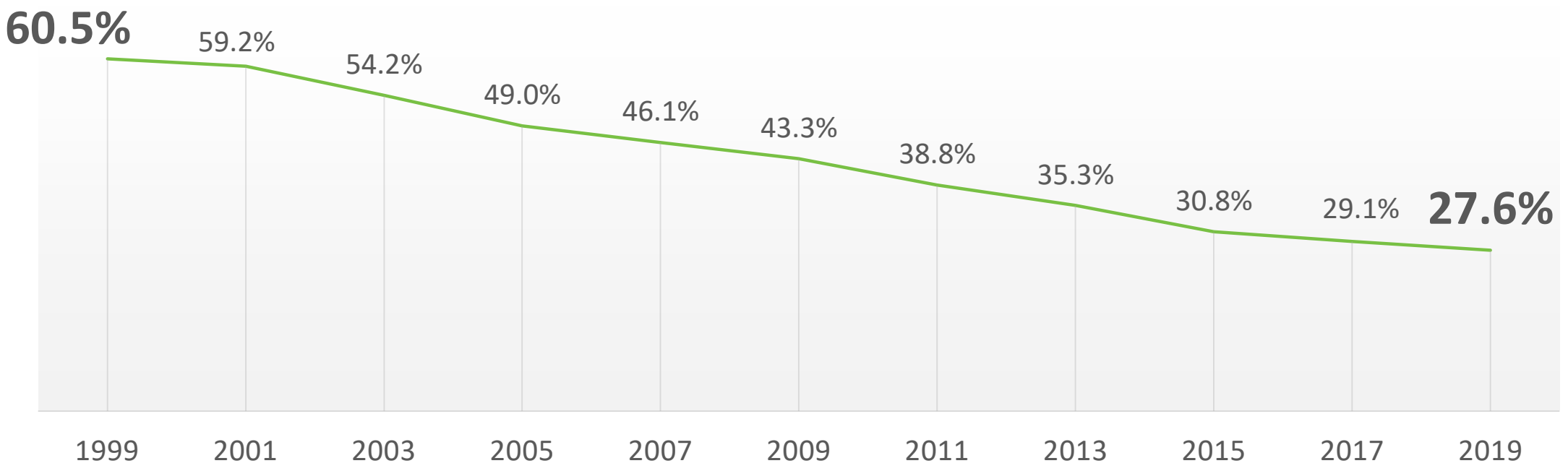




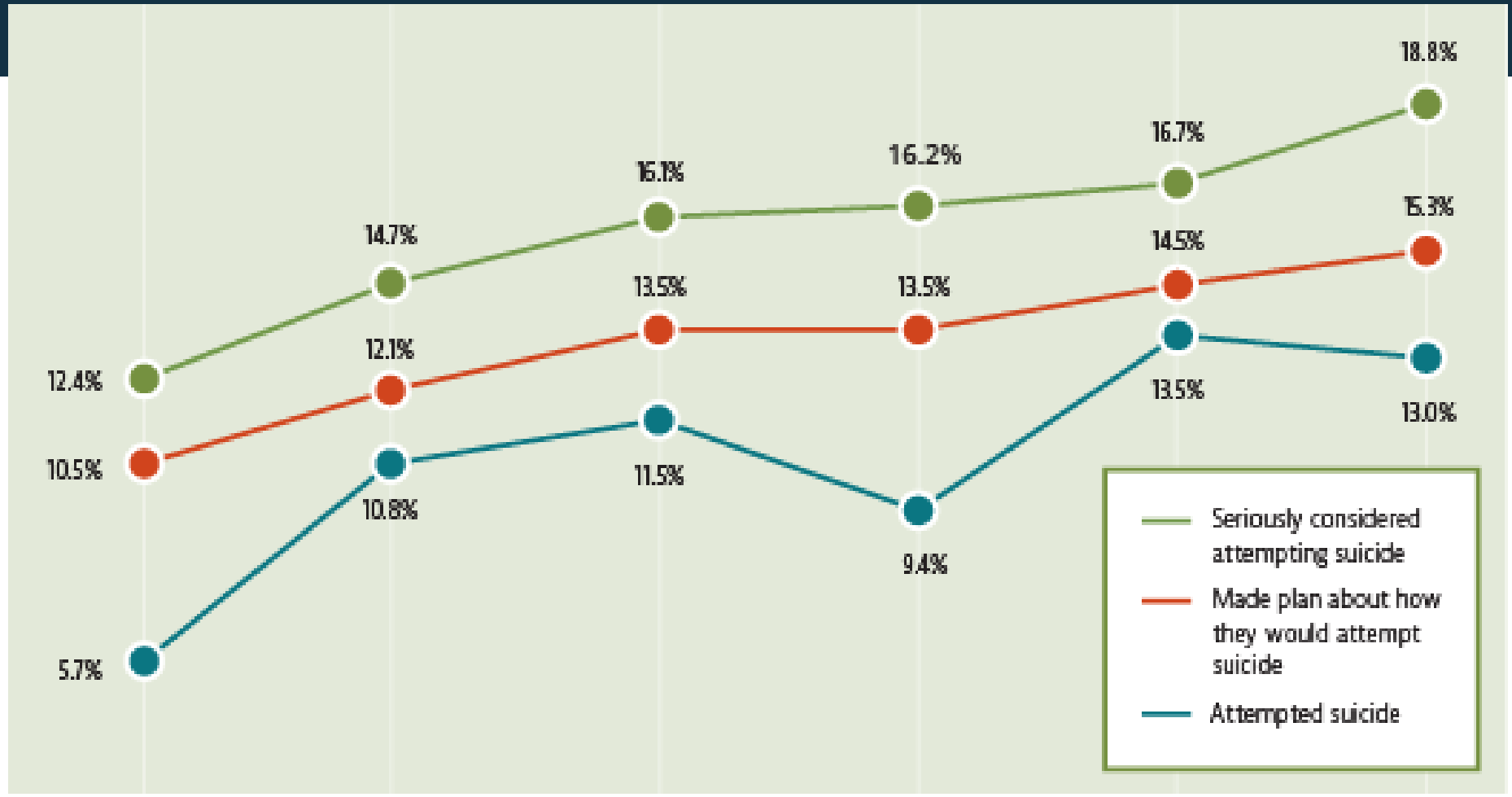
Prevention Works!

Current Alcohol Use (past 30 days) among ND High School Students

Youth Risk Behavior Survey

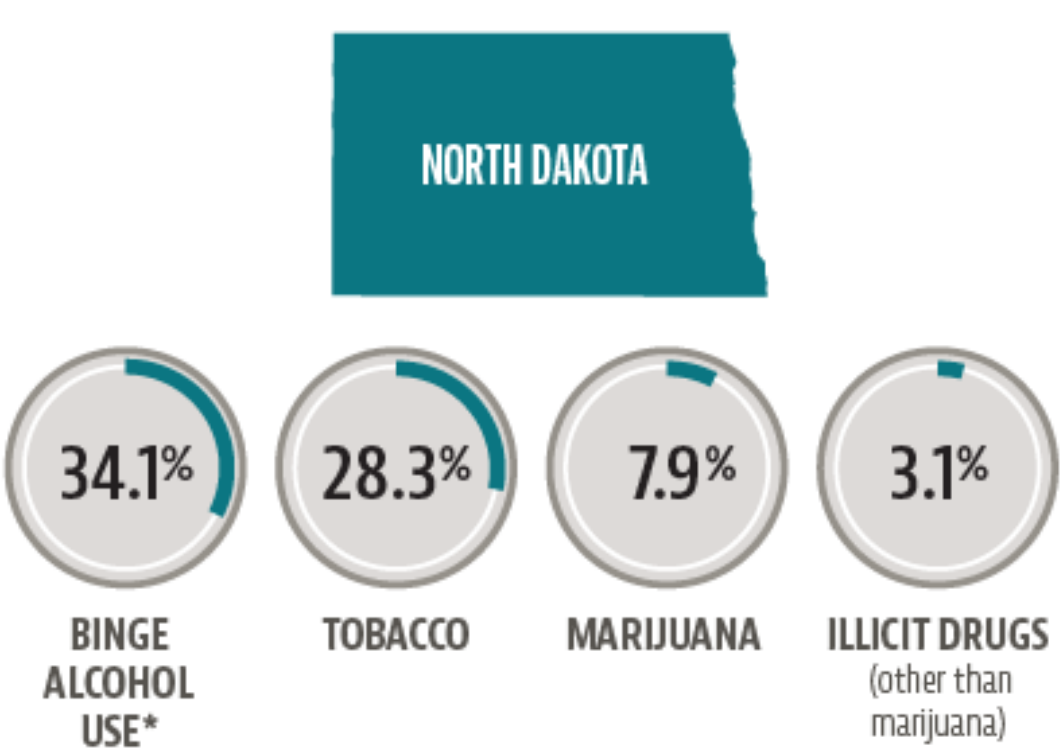


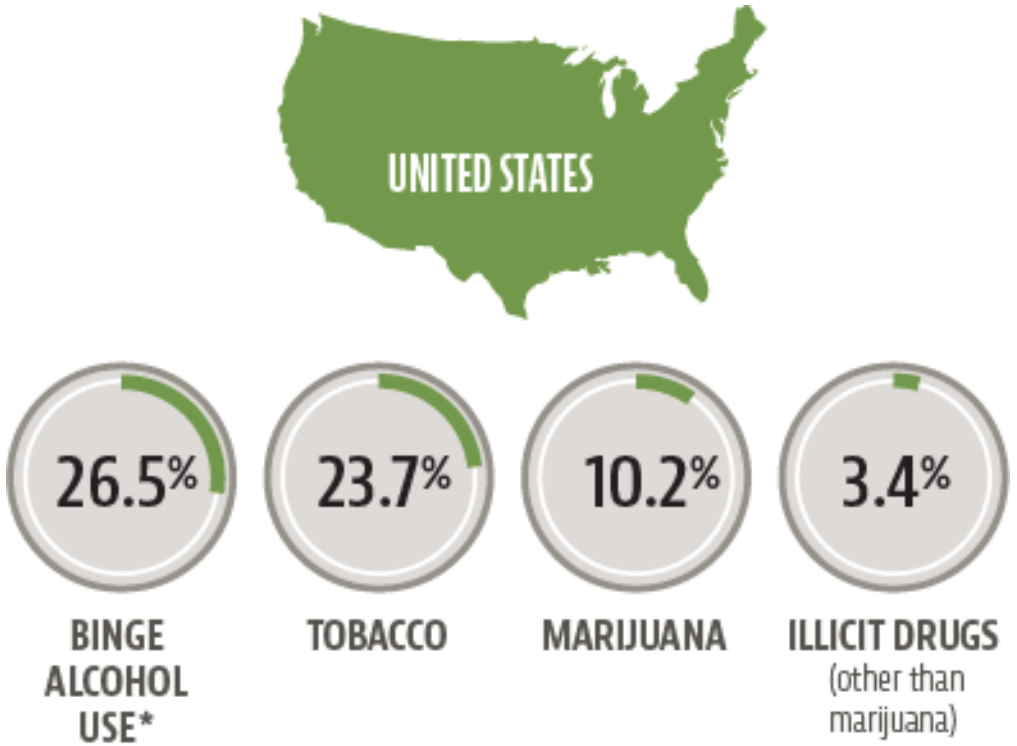
Youth Suicide
(High School Students; past 12 months)



Adult Substance Use
(Age 18+; past 30 days)





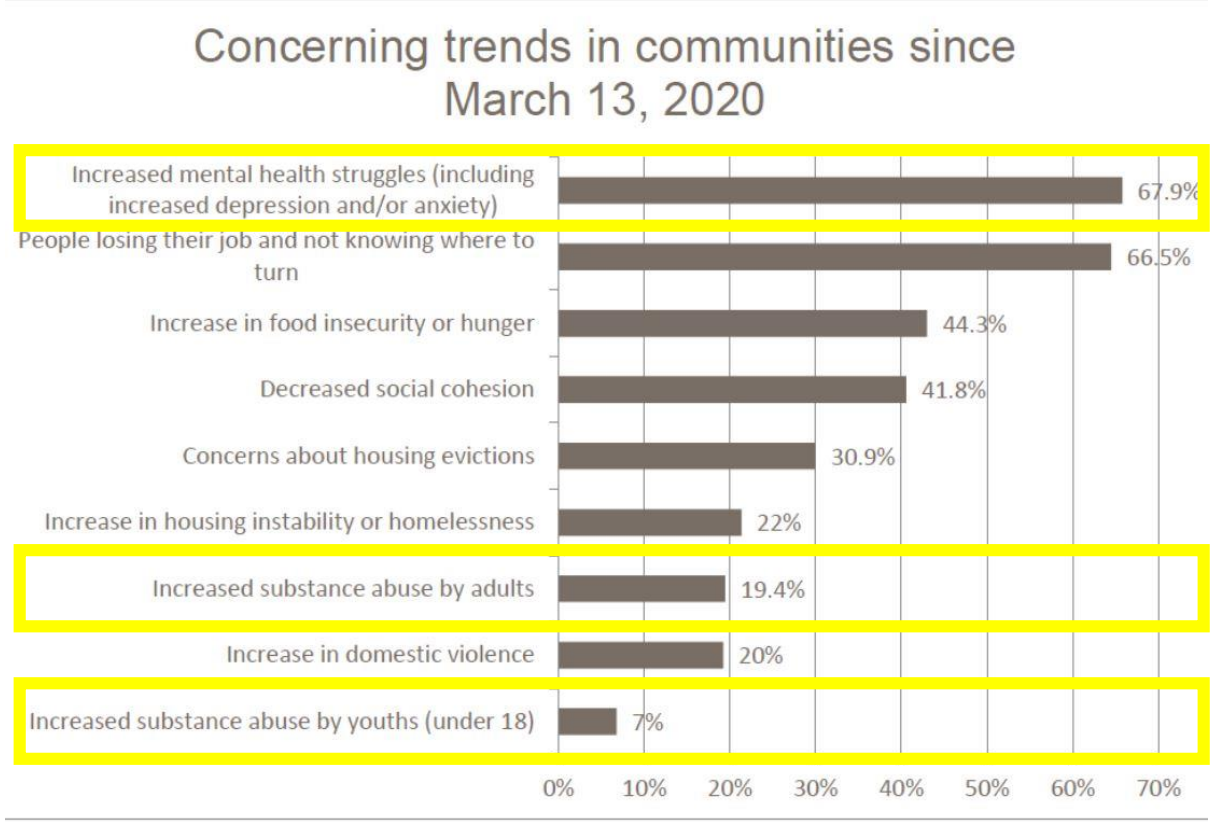


Disaster Impacts to Behavioral Health

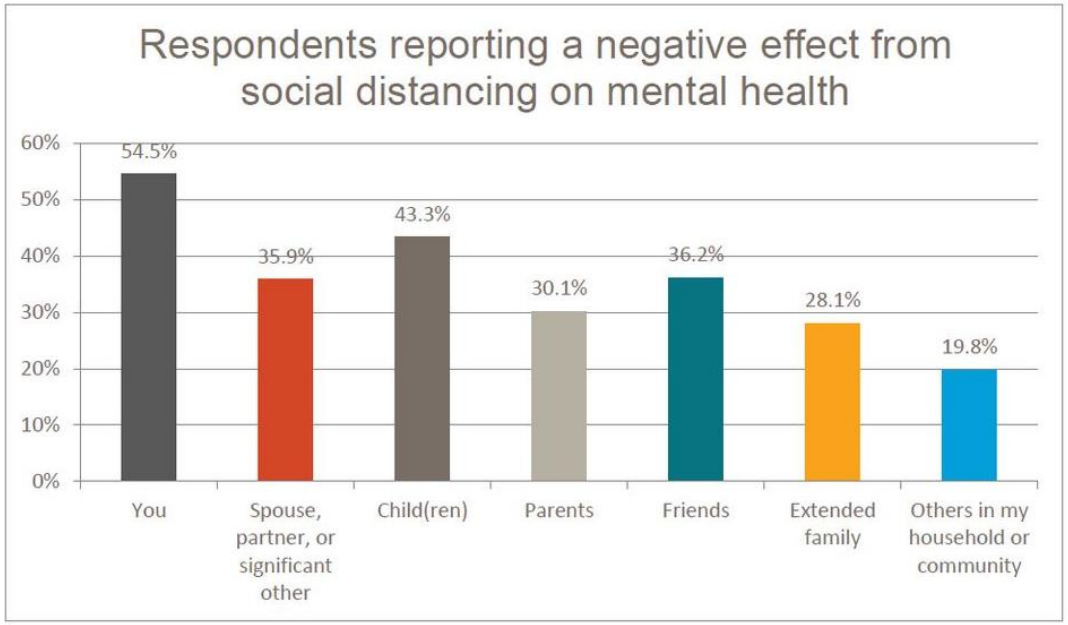


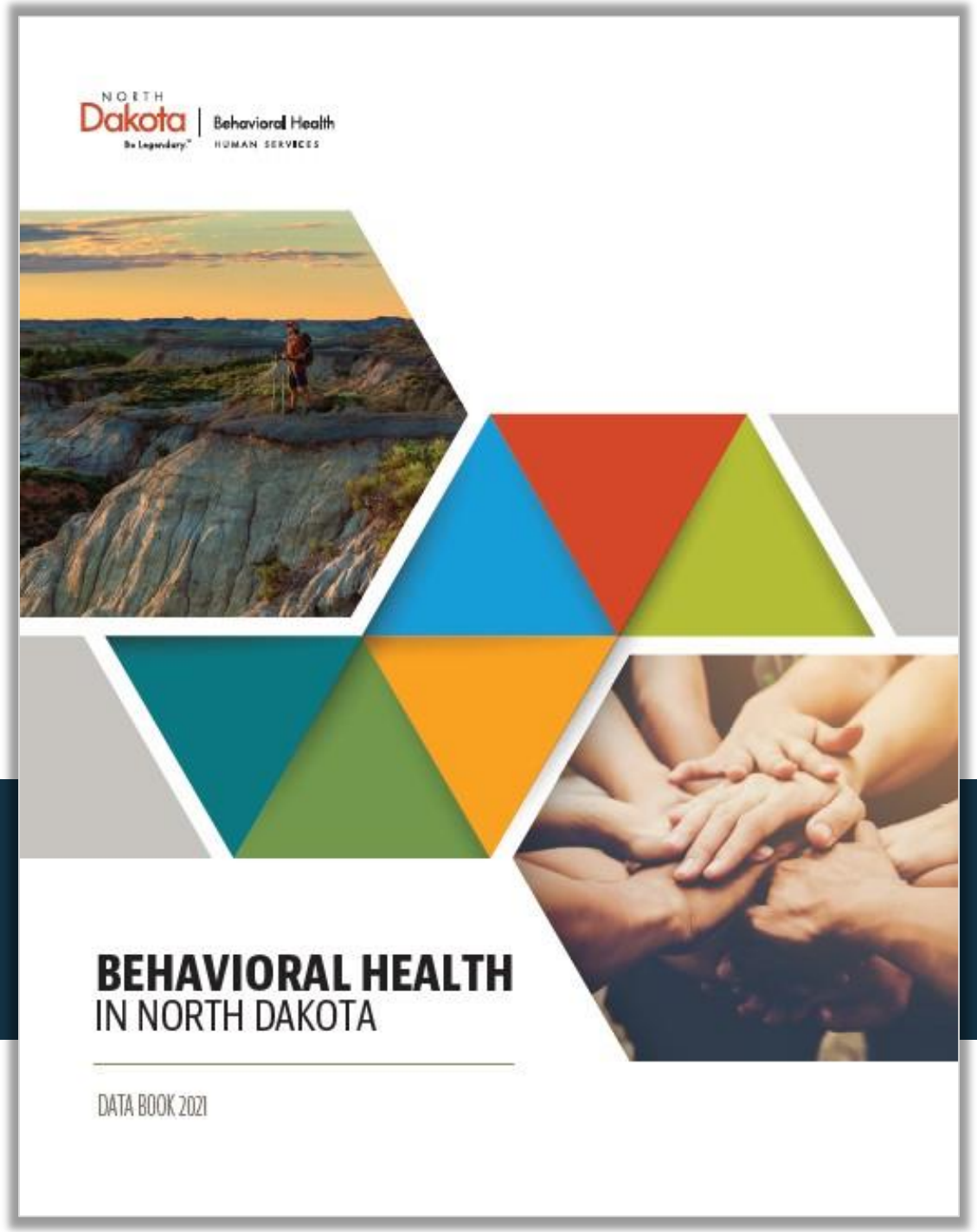
COVID-19 Impacts on Behavioral Health

ND Dept. of Commerce Survey May 2020



Respondents Reporting Negative Effect on Mental Health



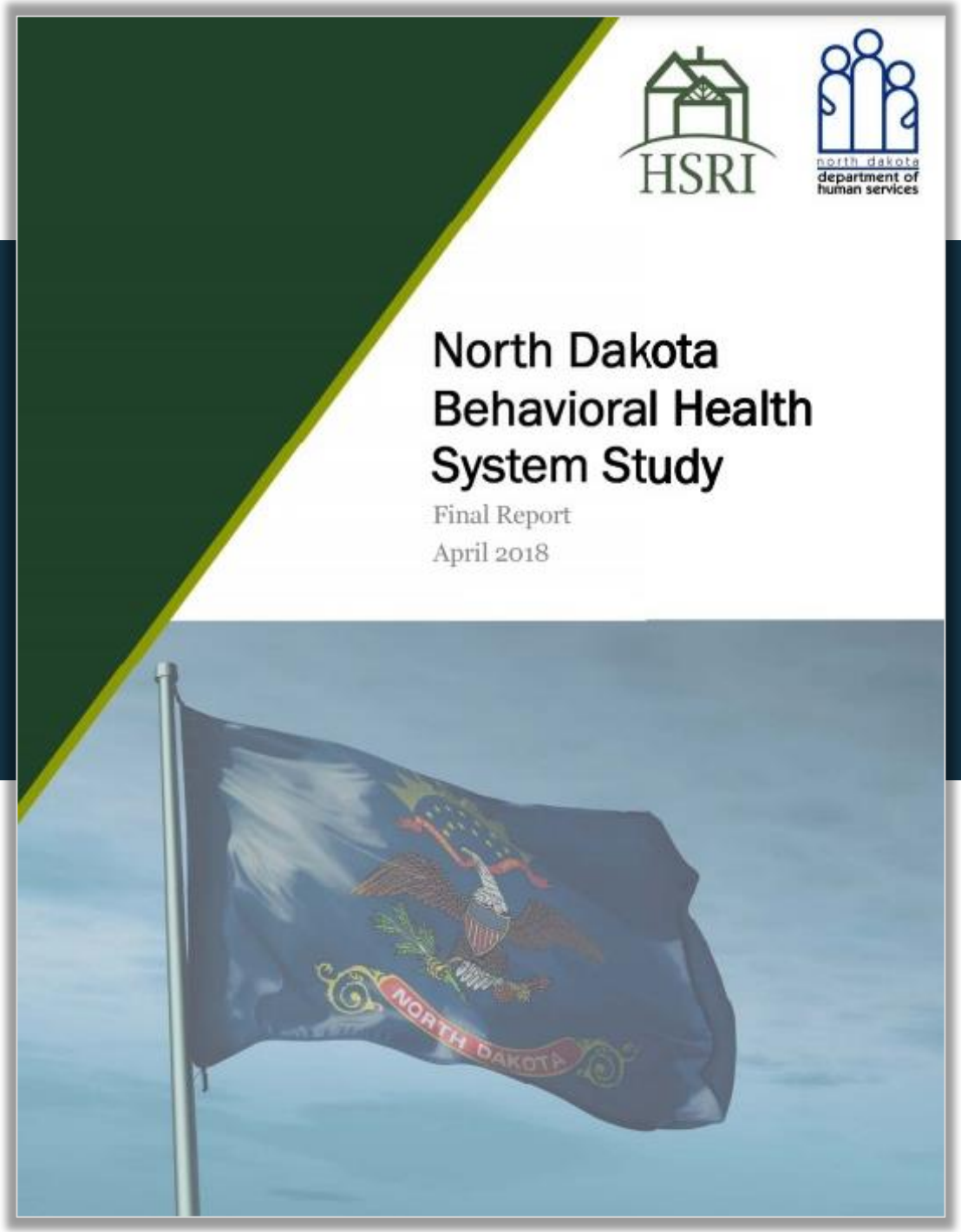


BEHAVIORAL HEALTH DATA BOOKLET

All data resources are available at www.behavioralhealth.nd.gov/data.

ROADMAP

The Behavioral Health Systems Study, April 2018



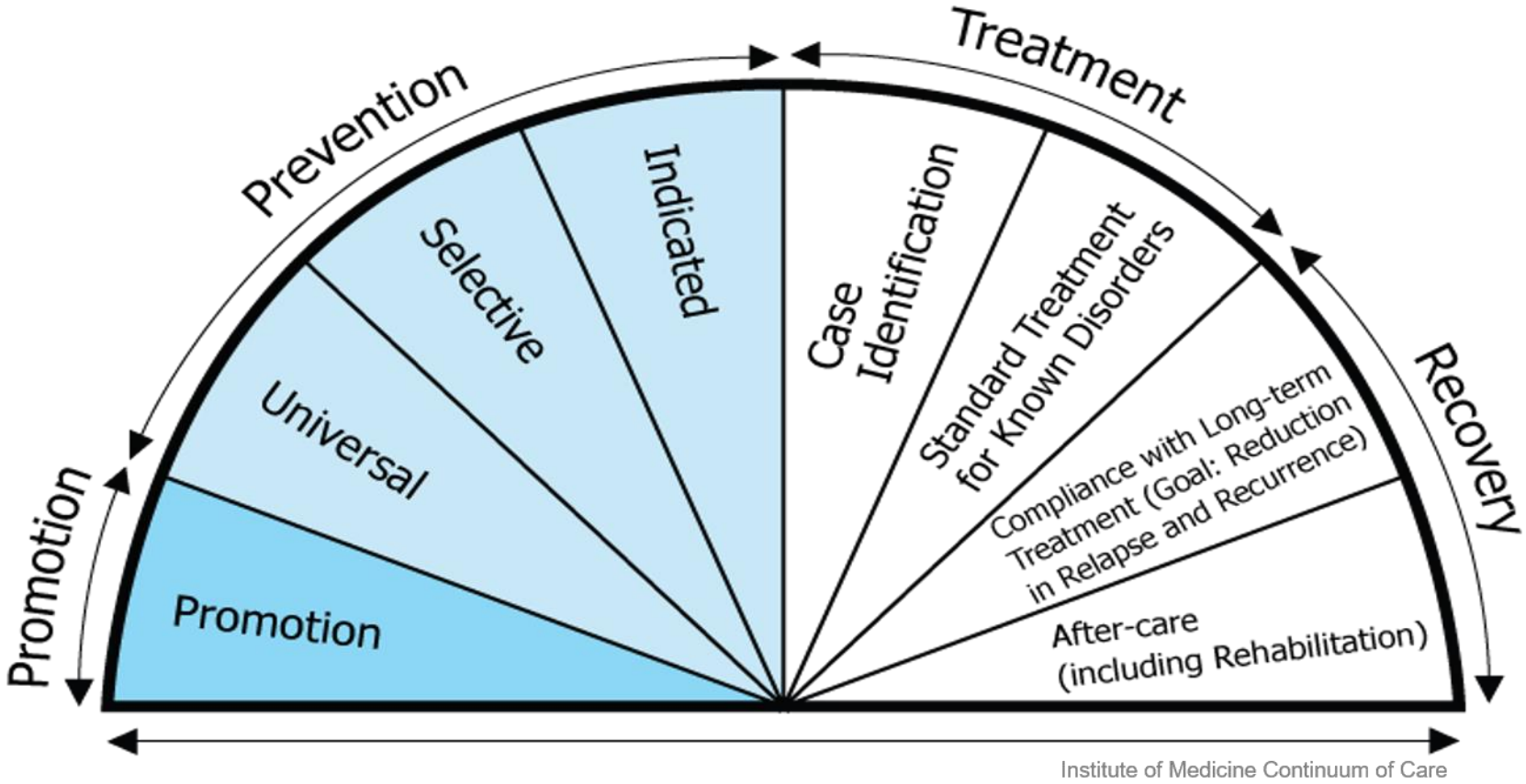
North Dakota Behavioral Health System Study **RECOMMENDATIONS**

The 250-page report provides more than 65 recommendations in 13 categories.

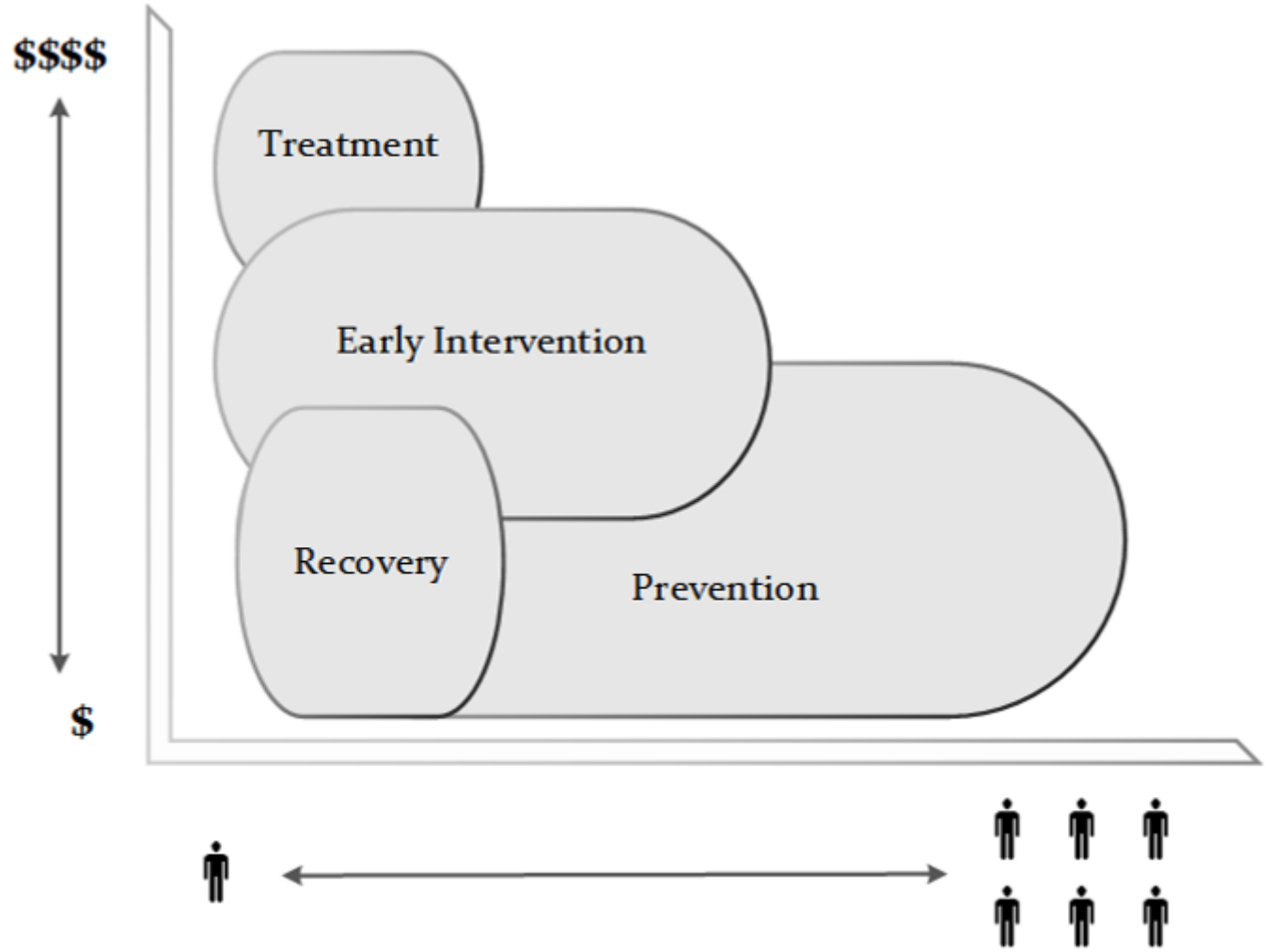
1. Develop a comprehensive implementation plan
2. Invest in prevention and early intervention
3. Ensure all North Dakotans have timely access to behavioral health services
4. Expand outpatient and community-based service array
5. Enhance and streamline system of care for children and youth
6. Continue to implement/refine criminal justice strategy
7. Engage in targeted efforts to recruit/retain competent behavioral health workforce
8. Expand the use of tele-behavioral health
9. Ensure the system reflects its values of person-centeredness, cultural competence, trauma-informed approaches
10. Encourage and support the efforts of communities to promote high-quality services
11. Partner with tribal nations to increase health equity
12. Diversify and enhance funding for behavioral health
13. Conduct ongoing, system-side data-driven monitoring of needs and access

Behavioral Health **Continuum of Care Model**

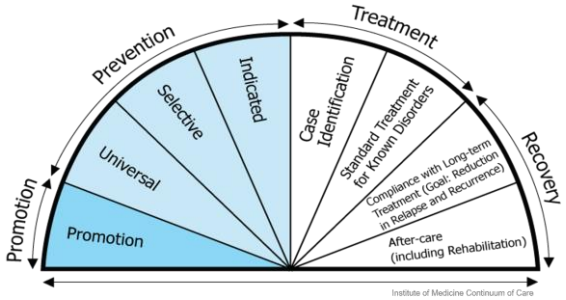
The goal of this model is to ensure there is access to a full range of high-quality services to meet the various needs of North Dakotans.



Return on Investment



Keys to Reforming North Dakota's Behavioral Health System



Support the full Continuum of Care



Increase Community-Based Services



Prevent Criminal Justice Involvement for Individuals with a Behavioral Health Condition



OVERVIEW

Behavioral Health Division

NORTH Dakota Be Legendary.™ | Behavioral Health HUMAN SERVICES

The Behavioral Health Division is a policy division, with responsibilities outlined in NDCC 50-06-01.4

1

Reviewing and identifying service needs and activities in the state's behavioral health system in an effort to:

- ensure health and safety,
- access to services, and
- quality services.

2

Establishing quality assurance standards for the licensure of substance use disorder program services and facilities

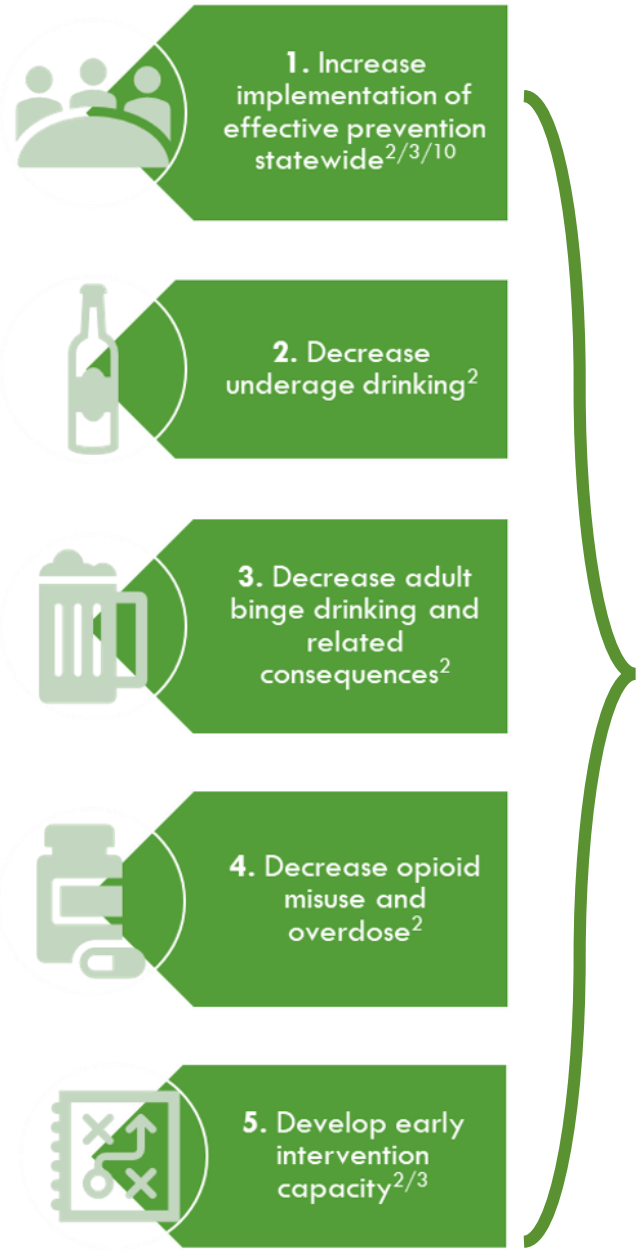
3

Providing policy leadership in partnership with public and private entities

The Division identifies goals and administers **over 70 programs/projects** in these four primary areas.

- Community Behavioral Health Promotion
- Children's Behavioral Health
- Adult Mental Health Program and Policy
- Adult Addiction Program and Policy

COMMUNITY BEHAVIORAL HEALTH PROMOTION



Community and Tribal Efforts

Training and Technical Assistance
(Substance Abuse Prevention and Treatment Block Grant)

Youth Tobacco Enforcement (Synar)

Early Intervention (MIP/DUI)

Parents Lead

Statewide Campaigns
(Opioids: Fill with Care; Speak Volumes)

CHILDREN'S BEHAVIORAL HEALTH



Adolescent Residential Treatment
(Substance Abuse Prevention and Treatment Block Grant)

Regulation of Youth Residential Psychiatric Facilities (PRTF)

Prevention of Out-of-Home Placement for Children
(Voluntary Treatment Program [VTP])

Behavioral Health and Education
(Children's Prevention and Early Intervention School Behavioral Health Pilot; Behavioral Health School Grant; Behavioral Health Resource Coordinator Support)

Children with Serious Emotional Disturbance Programs
(Mental Health Block Grant)

Systems for Individuals with a First Episode of Psychosis
(Mental Health Block Grant)

ADULT MENTAL HEALTH PROGRAM AND POLICY



Peer Support

Free Through Recovery

Community Connect

Adult Mental Health Programs
(Mental Health Block Grant)

Military and Behavioral Health

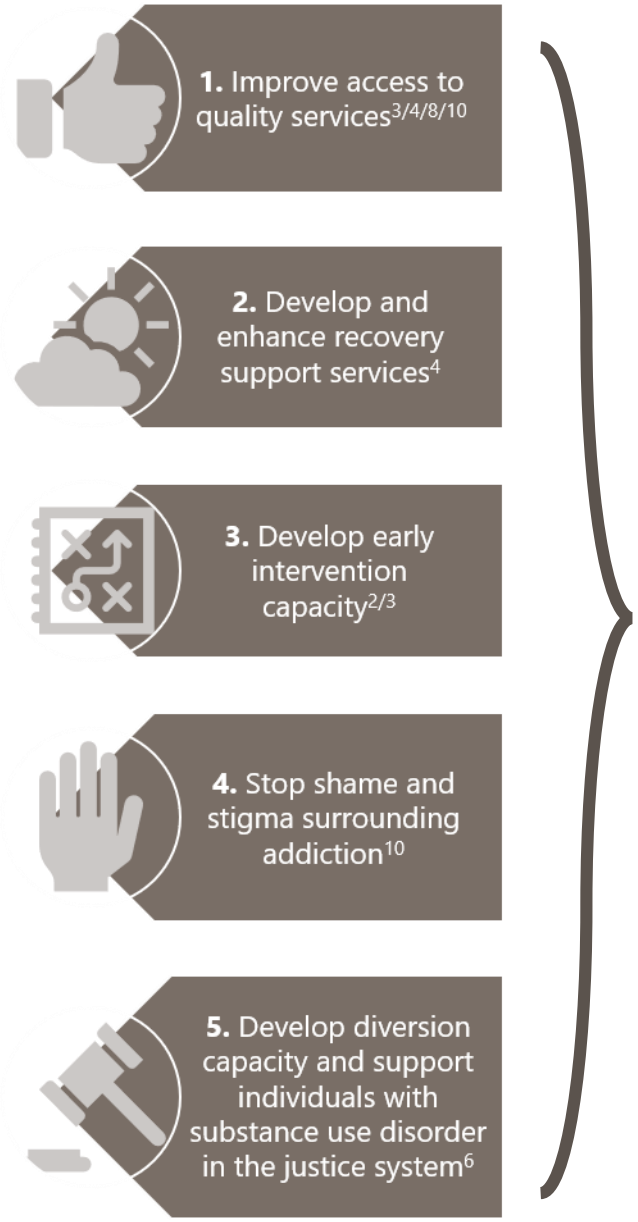
Mental Illness and Homelessness
(PATH Grant)

Brain Injury Programs

Problem Gambling Programs

Disaster Crisis Counseling

ADULT ADDICTION PROGRAM AND POLICY



- Peer Support
- Free Through Recovery
- Community Connect
- Pregnant and Parenting Women Treatment Programming (Substance Abuse Prevention and Treatment Block Grant)
- Tribal Treatment and Recovery Supports (Substance Abuse Prevention and Treatment Block Grant)
- Medication Assisted Treatment (Opioid Treatment Programs)
- Recovery Supports
- Military and Behavioral Health
- Substance Use Disorder (SUD) Voucher Payment System
- Community-based Behavioral Health (CBH) Program
- Regulation of Substance Use Disorder Treatment Facilities



KEY INITIATIVES

Behavioral Health

NORTH Dakota Be Legendary.™ | Behavioral Health HUMAN SERVICES

FREE THROUGH Recovery

GOAL:

- Engage community organizations to be providers of care coordination & recovery support services

Overall, from March 2018 through October 2020, providers earned performance pay for 68.3% of their participants.



2,905 Individuals have Participated



961 Active Participants



40 Providers

1915i State Plan Amendment



The amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.

Individual Eligibility	Services
• The individual is age 0+; and • The individual is currently enrolled in ND Medicaid or Medicaid Expansion; and • The individual resides in and will receive services in a setting meeting the federal home and community-based setting requirements, and • The individual has a mental illness, substance use disorder or traumatic brain injury diagnosis The individual has a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting, as evidenced by a complex score of 50 or higher on the WHODAS 2.0.	• Care Coordination • Training and Supports for Unpaid Caregivers • Community Transitional Services • Benefits Planning • Non-Medical Transportation • Respite • Prevocational Training • Supported Education • Supported Employment • Housing Support Services • Family Peer Support • Peer Support



Substance Use Disorder (SUD) Voucher

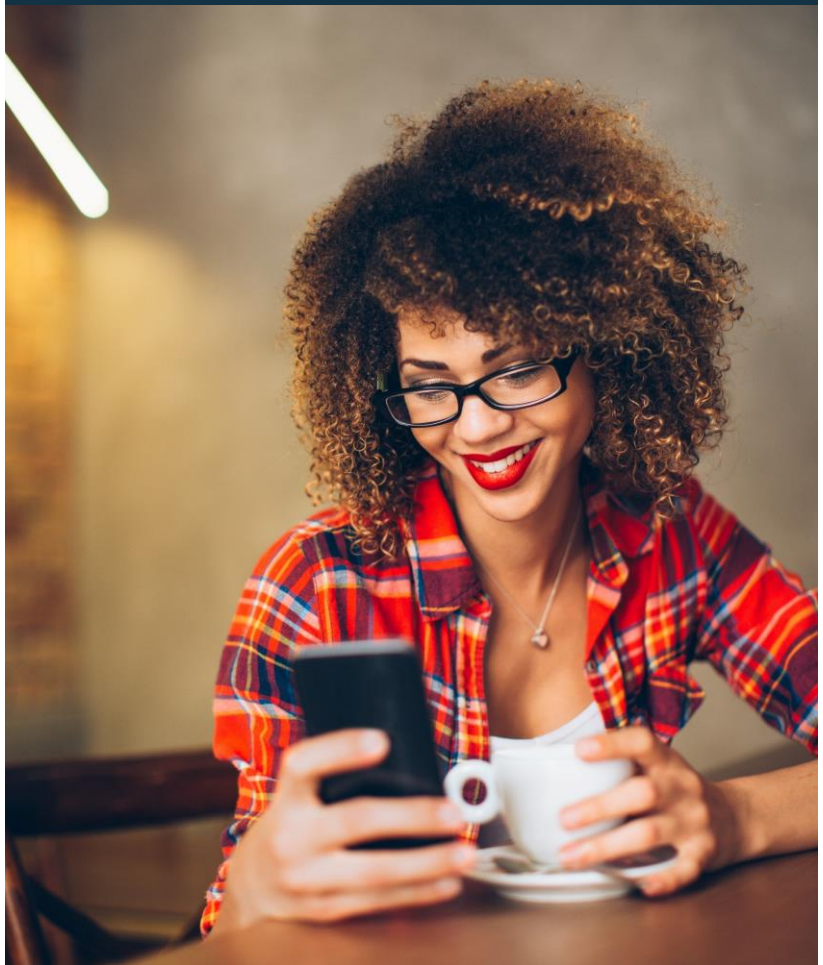
21 Substance Use Disorder Treatment Programs are providing services through the SUD Voucher.

4,200+ individuals have been approved since inception of the SUD Voucher program.

GOALS: Improve access to quality services & provide choice of provider

	2015-2017	2017-2019	2019-2021
TOTAL BUDGET	$575,000	$4,917,087	$7,997,294
AMOUNT EXPENDED	$252,293.85	$8,288,293.05	$9,194,310.72 (as of November 30, 2020)

Peer Support Certification



The ND 66th Legislative Assembly passed Senate Bill 2012 giving the Behavioral Health Division authority to develop and implement a program for the certification of peer support specialists.

Administrative Rules 75-03-43 were promulgated and outlines the requirements and process for two levels of Peer Support Specialist certification:

- Certified Peer Support Specialist I (CPSS I)
  - **22 CPSS I (as of January 10, 2021)**
- Certified Peer Support Specialist II (CPSS II)
  - **9 CPSS II (as of January 10, 2021)**

*Since 2018 the Behavioral Health Division hosted **18 trainings** and trained over **450 individuals**.*



Behavioral Health and Education

Prevention and Early Intervention Pilot

The ND 66th Legislative Assembly passed Senate Bill 2012 appropriating $300,000 to the Department of Human Services for the purpose of establishing a children's prevention and early intervention behavioral health services pilot project in the school system; including services to children suffering from the effects of behavioral health issues.

October 2018 - Pilot project to Simle Middle School in Bismarck.

October 2020 – Pilot project expansion awarded to Dunseith Public School (tribal) and Barnes County North Public School (rural).

Behavioral Health School Grant Program

The ND 66th Legislative Assembly passed Senate Bill 2012 appropriating $1,500,000 to the Department of Human Services for the purpose of providing behavioral health services and support grants to school districts to address student behavioral health needs.

25 schools utilized ND State Medicaid reimbursement during the previous school year and are eligible for funding.

8 grant applications have been received (1/11/2021)

- 5 awarded (4 schools)
- 3 in review

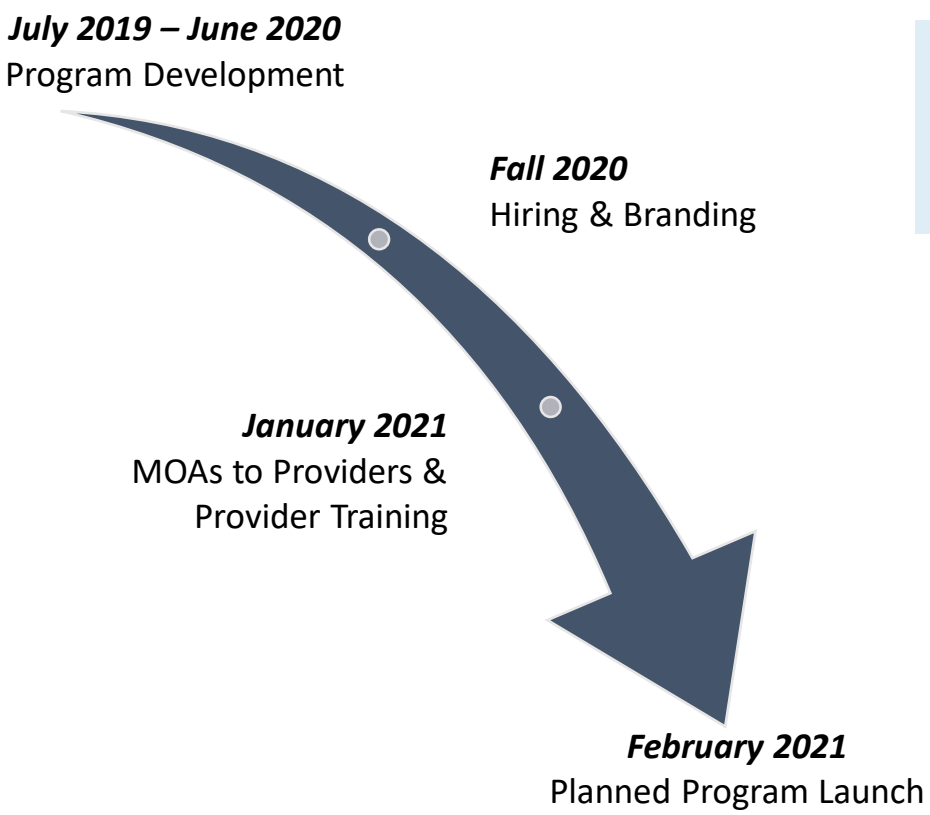
Behavioral Health Resource Support (B-HERO)

The ND 66th Legislative Assembly passed Senate Bill 2149 which established the requirement for each school within a district to designate an individual as a behavioral health resource coordinator and Senate Bill 2313 which established the requirement for DHS to provide resources to behavioral health resource coordinators.

The Central Regional Education Association (CREA) was awarded the contract (through a Request for Proposal) to provide resources, information, and support to school behavioral health resource coordinators at each school in North Dakota, collaborating with the Behavioral Health Division.

CommunityConnect

My Recovery. My Story.



MISSION: provide quality, community-based behavioral health services that promote collaboration and partnership to meet the individual needs of every person served.

To be **eligible** for the program individuals must be 18 years of age or older, reside in North Dakota, and have a mental health or substance use disorder diagnosis that is impacting their functionality in domains including housing, employment/financial, physical health, and community connections.

Priority will be given to the following populations: Parents and caregivers, parents and caregivers with child protection services involvement, pregnant women, Individuals that utilize emergency and detox centers, individuals who are homeless or at risk of homelessness, individuals who use drugs intravenously

COVID-19 Behavioral Health Supports

Crisis Counseling, Assistance and Training Program (CCP Grant)

- Project Renew (Lutheran Social Services of North Dakota)

Emergency COVID-19 Grant

- Support for Healthcare providers (Sanford Health, “Reach for Resilience”)
- Addiction treatment (Sharehouse and Heartview)
- Mental health treatment (Agassiz Associates)
- Crisis support (Field Services)



Resources: www.behavioralhealth.nd.gov/helpishere



BUDGET OVERVIEW

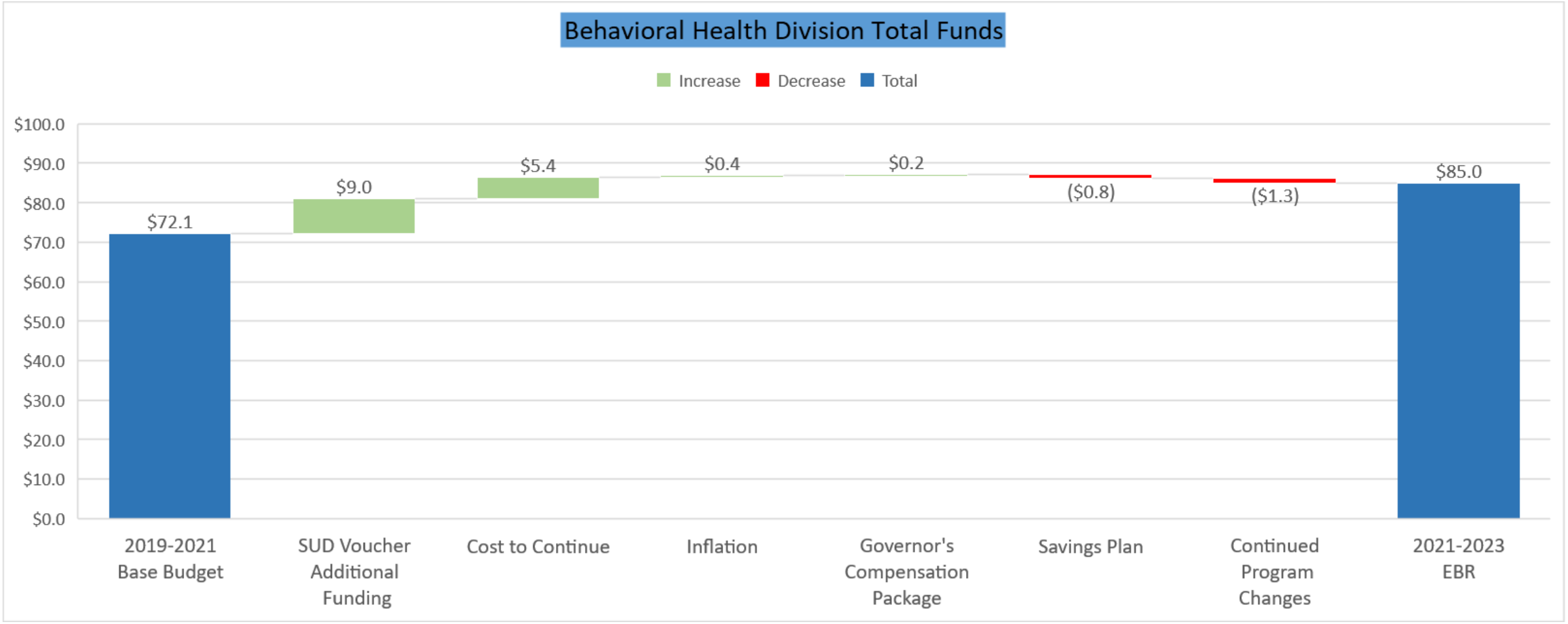
Behavioral Health Division

NORTH Dakota Be Legendary.™ | Behavioral Health HUMAN SERVICES

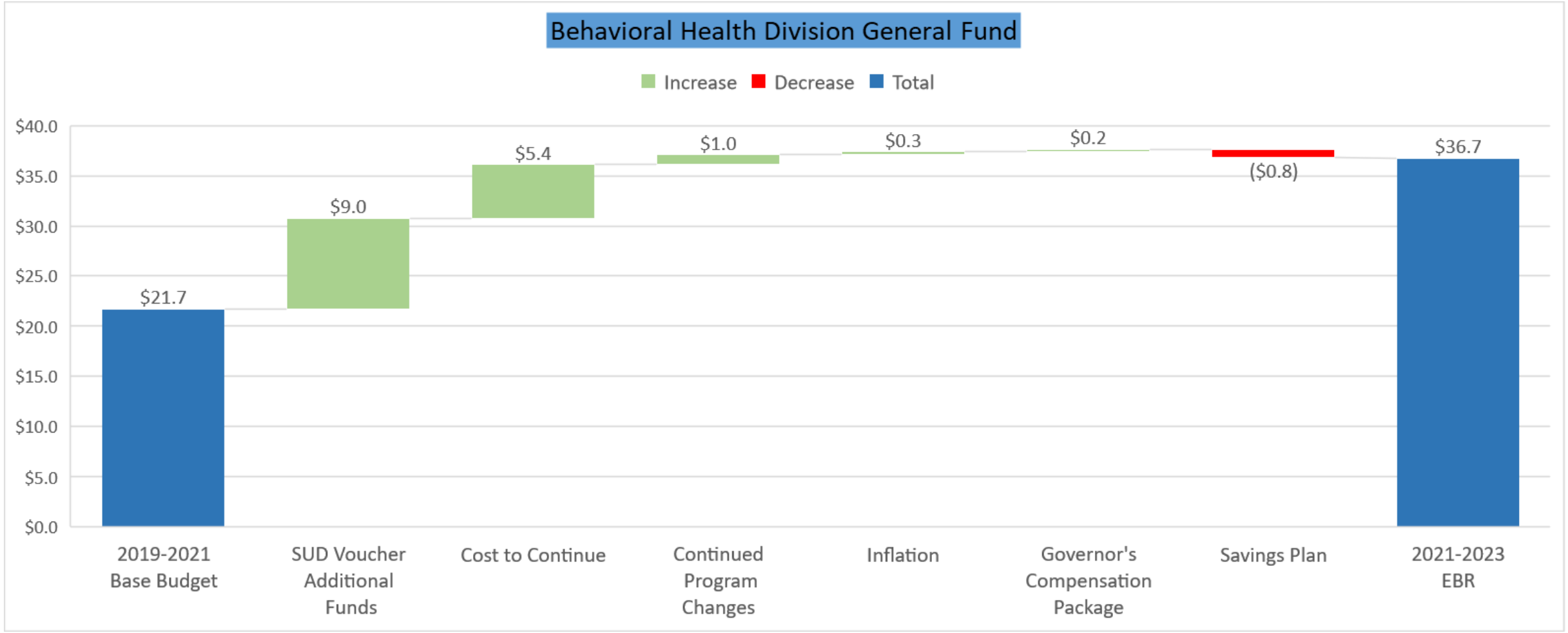
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	6,317,092	745,543	7,062,635
Operating	48,314,144	1,523,449	49,837,593
Grants	17,438,534	10,664,543	28,103,077
Total	72,069,770	12,933,535	85,003,305
General Fund	21,655,789	15,075,517	36,731,306
Federal Funds	42,723,467	(2,236,632)	40,486,835
Other Funds	7,690,514	94,650	7,785,164
Total	72,069,770	12,933,535	85,003,305
Full Time Equivalent (FTE)	36.00	0.00	36.00

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/12/2021 pm
House Appropriations – Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report

Chair Nelson called the meeting to order at 2:01 p.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Field Services
- Clinical Transformation
- Recovery Services
- Youth and Family Transformation
- Impact of Covid-19
- Budget Changes

Dr. Rosalie Etherington, Chief Clinic Director, and Jeff Stenseth, Field Services Operations Officer (2:02 pm) testified about the State Hospital in Jamestown #1104

Chair Nelson closed the meeting at 3:55 p.m.

Cole Fleck, Committee Clerk



HOUSE BILL 1012

HOUSE APPROPRIATIONS | HUMAN RESOURCES DIVISION

REPRESENTATIVE JON NELSON, CHAIRMAN #1104

FIELD SERVICES DIVISION

Rosalie Etherington, Chief Clinic Director/NDSH Superintendent

Jeff Stenseth, Field Services Operations Officer/ SEHSC Regional Director

NORTH Dakota | Human Services

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ABOUT US



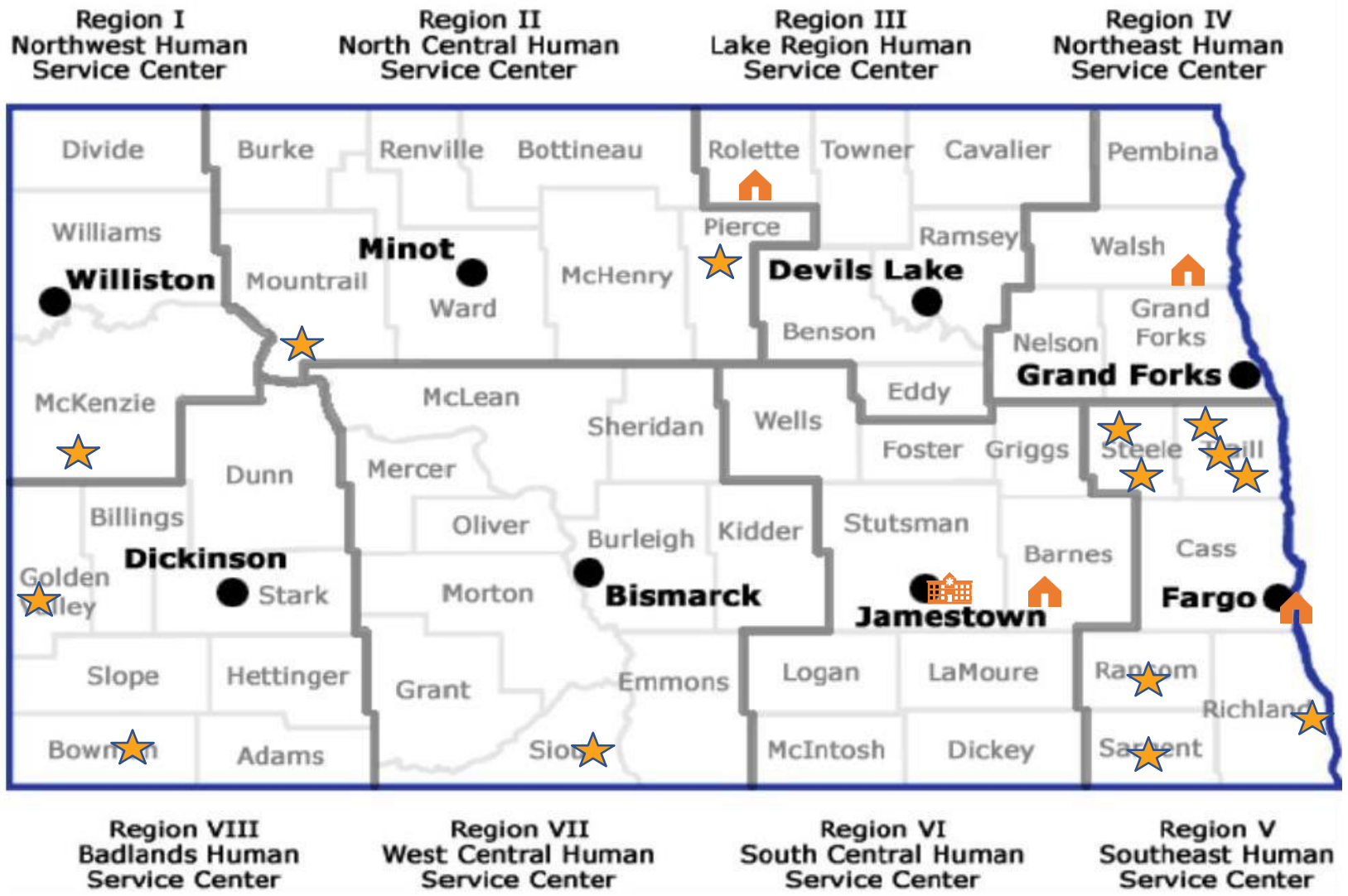
OUR MISSION

Provide timely and effective behavioral health services to citizens of North Dakota to improve the quality of life through achieving and sustaining recovery.

NORTH Dakota | Human Services
Be Legendary.™

FIELD
PUBLIC BEHAVIORAL HEALTH SYSTEM

8 Regional Human Service Centers
14 Outreach Offices
4 Satellite Clinics
1 North Dakota State Hospital



FIELD SERVICES:
Designing Behavioral Health Care



SERVE THOSE MOST FUNCTIONALLY IMPACTED



SUPPORT/INCREASE INDEPENDENT FUNCTIONING



SUPPORT INDIVIDUALS ACHIEVING THEIR RECOVERY GOALS

FIELD SERVICES
Our Clients

Field Services provided services to 22,972 clients between March 2019 and November 2020.



47% Serious Mental Illness (SMI) Primary Diagnosis

26% Substance Use Disorder (SUD) Primary Diagnosis

42% Co-Diagnosis of SUD and Mental Health Disorder

FIELD SERVICES
Our Clients

The HSCs served 21,743 clients between March 2019 and November 2020.

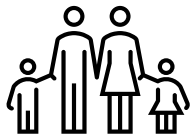
47%	Serious Mental Illness (SMI) Diagnosis
24%	Substance Use Disorder (SUD) Diagnosis
41%	Co-Diagnosis of SUD and Mental Health Disorder

The NDSH served 1,229 clients between March 2019 and November 2020.

46%	Serious Mental Illness (SMI) Diagnosis
55%	Substance Use Disorder (SUD) Diagnosis
67%	Co-Diagnosis of SUD and Mental Health Disorder

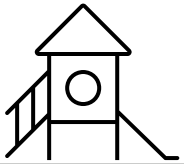
WHAT'S DRIVING US

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



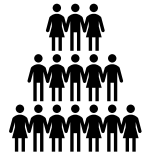
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



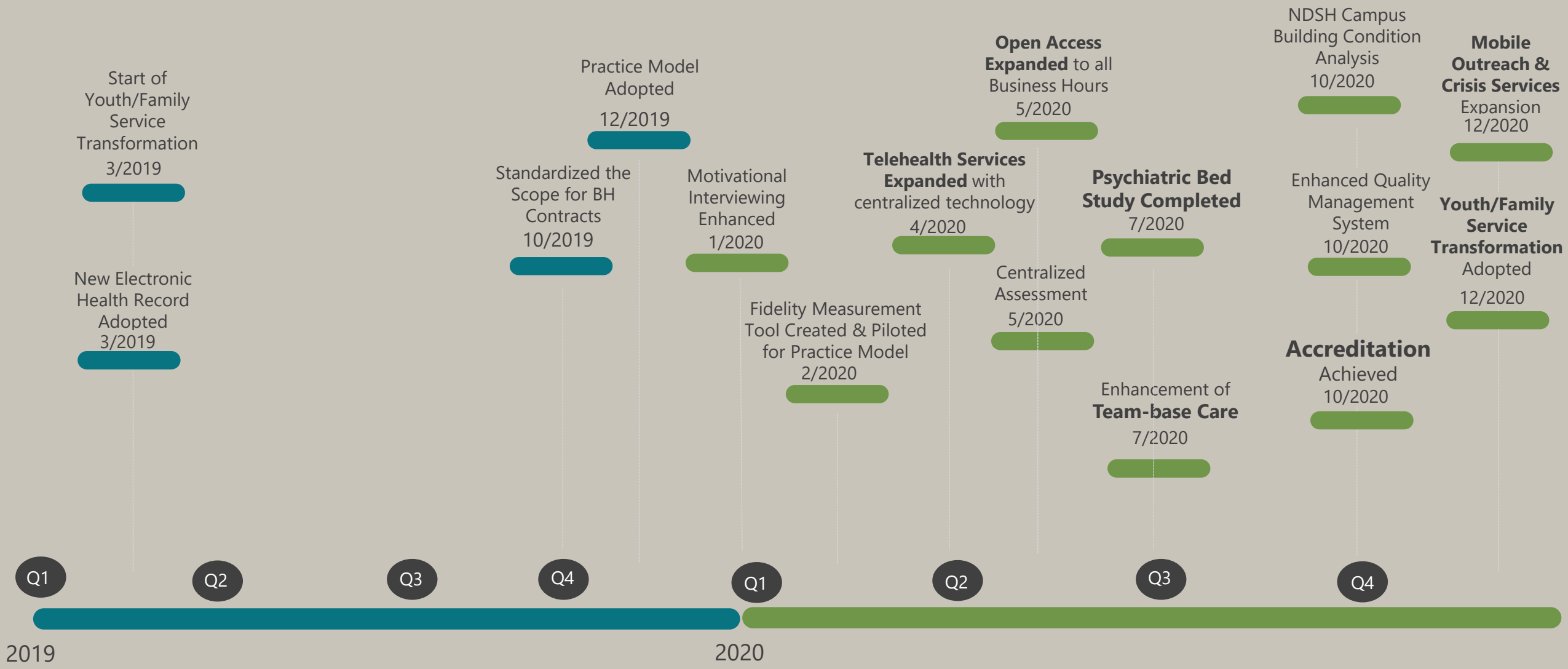
High Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

FIELD SERVICE INITIATIVES, 2019 - 2020



KEY APPROACHES

24/7 Centralized Call Center

Flexible Crisis Response

Crisis Stabilization Facilities

COMPREHENSIVE CRISIS CARE SYSTEM

- Anyone
- Anywhere
- Anytime

CLINICAL TRANSFORMATION

REHABILITATION & RECOVERY SERVICES

- Multidisciplinary Team-Based Services
- Focus of Service is Everyday Function
- Client Function and Satisfaction Measured
- Service Quality and Accuracy Measured
- Accreditation Compliance Measured
- Continuous Quality Assessment

SERVICE FOR JUSTICE INVOLVED

- Adolescent and Adult Drug Court Services
- Tompkins Rehabilitation Center Voluntary Treatment
- SCHSC/NDSH Cooperative Release SUD Treatment
- Specialized Services to Individuals with Serious Mental Illness
- Expanded Court Criminal Responsibility Assessment Services
- Court-ordered Diagnostic Assessment and Treatment Services
- Expanded Court Competence Assessment Services
- Expanding Jail Medication and Crisis Services

YOUTH & FAMILY TRANSFORMATION

- New Youth/Family Multidisciplinary Teams
- Specialized Intensive Youth/Family Therapies
- Solution-Focused Regional Review Teams
- Psychiatric Residential Treatment Safety-Net

HUMAN SERVICE CENTER OVERVIEW

All 8 Human Service Centers



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ACCREDITATION:
Reviewer's Comments

You should be very proud, of the 130+ site visits I have done, less than 10% have gotten an expedited review. (COA Reviewer Team Leader)

I am really blown away with your services. You provide great service to people who other agencies might not even consider.

....met high performance standards and have made a commitment to their stakeholders to deliver the very best quality services.

COUNCIL ON ACCREDITATION

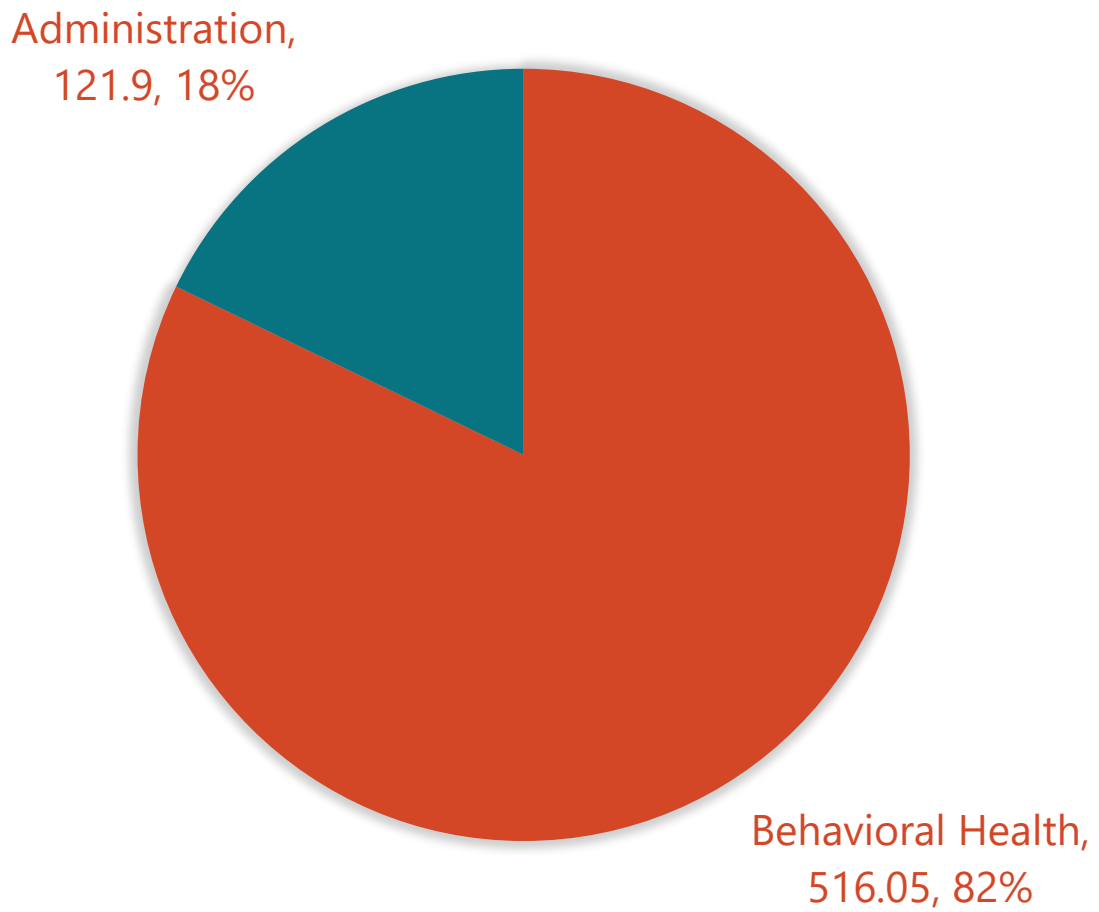
COVID

HSC COVID RESPONSE

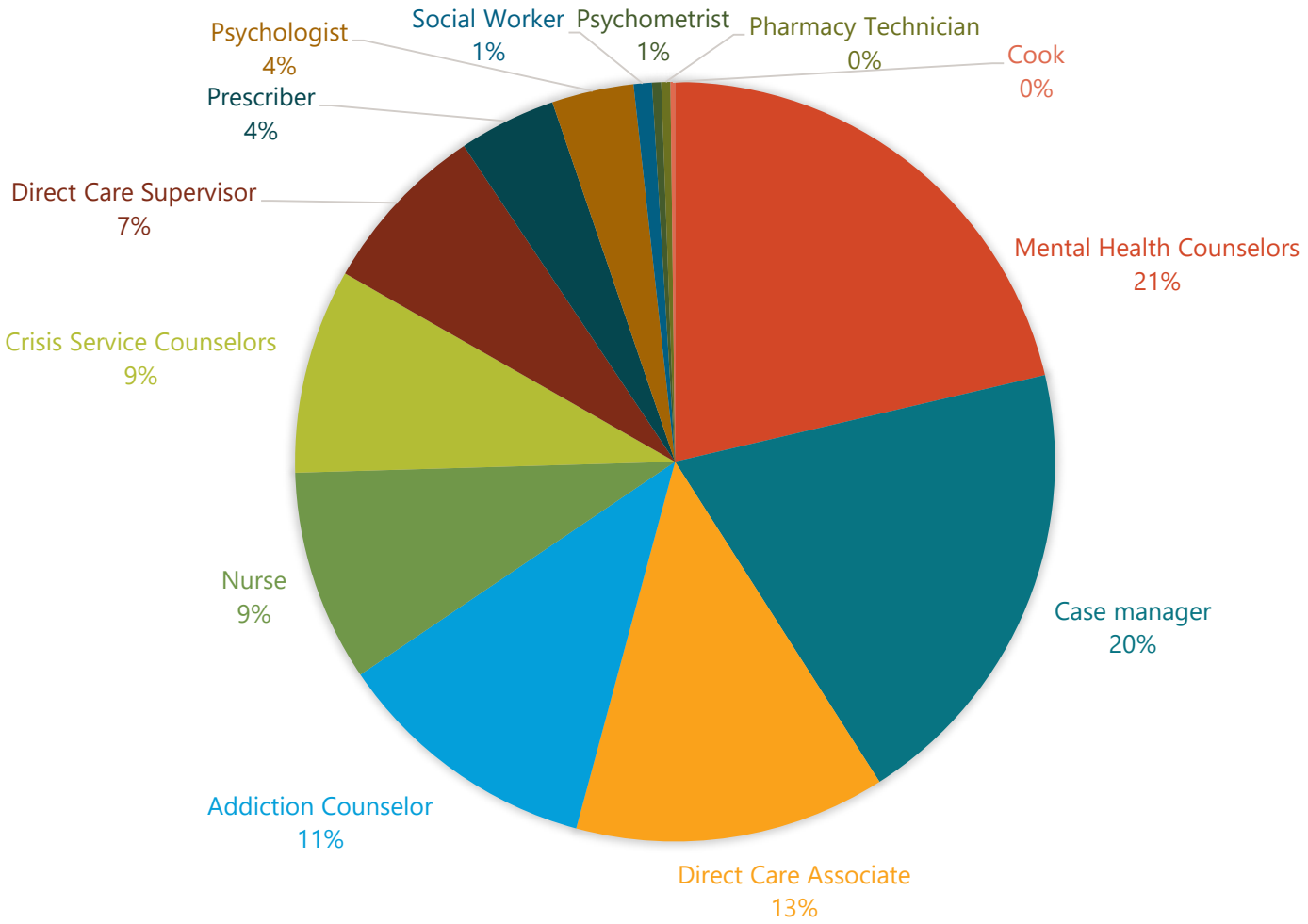
- Expanded telehealth capacity to 350 providers
- Prioritized on-site staff and services
- Retained limited in-person care
- Expanded in-person care in November



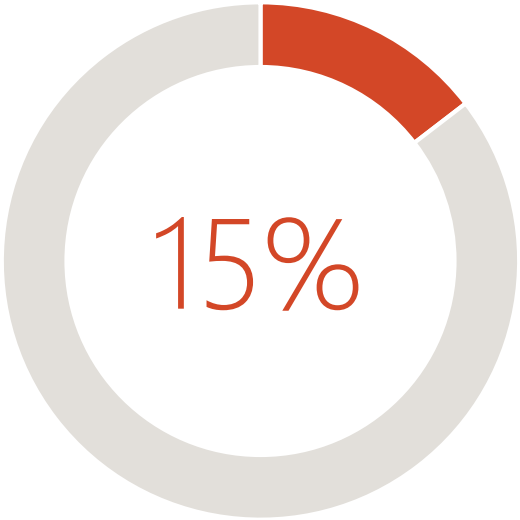
HUMAN SERVICE CENTER STAFFING:
637.95 Total FTE Statewide



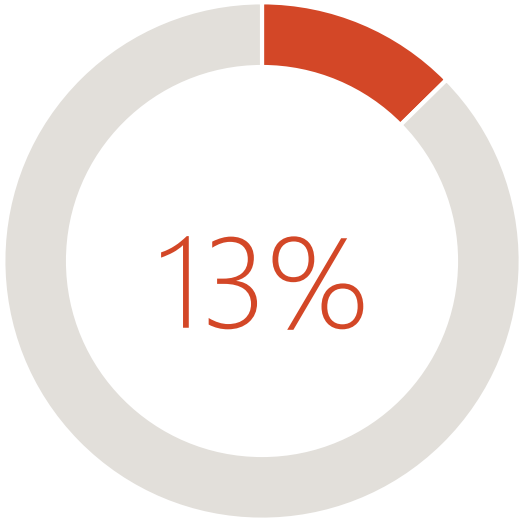
HUMAN SERVICE CENTER STAFFING
516 Behavioral Health FTE Statewide



HUMAN SERVICE CENTER STAFF TURNOVER



2019



2020

HUMAN SERVICE CENTERS AT-A-GLANCE
March 2019 – February 2020 *

569,454
Services

18,308
Clients

15,419
Services provided by Telehealth

12,157
Services provided in home

215,246
Services provided in community

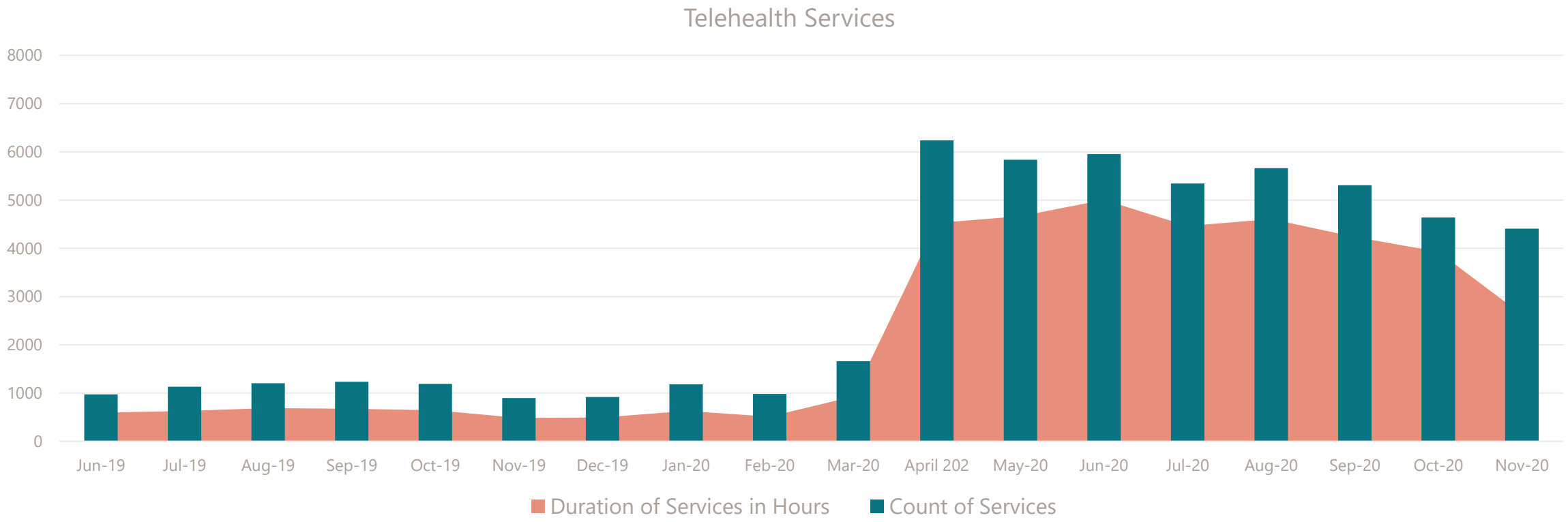
5,628
Crisis Services

2,230
Youth (<18) clients served

*New EHR was adopted in March 2019, thus a full calendar year for 2019 was not able to be provided.

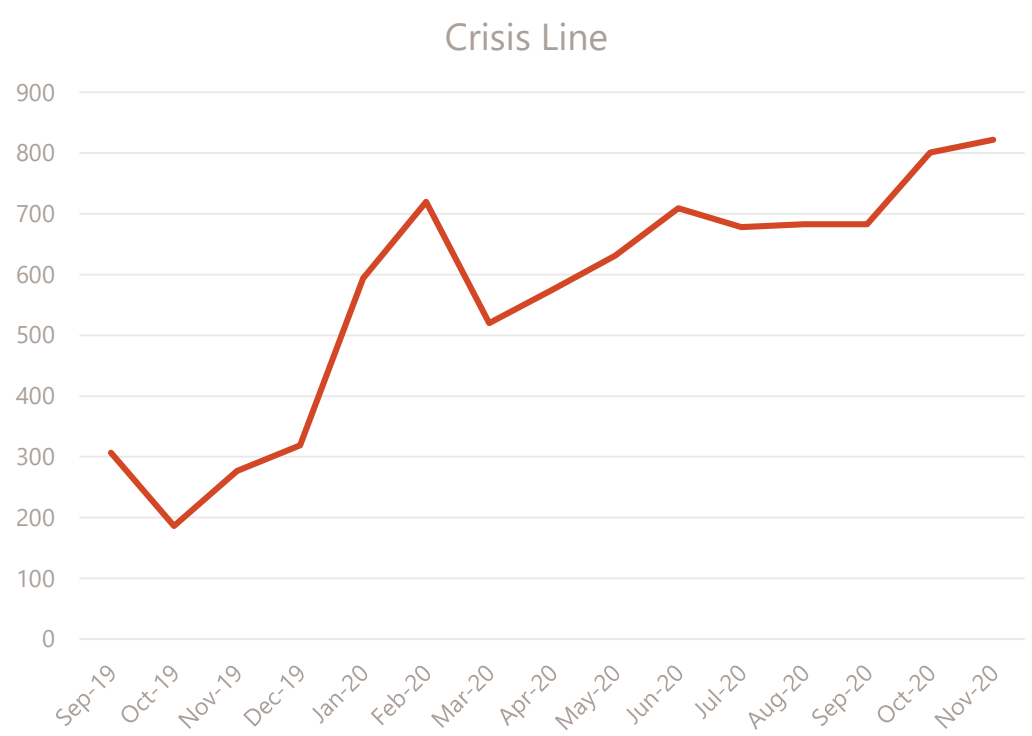
HUMAN SERVICE CENTERS
Telehealth Service Expansion

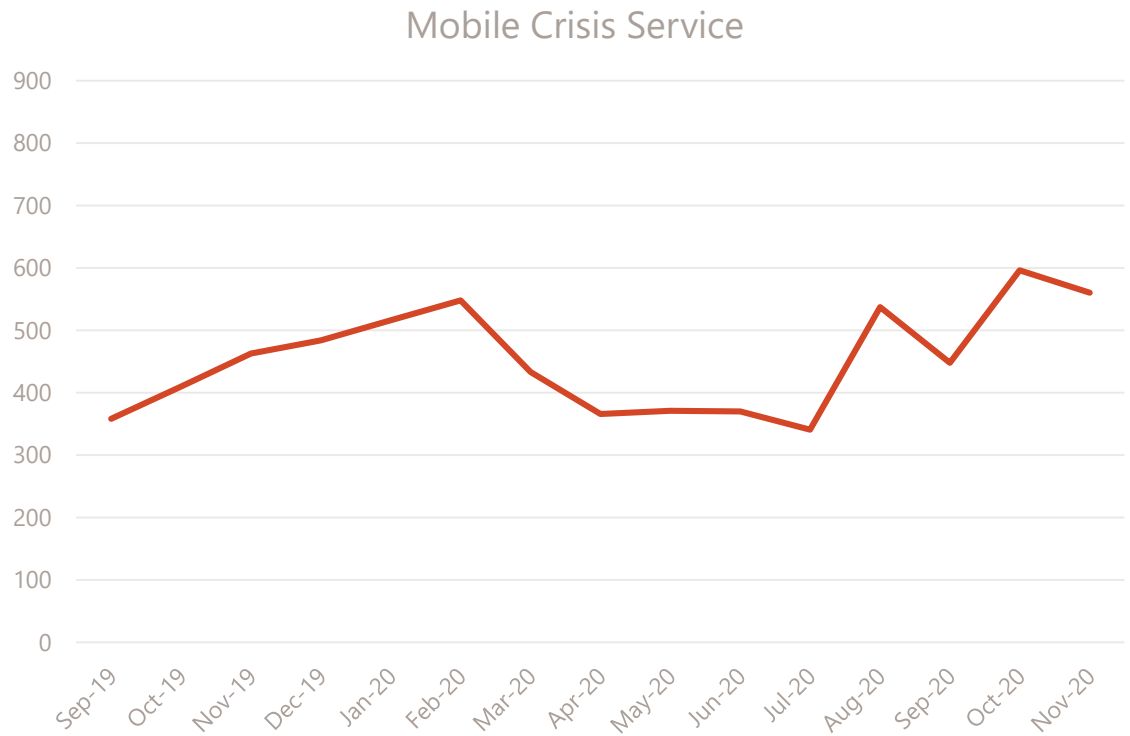
The Human Service Centers transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



HUMAN SERVICE CENTERS
Crisis Service Transformation

The Human Service Centers provided **15,300** crisis services from September 2019 through November 2020.

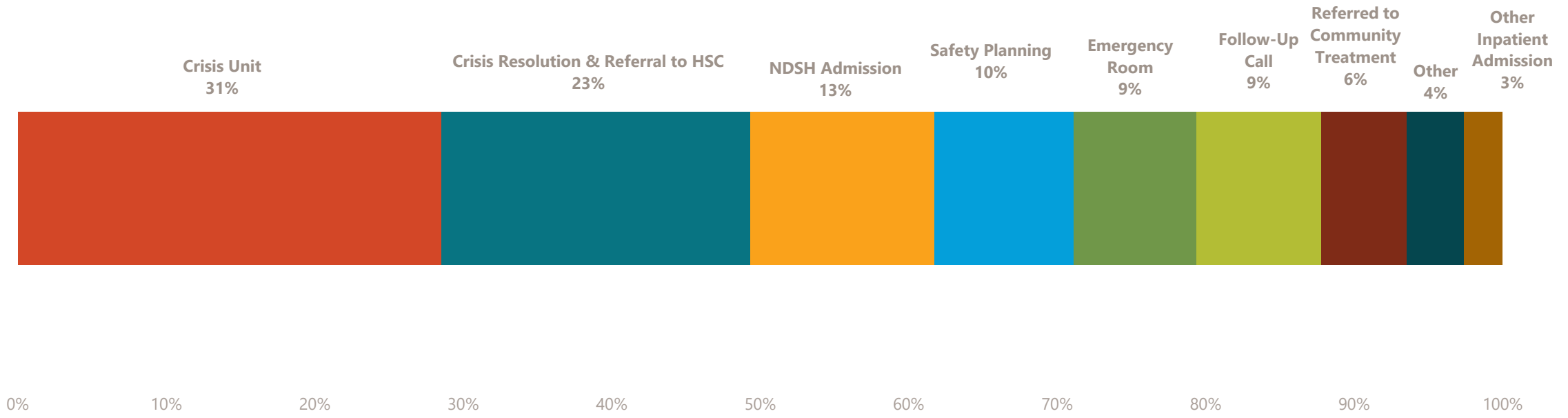




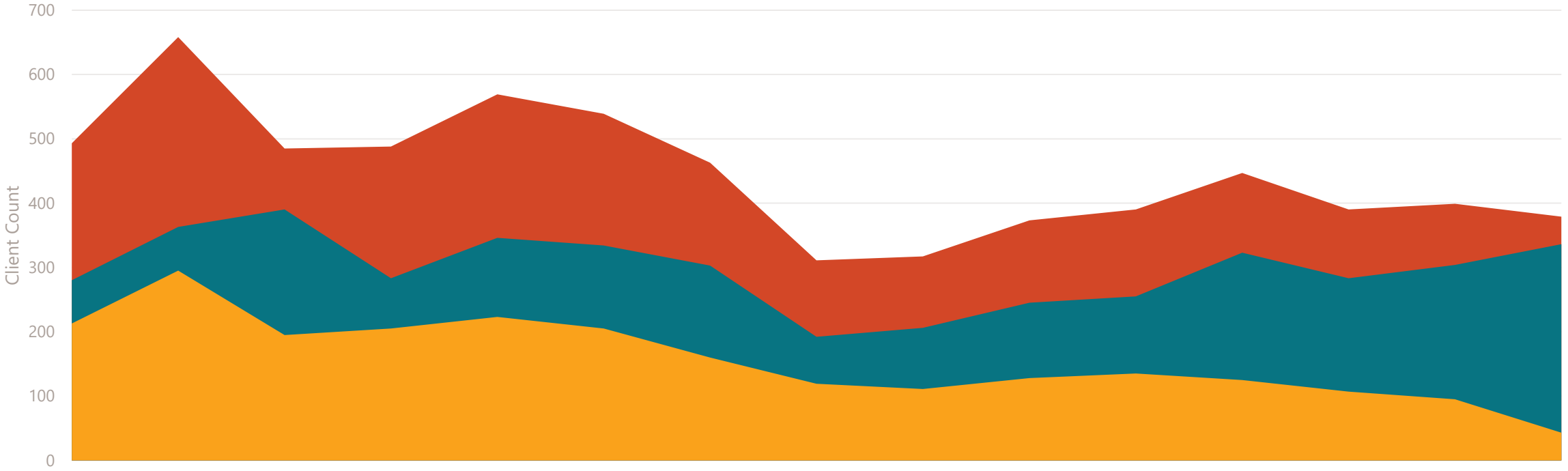
HUMAN SERVICE CENTERS

Crisis Resolution Increasing

Between September 2019 through November 2020, Human Service Centers triaged and screened 4,202 individuals for crisis services. Of those individuals, 67% were either referred to Crisis Unit, Crisis Resolution & Referral to HSC, or North Dakota State Hospital.

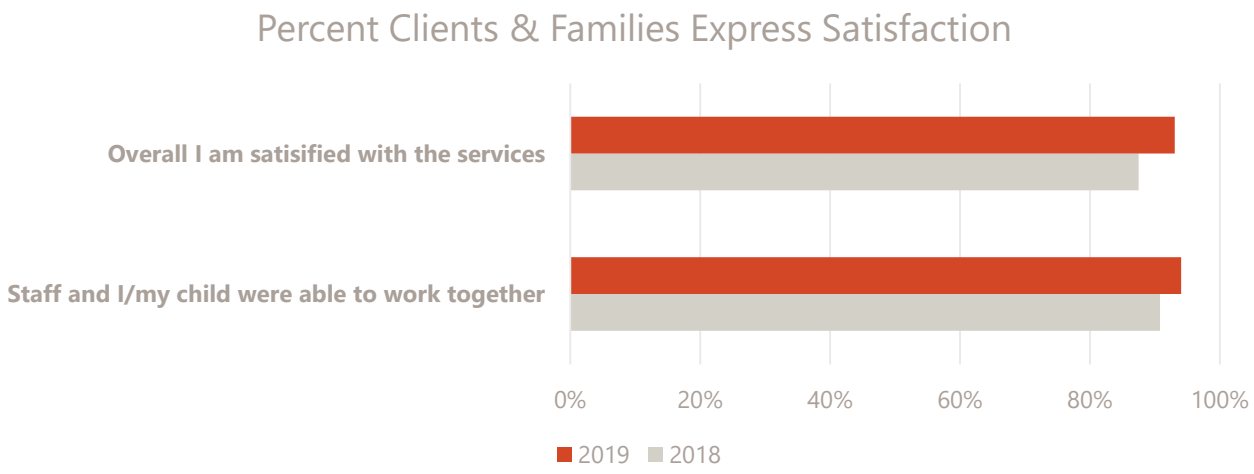


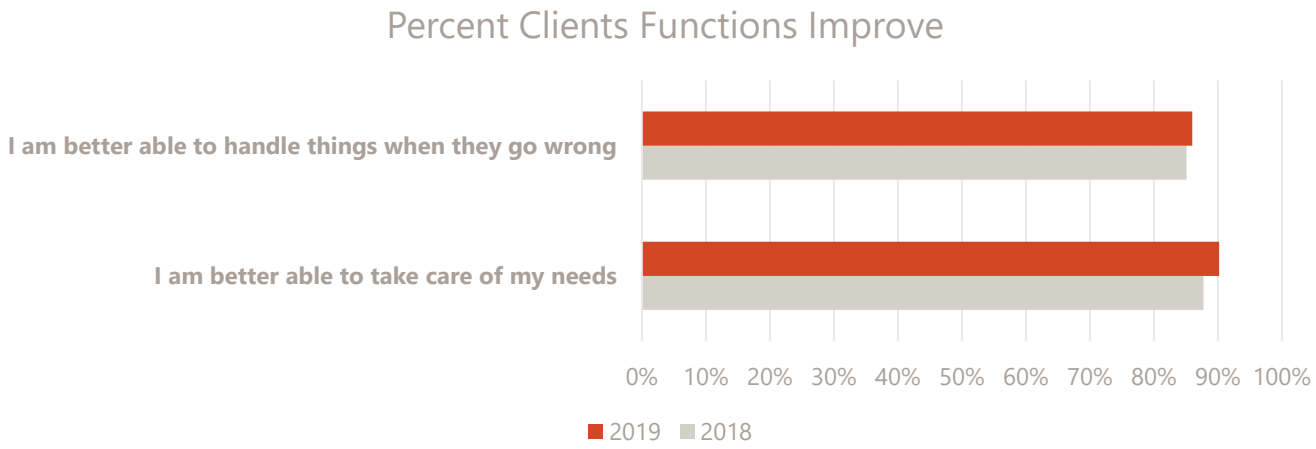
HUMAN SERVICE CENTERS:
Open Access



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	493	658	485	488	569	539	463	311	317	373	390	447	390	399	379
Referred to HSC	280	363	390	283	346	334	303	192	206	245	255	323	283	304	336
Referred Out	213	295	195	205	223	205	160	119	111	128	135	125	107	95	43

HUMAN SERVICE CENTERS:
Client Satisfaction & Improvement





"I was treated extremely well and with genuine concern. I felt cared for and loved as a human being. There is nothing that I would like to see changed, as I was well cared for. "

"I am very satisfied with the service as I get from the Human Services mental health. I would strongly recommend this agency to someone who needs help. Keep up with the awesome job!"

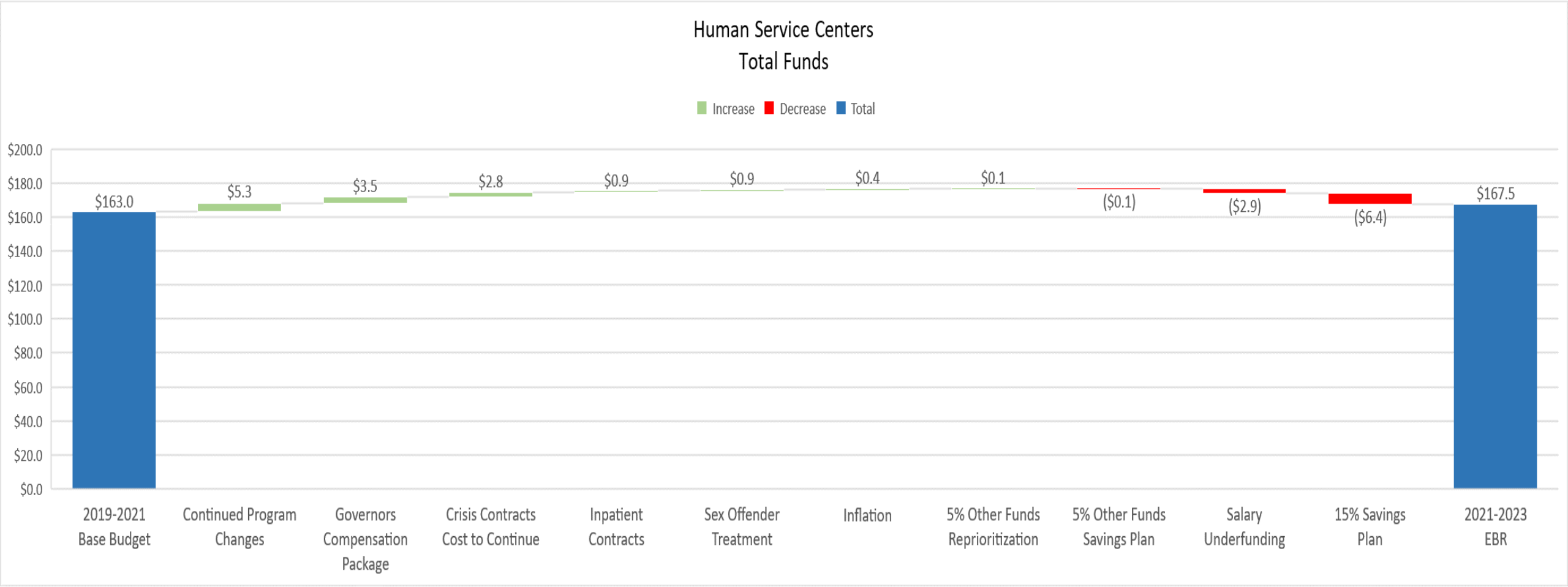
"The Human Services has changed my life to my best life. I am so thankful. Love them all dearly. The quality of my life would not have changed without them. I feel they sincerely care about me. "

21-23 BUDGET

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	117,595,353	6,901,854	124,497,207
Operating	16,435,561	(969,915)	15,465,646
Capital	80,000	0	80,000
Grants	28,873,633	(1,398,175)	27,475,458
Total	162,984,547	4,533,764	167,518,311
General Fund	104,546,617	(8,374,845)	96,171,772
Federal Funds	40,391,387	4,295,666	44,687,053
Other Funds	18,046,543	8,612,944	26,659,487
Total	162,984,547	4,533,764	167,518,311
Full Time Equivalent (FTE)	637.95	0	637.95

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



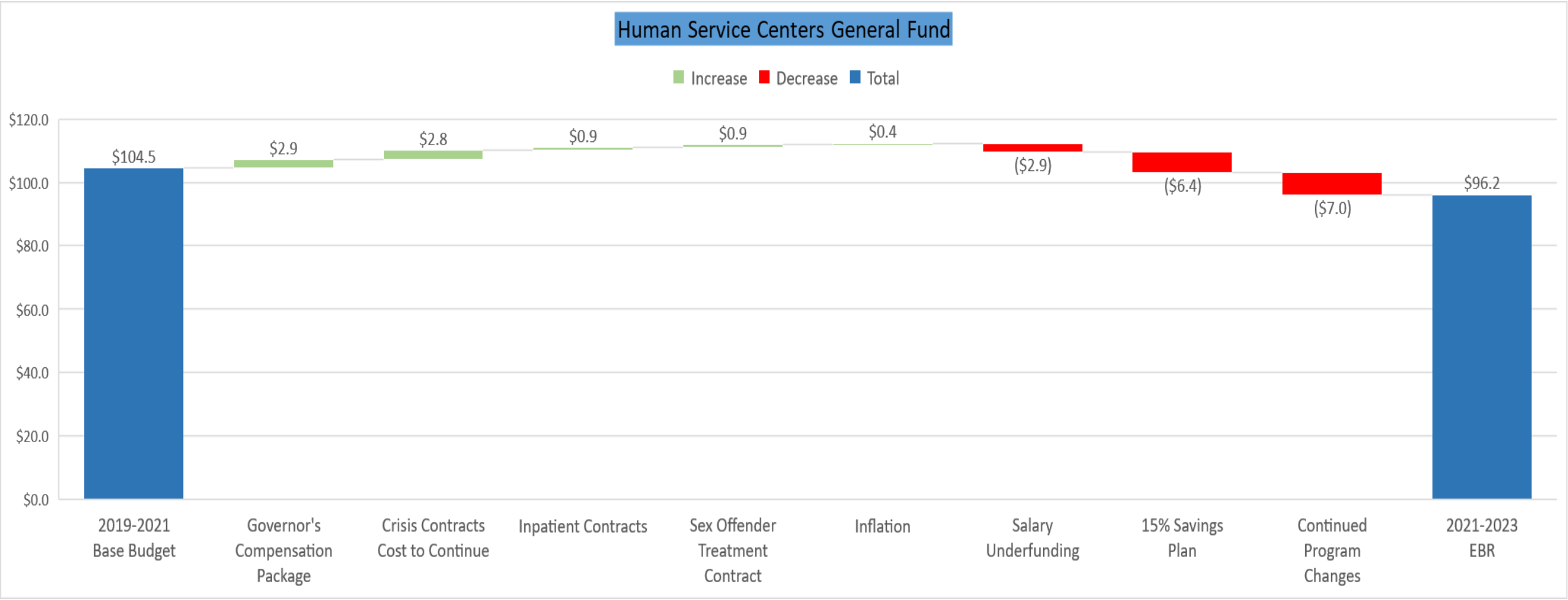
HSC Changes

15% Savings Plan

- (476,417) due to Operating efficiencies
- (170,000) due to program ended
- (2,336,578) due to Program efficiencies
- (3,431,998) funding changes due to 1915i implementation



GENERAL FUND CHANGES(IN MILLIONS)

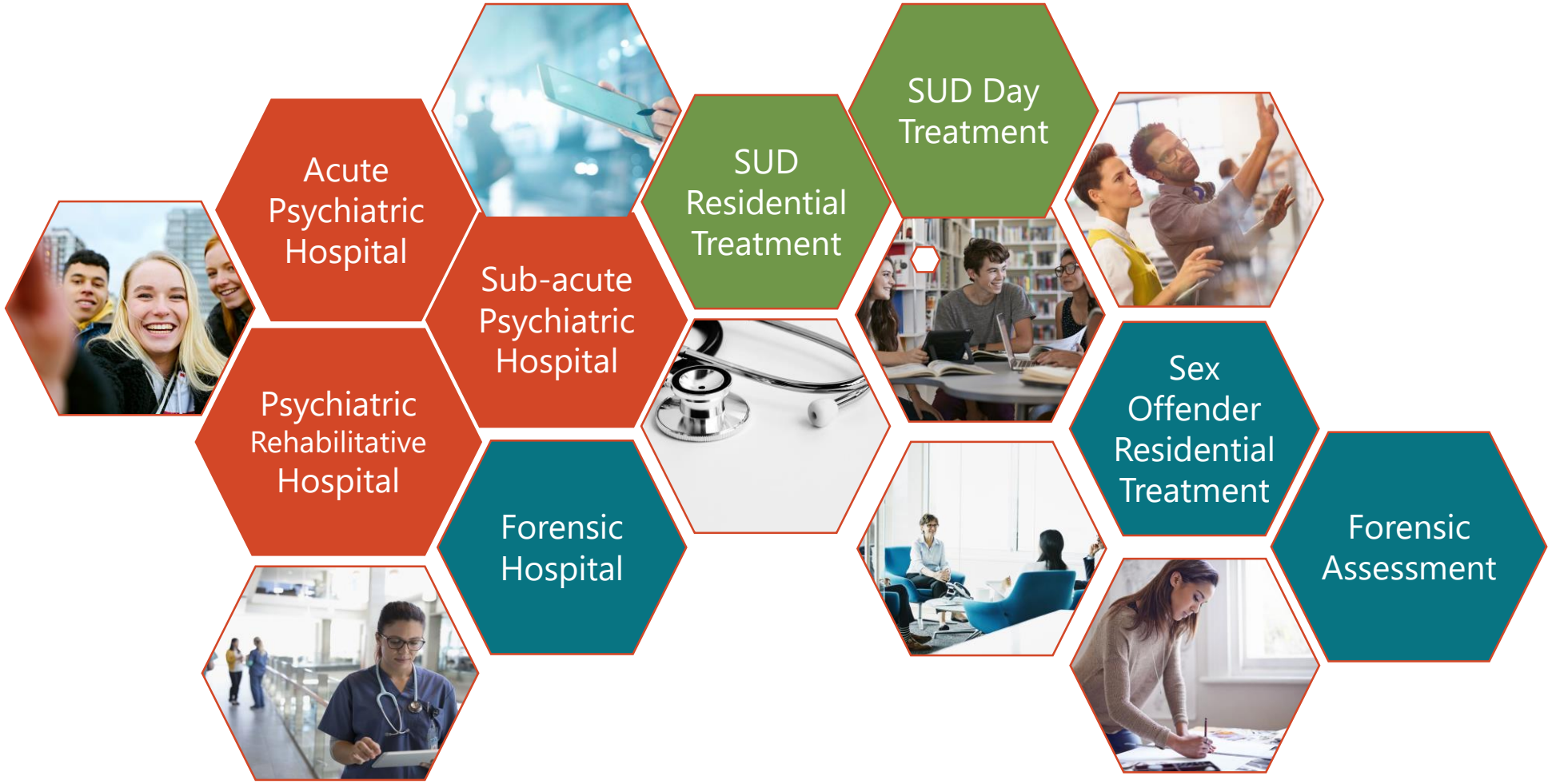


NORTH DAKOTA STATE HOSPITAL OVERVIEW

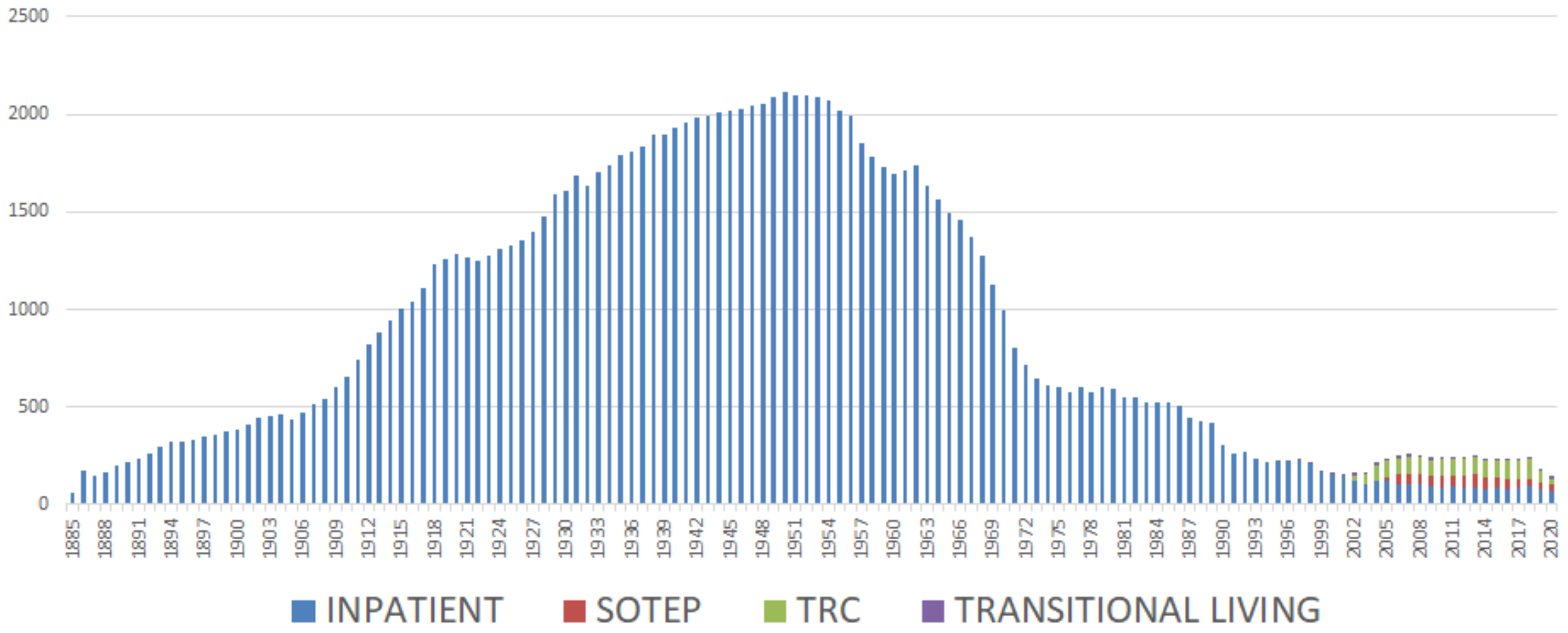
ABOUT US

STATE HOSPITAL SERVICES

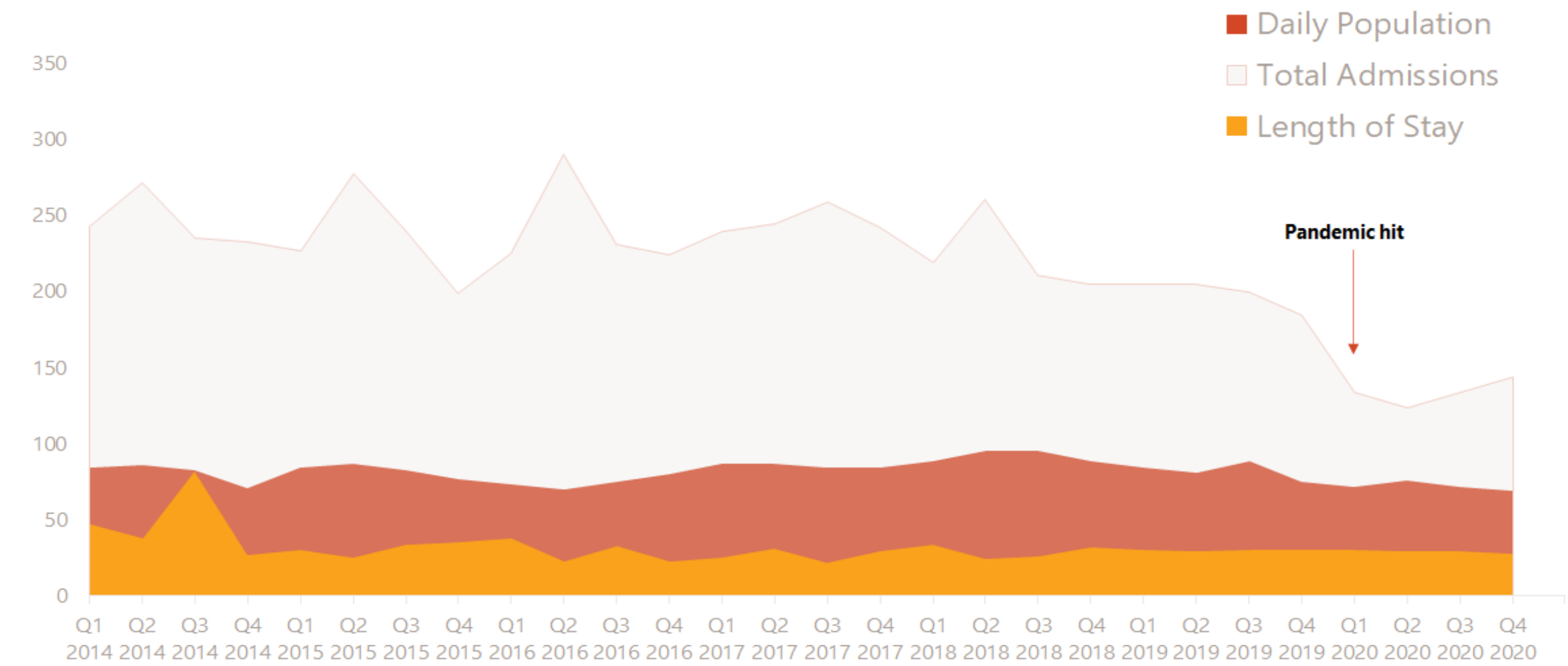
Specialized Safety-Net Quick Glance



NDSH CENSUS OVER TIME



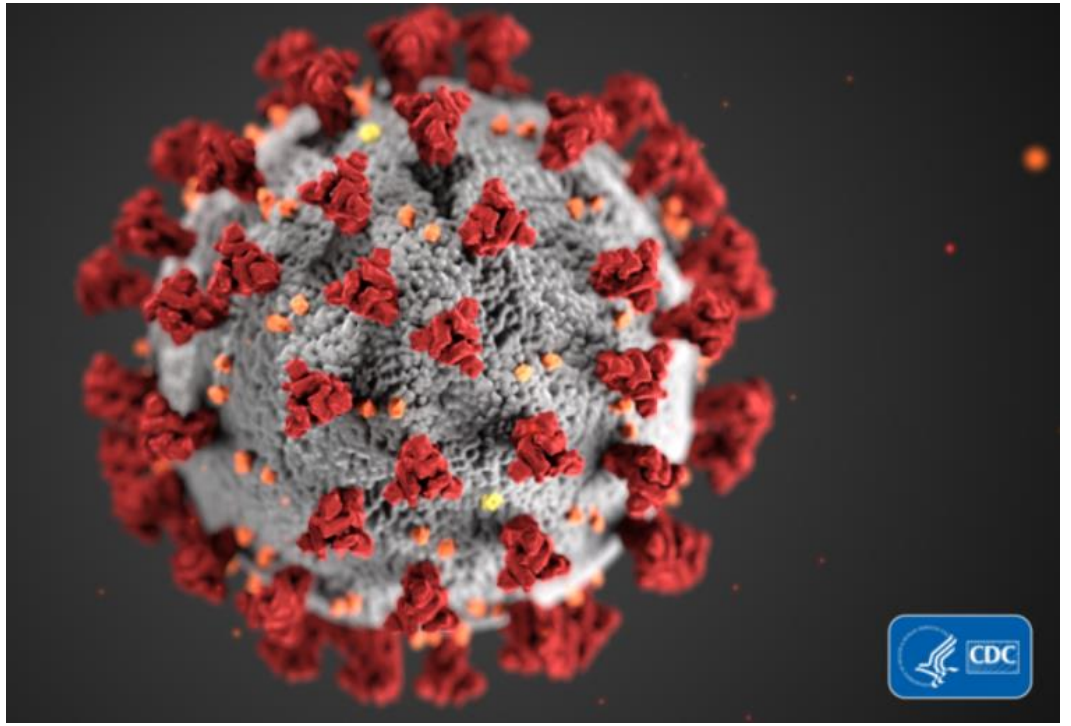
NDSH ADMISSIONS AND DAILY POPULATION



COVID

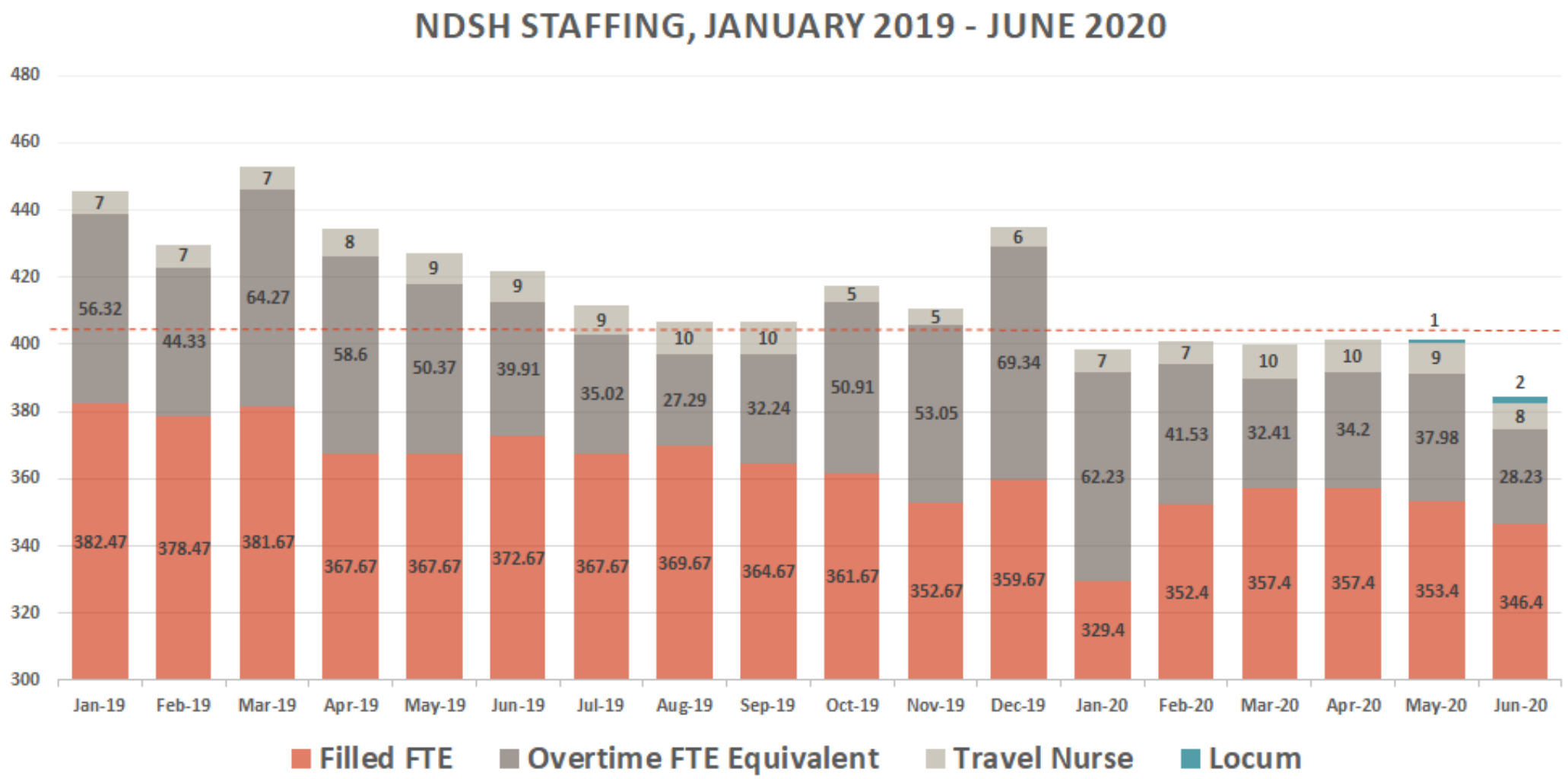
NDSH PANDEMIC RESPONSE

- Infection Control Procedures Expanded
- Weekly Surveillance Testing
- Visitor and Community Restrictions
- NDSH Role in North Dakota Bed Surge Plan
- Mandatory overtime and other staff shortage issues



NDSH STAFFING

OVERTIME AND AGENCY STAFF MAKE UP THE DIFFERENCE



KEY APPROACHES

NDSH BIENNIAL ACCOMPLISHMENTS

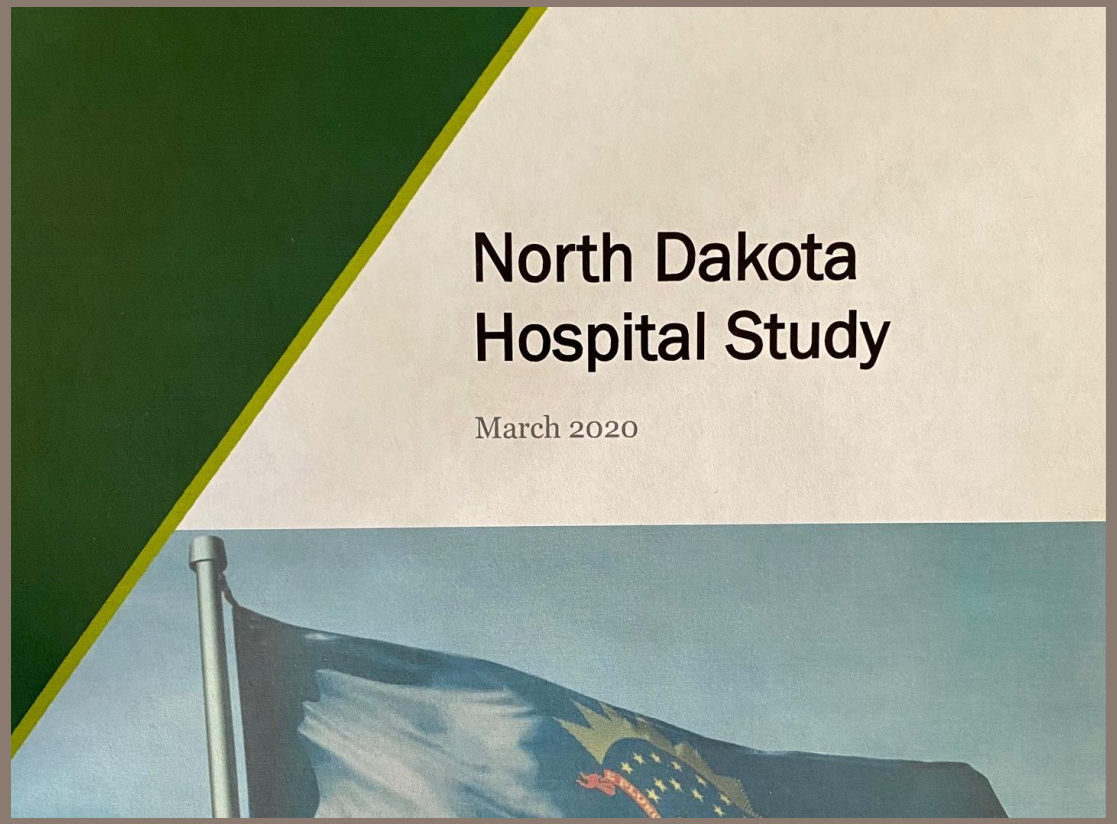
- Psychiatric and residential bed studies
- Campus infrastructure and building conditions analysis
- Forensic services expanded

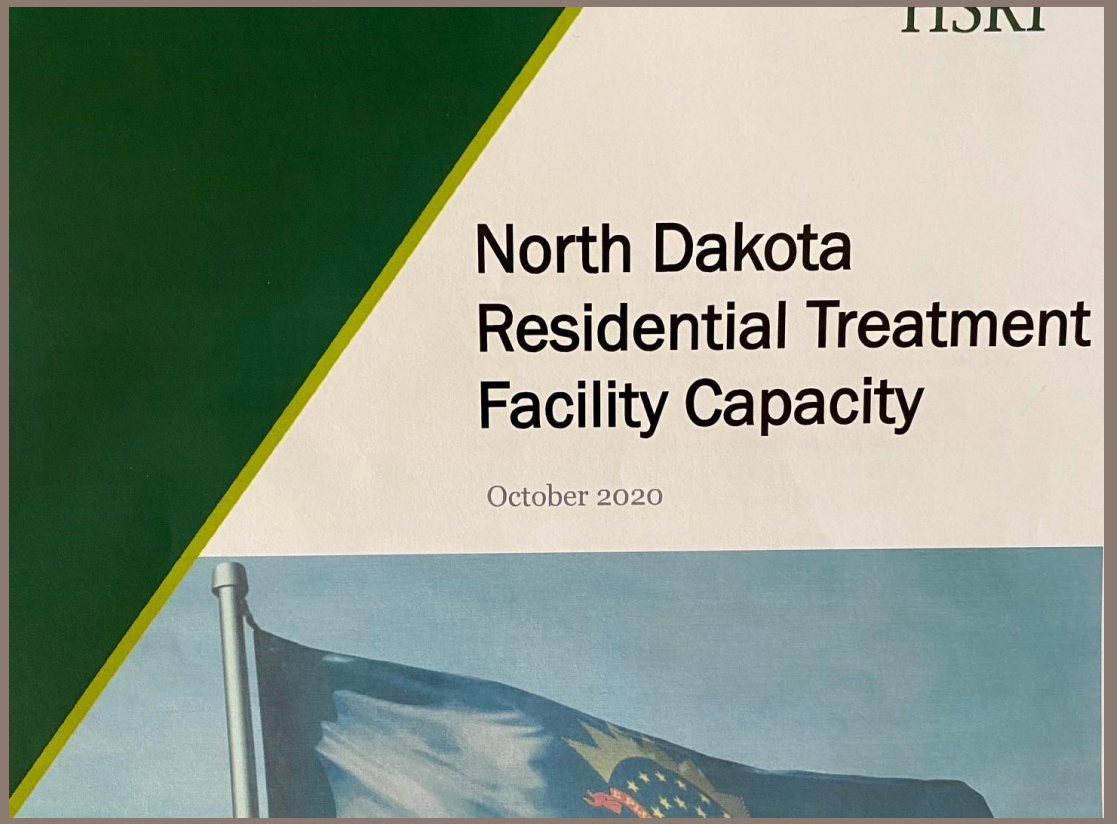


SB 2012 SECTION 18
REPORT TO LEGISLATIVE MANAGEMENT

- Identify size and use of new state hospital
- Identify impact of crisis service expansion
- Identify potential use of Medicaid waivers
- Identify balance of inpatient, residential, and community services







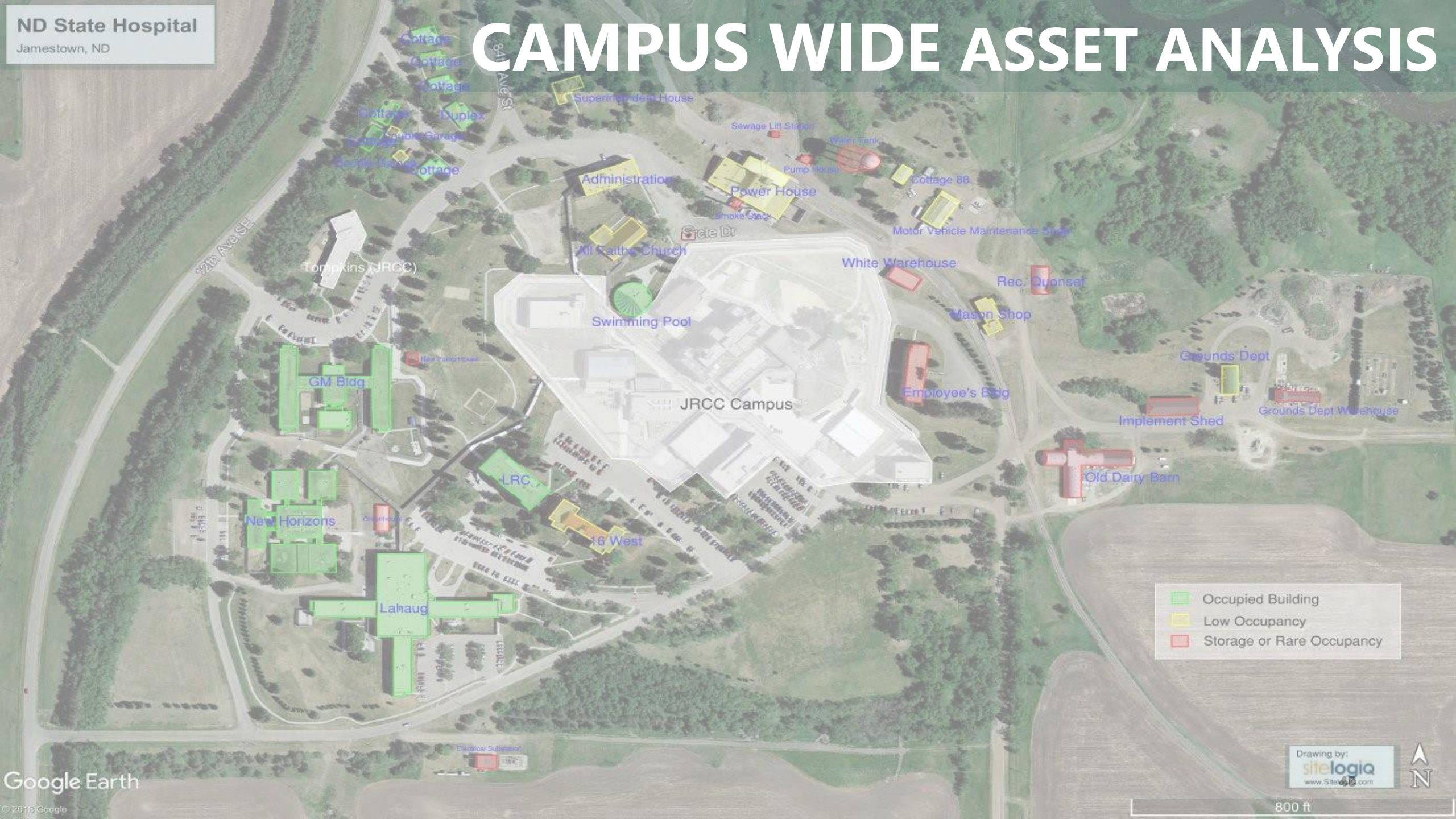
HSRI RECOMMENDATIONS

STATEWIDE PLAN RECOMMENDATIONS

STATE HAS SUFFICIENT PSYCHIATRIC HOSPITAL AND RESIDENTIAL BEDS

- Sufficient hospital and residential bed capacity
- 6-10 hospital beds needed in western North Dakota
- Build new state hospital at 75-85 beds
- Develop and expand alternatives to inpatient treatment
- Develop standardized coordination of services
- Integrate behavioral health services into physical health
- Do not pursue Medicaid IMD exclusions

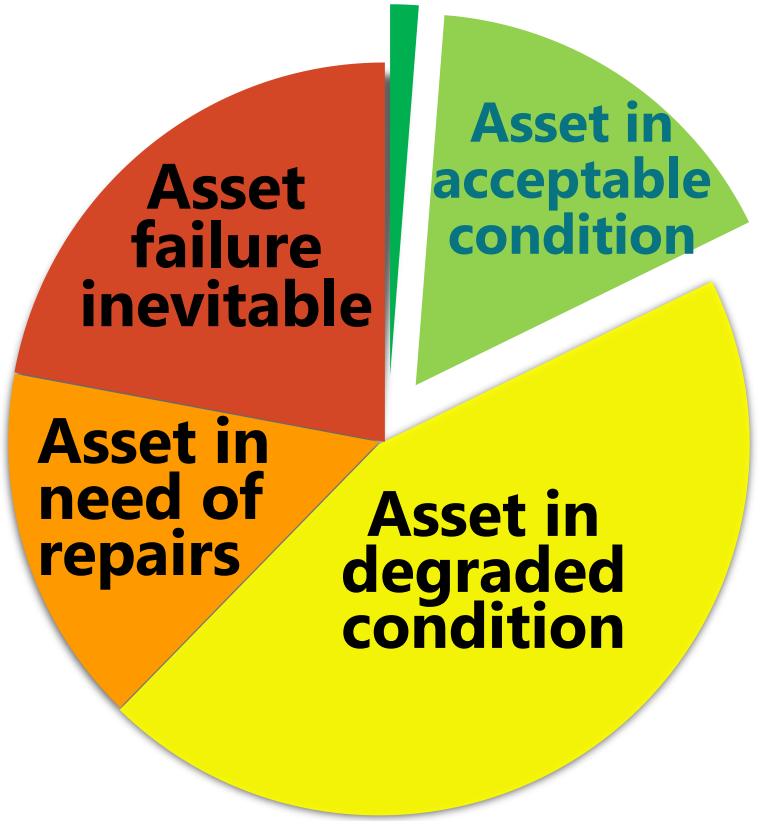
CAMPUS WIDE ASSET ANALYSIS



ASSET ANALYSIS CONCLUSIONS

IMMEDIATE NEEDS FOR FAILING INFRASTRUCTURE

- Way past life expectancy
- At end of life
- Nearing end of life
- Middle of useful Life
- Beginning of useful life



NEW TREATMENT CAMPUS GOALS

IMPROVE CARE AND SAVE COSTS

01 An innovative approach to deliver a new Treatment Campus to accomplish Legislature's directive

02 Finance new construction with minimal to no upfront capital spending

03 **Eliminate over $5M in annual operating inefficiencies and duplicative support**

04 Provides operating and lifecycle cost certainty for the next 40 years

05 Provide a new facility that improves patient and staff safety and improved treatment

06 **Eliminate $148M of deferred Maintenance needs and provides a new facility with essentially a 40-year warranty**

07 Significantly reduce operating costs, and ensure cost certainty and facility condition for the next 40 years

WHY A NEW HOSPITAL

Offer safer & better care at a lower cost



Safety Concerns

Secure Entrance Issues

- The ability to have unwanted ingress/egress

Limited Sightlines

- Impacts ability of staff to observe patients at all times

Outdated Configurations

- Does not meet current care needs
- Anti-ligature limited

Care Concerns

Regulatory Deficiencies

- Joint commission requirements
- Life Safety Code requirements

Indoor Environment

- Contributes to longer stays
- Staff satisfaction and performance suffer

Cost Concerns

Operating Cost Inefficiency

- Aged facility systems are nearing (or have exceeded) end of useful life
- Deferred maintenance list continues to grow
- Difficult to staff maintenance FTEs

Excess Campus Footprint

- Multiple buildings and excess square footage requires higher staffing
- Duplication of FTE services and/or roles

NEW STATE HOSPITAL VIA PUBLIC / PRIVATE PARTNERSHIP (LEASE)

Patients recover faster when treated in a modern, therapeutic environment.



Annual costs and savings to build a new State Hospital via private / public partnership (lease)	**$$$**
Annual lease payment (principal and interest)	$7,160,000
Annual facility operations cost savings (e.g.: carpet, light fixtures, plumbing)	($850,000)
Annual utility cost savings	($50,000)
Annual new hospital FTE reductions	($2,680,000)
Annual capital reinvestment savings	($1,8666,667)

BUDGET BUILT ON SMALLER HOSPITAL

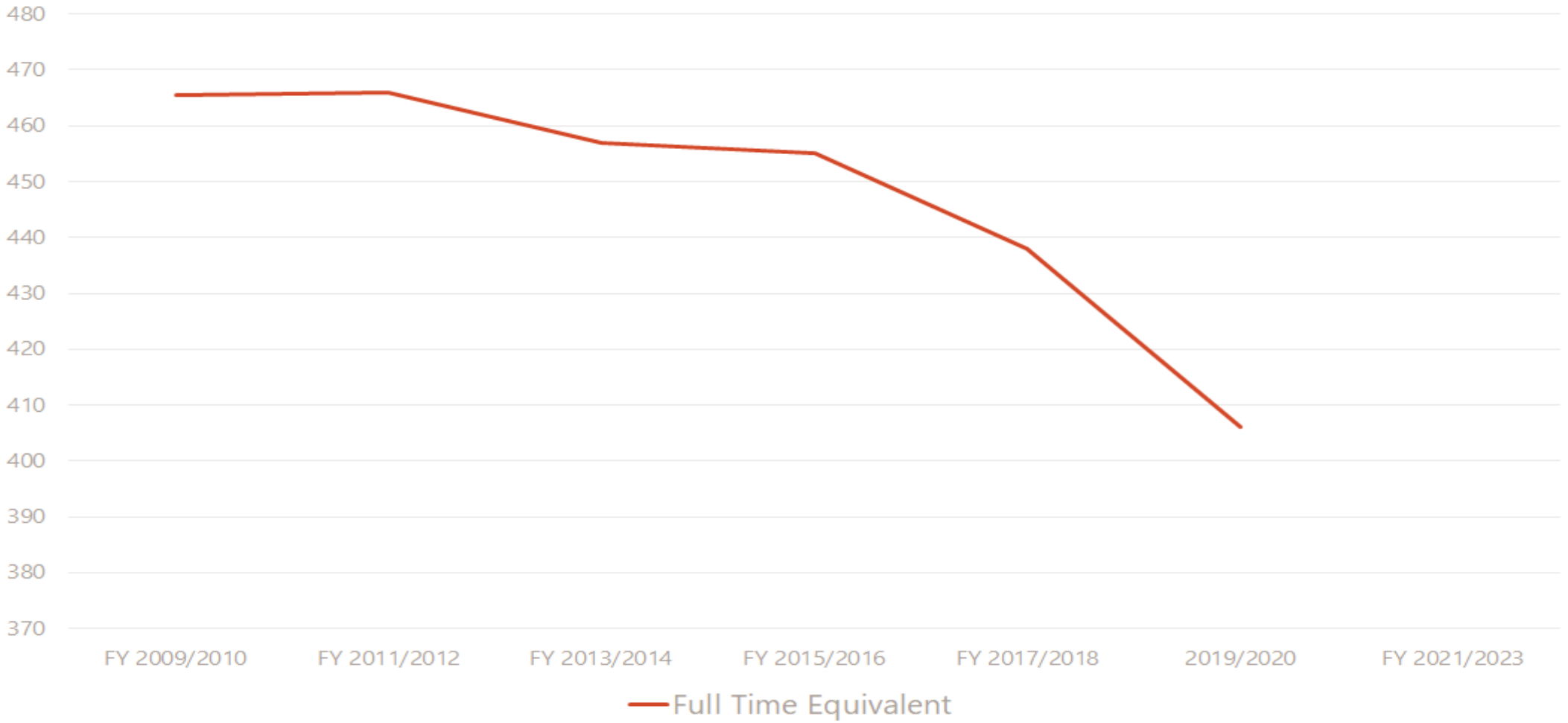
BUDGET REDUCTION CONTINGENT ON THREE THINGS

1. 6-10 hospital beds needed in western North Dakota
2. Statutory authority to decline admissions when full
3. New hospital without costly deferred maintenance

Reduce state hospital inpatient services to 75 beds



CURRENT BUDGET REDUCES BY 27 FTE



OTHER PROPOSED BUDGET CHANGES

PROPOSED REDUCTIONS CONTINGENT ON CERTAIN FACTORS

- End DOCR contract and close treatment beds
- Provide land for National Guard training center

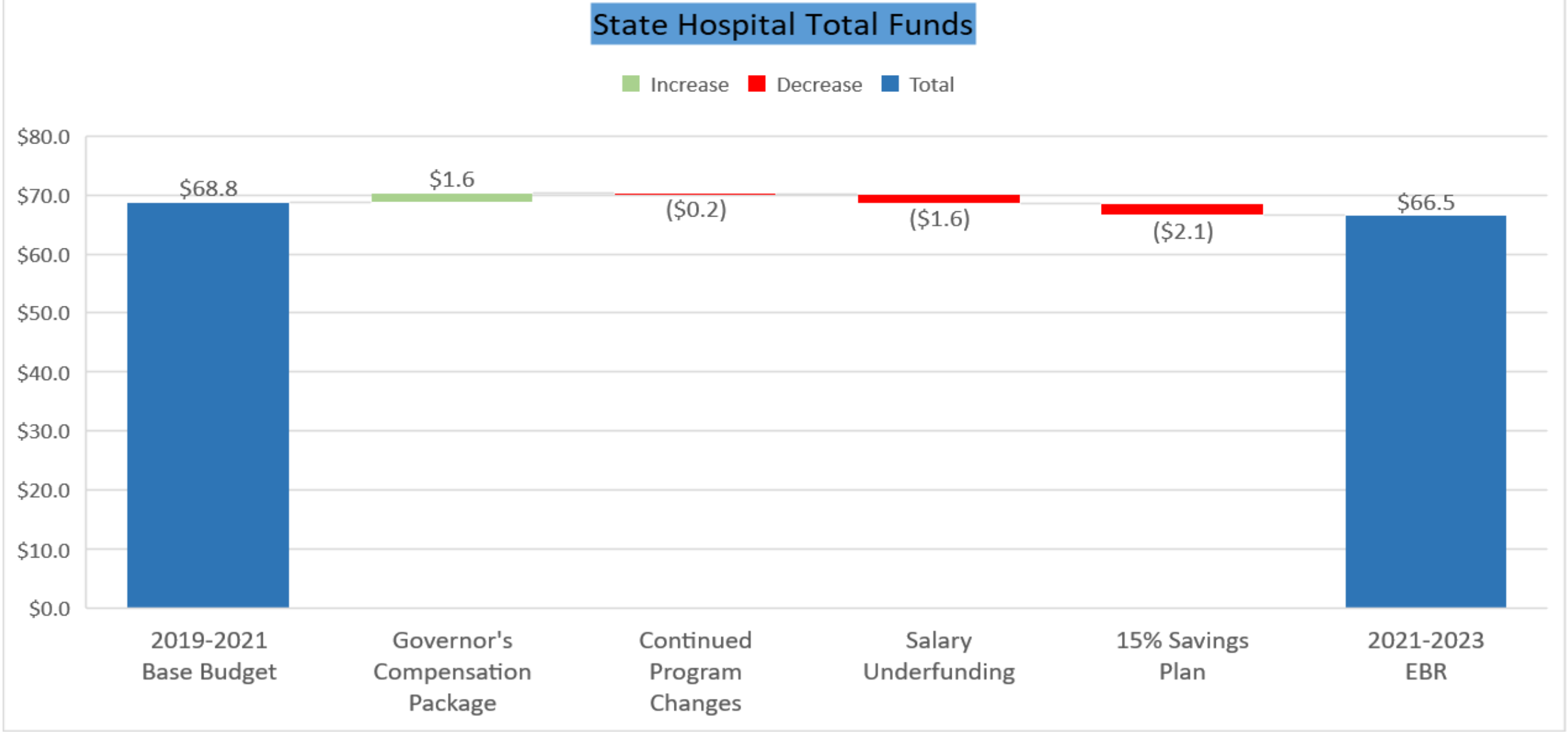



BUDGET OVERVIEW
NORTH DAKOTA STATE HOSPITAL
NORTH
Dakota
Be Legendary.™

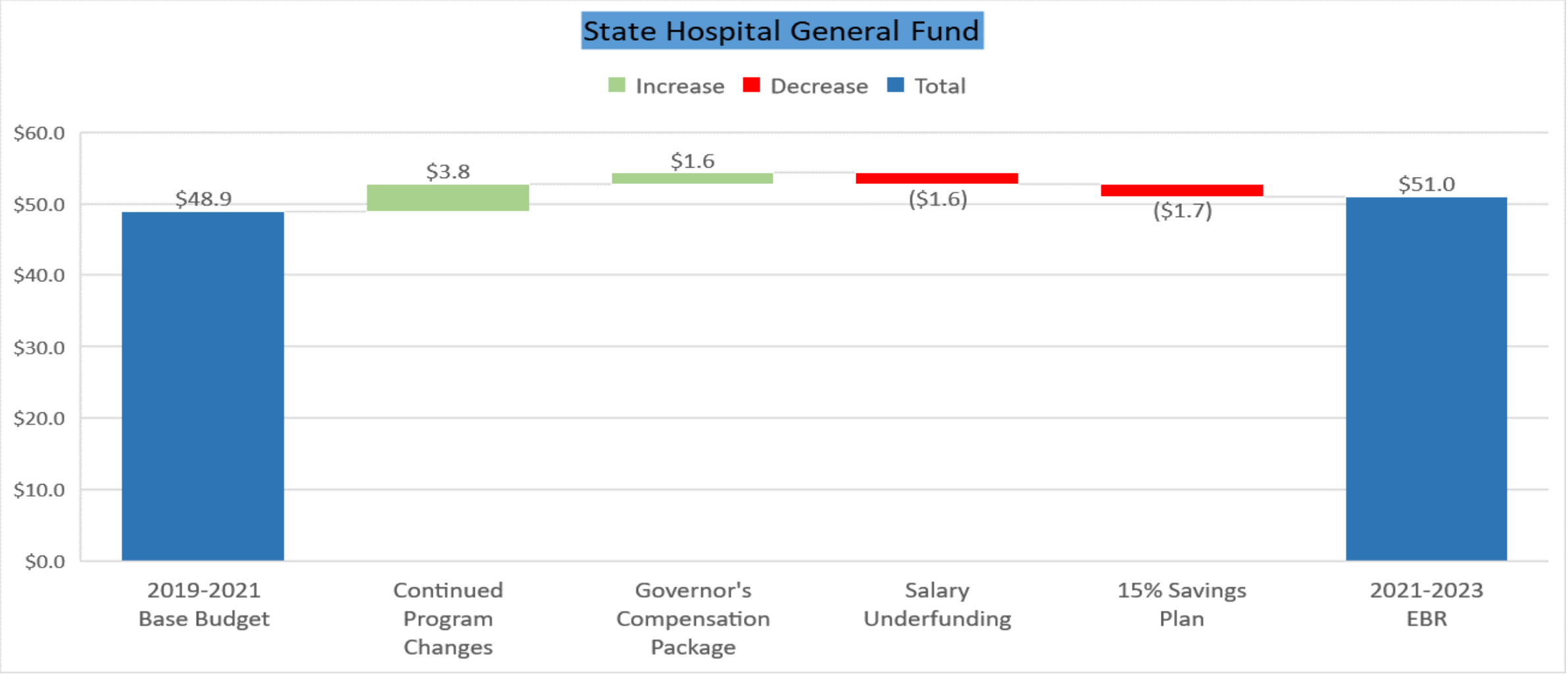
OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries	55,100,672	(1,170,825)	53,929,847
Operating	12,367,468	(1,195,691)	11,171,777
Capital	1,333,349	19,950	1,353,299
Total	68,801,489	(2,346,566)	66,454,923
General Fund	48,936,041	2,094,398	51,030,439
Federal Funds	1,759,125	(543,618)	1,215,507
Other Funds	18,106,323	(3,897,346)	14,208,977
Total	68,801,489	(2,346,566)	66,454,923
Full Time Equivalent (FTE)	330.62	(20.10)	310.52

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



OVERVIEW OF GENERAL FUND CHANGES (IN MILLIONS)

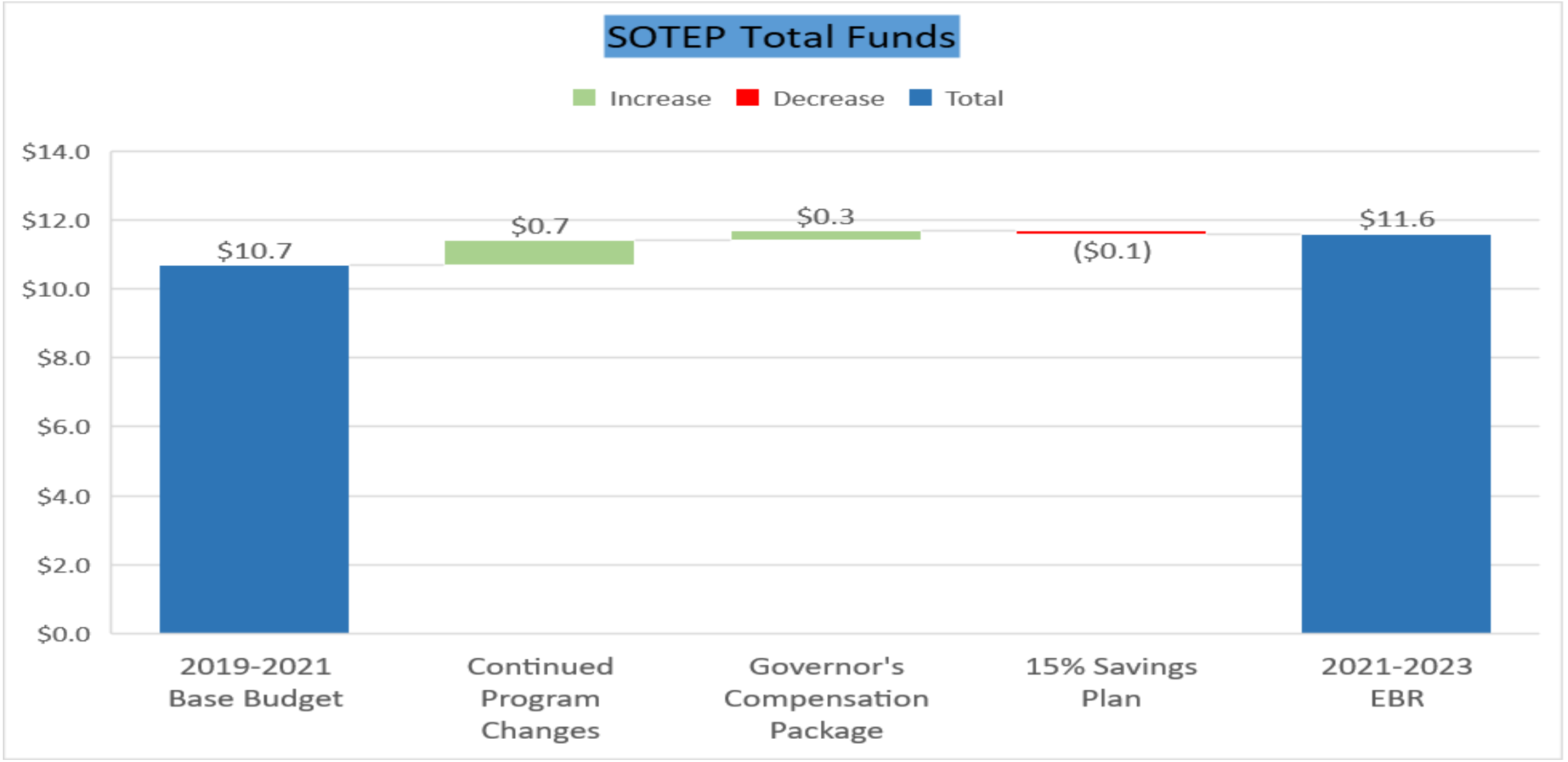



BUDGET OVERVIEW
SEX OFFENDER TREATMENT AND EVALUATION PROGRAM
NORTH
Dakota
Be Legendary.™

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries	9,501,071	547,157	10,048,228
Operating	1,266,291	302,894	1,569,185
Capital	19,950	(19,950)	0
Total	10,787,312	830,101	11,617,413
General Fund	10,787,312	830,101	11,617,413
Federal Funds	0	0	0
Other Funds	0	0	0
Total	10,787,312	830,101	11,617,413
Full Time Equivalent (FTE)	68.5	0	68.5

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



Contact information

Rosalie Etherington
Chief Clinics Officer/NDSH Superintendent
E-mail: retherington@nd.gov

Jeff Stenseth
Chief Operating Officer/SEHSC Director
E-mail: jstenseth@nd.gov

FIELD SERVICES DIVISION

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/13/2021 am
House Appropriations – Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 8:31 a.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Council of Developmental Disabilities
- Improving Programs and Policies
- The people that have been reached
- The organizations that are involved
- Budget changes

Julie Horntvedt, ND Council on Developmental Disabilities (8:33 am) testified about the ND State Council on Developmental Disabilities #1105

Sue Foerster, Superintendent, Life Skills Transition Center (8:57 am) testified about the Life Skills Transition Center #1106

Nancy Nikolas Maier, Aging and Adult Services (10:26 am) testified about the Aging and Adult Services #1108

Chair Nelson closed the meeting at 11:29 a.m.

Cole Fleck, Committee Clerk



House Bill 1012 #1105

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTH Dakota | Human Services

Be Legendary.™

ND State Council on Developmental Disabilities

ND STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Purpose / Mission

The Council advocates for policy changes that promote choice, independence, productivity and inclusion for all North Dakotans with developmental disabilities. The Council provides funding for and supports projects and activities that maximize opportunities in these areas for consumers and families.

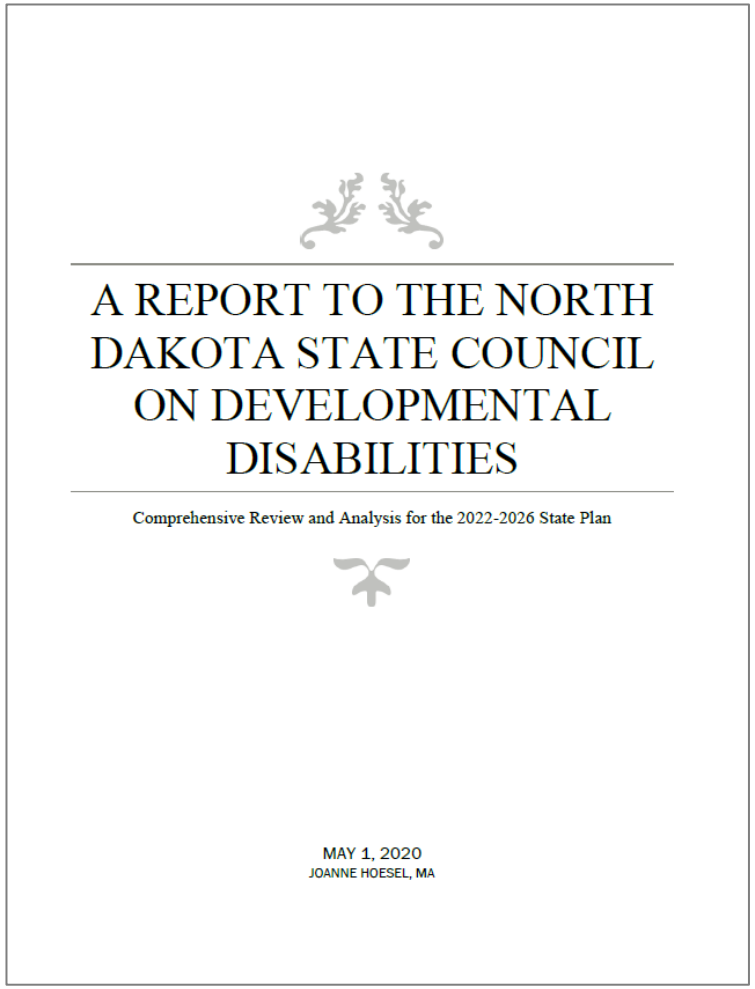


ND STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Key Findings: 2022-26 State Plan Comprehensive Review and Analysis

The following recommendations are offered as a roadmap for system improvement and present a range of possible options for consideration.

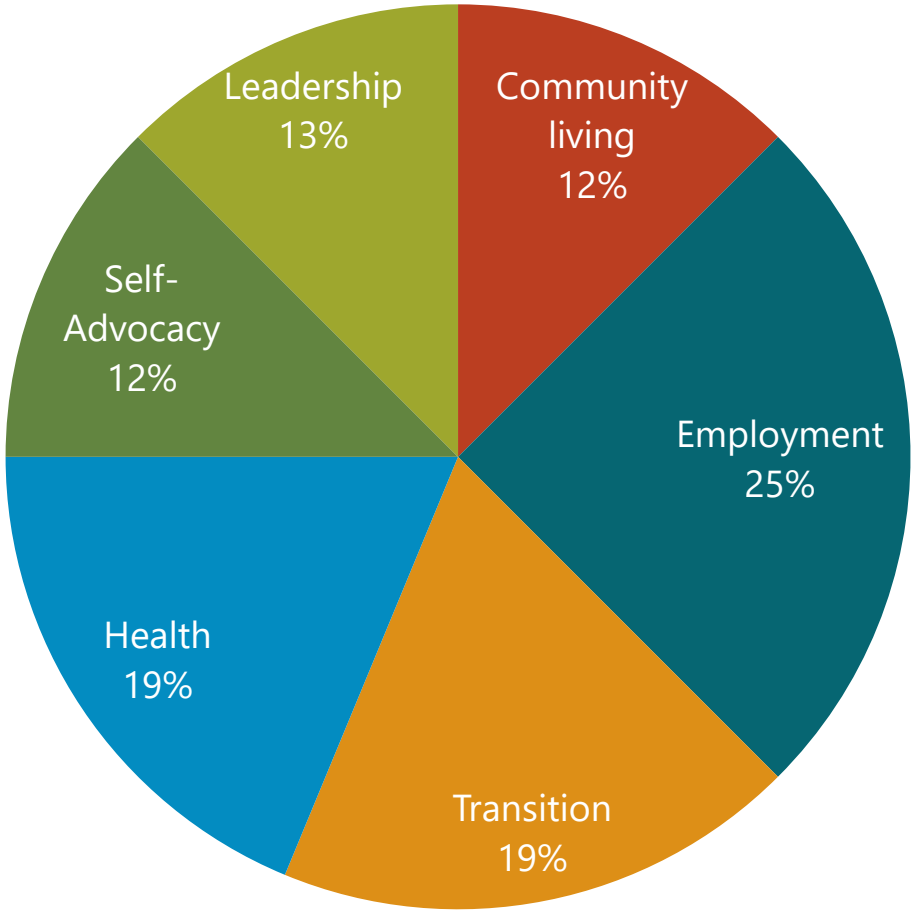
1. Fetal Alcohol Syndrome
2. Immunizations
3. Telehealth for IDD
4. Money Follows the Person
5. Culturally appropriate services
6. Infant Development services
7. Rental Assistance
8. Supported Decision-Making
9. Special Needs child care



DEVELOPMENTAL DISABILITIES COUNCIL

Our Work: Programs & Policies created or improved

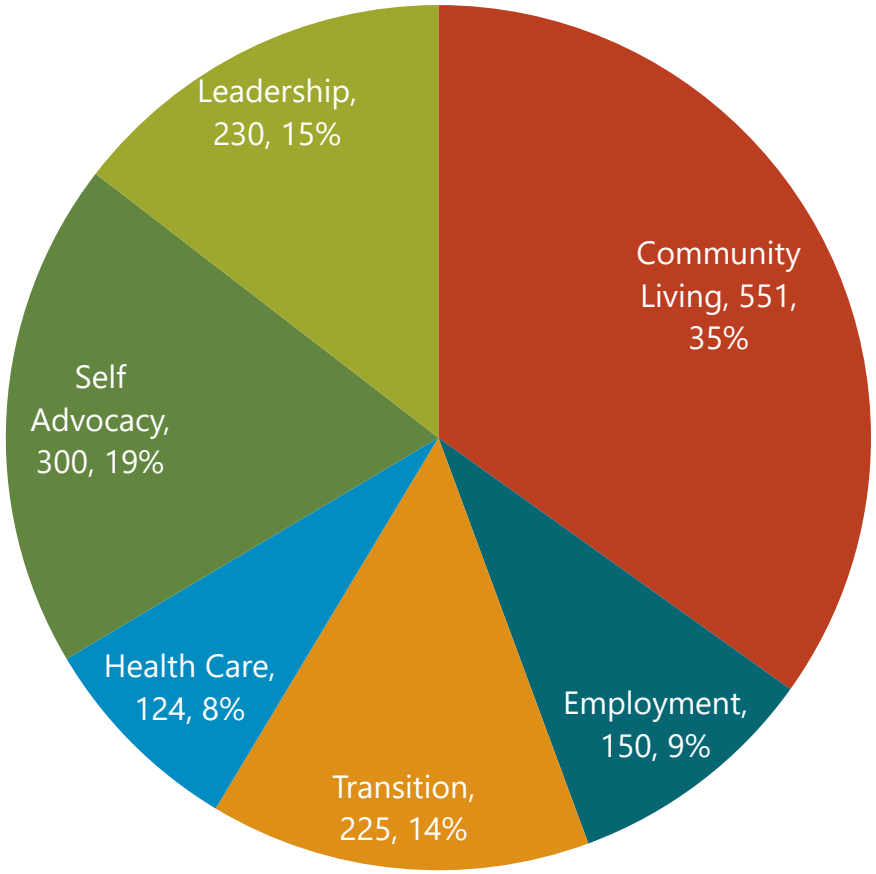
- SAFE-Self Advocates Feeling Empowered Training.
- Advocates Leading their Lives
- Disability Awareness Training for First Responders
- Power Up Health Conference
- Supported Employment for Transition Age Youth
  - Kalix
  - Community Living Services



DEVELOPMENTAL DISABILITIES COUNCIL

Our Work: General public reached as a result of Council initiatives

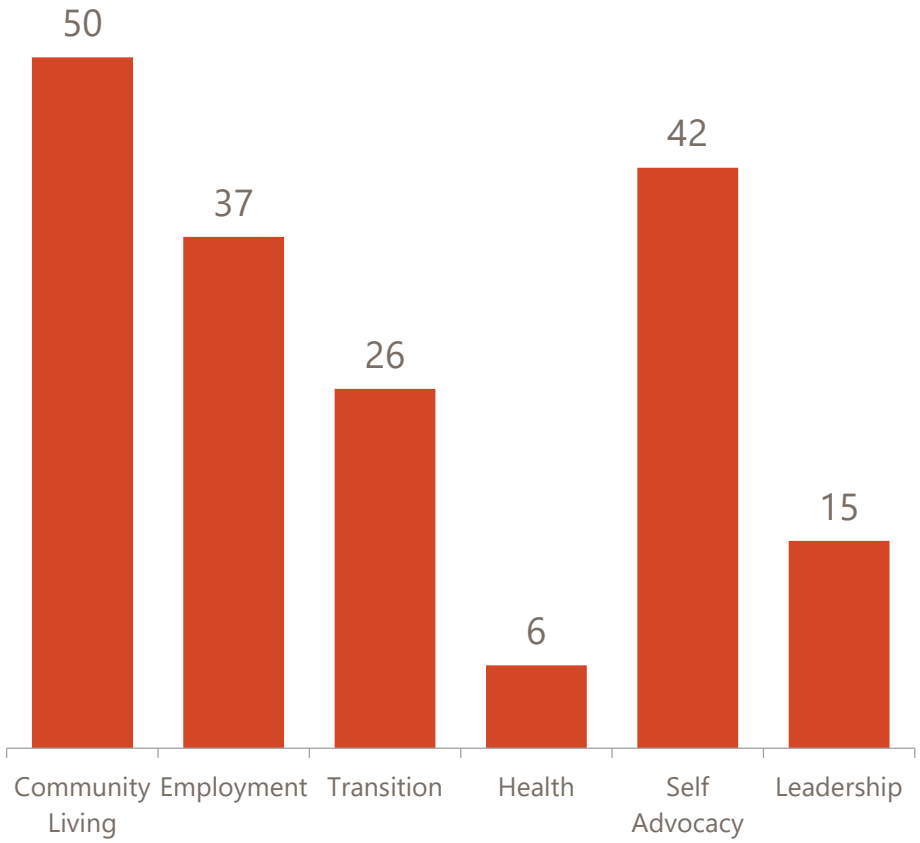
- Monthly zoom **stakeholder calls**, quarterly self-advocacy meetings, monthly self-advocacy board meetings.
- Granted funds to the North Dakota Association of Community Providers to **recruit/retain workforce** to developmental disabilities field
- Partnered on a project with **Money Follows the Person**
- Funded the **Supported Decision-Making** Project
- Hosted a 3-part virtual **Self Advocacy Conference**
- Hosted a one-day **Health Conference**
- Provided funding to 9 **families to attend** trainings/conferences. They share the information learned.
- Provided funding for **13 Small Innovative Projects** of $10,000 or less. Examples: adapted swimming at the YMCA, assistive technology to Bismarck State College for students with disabilities, funded the GROW garden project, updated DD modules, Provided funding for more work with transition age students on the reservation on Discovery, etc.
- Provided **21 Grants** to individuals, providers, and other entities for **COVID relief**. Grants to include; assistive technology, starting an online workout program, materials for activities, accessible gardening, communication tools, laptops, etc.



DEVELOPMENTAL DISABILITIES COUNCIL

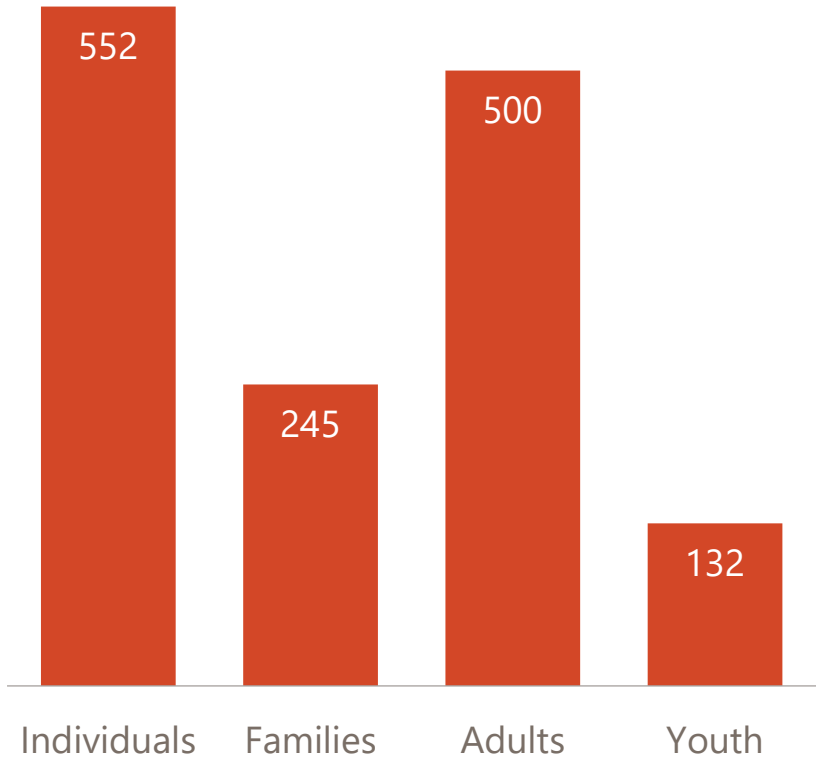
Organizations involved in Coalitions, Networks or Partnerships

- Member of the DPI Community of Practice Group
- Chairperson of the North Dakota Disability Advocacy Consortium
- Member of the Olmstead Commission
- Partner on projects, training, and advocacy with Protection and Advocacy and the North Dakota Center for Persons with Disabilities as required by our Federal funders
- Treasurer of the National Association of Councils on Developmental Disabilities

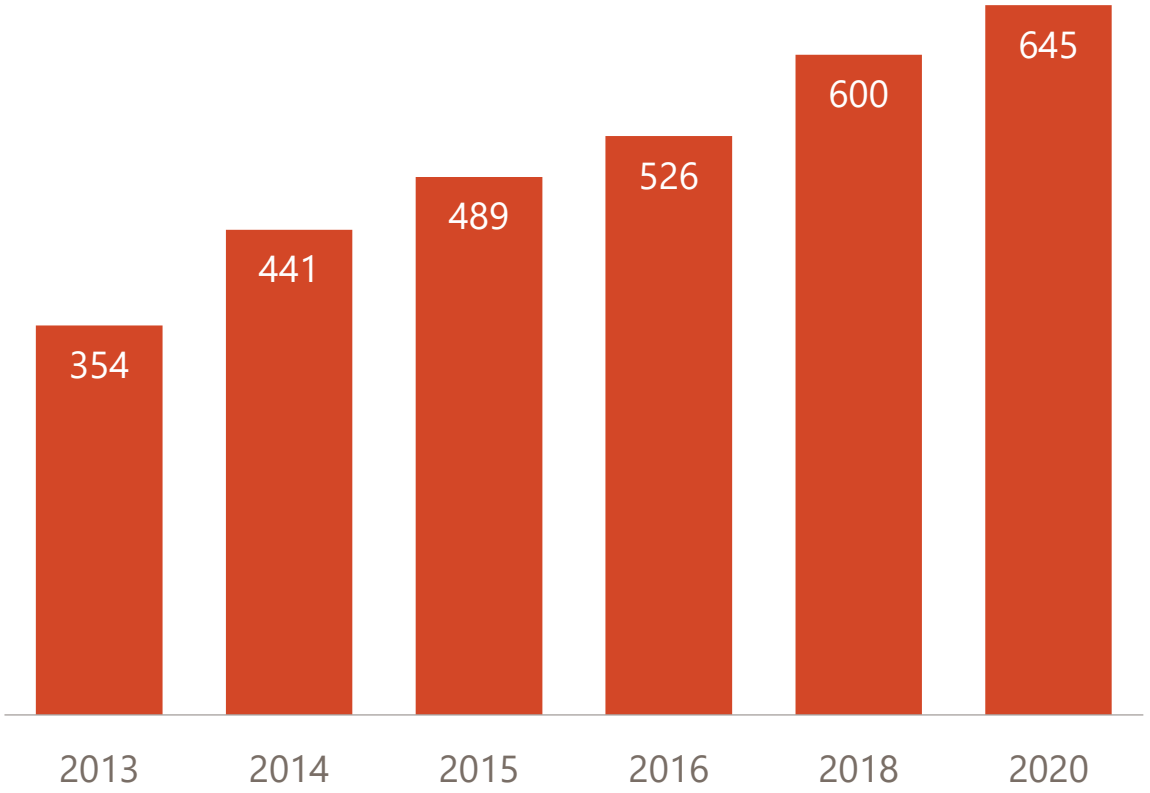


DEVELOPMENTAL DISABILITIES COUNCIL
Individuals Engaged in Training and Advocacy

People Trained Through 5-Year Plan Goals



People Active in System Advocacy



NDSCDD 21-23 Legislative Priorities

Diverse projects that improve opportunities for people with intellectual and developmental disabilities

Build capacities of individuals, families and communities, enabling each to become more self sufficient through the Developmental Disabilities Assistance and Bill of Rights Act



DEVELOPMENTAL DISABILITIES COUNCIL

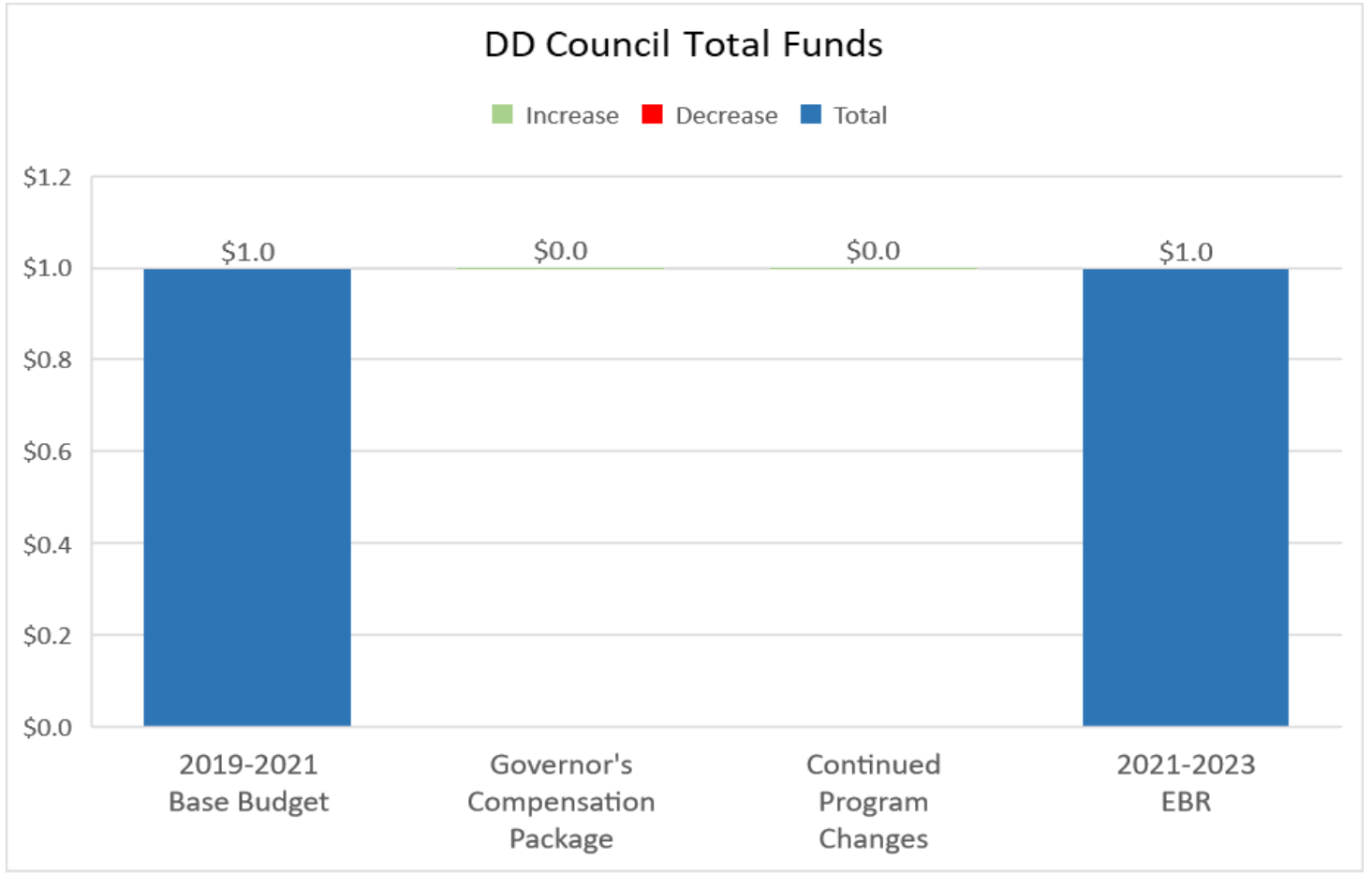
Budget Overview / Summary

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	307,854	(89,492)	218,362
Operating	345,036	(103,092)	241,944
Grants	360,131	228,041	588,172
Total	1,013,021	35,457	1,048,478
General Fund			
Federal Funds	1,013,021	35,457	1,048,478
Other Funds			
Total	1,013,021	35,457	1,048,478
Full Time Equivalent (FTE)	1.0	0	1.0

DEVELOPMENTAL DISABILITIES COUNCIL
Total Budget Changes (100% federal)

Continued Program Costs

- Wage Decrease $93,000
- Operational Changes $103,0000
  - Increases
    - Grants
  - Decreases:
    - Travel
    - Office Space





House Bill 1012 #1106

House Appropriations Human Resource Division

Representative Jon Nelson, Chairman

Life Skills and Transition Center

Providing supports and services so people can move back to homes of their choice.

NORTH Dakota | Human Services

Be Legendary.™

LIFE SKILLS TRANSITION CENTER
What we do

Traditional (ICF/IID) Services

- Residential Services
- Vocational Services

Home and Community-Based Waiver Services

- Residential Habilitation Services
- Vocational Habilitation Services
  - Day Habilitation
  - Pre-vocational Services
  - Small Group Employment
  - Individual Employment

Statewide Crisis and Support Services

- Applied Behavioral Analysts
- CARES Crisis Coordinators
- CARES Services
- Transition to the Community Supports

LSTC Residential Crisis Units

- Adult Crisis Beds
- Youth Crisis Beds

LIFE SKILLS TRANSITION CENTER
Accreditation

Dec. 2019 - LSTC achieved accreditation by Council on Quality Leadership (CQL) for **Person-centered excellence**

From the report:

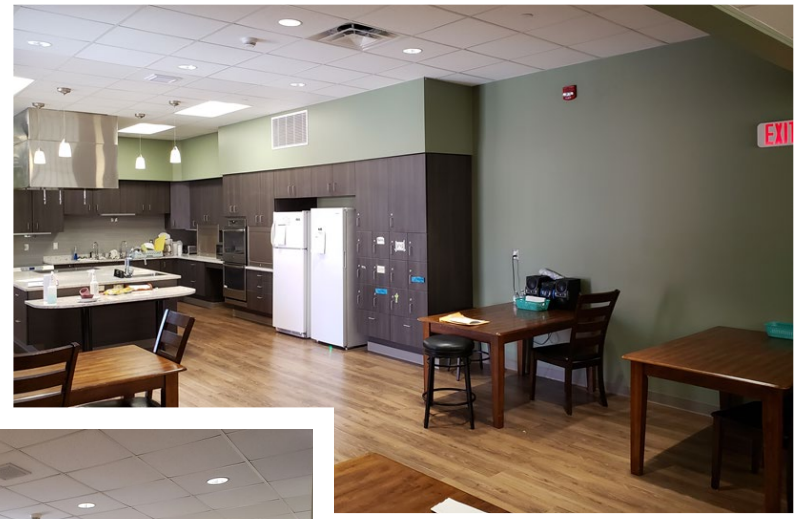
"LSTC recognizes its value as a safety net … aims to arm people with supports and resources, they need to be supported in a less restrictive environment."



LIFE SKILLS TRANSITION CENTER
Our space

Reduced footprint
The LSTC is in the process of consolidating residences and services to become more efficient in resource utilization and delivery of services.











LIFE SKILLS TRANSITION CENTER
Our space

Other Capital Projects

- Window replacement (April 2021)
- Transfer switch replacement (March 2020)
- Roofing (Aug. 2020 and Nov. 2021)
- Demolition (Oct. 2020) (at right)

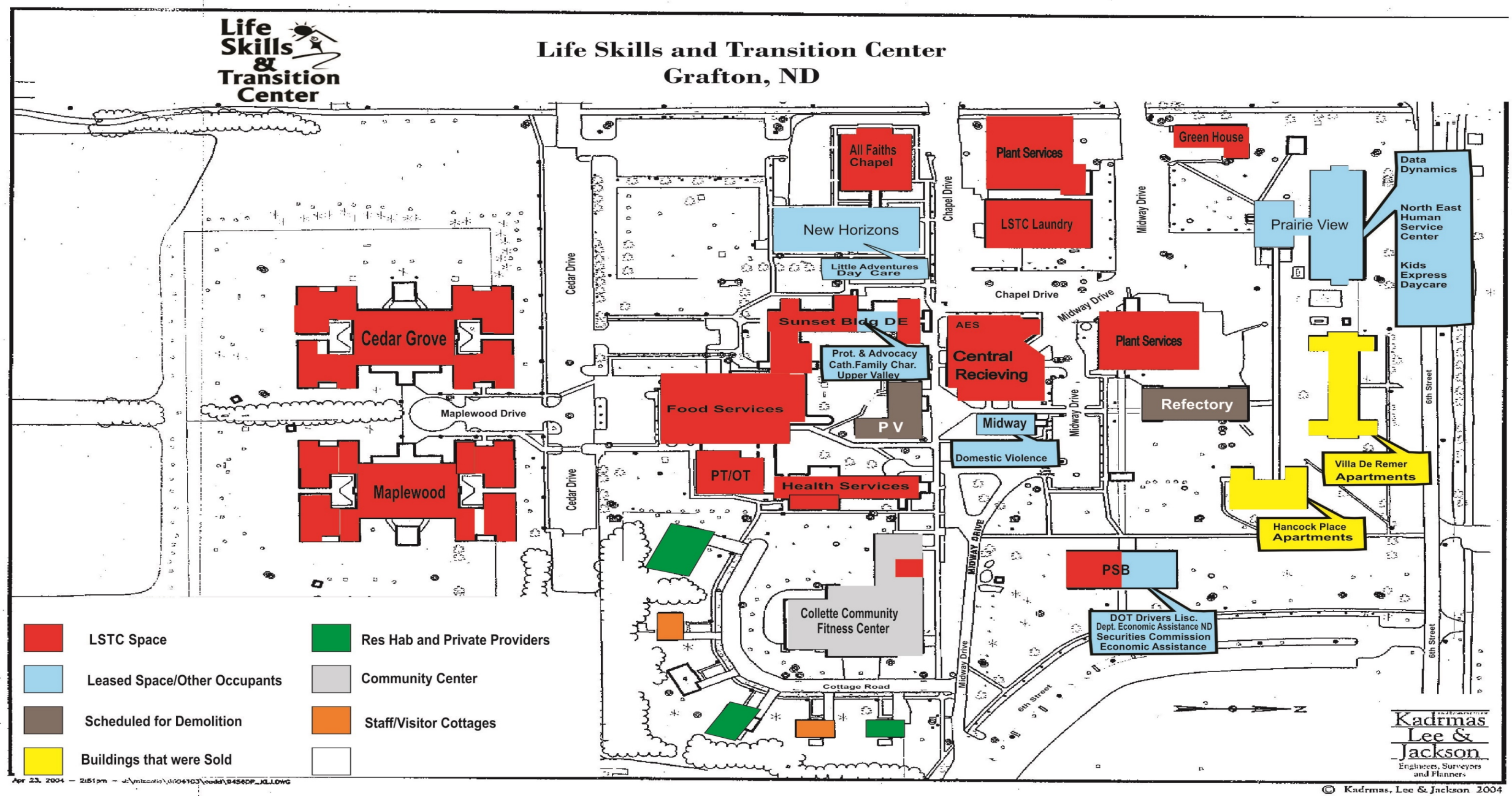








Life Skills and Transition Center
Grafton, ND



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© Kadrmas, Lee & Jackson 2004

LIFE SKILLS TRANSITION CENTER
Census and Admission Trends

	Adult	Youth
2018 – June 30	53	15
2019 – June 30	52	20
2020 – Dec 31	46	19

	Adult		Youth	
	Adm	Dis	Adm	Dis
2019	7	2	5	3
2020	5	5	11	7

Reasons for Admission to LSTC

- Physical aggression within the family home or residential setting (towards family, employees, or other vulnerable people that they live with)
- Significant property destruction
- Self-abuse
- Other unsafe behaviors

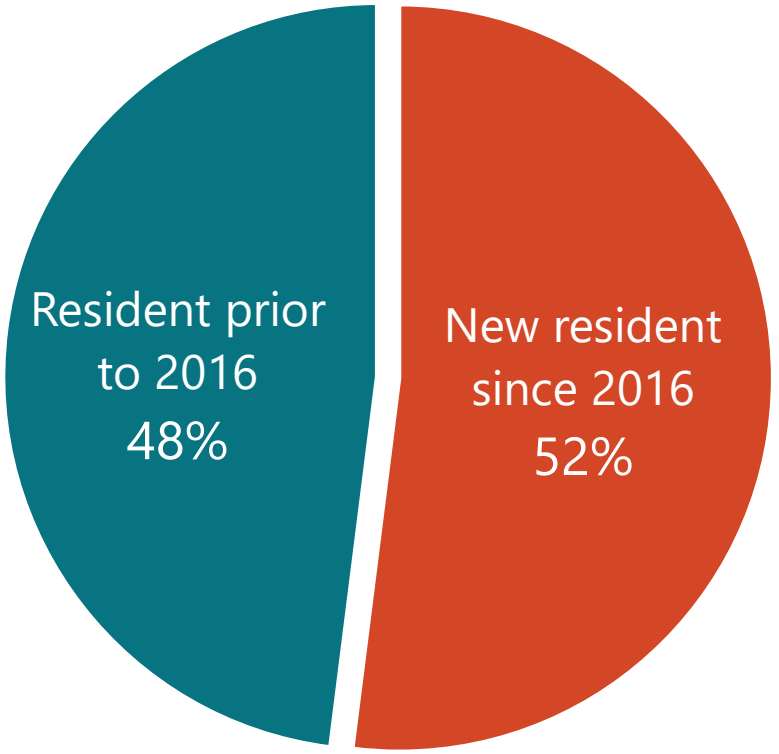


Increase in admissions with higher cognitive abilities (13 of 15 with mild/moderate IDD)

LIFE SKILLS TRANSITION CENTER
Residential Turnover

Transition Planning begins upon admission to LSTC

Care Team works together to identify long-term solutions for individual that reflect their choice and their needs





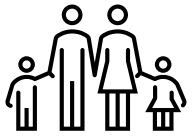
DHS Invests in People

Human services is the infrastructure of well being.

Human services can help people realize their full potential.

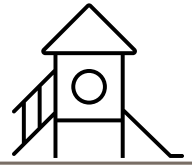
Our communities are stronger when all people can realize their full potential.

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



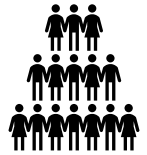
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health



Services Closer to Home

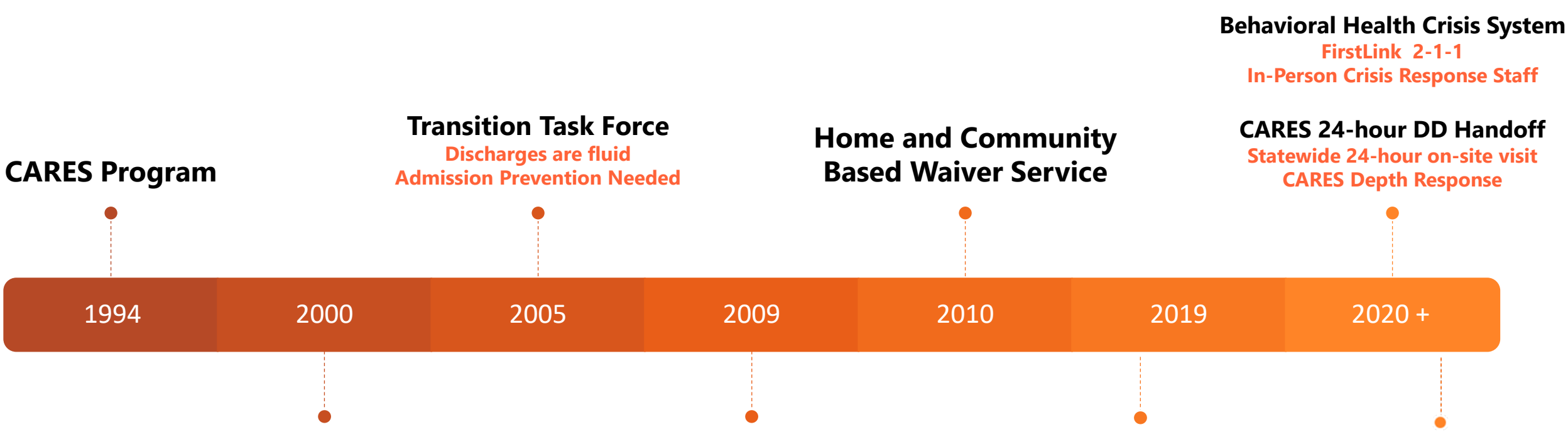
- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

DHS Key Priority

BIG Idea

Accelerate our efforts to transition adults and youth to smaller community settings.

TRANSFORMATION OF LSTC SERVICES



Transition

The result of a range of supportive activities that, together, help ***prepare*** an individual currently who currently lives in an institutional setting to return to living in their community, if that is their choice.

Rehabilitation
Financial Planning
Options Counseling
Care Provider(s) Recruitment

Housing Assistance
Natural Support Coordination
Home Modifications
Family Engagement

LSTC STATEWIDE CRISIS SERVICES

DD Behavioral Health Services

- Applied Behavior Analysts located statewide with human service center regions

Statewide Crisis Supports

- Cares Crisis Coordinators
- CARES
- CARES Clinic

Transition to the Community Supports

- LSTC Program Coordinators and Direct Support Professionals supporting moves to the community

2020 LSTC Statewide Crisis Services

Cares Application
Total: 19
Youth: 9
Adult: 10

Technical Assistance
Events: 62
People: 47

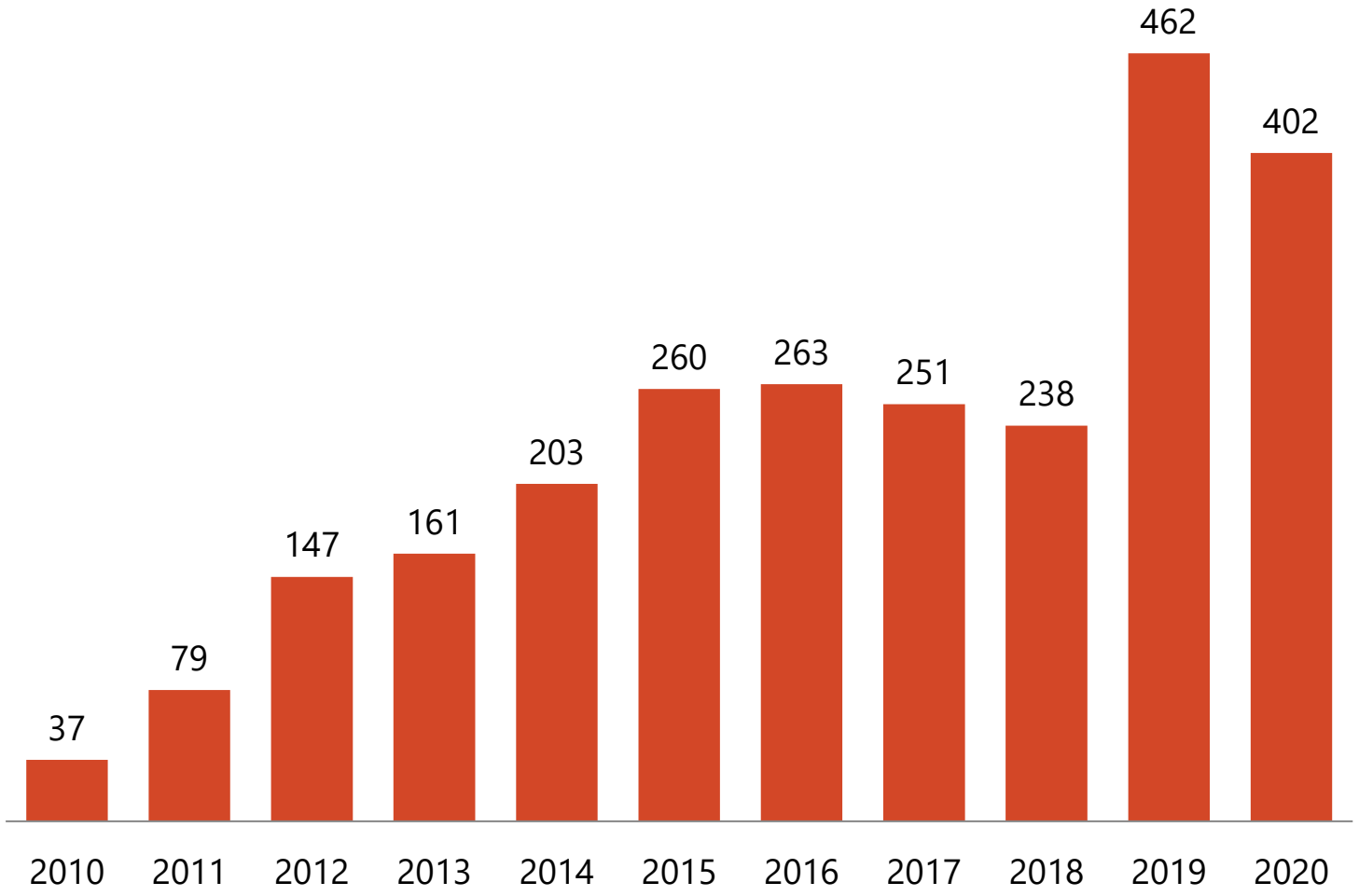
In-Home Crisis Service
Events: 24
People: 4
Service Hours: 230

Transition Supports
People: 21
Service Hours: 2,028

Crisis Admissions
Events: 6
People: 6

In Home Observations
Events: 18
People: 7
Service Hours: 138

DD Behavioral Health Services



Caseload 2020: 402

- Regions: All 8
- Providers: Over 20
- Communities: Over 30

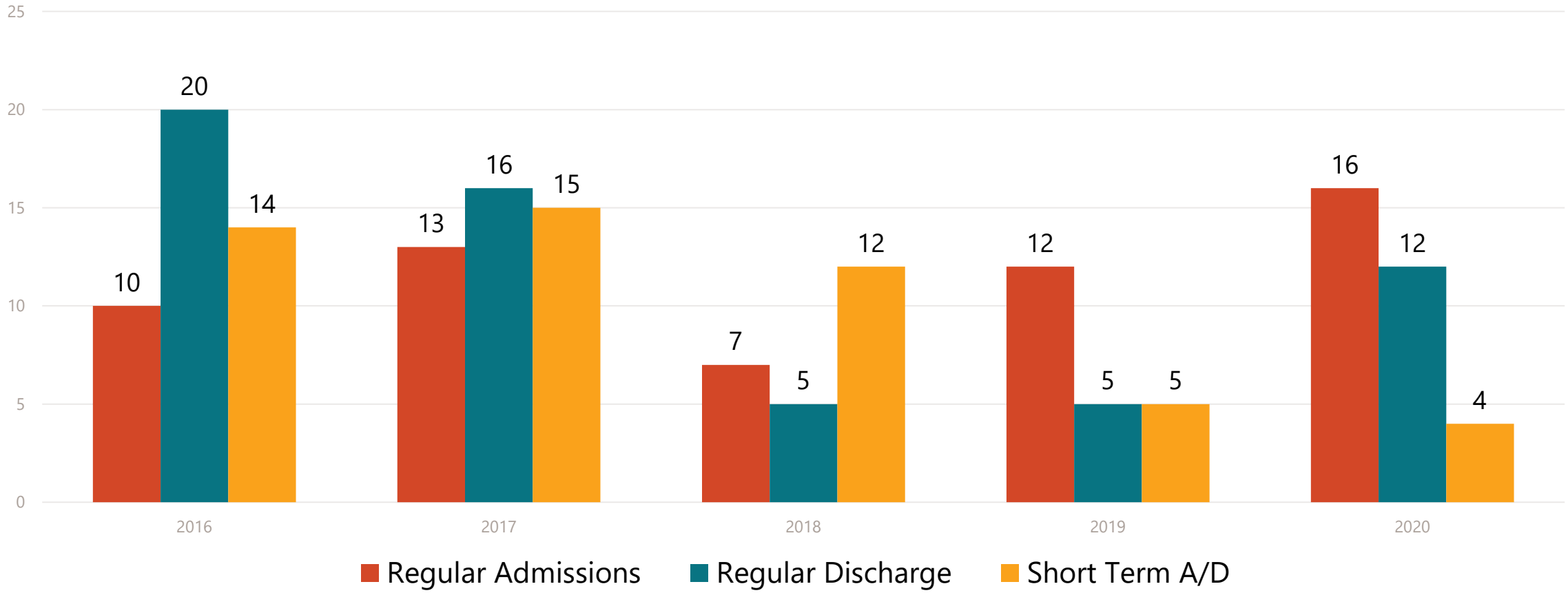
Applied Behavior Analysts:

- Positions: 10 (9 + 2x0.5)
- Filled: 9 of 11 slots
- Credentials as of 12/20:
  - 7 Licensed/Registered
  - Training: 2 of 9 slots

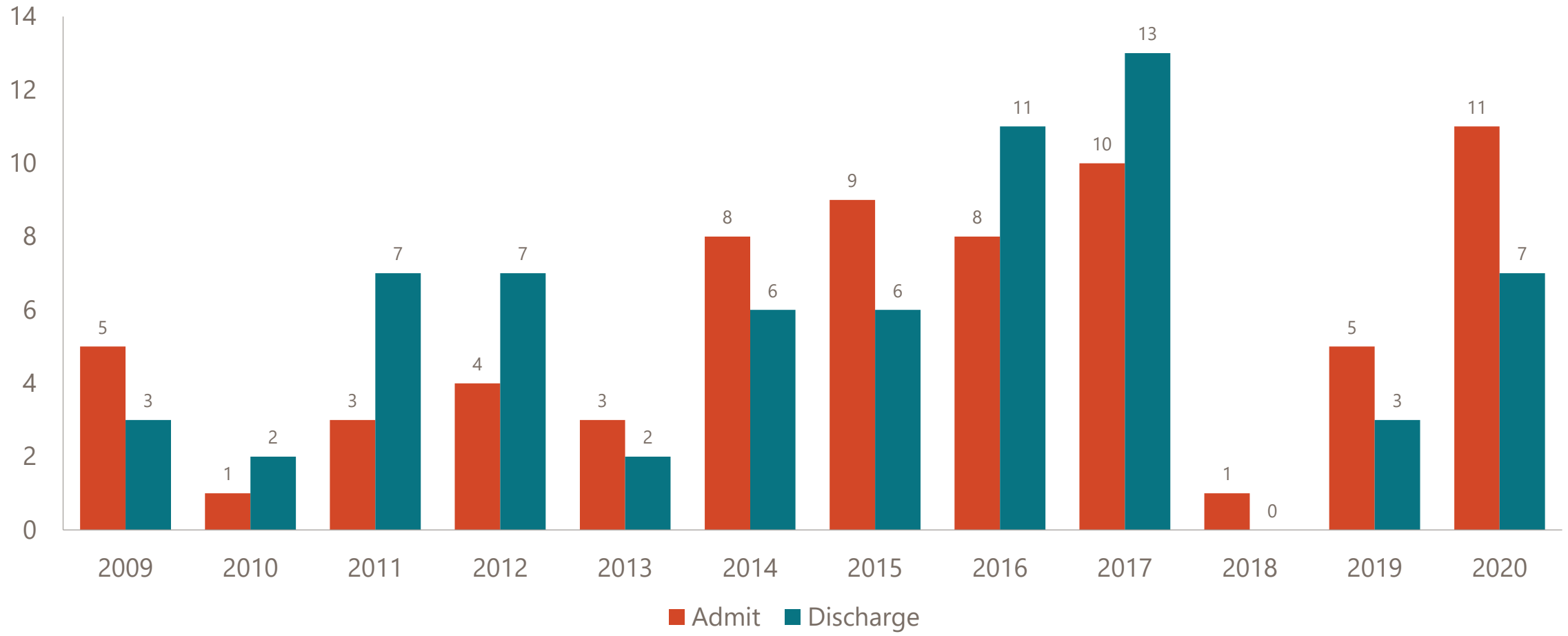
Barriers:

- 2-year recruiting per slot
- Training young ABA's
- COVID-19 impact

LIFE SKILLS TRANSITION CENTER
Admission and Discharge Trends

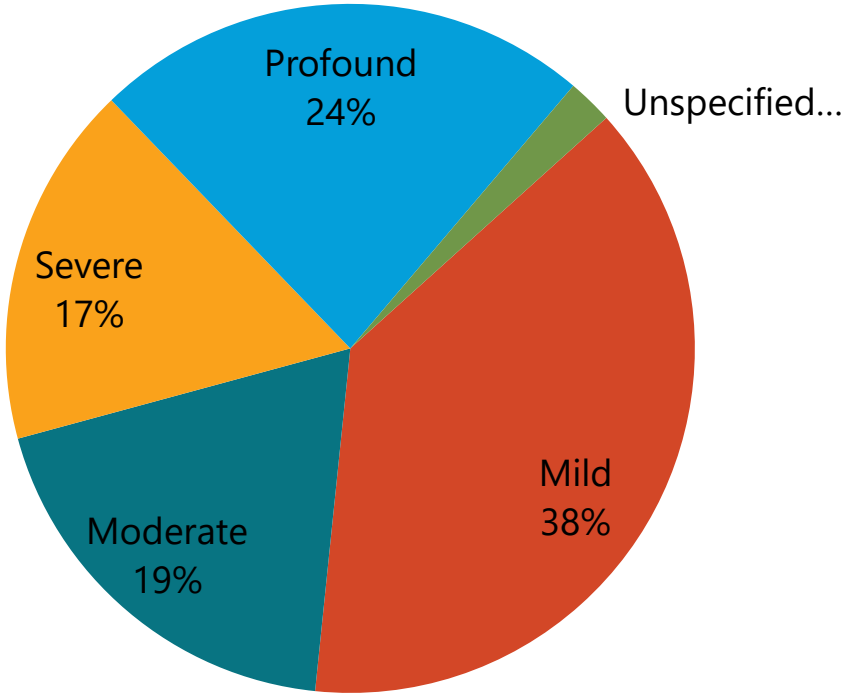


LIFE SKILLS TRANSITION CENTER
Youth Admission and Discharge Trends

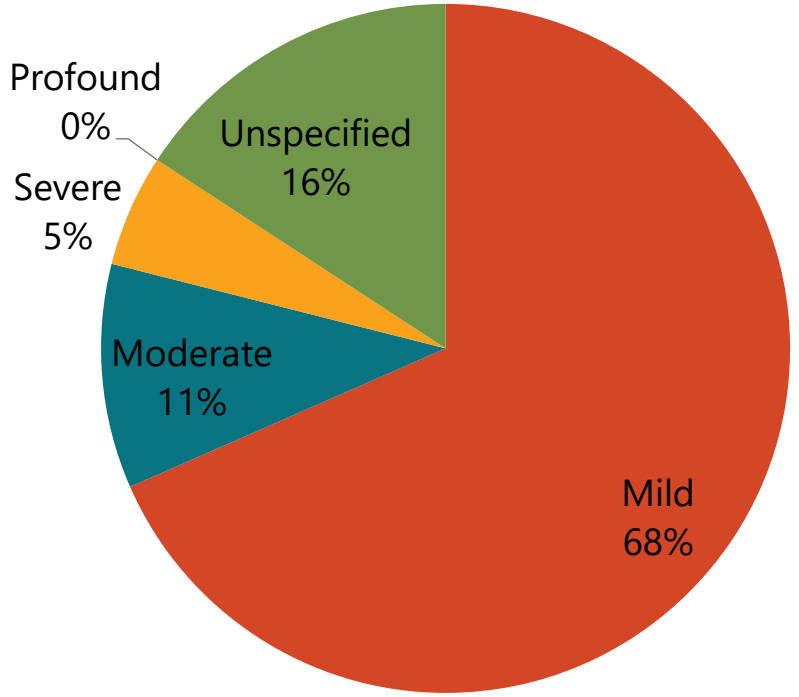


LIFE SKILLS TRANSITION CENTER
Disability Level – Adult and Youth

2020 LSTC **Adult** by
Level of Intellectual and Dev. Disability



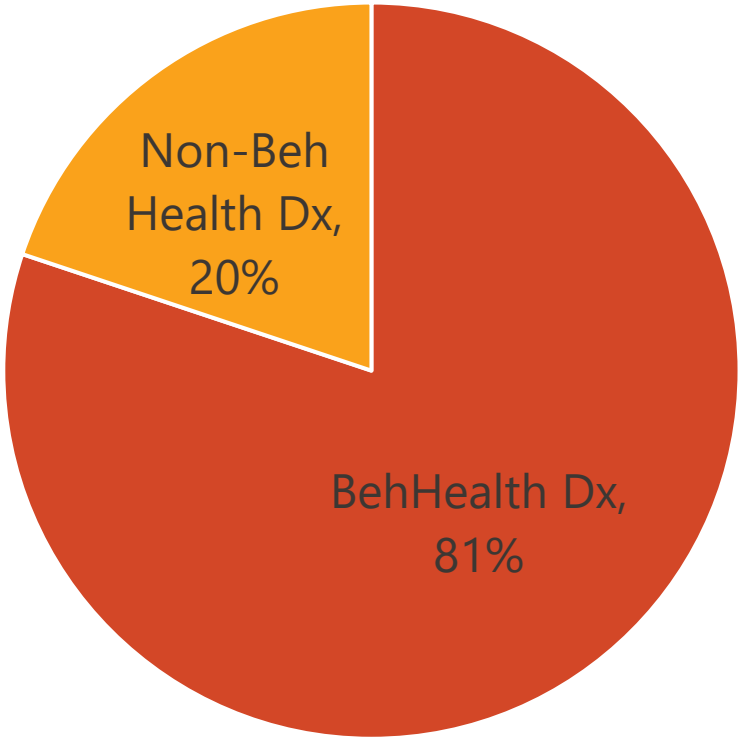
2020 LSTC **Youth** by
Level of Intellectual & Dev. Disability



LIFE SKILLS TRANSITION CENTER
Youth - presence of behavioral health diagnosis

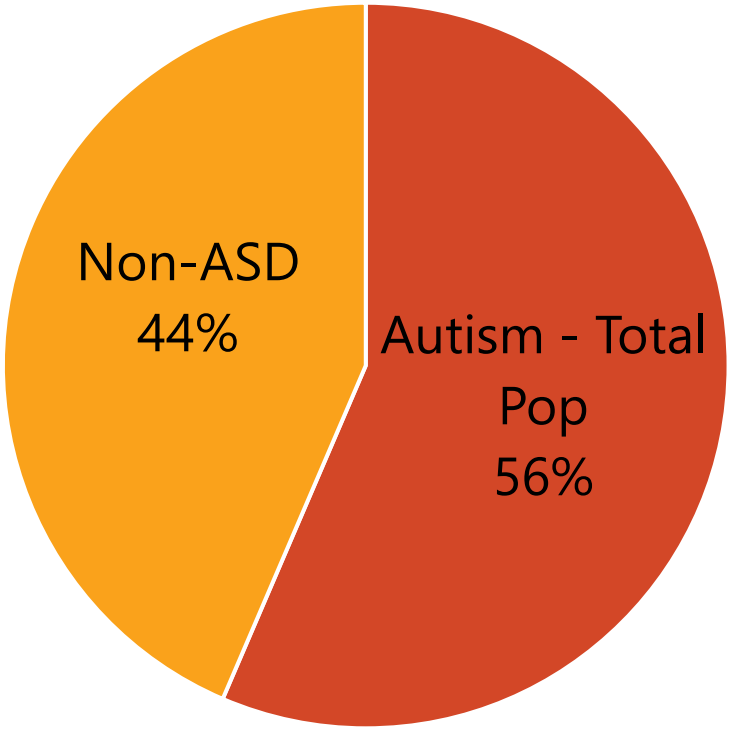
YOUTH AT LSTC

0%	**Profound intellectual disability**
5%	**Severe intellectual disability**
11%	Moderate intellectual disability
68%	Mild intellectual disability
16%	Unspecified intellectual disability
58%	**Autism Spectrum diagnosis**
81%	**Behavioral health diagnosis**

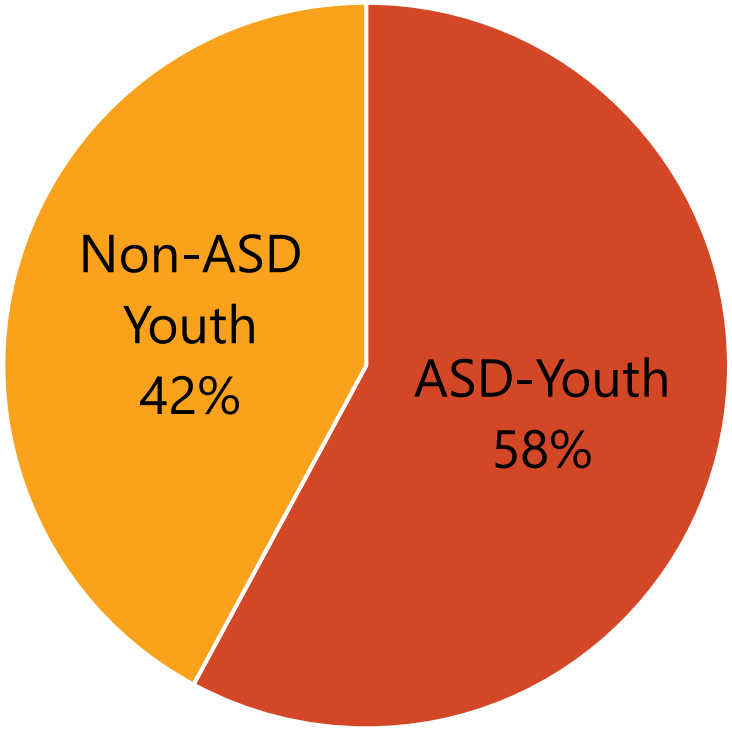


LIFE SKILLS TRANSITION CENTER
Prevalence of Autism Spectrum Diagnoses (ASD)

Proportion of Total ICF Population 2020



Proportion of Youth Population 2020





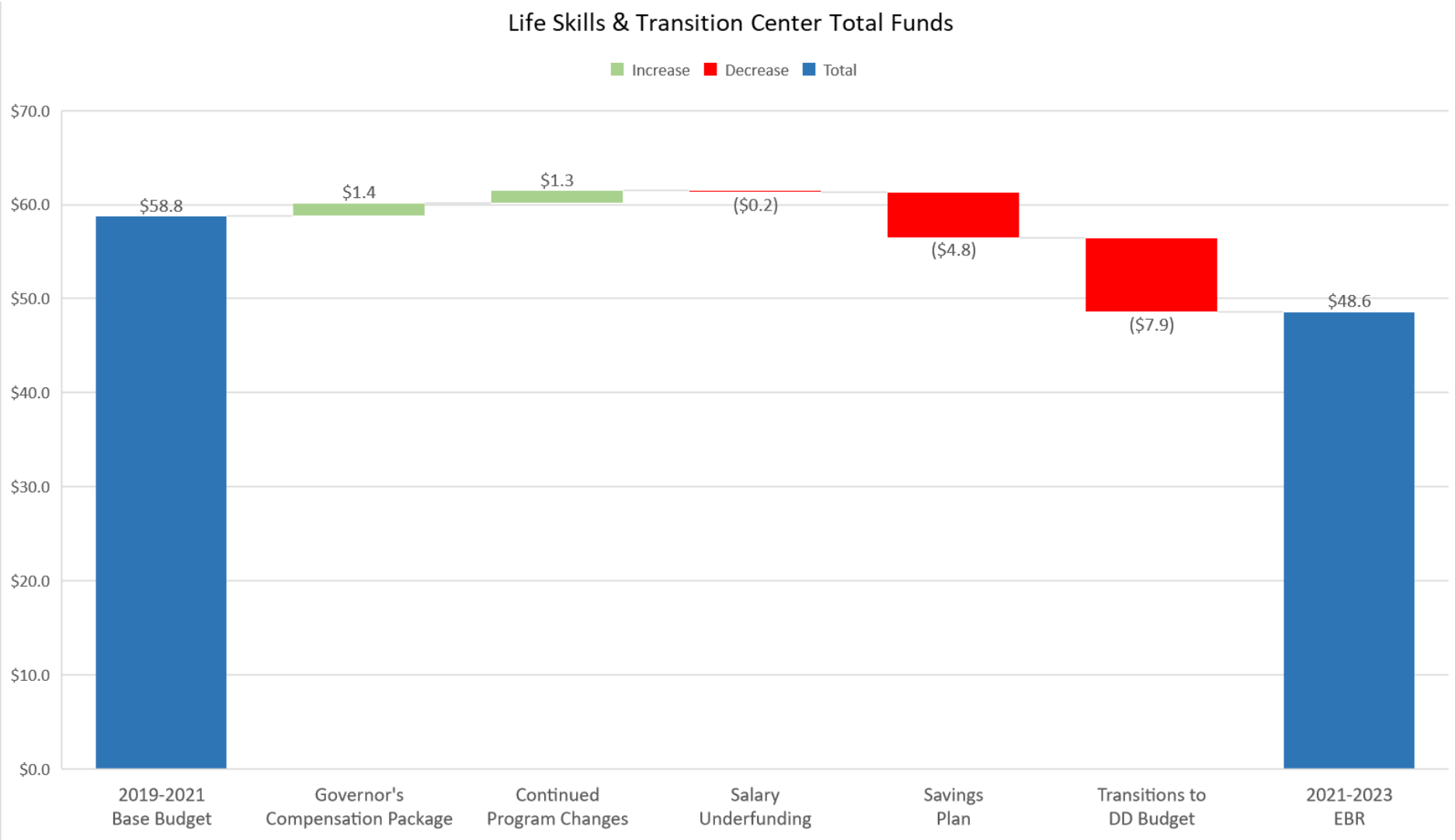
COVID PANDEMIC IMPACT

- COVID Response Administrative Team
- Tier 1 and Tier 2 employee screening
- Ongoing training: People living at LSTC and employees
- Personal Protective Equipment
- COVID Ready Unit and other safety measures
- Surveillance testing
- Phases of operation corresponding with prevalence in state and county

Overview Of Budget Changes (In Millions)

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	48,807,542	(8,851,333)	39,956,209
Operating	9,141,275	(1,324,010)	7,817,265
Capital	846,131	0	846,131
Total	58,794,948	(10,175,343)	48,619,605
General Fund	29,426,161	(7,777,688)	21,648,473
Federal Funds	26,880,105	(2,430,575)	24,449,530
Other Funds	2,488,682	32,920	2,521,602
Total	58,794,948	(10,175,343)	48,619,605
Full Time Equivalent (FTE)	322.84	(14.50)	308.34

Overview Of Total Budget Changes (In Millions)



15% Savings Plan

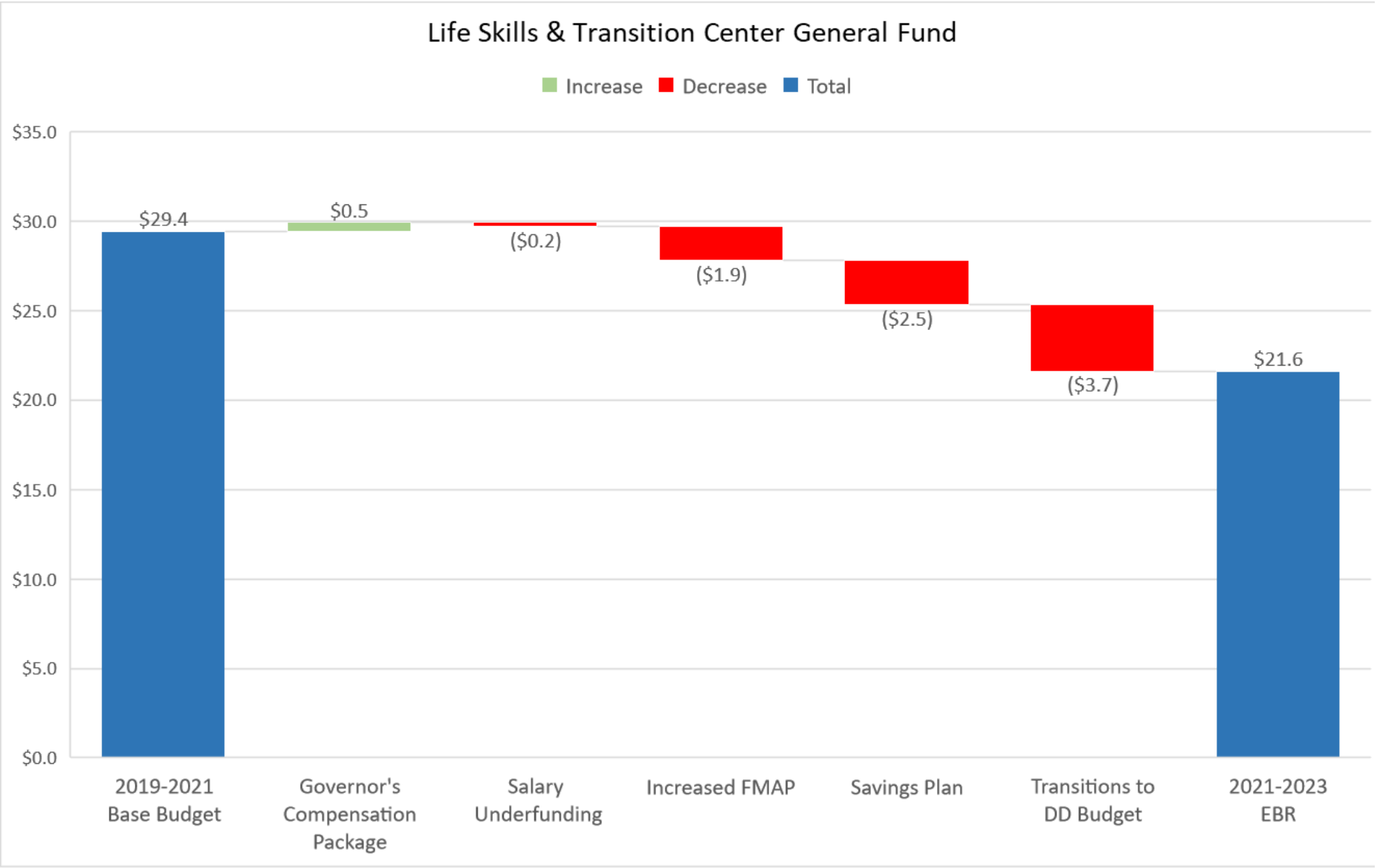
- LSTC Savings
  - Operational ($0.2) million
  - FTE ($1.4) million
- Net Savings ($3.2) million

Transitions to DD ($7.9) million

- Budget incrementally as people move to the community

The Net Savings DHS will realize from the 15% Savings Plan and Transition to DD Budget will be $3.2 million.

Overview Of General Fund Changes (In Millions)



15% Savings Plan

- LSTC Savings
  - Operational ($0.2) million
  - FTE ($0.8) million
- Net Savings ($1.5) million

Transitions to DD ($3.7) million

- Budget incrementally as people move to the community

The Net Savings DHS will realize from the 15% Savings Plan and Transition to DD Budget will be $3.3 million.

OTHER BUDGET IMPACTS

Permission to convey a portion of 2 parcels of land commonly referred to “the bowl” to the Grafton Park Board

Payment of special Assessments



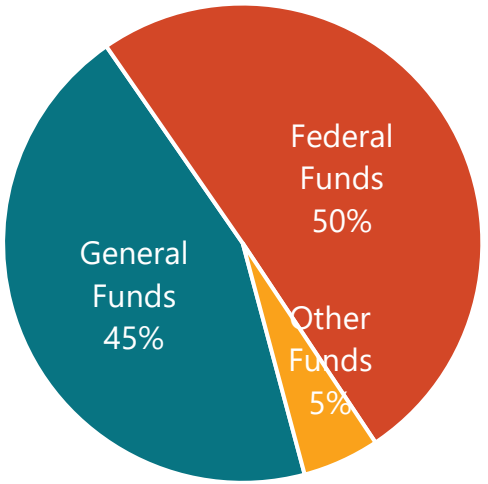
LSTC Budget Summary

19-21 Budget	**$58,794,948**
21-23 Budget (exec)	**$48,619,605**

Reduction of 14.5 FTEs; $10,175,343 budget reduction (50% in federal funds)

- Reduce census by 26 (16 youth, 10 adults) via both transitions and diversions
- Shift operations to re-orient toward crisis and stabilization service
- Reduce general fund contribution to adaptive equipment service, seeking alternate revenue sources

NOTE: Interconnection between LSTC, CFS, and DD budgets as service models shift



Keys to successful acceleration of transition to community

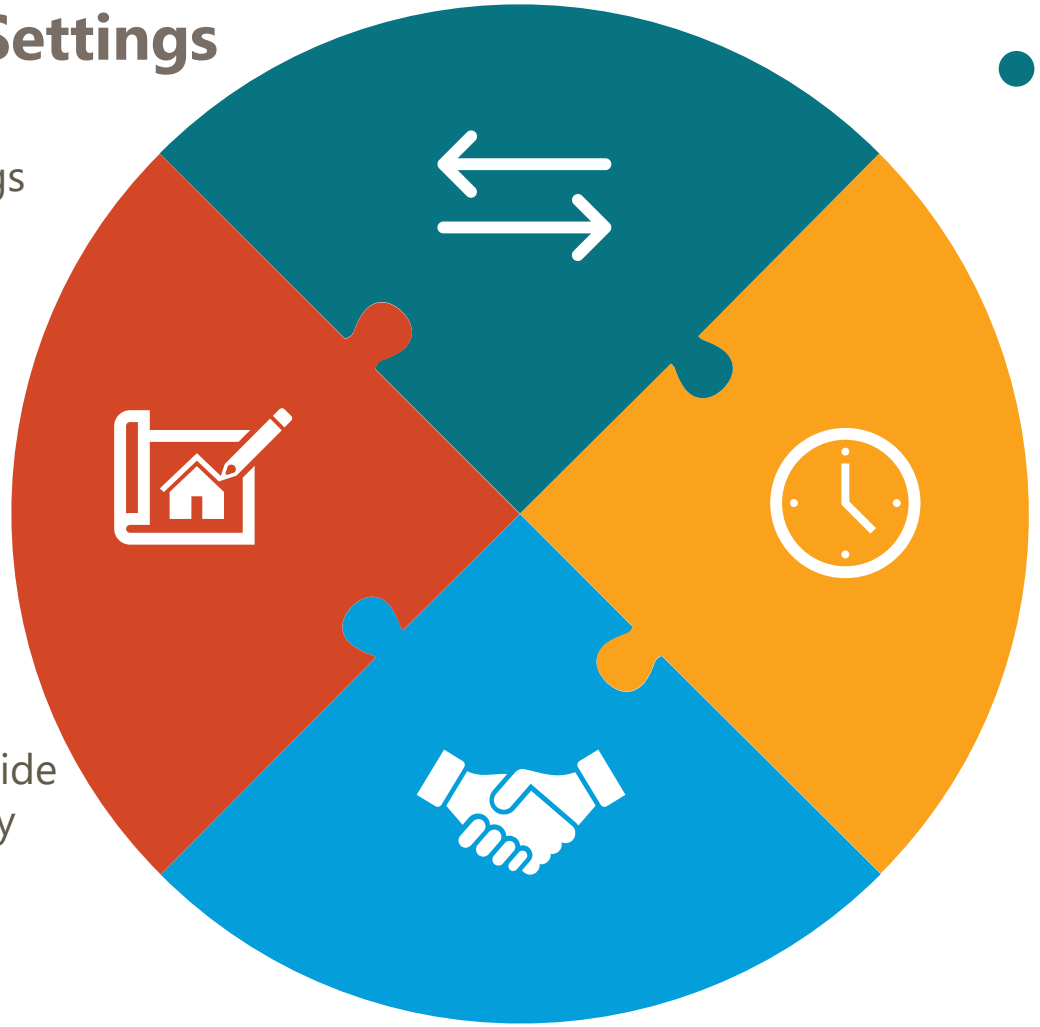
Marshalling our resources to support a person's ability to make an informed choice about the most integrated setting that is right for them

New Community Settings

Create new small scale specialized residential settings (behavioral focus) in 2-3 communities

Shared Understanding of LSTC Role

Re-establish LSTC as a setting that specializes in crisis and stabilization services



Community Crisis Support

Continue to build LSTC crisis support team capacity to provide on-site response to emergency crisis in various community settings within 24-hours

Crisis Stabilization

Build staffing model and operational processes to support admission to LSTC within 48-hour

LSTC Net Budget Savings Plan Requires Partnership

Collaboration between LSTC, DD, and Children Family Services as well as ND community providers.

Census reduction of 16 youth and 10 adults to homes in their community.

The transition of people will occur gradually throughout the biennium as appropriate settings are developed by community providers.

Each person and their family/guardian will be involved in the development of their Person-Centered Transition Plan.

The LSTC is recognized as a setting that specializes in crisis and stabilization services.

Meet Janie.



Meet Janie's Family.

Janie is 14. Janie is on the Autism Spectrum. She receives services through the Medicaid DD waiver.

She was living at home in Velva with her parents and two sisters, attending school part time.

Things at home were escalating. Her intensifying behaviors became too much for the family to handle. Everyone was exhausted.

Janie's family received in-home support (40-60 hrs/wk).

As things escalated, they worked with their DD case manager and DD diversion coordinator to identify options.

In-community options were limited. A crisis placement at LSTC was approved.

- Mom works part time at the elevator. Dad works full time at the nursing home.
- All three girls attend the local school (ages 7, 9 and 14).

A young girl is struggling. So is her family. What do we do?

Understanding how systems can help families find stability amidst crisis

Service Continuum

Independent no Supports | Independent with Supports | Supervised Housing | Monitored Housing | Acute Care

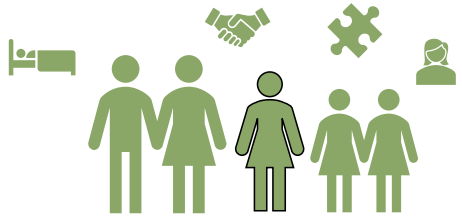
Most Integrated — Least Integrated

Service Strategy

Early Intervention | Care Plan | Transition Plan | Discharge Plan

Intellectual/ Dev Disability

At home with family no Services | At home with family with services | Family Care Option | Foster Care | Therapeutic Foster Care | ICF Youth | ICF Group Facility - LSTC | Hospital



Crisis

Team looks for solutions

In home supports

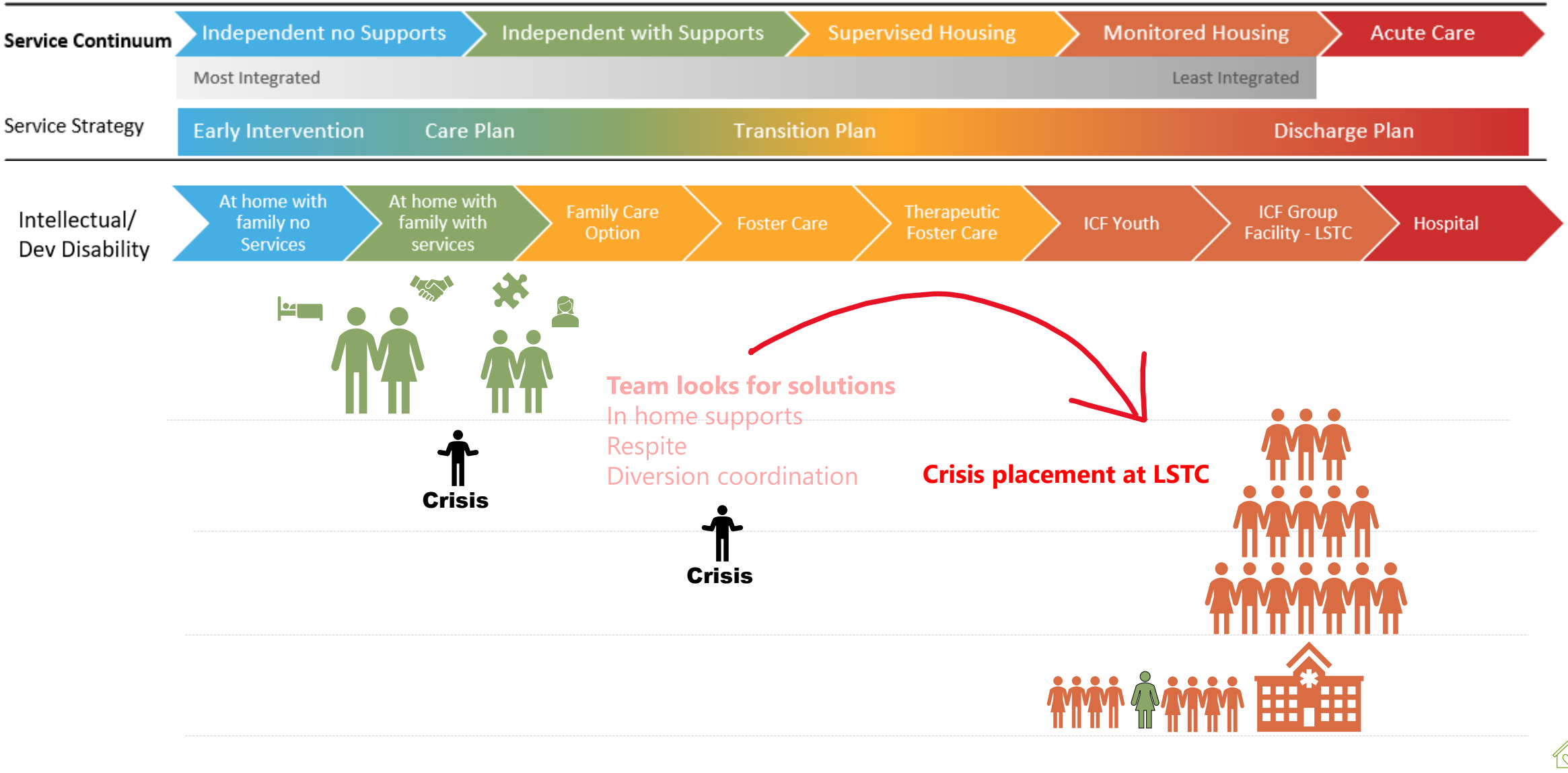
Respite

Diversion coordination

Crisis

A young girl is struggling. So is her family. What do we do?

Understanding how systems can help families find stability amidst crisis



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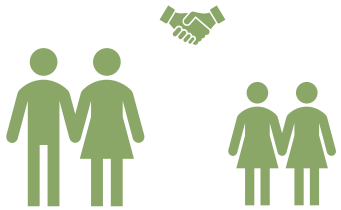


Crisis

Team looks for solutions
In home supports
Respite
Diversion coordination



Crisis

Crisis placement at LSTC

Stabilization (8 mo)
Structure & Routine
Educational supports
Svc during transition





Placement at Youth ICF



LIFE SKILLS TRANSITION CENTER

Successful stabilization happens with comprehensive support

- **Interdisciplinary team** to review, assess, case plan, and support
- Implementation of **Positive Supports** by professionals with expertise in both developmental disabilities and mental illness
- Professional **assessment of functional communications**/behavior
- Accessible, regular **interdisciplinary healthcare** consultations
- **Consistent structure and routine**
- Services and **supports to re-integrate** into family home, community group home, school and vocational environments





Contact Information

Sue Foerster, Superintendent
Life Skills Transition Center
701 W 6th Street
Grafton, ND 58237

Phone: 701-352-4302
Toll Free: 1-800-252-4911
ND Relay TTY: 7-800-366-6888
E-mail: sfoerster@nd.gov





House Bill 1012 #1108

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

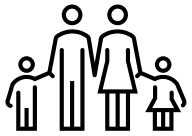
NORTH Dakota | Human Services

Be Legendary.™

Aging & Adult Services

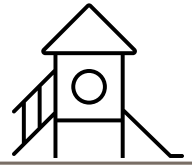
Helping older adults and adults with physical disabilities to remain living in their homes and communities

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



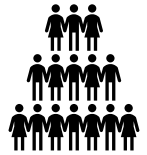
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

AGING & ADULT SERVICES
Program Purpose

Help older adults and individuals with physical disabilities to remain in their own homes and communities.

Protect the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community.



AGING & ADULT SERVICES
New in 19-21

- SPED Eligibility
- New Waiver Services
- HCBS Case Managers
- DOJ Settlement
- Electronic Visit Verification



AGING & ADULT SERVICES
What we do

Aging & Disability Resource Link (ADRL)

- Toll free resource line for people with questions about how to access services
- Centralized intake for HCBS services
- Proactive in-reach and out-reach to build awareness of HCBS options

HCBS Case Management

- HCBS case management provided to consumers
- Eligibility review
- Care Team planning
- Service authorization

Protective Services

- Vulnerable Adult Protective Services delivered statewide
- Ombudsman services for long term care residents

Senior Nutrition & Community Supports

- Administration of Older Americans Act
- Senior nutrition program
- Support for Family Caregivers
- Lifespan Respite grant

Administration HCBS and Partnerships

- HCBS 1915(c) Medicaid waiver
- Medicaid State Plan – Personal Care
- SPED / Expanded SPED
- Money Follows the Person

AGING & ADULT SERVICES
Aging & Disability Resource Link (ADRL)

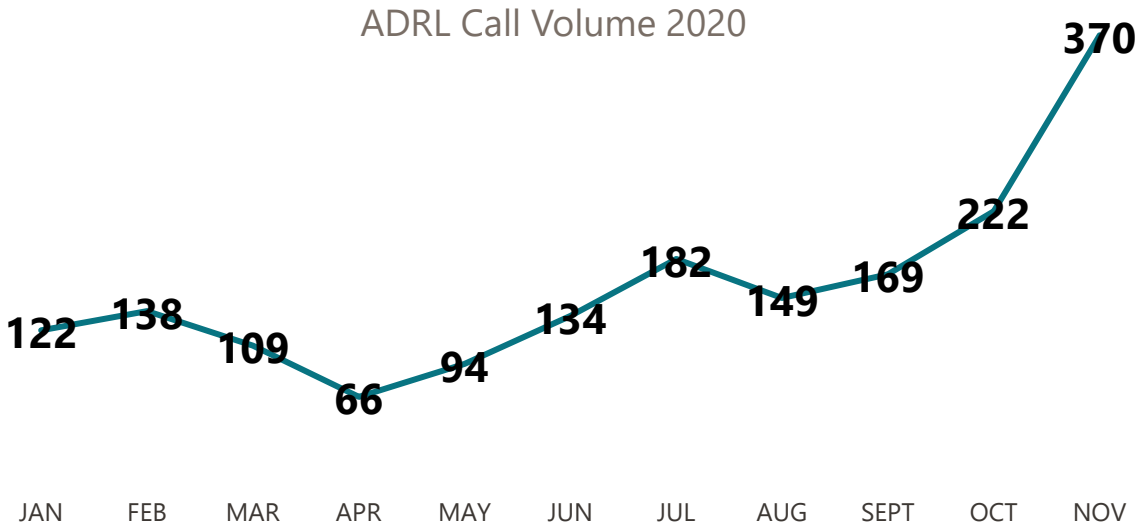
Top 5 Information Requests

- In-home assistance
- Adult protective services
- Medicaid information
- Family caregiver support program (FCSP)
- Older adults/aging Issues



AGING & ADULT SERVICES
ADRL Centralized Intake

- Process to receive HCBS referrals
- Based on no wrong door (NWD) approach
- Network built to support individuals needing LTC services by simplifying and streamlining access to information and services
- 6 FTE dedicated to centralized intake
- Fully implemented January 2021



7 in 10

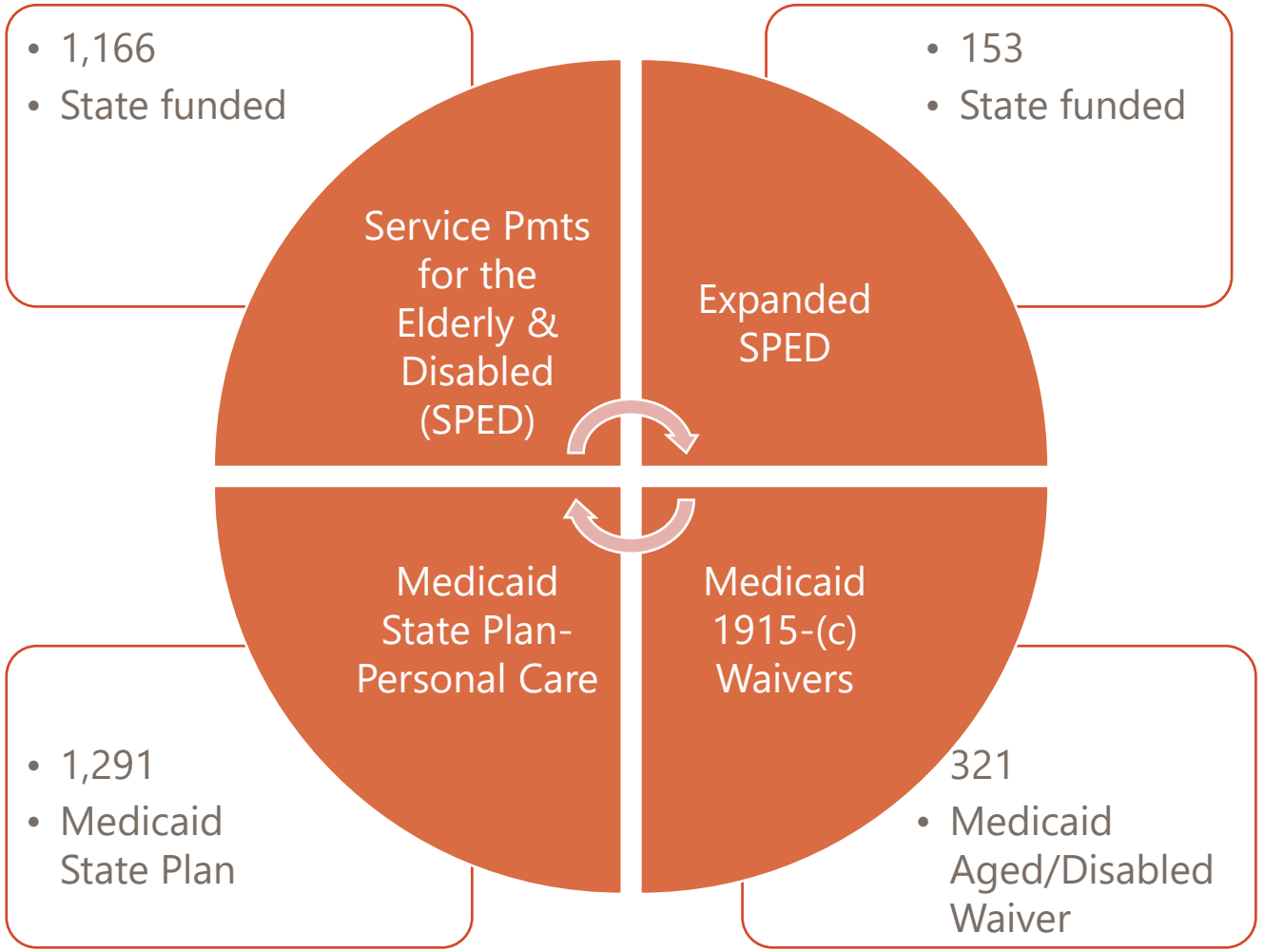
Americans 65+ will need LTC services for an average of 3 years

AGING & ADULT SERVICES
Home and Community Based Services

2,300

HCBS supported 2,300 unduplicated recipients

- Primarily serves older adults and individuals with physical disabilities
- Recipients must be both functionally and financially eligible
- May have client cost share based on income
- Federal and state funds

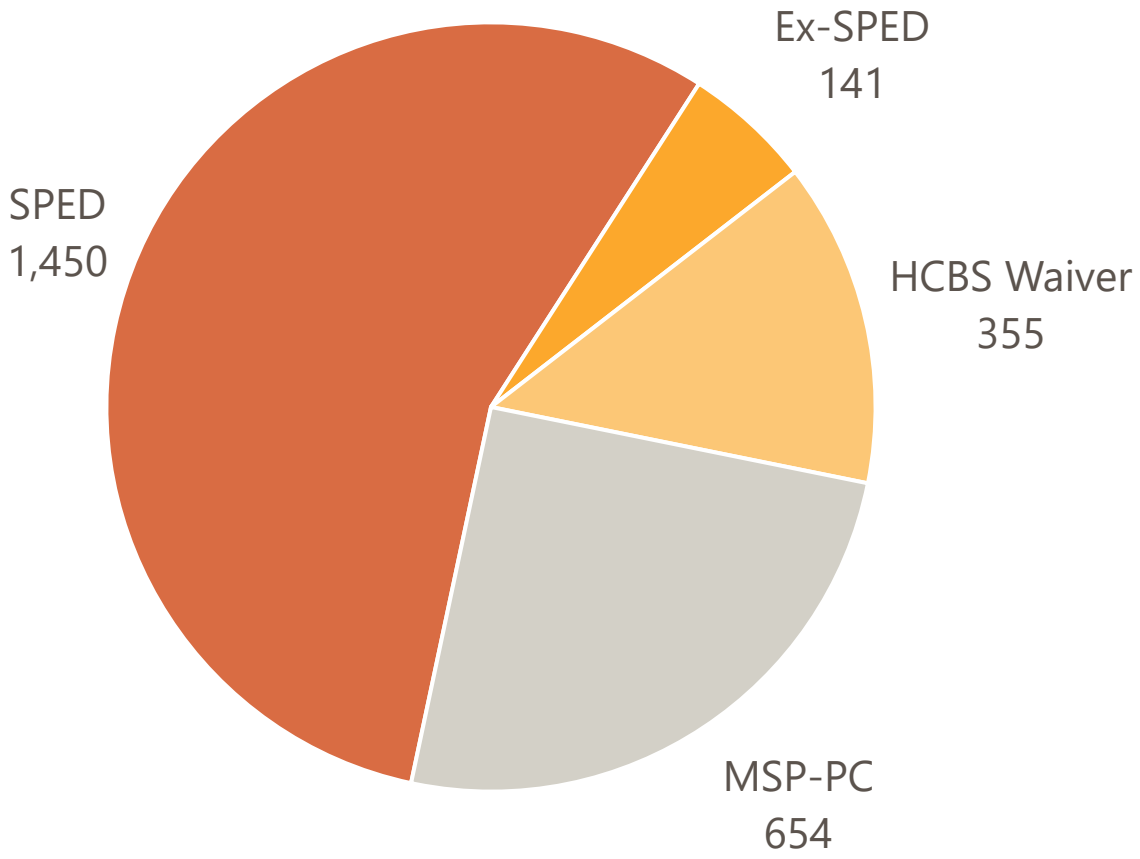


AGING & ADULT SERVICES
Types of *Support Services* available via HCBS

- Adult Day Care
- Adult Foster Care
- Adult Residential Care
- Attendant Care
- Case Management
- Chore Service
- Community Support Services / Residential Habilitation
- Community Transition Services
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care
- Emergency Response System
- Environmental Modification
- Family Home Care & Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Care Services
- Respite Care
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Care

AGING & ADULT SERVICES
Individuals receiving HCBS services (Nov 2020)

ND's HCBS for older adults and people with physical disabilities are coordinated by 64 HCBS case managers and delivered by 1149 Qualified Service Providers (QSPs) who served 2,300 people ages 18-104 in 2020



Source: DHS HCBS Caseload Data Nov 2020

AGING & ADULT SERVICES
HCBS Case Managers

64

HCBS case managers who work in 19 Human Service Zones across ND

3,057

Individuals served by HCBS case managers (Nov 2020)

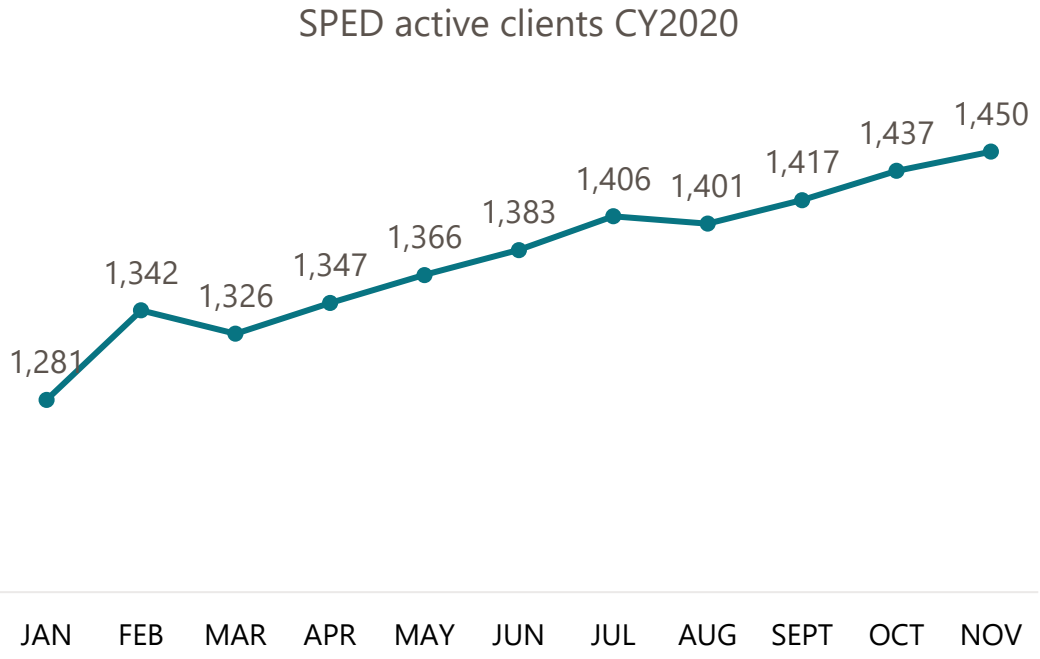
283 & 54

On average, 283 new referrals and 54 new cases opened for HCBS each month



AGING & ADULT SERVICES | NEW IN 19-21
HCBS Investments – SPED Eligibility

- Rebased client fee schedule and annual Cost of Living Adjustment (COLA)
- Updated functional eligibility criteria
- Resulted in **730 new clients** accessing services in CY2020
- **25% increase** in the total number served in CY2019
  - 94% have assets less than $25,000
  - Average monthly service cost of **$486** per person



AGING & ADULT SERVICES | NEW IN 19-21
HCBS Investments – Enhanced services

Added Services to Medicaid 1915(c) Aged & Disabled Waiver

- Residential habilitation
- Community supports
- Companionship

Services provide for up to 24-hour care in a private home or agency adult foster care and reduce social isolation of Medicaid eligible adults who screen at a Nursing Facility Level of Care



Meet Joan



In ND we served 1,166 people like Joan in CY2020

Joan is 83 years old

She lives alone in her own home

Joan has assets of less than $25,000. She has a monthly income of $1,020 per month

Joan has several age-related physical impairments (vision loss, rheumatoid arthritis, heart disease) that make it hard for her to complete housework and personal cares

Joan is a good candidate for **SPED** services.

Meet Lana



In ND we served 153 people like Lana in CY2020

Lana is 62 years old

She lives alone in an apartment.

Lana is Medicaid eligible. Her monthly income is from SSI, $783 per month

Lana has some behavioral health needs and difficulty remembering to take her medications. Lana needs a safe, supervised, structured environment.

Lana is a good candidate for **Expanded SPED** services.

Meet Betty



In ND we serve an average of 321 people like Betty each year

Betty is 67 years old

Betty lives with her husband who is her primary caregiver.

Her monthly income comes from SSI is $1191 each month. Betty is Medicaid eligible.

She meets a Nursing Facility Level of Care because of her dementia and related impairments. She needs supervision and help with her personal cares.

Betty is a good candidate for the **HCBS Medicaid Waiver.**

Meet Margo



In ND we served an average of 588 people like Margo each year

Margo is 63 years old

Margo has a number of disability-related physical impairments. She needs hands-on care for an average of 240-300 hours per month.

She is Medicaid eligible and meets a nursing home level of care.

Margo is considered high need as she is impaired in at least 5 activities of daily living (ADLs). For Margo, this includes bathing, dressing, feeding, toileting, continence, transferring, mobility inside.

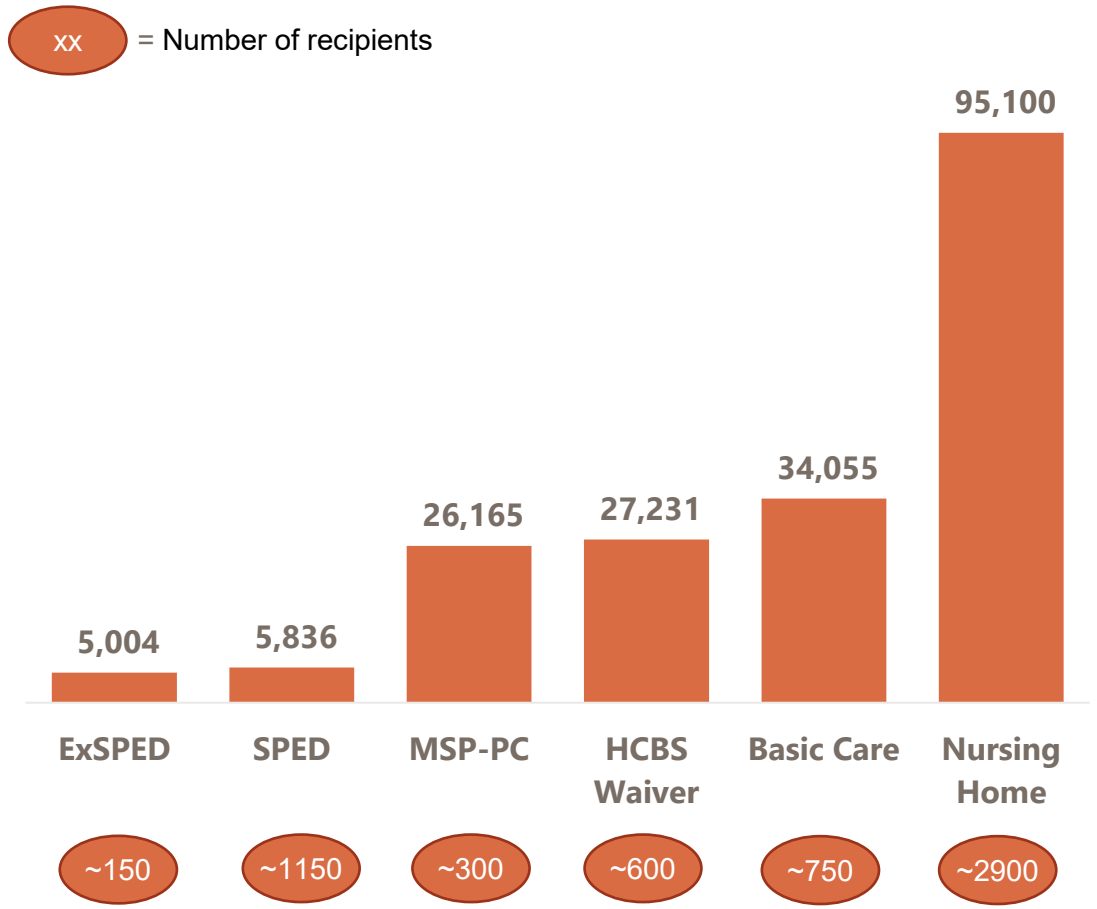
Margo is a good candidate for **Medicaid State Plan-funded Personal Care**

DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

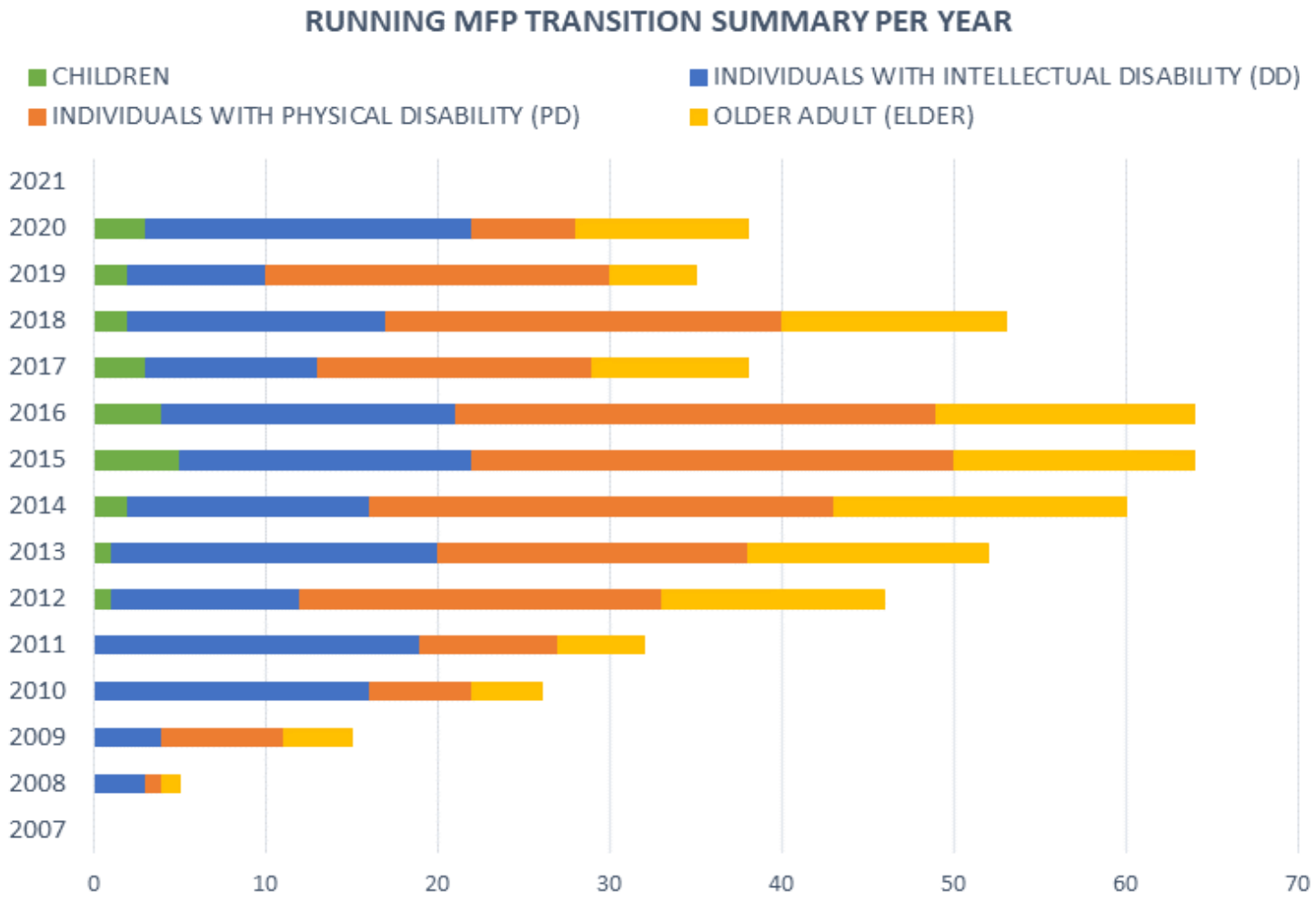
- **Service Payments for the Elderly and Disabled (SPED):** Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- **Expanded SPED (Ex-SPED):** Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- **Home and community-based services (HCBS) waiver:** This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- **Medicaid State Plan personal care (MSP-PC):** Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

AGING & ADULT SERVICES
Money Follows the Person

Federal Grant designed to assist states to increase the use of home and community-based services (LTSS System Rebalancing)

- Eliminate barriers that prevent individuals from receiving LTSS in the settings of their choice

- Original award - $8.9 million (2007)
- Award through 2020 - $29 million (fed) and $1.7 million (state)
- Transitioned 528 individuals from institutional settings back to the community

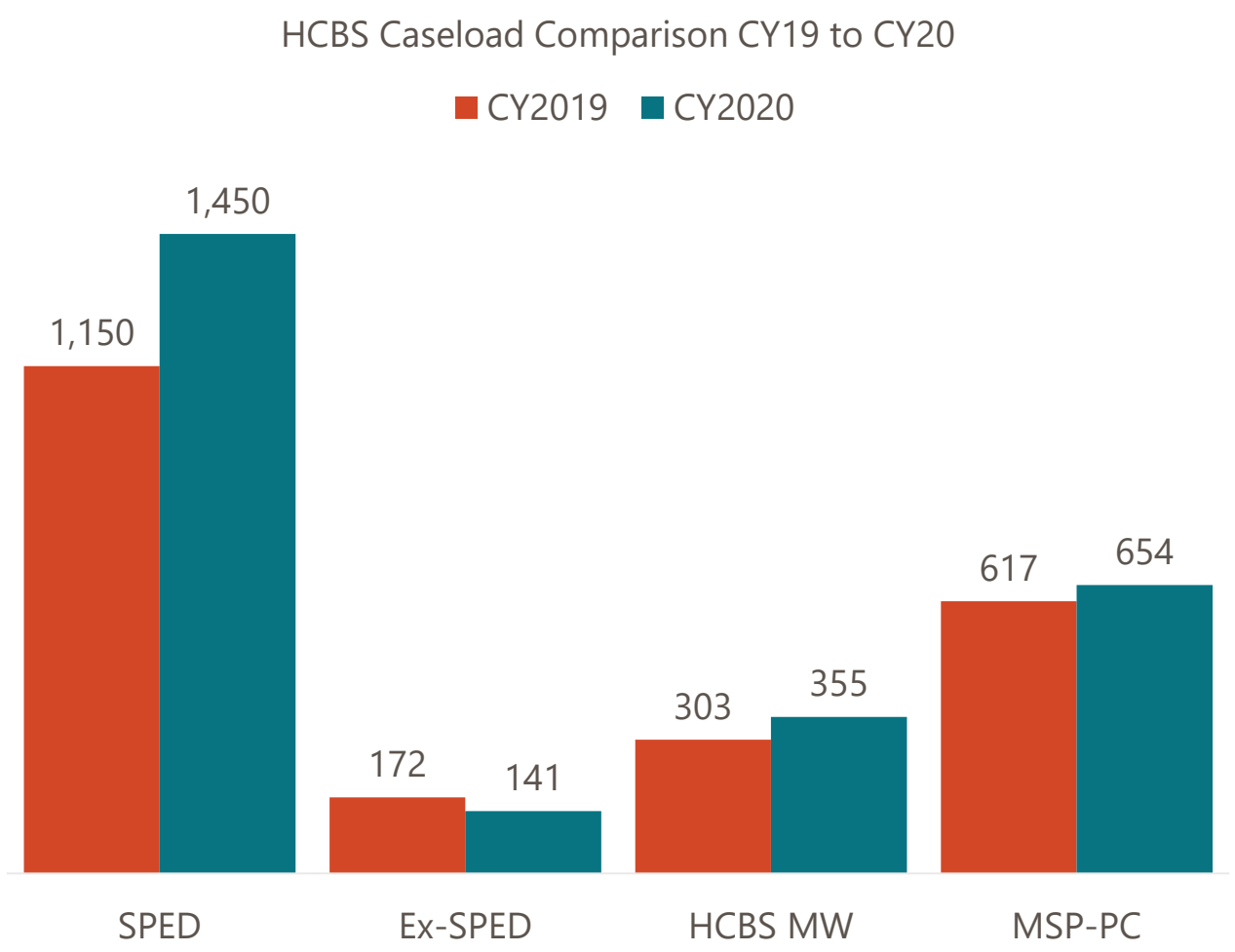


AGING & ADULT SERVICES
Key Changes due to COVID: Home & Community Based Services

HCBS services have continued to be provided throughout pandemic

- Administrative Flexibility
- Allowed virtual case management
- Service flexibility e.g., authorize family to provide care
- Temporary increase service rates for family personal care and supervision
- Modified provider qualifications to speed enrollment

Noted increase in Social Isolation among HCBS recipients



AGING & ADULT SERVICES
Vulnerable Adult Protective Service (VAPS)

The program addresses the safety of vulnerable adults who are at-risk of harm due to the presence or threat of abuse, neglect, or exploitation.



AGING & ADULT SERVICES
Vulnerable Adult Protective Service (VAPS)

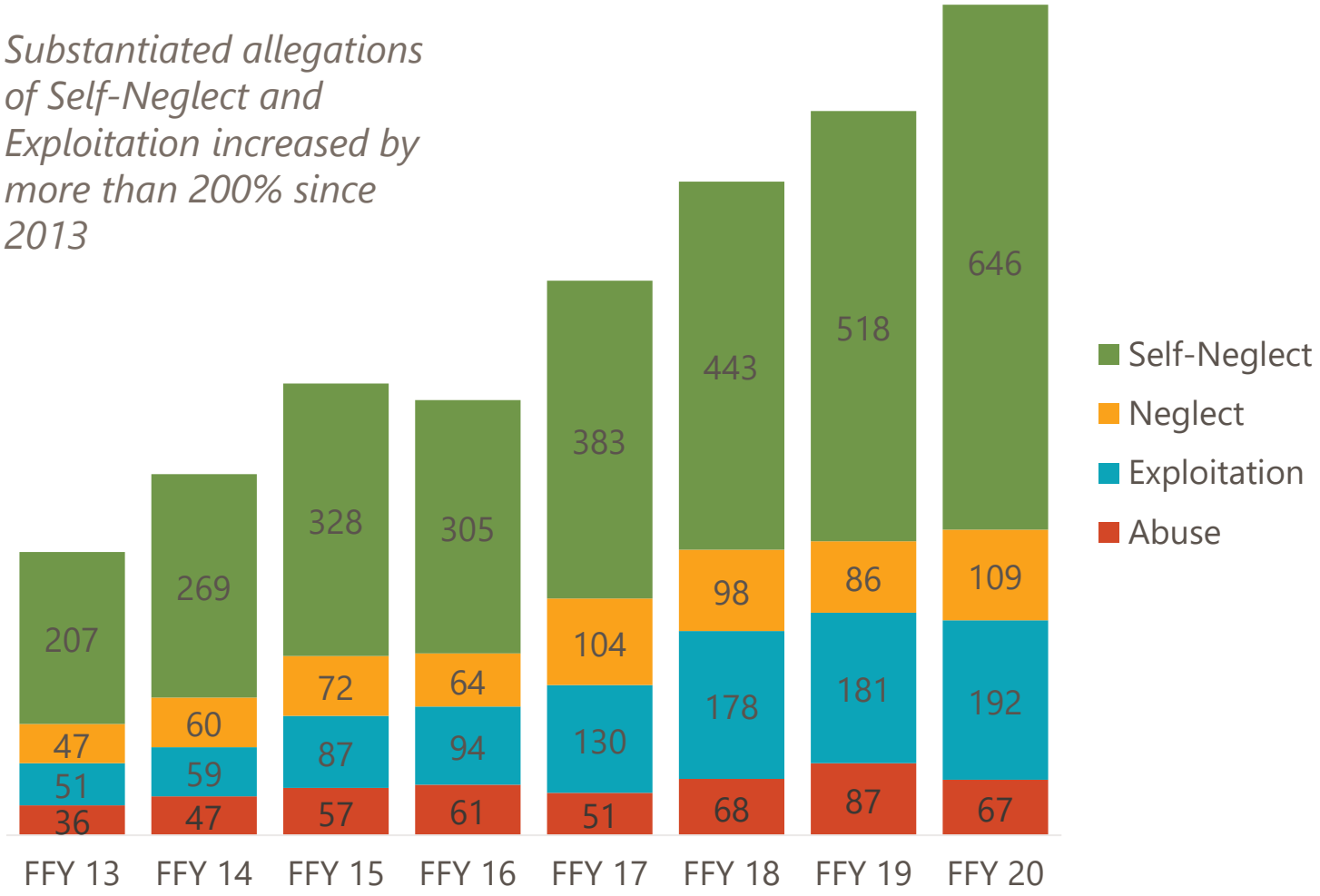
1,695 allegations

1,418 investigations

1,014 substantiated

Most common allegation:
Self Neglect

Substantiated allegations of Self-Neglect and Exploitation increased by more than 200% since 2013



AGING & ADULT SERVICES
Long Term Care Ombudsman

Long-Term Care Ombudsmen are advocates for resident rights. They help protect the quality of life and quality of care of anybody who lives in a nursing home, basic care or an assisted living facility.



AGING & ADULT SERVICES
Long Term Care Ombudsman

ND Long Term Care System

5,635 Nursing Facility Beds*
676 Swing Beds
2,054 Basic Care Beds
3,066 Assisted Living Units

**In 252 facilities located in 79 communities*

Most Common Complaints

Nursing Homes/Swing Bed

- Autonomy, Choice, Preference, Exercise of Rights, Privacy
- Care
- Systems/Others

Basic Care & Assisted Living

- Autonomy, Choice, Preference, Exercise of Rights, Privacy
- Admission, Transfer, Discharge, Eviction
- Financial, Property (Not due to Financial Exploitation)

1,267
Information and Consultations

448
Complaints Received

305
Cases opened

AGING & ADULT SERVICES
Guardianship Establishment Fund

Fund covers most petitioning costs for eligible incapacitated adults

151

incapacitated adults served in 17-19 biennium. 147 served to date in 19-21 biennium

$2,500

Max petitioning cost per person



AGING & ADULT SERVICES
Older Americans Act (OAA)

24,600

Older adults served in FFY2019

Serves people age 60+

No income limits

Voluntary contribution

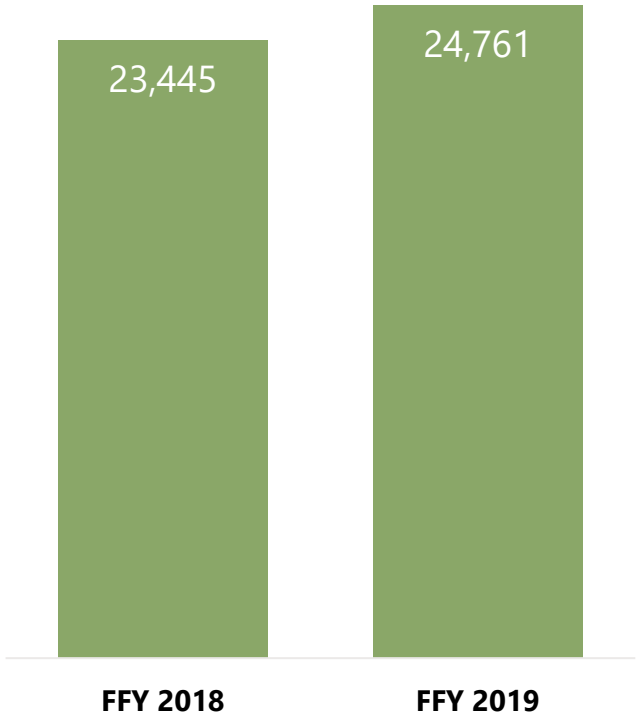
Cannot deny service due to unwillingness or inability to contribute

Federal, state, and local funds



AGING & ADULT SERVICES
Older Adults served with Older American Act Funds

Clients Served with OAA Funds increased by 6%



3,919
Clients with household income at or below **poverty** level (increase of 5% over FFY2018)

4,457
Clients **over age 85** (increase of 2% over FFY2018)

11,882
Clients who lived in **rural** areas (increase of 2% over FFY2018)

AGING & ADULT SERVICES
Senior Nutrition Services

Nutrition services **reduce** hunger, **food insecurity**, malnutrition, and **promote socialization** of older adults.

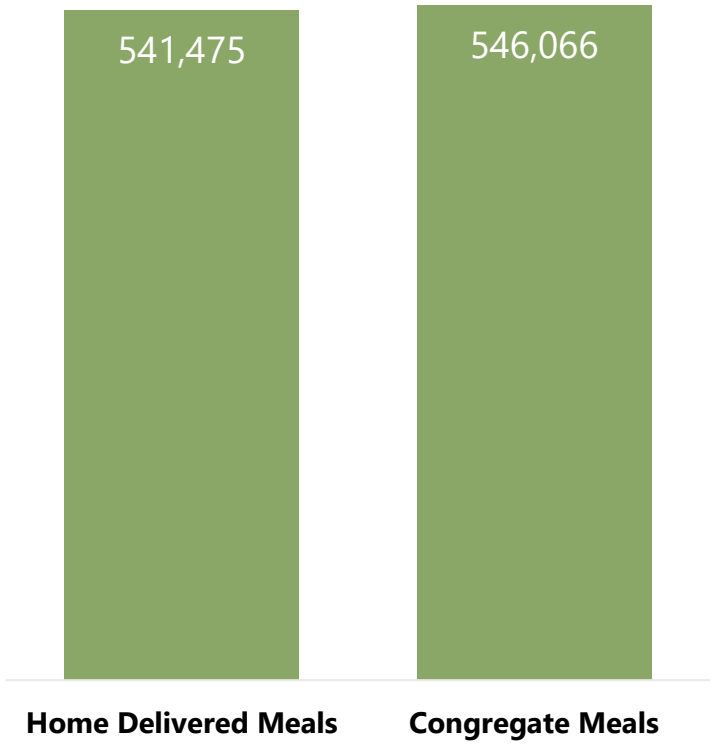
Seniors with food insecurity can have many negative health consequences:

- Prolonged hospital stays
- Unintentional weight loss that can increase need for physical assistance



AGING & ADULT SERVICES
Older American Act Funds Nutrition Services

In 2019 people utilized home delivered and congregate meals in roughly equal rates



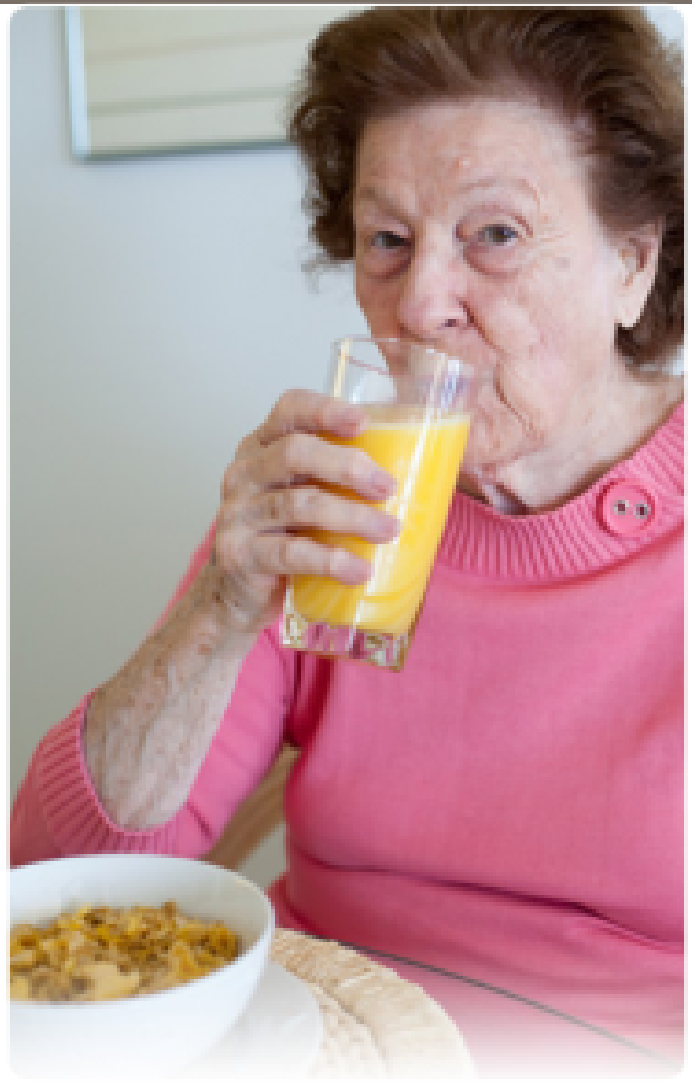
23%

Seniors receiving home delivered meals who are "high nutrition risk"
(1,113 of 4,801 individuals served)

9.5% of the 14,311 individuals who received congregate meals in 2019 were "high nutrition risk"

23%

of Seniors receiving home-delivered meals have 2 or more ADL limitations
(1,124 of 4,801 individuals served)



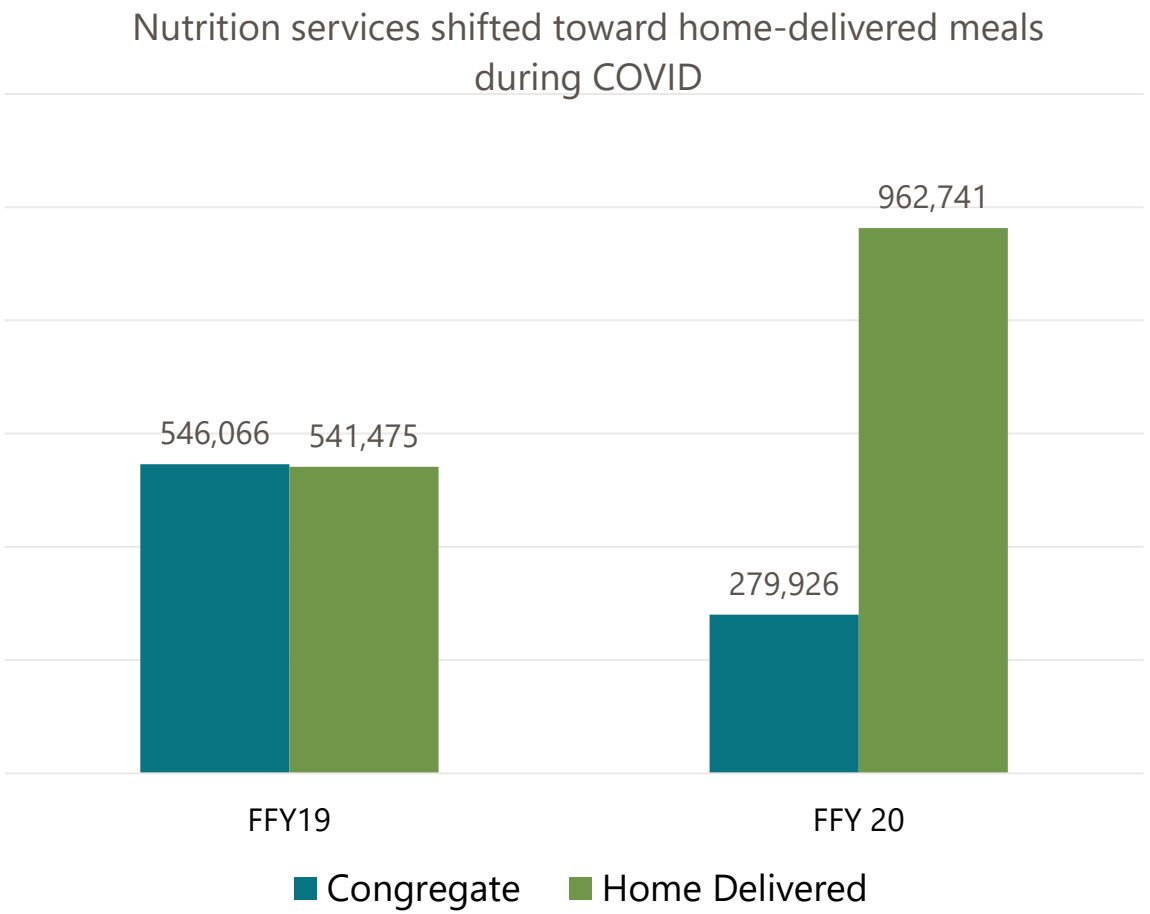
AGING & ADULT SERVICES
Key Changes due to COVID: Nutrition Services

The pandemic changed the way meals are delivered to older adults.

Meals options:
- Home delivered
- Pre-packaged grab-and-go
- Curbside pickup
- Frozen meal options

1,242,667
Meals served FFY2020 increased by 14% over FFY2019

9,362
Consumers served



AGING & ADULT SERVICES
Key Changes due to COVID: Nutrition Services

Home-Delivered Meals

Increased per meal rate from $4.60 to $7.00 to account for increased administrative costs

Funding

FFCRA	$1.2 M
CARES	$2.4 M
ND CARES	$1.132 M



NORTH DAKOTA OLDER AMERICANS ACT NUTRITION SITES

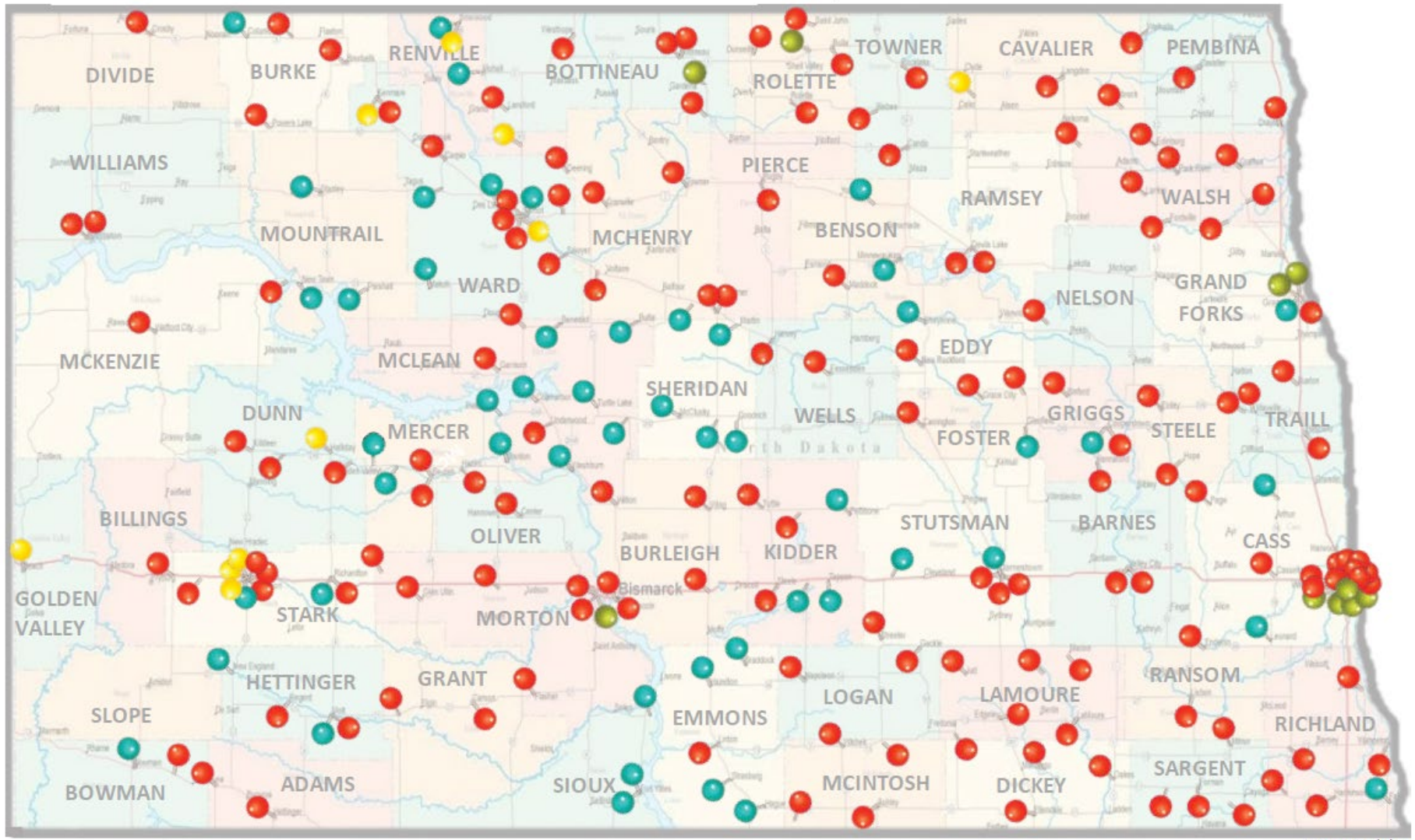
MAP LEGEND:

- Congregate Nutrition Sites Only
- Home Delivered Meals (HDM) Only
- Both Congregate and HDM Options
- Café 60 Nutrition Sites

STATE TOTAL:

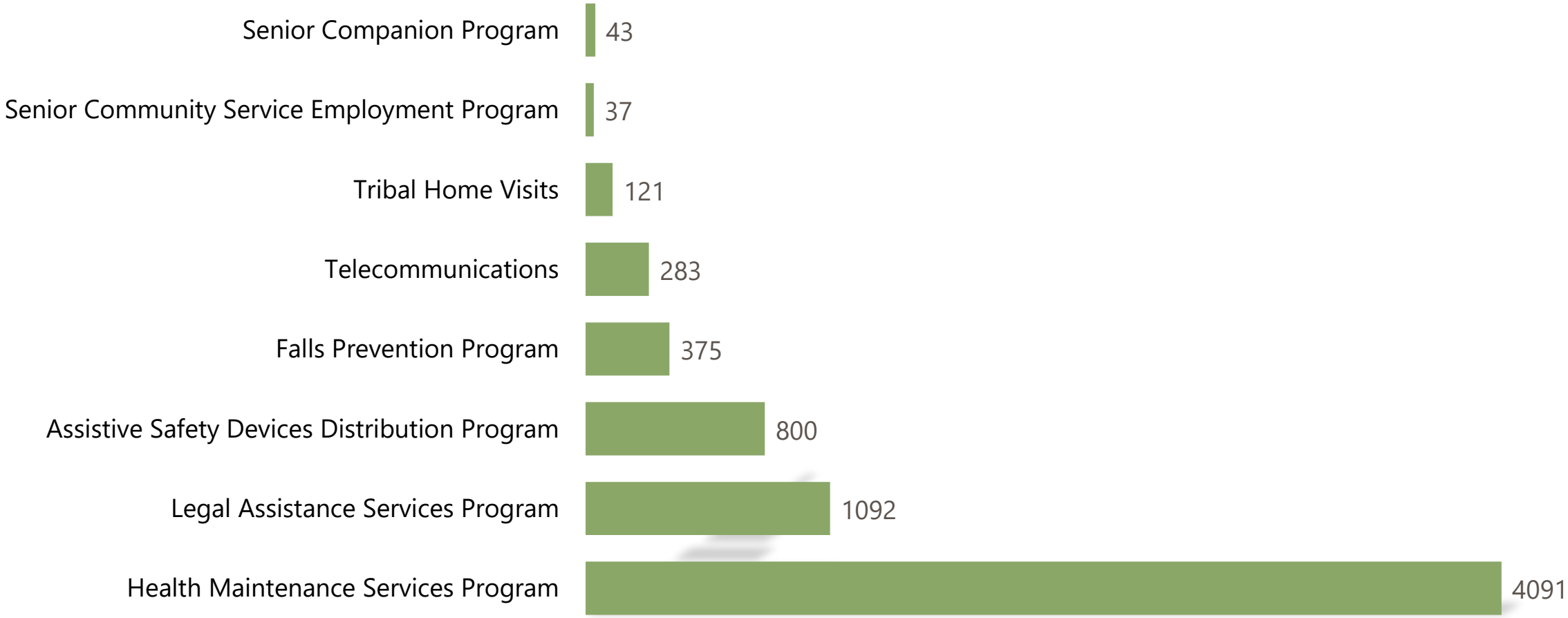
219

- 09 Congregate Nutrition Sites Only
- 51 Home Delivered Meals (HDM) Only
- 149 Both Congregate and HDM Options
- 10 Café 60 Nutrition Sites



Last Updated 12/08/2020

AGING & ADULT SERVICES
Other OAA services that support older adults



AGING & ADULT SERVICES
State-funded Supportive Service programs

Dementia Care Program

- Care Consultation
- Education, training, information and referral for professionals, caregivers and the public

Telecomm Equipment Distribution

- Specialized telecommunications equipment for individuals with communication impairments

AGING & ADULT SERVICES
Key Changes due to COVID: Supportive Services

The COVID-19 pandemic disproportionally impacted older adults.

Supportive Community Services
Funds companionship and shopping support for older adults

Funding

CARES	$1.0 M

Family Caregiver Services
Increased allowable amount of respite and supplemental services

Funding

CARES	$0.5 M

Ombudsman Activities
Technology to allow for virtual visits in skilled nursing facilities and basic care

Funding

CARES	$0.1 M

AGING & ADULT SERVICES
Key Changes due to COVID: Aging Disability Resource Link (ADRL)

- Additional $305K ADRL grant (ACL via FFCRA / CARES)
- Serves individuals 18+ with a disability impacted by COVID-19
  - Transition coordination services
  - Financial assistance for one-time moving costs, and rental assistance
  - Companionship services and shopping
  - Technology to allow for virtual visits in skilled nursing facilities & basic care



AGING & ADULT SERVICES
Settlement Agreement between U.S. DOJ & State of ND

Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective December 14, 2020

Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.



AGING & ADULT SERVICES | DOJ SETTLEMENT
Americans with Disabilities Act

The Americans with Disabilities Act (ADA) requires public agencies to **eliminate unnecessary segregation** of persons with disabilities and provide services in the **most integrated setting appropriate** to the needs of the individual.

In **1999** the Federal Supreme Court **Olmstead** decision **affirmed** the **ADA** requirements.



AGING & ADULT SERVICES | DOJ SETTLEMENT
Benefits of DOJ Agreement

1. **Expands and raises awareness** about community-based care options available to adults with physical disabilities

2. Allows individuals to make **informed choices**, including the option to receive care while enjoying the benefits of community living in the least restrictive setting

3. Builds upon the investments made by the 2019 Legislature and our **shared goal** of improving services to citizens

WHO ARE WE TRYING TO REACH?

TARGET POPULATION

Basic Eligibility

- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.



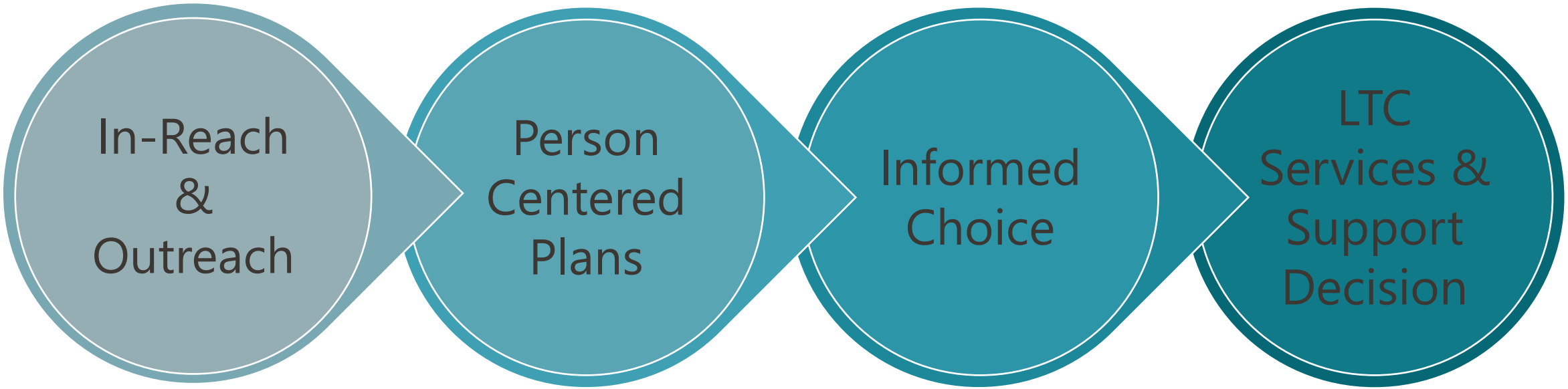
IF in skilled nursing setting

- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

IF in hospital or home setting

- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL

AGING & ADULT SERVICES
Informed Choice Strategy – Implemented January 1, 2021



- Process to identify individuals and give them an opportunity to make an informed decision about where to receive services.
- In-Reach: Making connections when individual is in hospital or skilled nursing facilities.
- Out-Reach: Connecting with someone who is living in their home and searching for care.

- Process, driven by the individual that identifies supports and services that are necessary to meet the individual's needs in the most integrated setting.
- Consumer works with HCBS case manager to examine range of options.

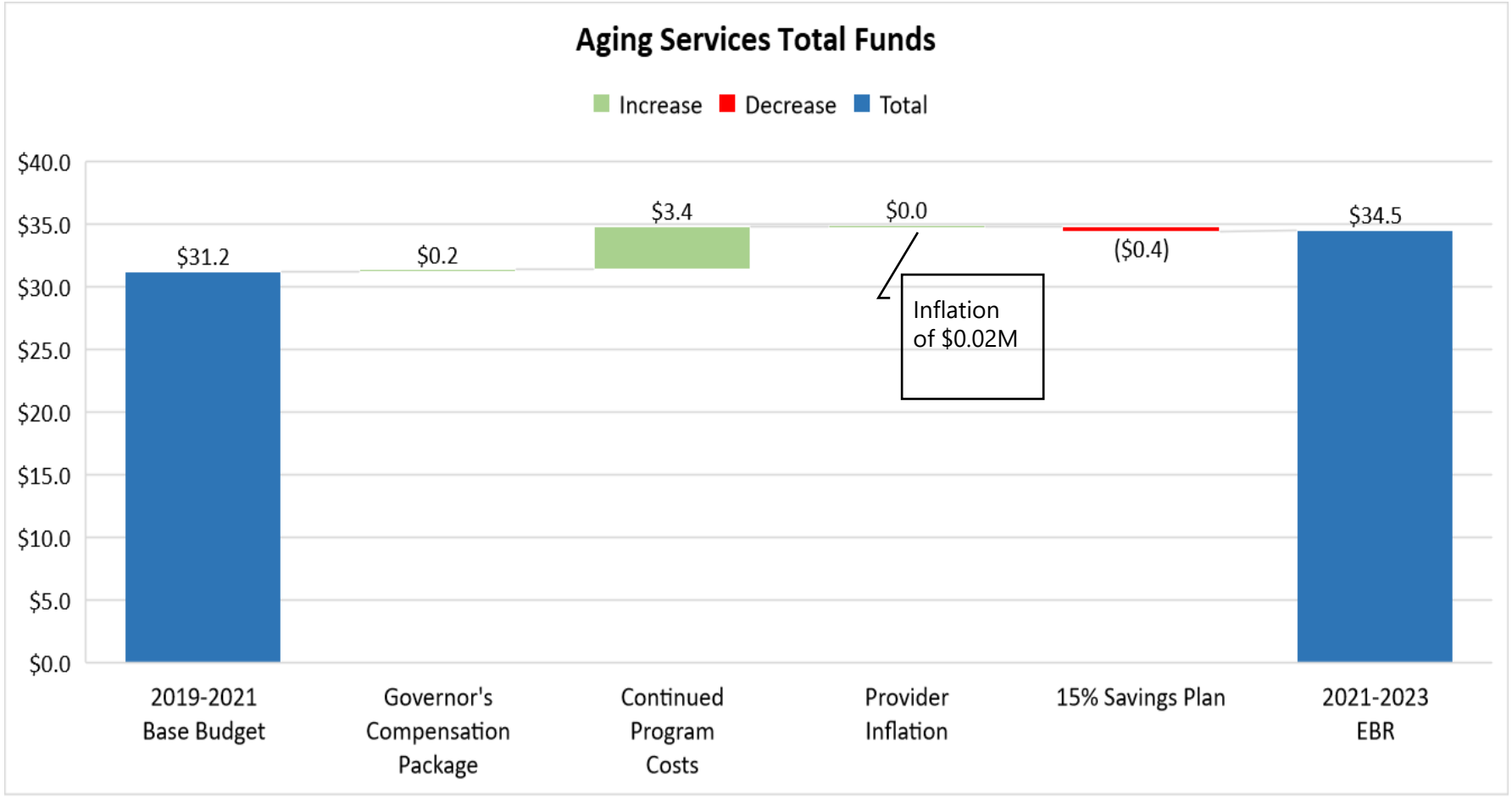
- The choice that is made after person has been provided with information about options for integrated settings and engaged in person-centered planning.
- Finalization of Care Plan and connection to resources as needed.

- Decision about individual care. All decisions are respected, and consumer is assisted in accessing HCBS if desired.
- Individual receives services in the setting and manner they selected; periodic follow up with case manager continues.

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	7,531,996	1,115,342	8,647,338
Operating	20,507,198	1,178,637	21,685,835
Grants	3,175,102	944,491	4,119,593
Total	31,214,296	3,238,470	34,452,766
General Fund	12,128,232	297,546	12,425,778
Federal Funds	18,109,325	3,171,725	21,281,050
Other Funds	976,739	(230,801)	745,938
Total	31,214,296	3,238,470	34,452,766
Full Time Equivalent (FTE)	44.00	0.00	44.00

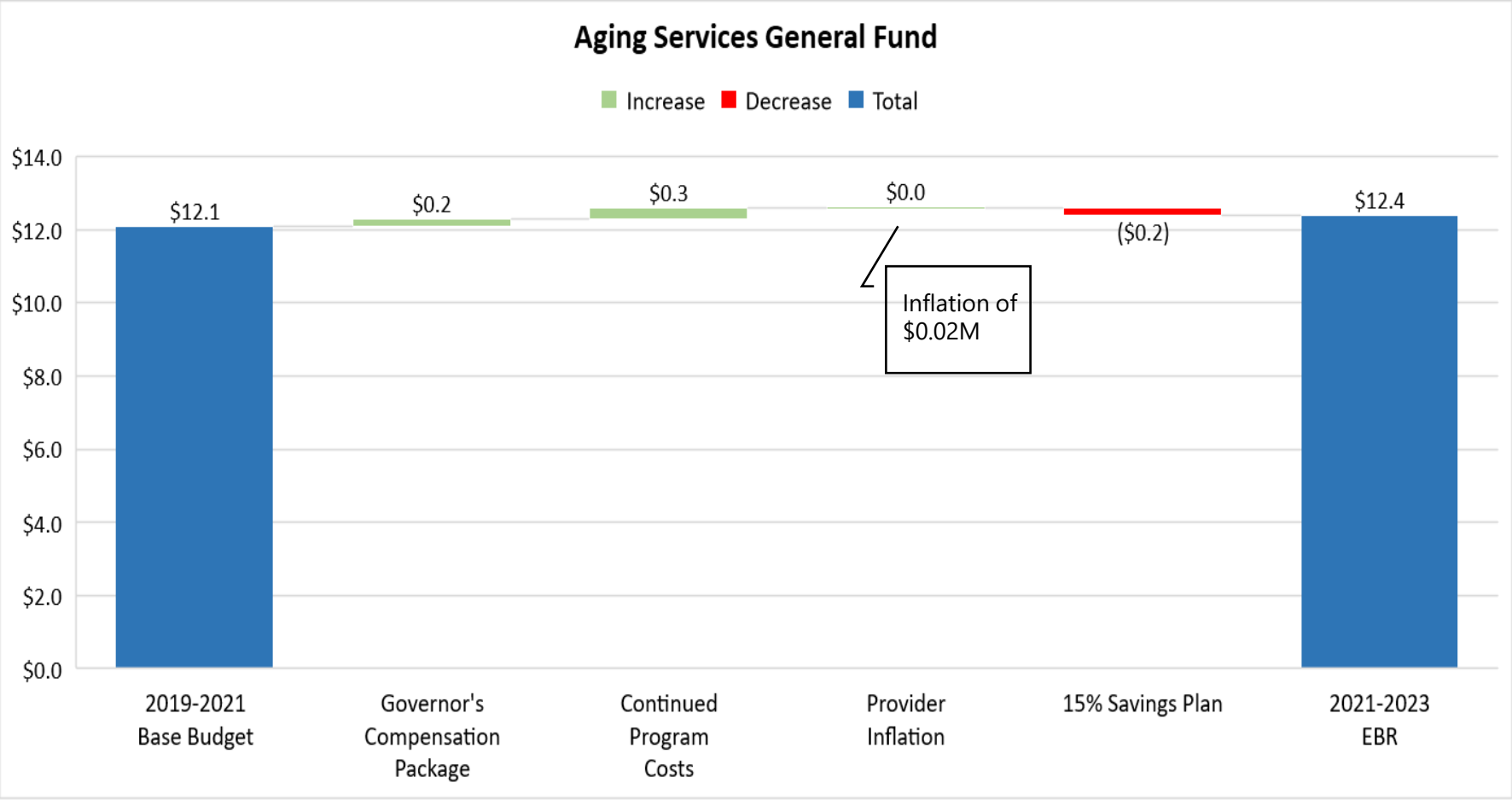
AGING & ADULT SERVICES
Overview of Total Budget Changes (in millions)



Overall increase of $3.2M from 2019-2021 Base Budget

- Continued Program Costs of $3.4M:
  - Annual salary adjustments of $0.9M
  - Increase in rent at PHP of $0.2M
  - Increase in contracted costs of $2.3M
- Provider Inflation of $0.02M:
  - VAPS contracts with counties
  - State Funds to Providers
- 15% Savings Plan of ($0.4M):
  - Elimination of rent at PHP of ($0.2M)
  - Reduction of contracted costs for Alzheimer's Association Dementia Care of ($0.2M)

AGING & ADULT SERVICES
Overview of General Fund Budget Changes (in millions)



Overall increase of $0.3M from 2019-2021 Base Budget

- Continued Program Costs of $0.3M:
  - Annual salary adjustments of $0.4M
  - Operating costs of ($0.1M)
- Provider Inflation of $0.02M:
  - VAPS contracts with counties
  - State Funds to Providers
- 15% Savings Plan of ($0.2M):
  - Elimination of rent at PHP of ($0.08M)
  - Reduction of contracted costs for Alzheimer's Association Dementia Care of ($0.168M)

AGING & ADULT SERVICES
Nutrition Walk-Through

North Dakota Department of Human Services

Changes in Nutrition Services from 2019-2021 Appropriation to 2021-2023 Executive Budget To House

Service Description	**2019-2021 Appropriation**	Changes in federal funds	Changes in general fund	**2021-2023 Budget to OMB**	Inflation 1%/1%	**2021-2023 Budget To House**
Congregate Meals	5,102,530	0	0	5,102,530	0	5,102,530
Home Delivered Meals	3,826,794	0	0	3,826,794	0	3,826,794
Nutrition Services Incentives	1,693,820	0	0	1,693,820	0	1,693,820
State Funds to Providers	1,392,038	0	0	1,392,038	20,950	1,412,988
Total	12,015,182	0	0	12,015,182	20,950	12,036,132
General Funds	4,182,656	0	0	4,182,656	20,950	4,203,606

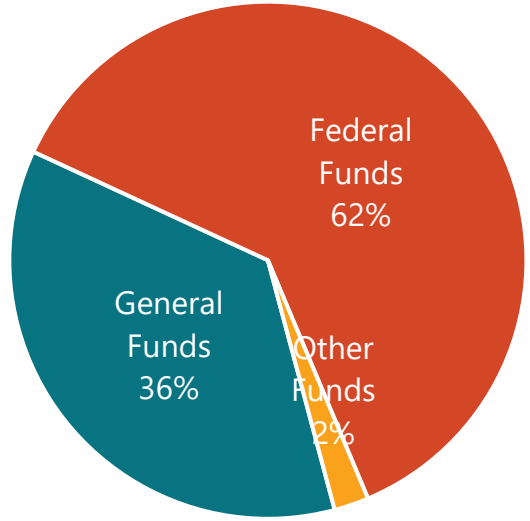


Aging & Adult Services Budget Summary

19-21 Budget	**$31,214,295**
21-23 Budget (exec)	**$34,452,766**

44 FTEs; no change in FTEs projected; $3,238,471 budget increase (98% in federal funds)

- Implementation of in-reach and out-reach and centralized intake for home and community-based services
- Continuation of Money Follows the Person
- Various programmatic and operating efficiencies





Contact Information

Nancy Nikolas Maier, Division Director
1237 W Divide Ave, Suite 6
Bismarck, North Dakota 58501-1208

Phone: 701-328-4601
Toll-Free Aging & Disability Resource LINK: 1-855-462-5465
E-mail: carechoice@nd.gov



2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/13/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 1:47 p.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Developmental Disabilities division
- The program's purpose
- What the program does
- Services provided
- Examples of clients
- Proposed Budget

Tina Bay, Dir. of Developmental Disabilities Division (1:48 pm) testified about the Developmental Disabilities Program #1110

Chair Nelson closed the meeting at 2:19 p.m.

Cole Fleck, Committee Clerk



House Bill 1012 #1110

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

Developmental Disabilities

Helping adults and children with disabilities realize their potential

NORTH Dakota | Human Services

Be Legendary.™

DEVELOPMENTAL DISABILITIES
Program Purpose

Maximize community inclusion, independence and self-sufficiency to prevent institutionalization, and to enable individuals to transition from institutions to community living.



DEVELOPMENTAL DISABILITIES
What we do

Case Management

- Case management provided by DD Program Managers to individuals and families
- Eligibility review
- Person centered planning
- Service authorization

Administration

- Provider licensing
- Training & Technical Assistance
- Policy Development
- Contract Management
- Provider Enrollment

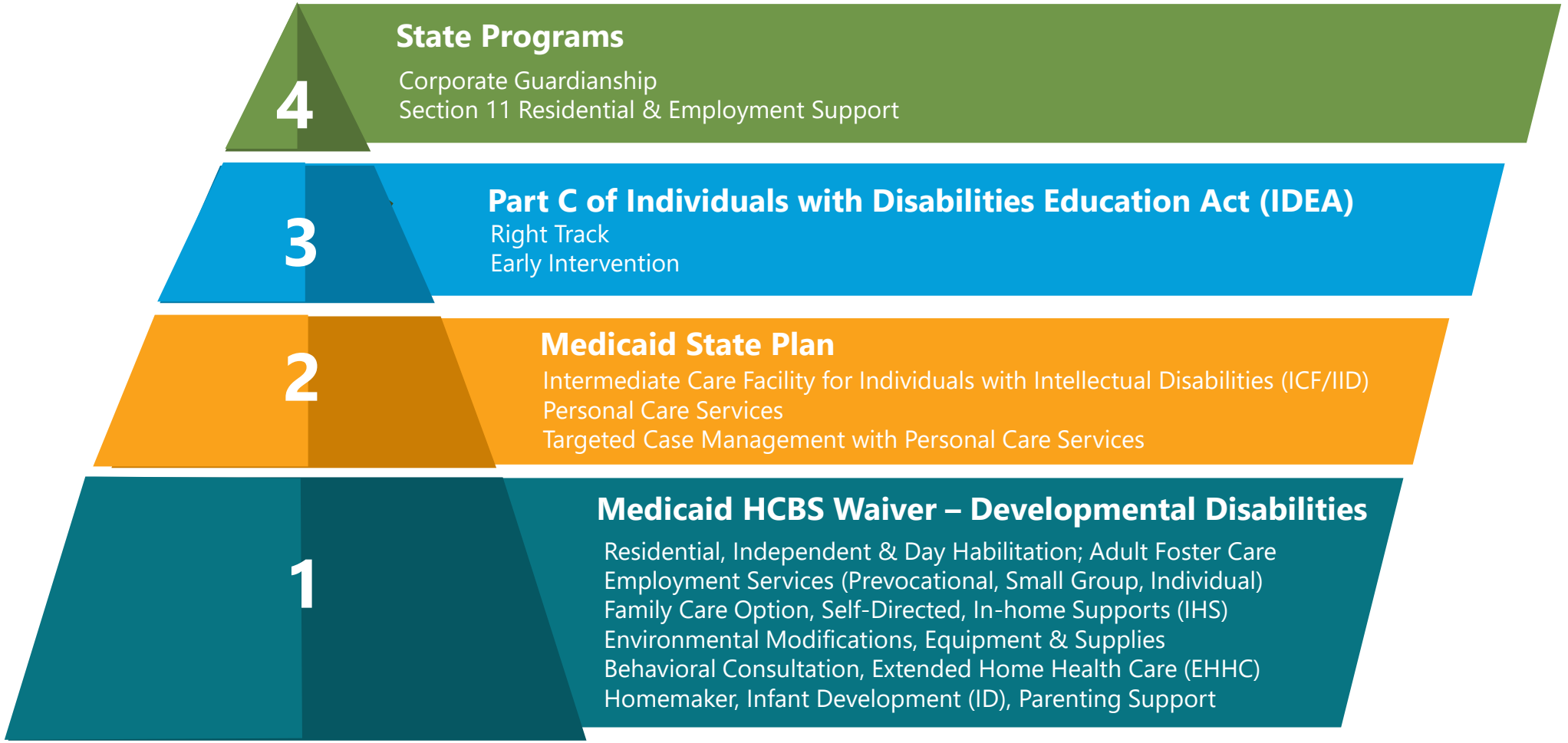
Program Integrity

- Regulatory compliance
- Provider Audits
- Case Reviews
- Federal & State Audits
- Quality Assurance

Partnerships

- North Dakota Interagency Coordinating Council
- State Rehabilitation Council
- Transition Task Force
- Money Follows the Person

DEVELOPMENTAL DISABILITIES
Service Array by Funding Authority



Meet Caden.



Meet Caden's family.

Age 14

Diagnosed with a mild intellectual disability. And PTSD, Autism, ADHD, and a mood regulation disorder.

History of self injurious behavior, physical aggression, running away.

Has been living at home and attending school with peers half days with significant in-school supports.

Was found eligible for DD services at age 11.

- Mom, dad and two brothers (age 10 and 8)
- Both mom and dad work full time and are Caden's guardians
- Family receives in-home supports 40-45 hrs/week to help manage behaviors

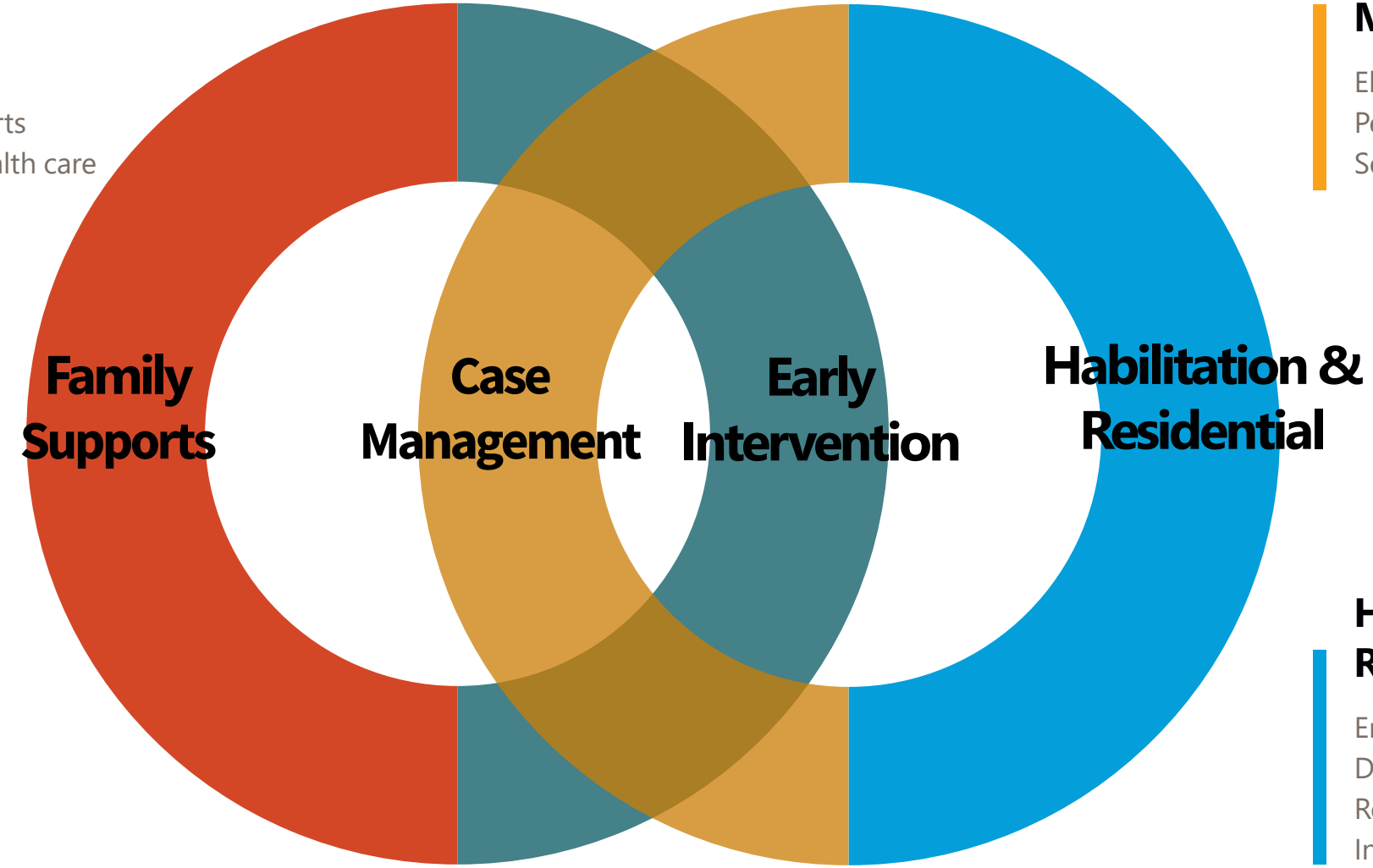
Case management and early intervention are a key intersection within the continuum of services available to people with Developmental Disabilities

Family Supports

In-home supports
Self-Directed supports
Extended Home Health care

Case Management

Eligibility
Person Centered Planning
Service Authorization



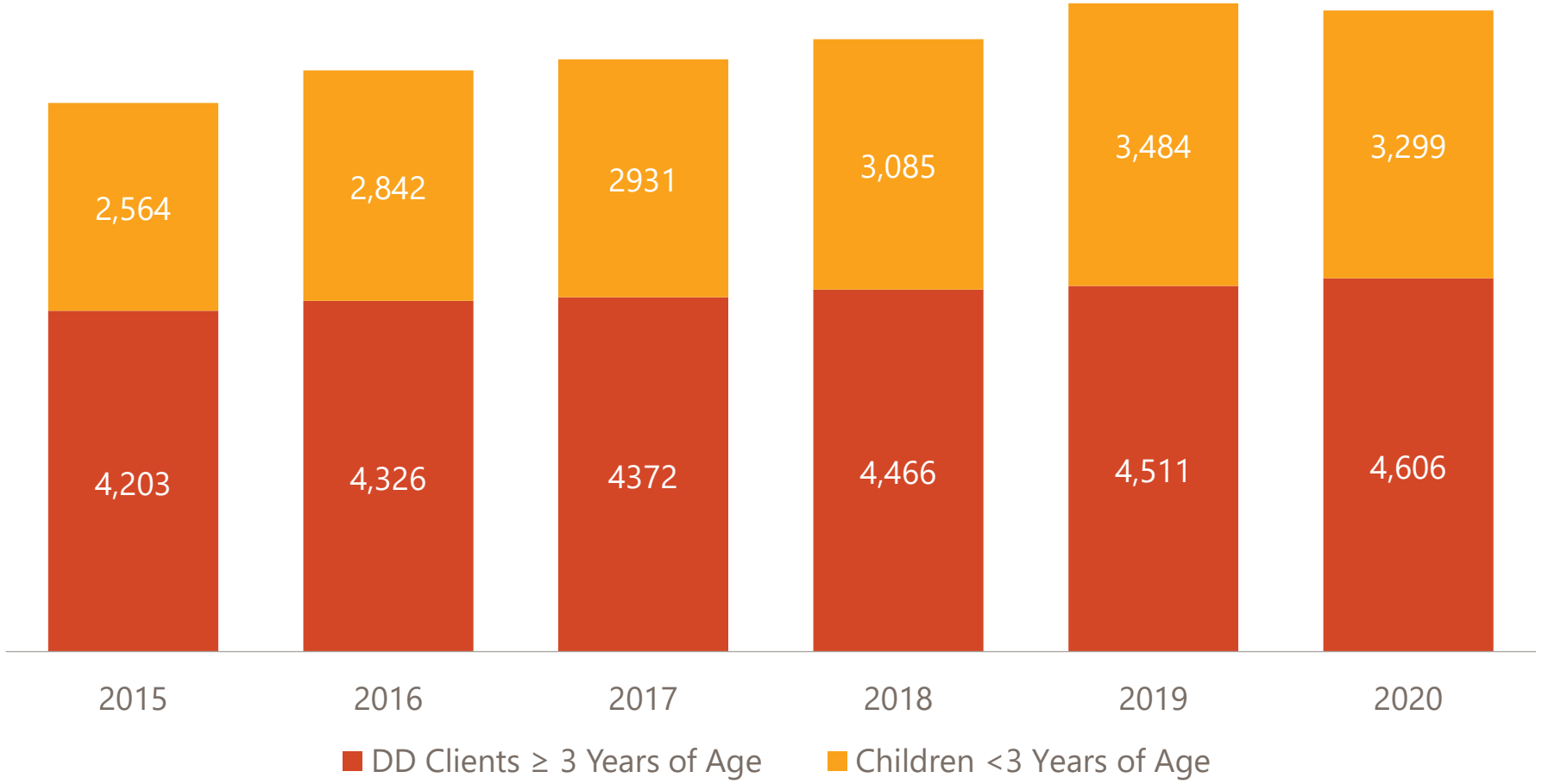
Early Intervention

Birth review
Right Track
Infant Development

Habilitation & Residential

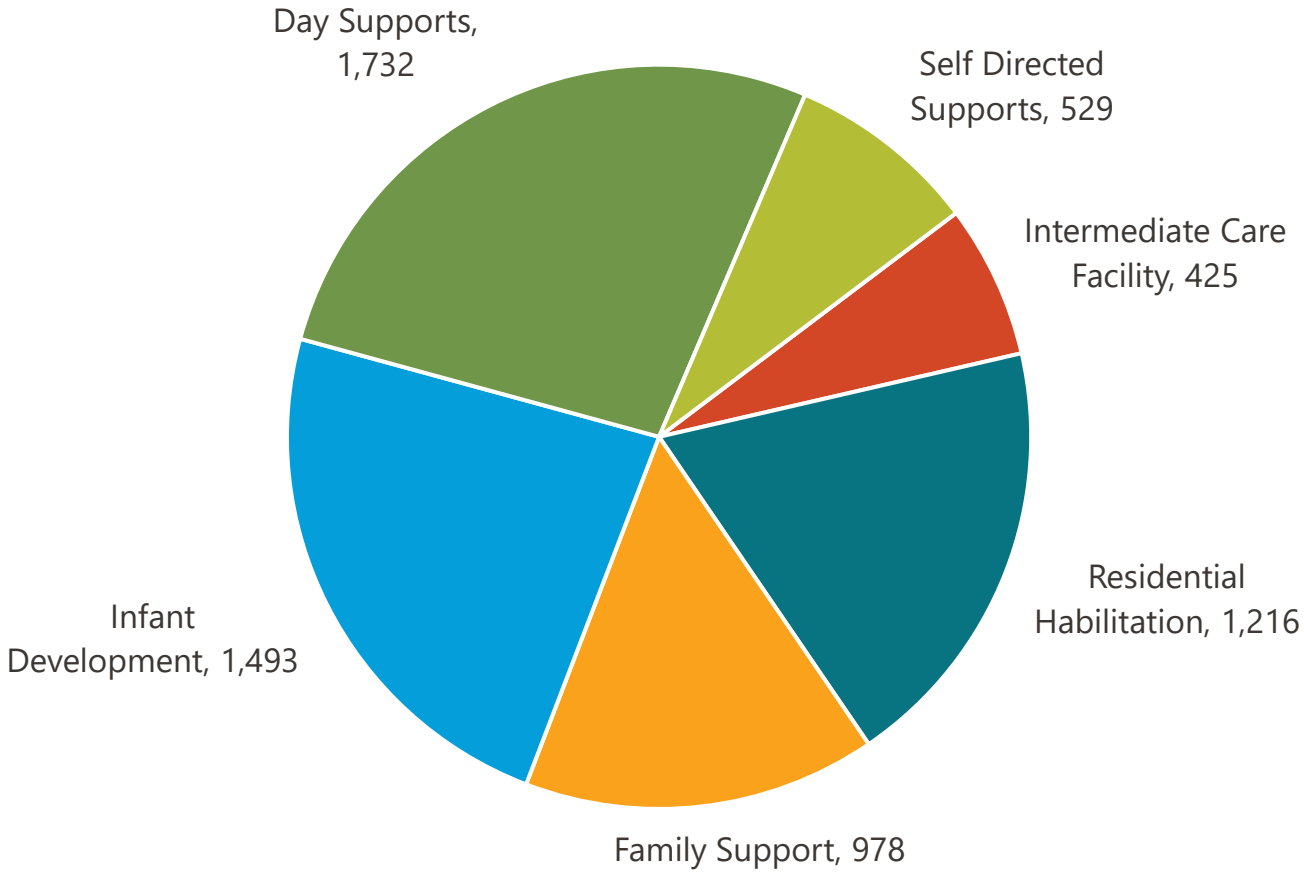
Employment
Day Services
Residential
Intermediate Care Facility

DEVELOPMENTAL DISABILITIES
Individuals receiving case management services



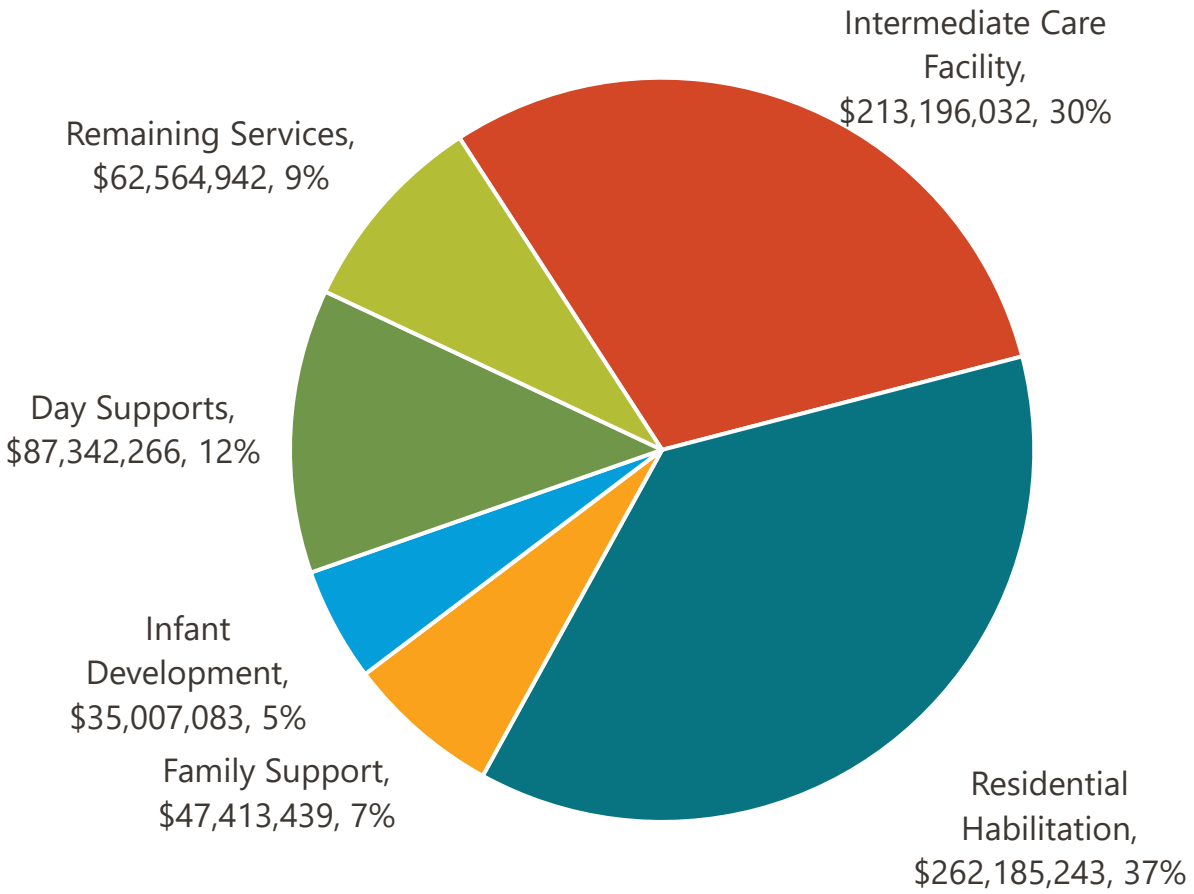
DEVELOPMENTAL DISABILITIES
Individuals receiving services in community setting

ND's 1915(c) waivered services for people with a range of developmental disabilities are coordinated by 120 DD program managers and delivered by 38 licensed providers who served 7,900 people ages 0-90+ in 2020

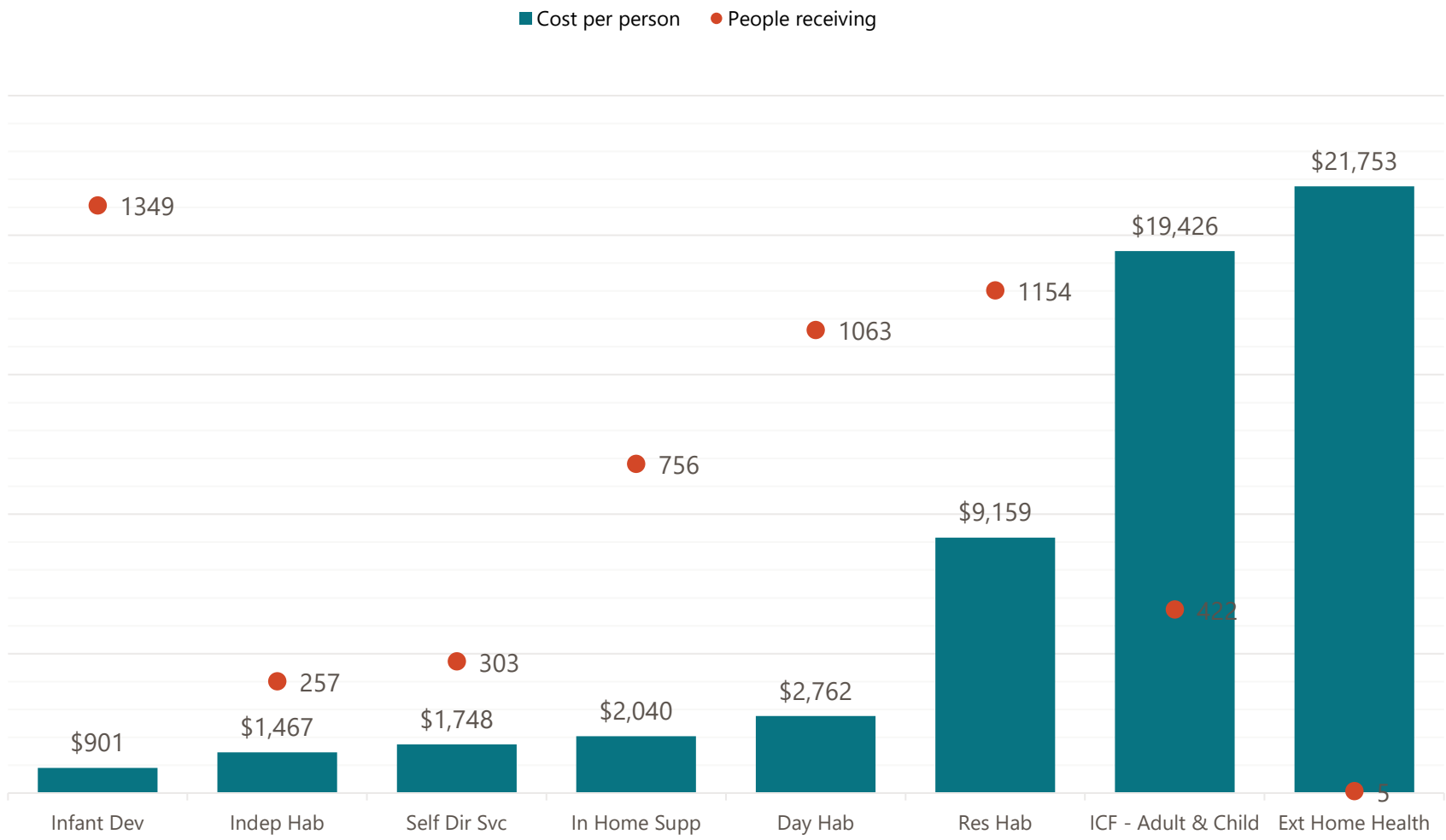


DEVELOPMENTAL DISABILITIES
Proposed 21-23 budget by type of service

67% of the total proposed 21/23 budget for DD services will support residential care for people with developmental disabilities



DEVELOPMENTAL DISABILITIES
Cost month per person per type of service – SFY20



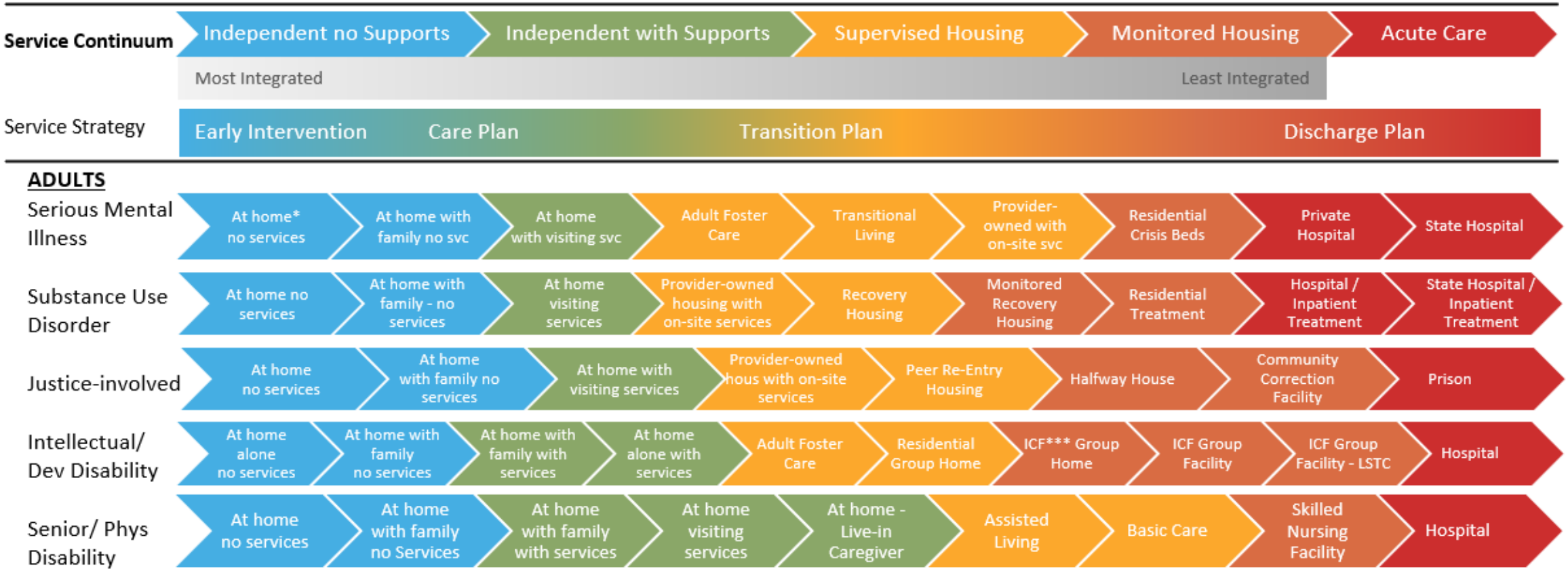






The Service Continuum - Adults

A critical concept defined



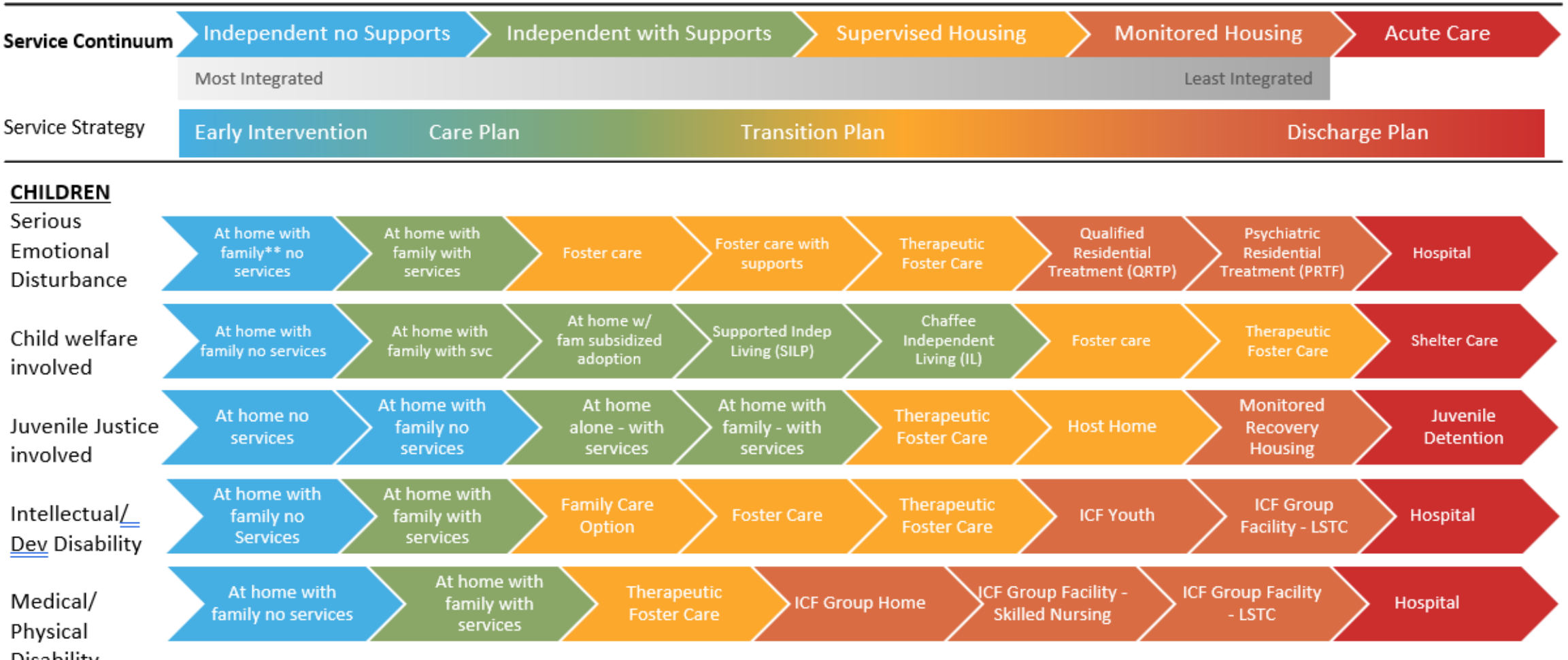
**Home = includes any type of home setting that is the responsibility of the individual (single family home, condo, apartment, mobile home)*

***Family = includes birth family, kin-caregiver, adopted family*

****ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)*

The Service Continuum - Children

Illustrating the work of transition and diversion



*Home = includes any type of home setting that is the responsibility of the individual (single family home, condo, apartment, mobile home)

**Family = includes birth family, kin-caregiver, adopted family

***ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)

Components of Quality

How are we doing? Can we do it better?

National Standards

Evidence Based Practices

Applying or translating research findings into care practices and decision making that will result in the best client outcomes

Accreditation

Assures quality, consistency and relevant approaches through application of research-based standards and a peer-review process

Licensure and Certification

Granting of authority to practice within health and safety guidelines and/or scope of practice

State Standards

Incident Reporting

Tracking of health and safety events that occur in the course of delivering care to clients



Outputs and Outcomes

National Core Indicators

Standard measures used across states to assess the outcomes of services provided to individuals and families

Core Set Measures

National standards of care and treatment processes for common health conditions

Quality Assurance

Monitoring desired level of quality in service delivery by examination of processes and procedures

Processes

Quality Control

Monitoring desired level of quality by examining results of processes and procedures

DEVELOPMENTAL DISABILITIES
Key Changes due to COVID

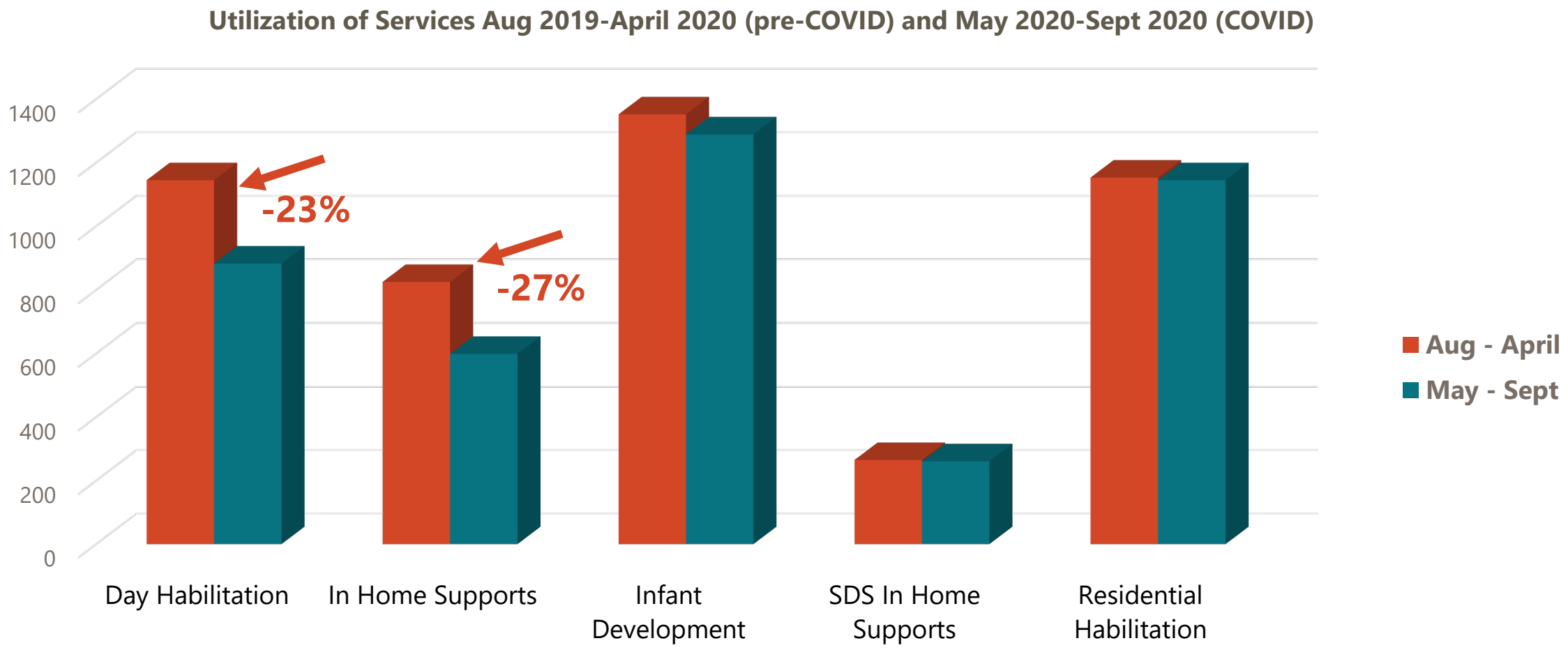
Policy
- Appendix K
- Training
- Background Checks
- Plan Development

Service
- Virtually
- Location or activity change
- In home support

Funding
- Retainer payments
- Temporary rate increases

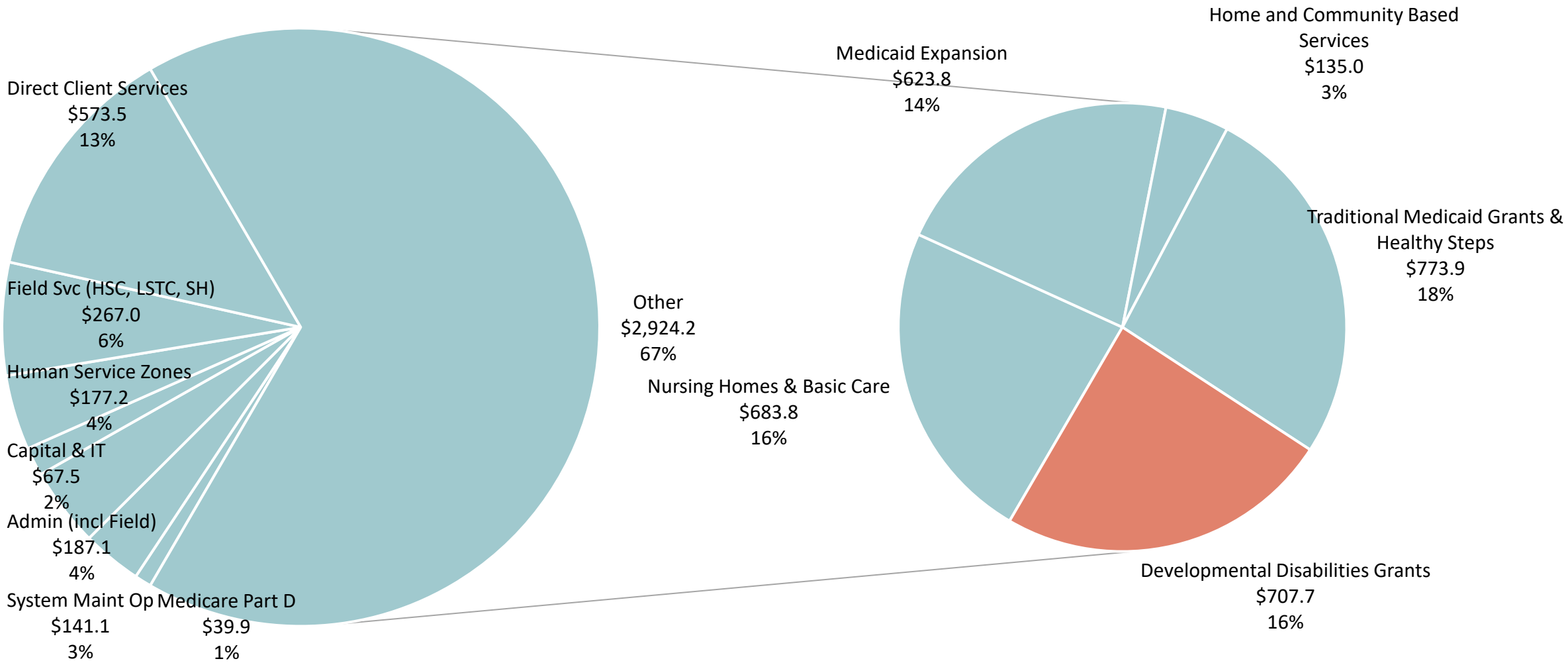


DURING COVID, UTILIZATION OF NON-RESIDENTIAL SERVICES ("DAY" AND "IN-HOME" SUPPORTS) DECLINED BY MORE THAN 20%



2021-2023 EXECUTIVE BUDGET DHS

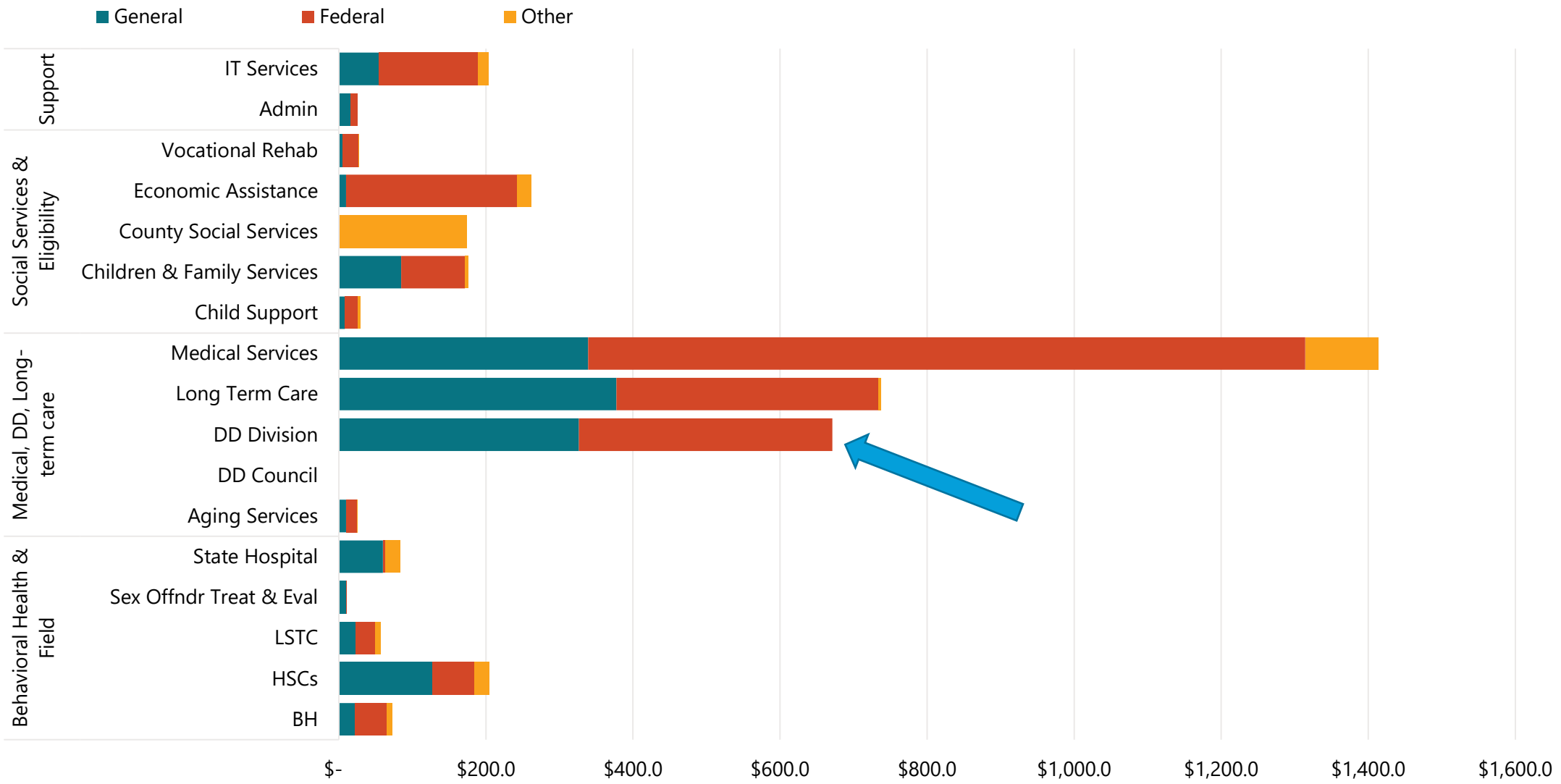
Total budget $4.378 billion, by category of expenditure



Direct Client Services include Economic Assistance Programs, Child Welfare Programs, and grants and service contracts for Aging, Behavioral Health, Vocational Rehabilitation, Medical Services, and Developmental Disability.

2019-2021 LEGISLATIVELY APPROVED BUDGET

Total budget (millions) by division



Budget as of March 30, 2020

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

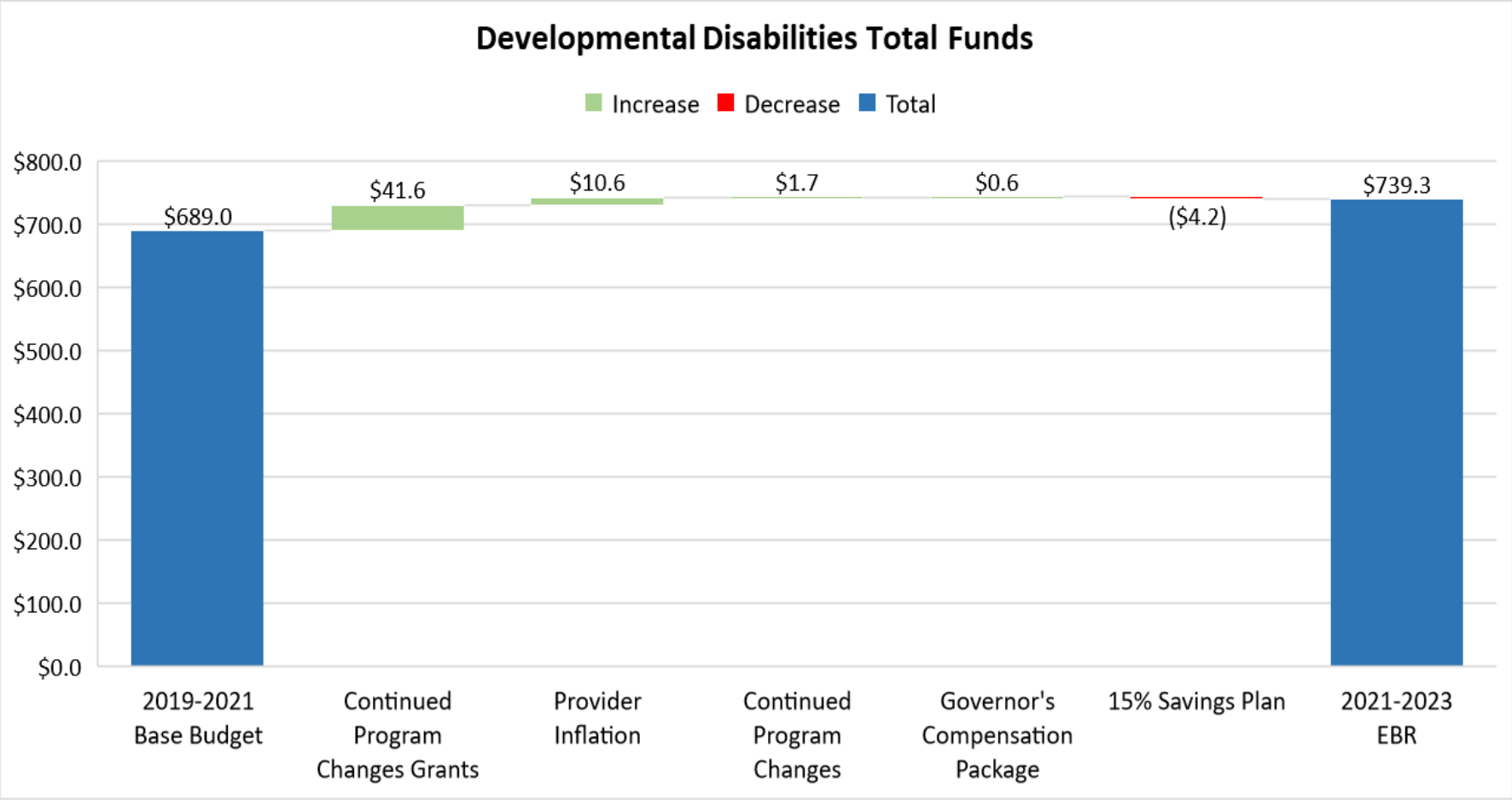
   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	21,041,554	2,147,049	23,188,603
Operating	8,402,117	(562,834)	7,839,283
Capital	10,000	-	10,000
Grants	672,928	(150,000)	522,928
DD Grants	658,889,923	48,819,082	707,709,005
Total	689,016,522	50,253,297	739,269,819
General Fund	336,131,217	8,629,327	344,760,545
Federal Funds	352,885,305	41,623,970	394,509,274
Other Funds	-	-	-
Total	689,016,522	50,253,297	739,269,819
Full Time Equivalent (FTE)	125.87	0.00	125.87

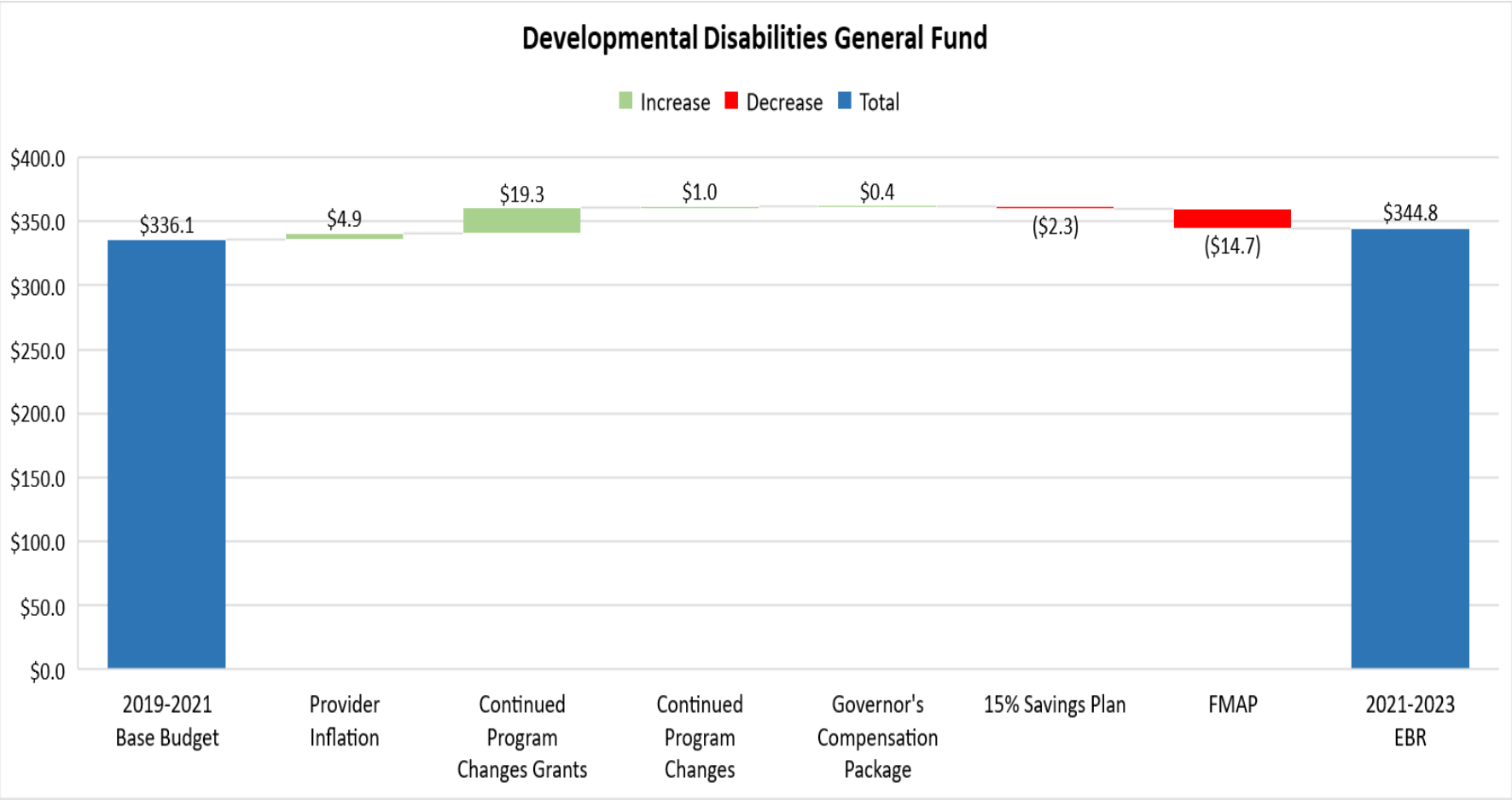
DEVELOPMENTAL DISABILITIES
Overview of Total Budget Changes (in millions)



Overall increase of $50.3M from 2019-2021 Base Budget:

- Continued Program Changes for services under DD Grants of $41.6M
- Provider Inflation of $10.6M:
  - For service providers under DD Grants of $10.52M
  - For corporate guardianship of $0.05M
- Continued Program Changes of $1.7M:
  - Includes changes in salaries, travel, professional development and right track.
- 15% Savings Plan of ($4.2M):
  - Rate adjustment for ICF, Residential & Day Habilitation of ($11.1M)
  - ICF transitions from LSTC of $7.9M

DEVELOPMENTAL DISABILITIES
Overview of General Fund Budget Changes (in millions)



Overall increase of $8.7M from 2019-2021 Base Budget

- Provider Inflation of $4.9M:
  - For service providers under DD Grants of $4.86M
  - For corporate guardianship of $0.05M
- Continued Program Changes for services under DD Grants of $4.7M including FMAP
- Continued Program Changes of $1.0M:
  - Adjustment in salaries, travel and professional development.
- 15% Savings Plan of ($2.3M):
  - Rate adjustment for ICF, Residential & Day Habilitation of ($5.2M)
  - ICF transitions from LSTC of $3.7M

DEVELOPMENTAL DISABILITIES
19-21 to 21-23 Services Overview

North Dakota Department of Human Services
Changes in Developmental Disabilities from 2019-2021 Appropriation to 2021-2023 Executive Budget

Service Description	2019-2021 Appropriation	Cost to Continue	FMAP	Rate Adj. for ICF, Res Hab & Day Hab *	ICF Transitions from LSTC ^	Total Changes	2021-2023 Budget To OMB	Inflation 1% / 1%	2021-2023 Budget To House
Intermediate Care Fac. for Intellectually Disabled	195,829,588	10,921,101	47	(4,516,667)	7,879,858	14,284,339	210,113,927	3,082,105	213,196,032
DD Home & Community Based Services	470,060,334	24,091,758	(47)	(6,633,333)		17,458,378	487,518,712	7,440,098	494,958,810
Residential Services - Daily Rates	248,973,777	18,201,674	(6)	(9,033,333)		9,168,335	258,142,112	4,043,131	262,185,243
Day Habilitation	121,540,853	(37,840,303)	(6)	2,400,000		(35,440,309)	86,100,544	1,241,722	87,342,266
Family Support Services - In Home Support	44,653,768	2,054,511	(3)			2,054,508	46,708,276	705,163	47,413,439
Infant Development	30,483,702	4,017,189	(3)			4,017,186	34,500,888	506,195	35,007,083
Remaining Services	24,408,234	37,658,687	(29)			37,658,658	62,066,892	943,887	63,010,779
Cost Settlement & Underfunding	(7,000,000)	6,554,163				6,554,163	(445,837)		(445,837)
Total	658,889,922	41,567,022		(11,150,000)	7,879,858	38,296,880	697,186,802	10,522,203	707,709,005
General Fund	319,198,437	19,323,007	(14,656,562)	(5,240,000)	3,706,523	3,132,968	322,331,405	4,859,222	327,190,627

Notes:

* Recommended Rate Adjustments for ICF, Residential Habilitation and Day Habilitation per Optumus analysis.

^ Budget Adjustment for ICF Transitions from LSTC (16 children and 10 adults)

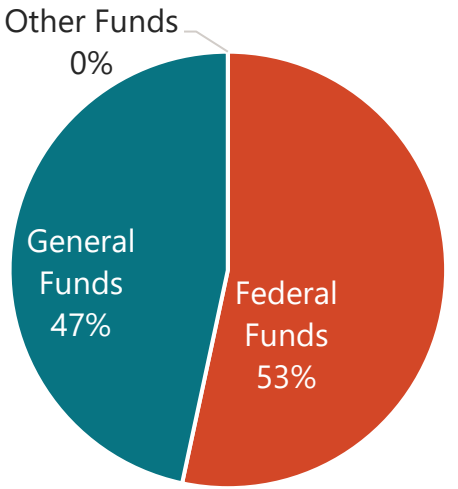


Developmental Disabilities Budget Summary

19-21 Budget	**$689,016,522**
21-23 Budget (exec)	**$739,269,819**

125.87 FTEs; no change in FTEs projected; $50.2 million increase in total budget (83% of increase is from federal funds)

- Diversion/Transition initiative with LSTC
- Payment system adjustments for ICF and Residential Group Homes
- Elimination of recreation and Section 11 grants
- Operating efficiencies related to travel and occupancy





Contact Information

Tina Bay, Director
Developmental Disabilities Division
1237 W Divide Ave, Suite 1A
Bismarck, ND 58501-1208

Phone: 701-328-8930
Toll Free: 1-800-755-8529
ND Relay TTY: 1-800-366-6888
E-mail: tbay@nd.gov



2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/14/21 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 9:00 a.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Human Service Zones
- Key priorities
- Improving Programs
- Covid-19 impact
- Zone Directors
- System redesign

Sara Stolt, Chief Operating Officer, DHS (9:03 am) testified about Human Service Zones #1113

Arnie Strebe, CEO, CFO (10:40 am) testified about the Administrative Support Budget Overview #1114

Chair Nelson closed the meeting at 11:56 a.m.

Cole Fleck, Committee Clerk



House Bill 1012 #1113

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTH Dakota | Human Services

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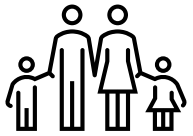
Human Service Zones

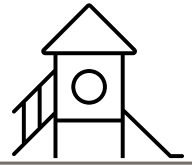
Local + State Partnerships For Effective and Efficient Service Delivery

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



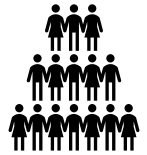
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

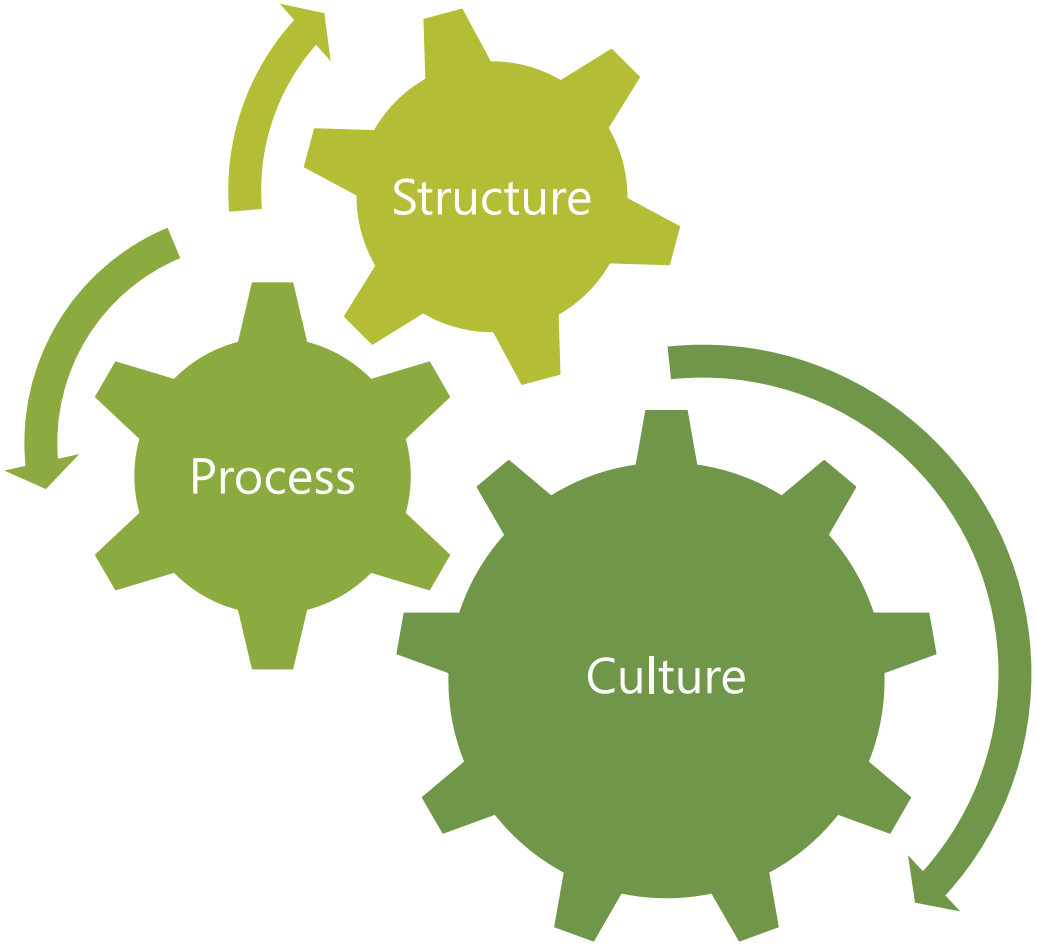
   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

IMPROVING PROGRAMS IS MORE THAN LOOKING AT STRUCTURE: Process and Cultural Change Must Accompany Structural Change



- 3 Core Areas
  - Process
  - Structure
  - Culture
- Focus is on service delivery to the client in the most effective and efficient way possible
- Seek to remove geographic, political and cultural boundaries to deliver smart, efficient and compassionate human services
- Primary Stakeholders
  - Individuals & Families
  - Taxpayers
  - Employees

Zone Transformation History

2017-2018

- SB2206 Passed
- System redesign began
- CPS Redesign Kick-off

2019

- SB2124 Passed
- Kick-off with County Social Services
- Zone Agreements

1.1.20

- Zones formed
- 1st payment to zones 1.10.20
- Transfer 112 FTE from county to DHS

COVID begins to impact clients, zones and the transformation project.

3.31.20

- Zone directors hired
- Begin zone plans

6.30.20

- Draft Zone plans completed
- 2nd payment to zones
- 2021 budgets due



HUMAN SERVICE ZONES



Gateway for Human Services

- Child Welfare
- Economic Assistance
- Indigent burials
- General Assistance
- County Supported HCBS
- Locally provided programs



Access Points Across ND

- Formerly known as County Social Services
- 19 Human Service Zones
- 46 Offices



Effectiveness + Efficiency

- Person-Centered
- Timeliness
- Quality

HUMAN SERVICES ZONES-MILESTONES

Zone Formation

- Formation of zone boards
- Zones formed 1/1/20
- Zone directors hired by 3/31/20
- Draft zone plans 6/1/20
- Final zone plans 12/1/20

Zone Operations

- Unified and consistent human resources policy and process manual 1/1/21
- Zone director performance appraisal process
- Consistent Chart of Accounts
- Indirect Costs*
- Equity Study*

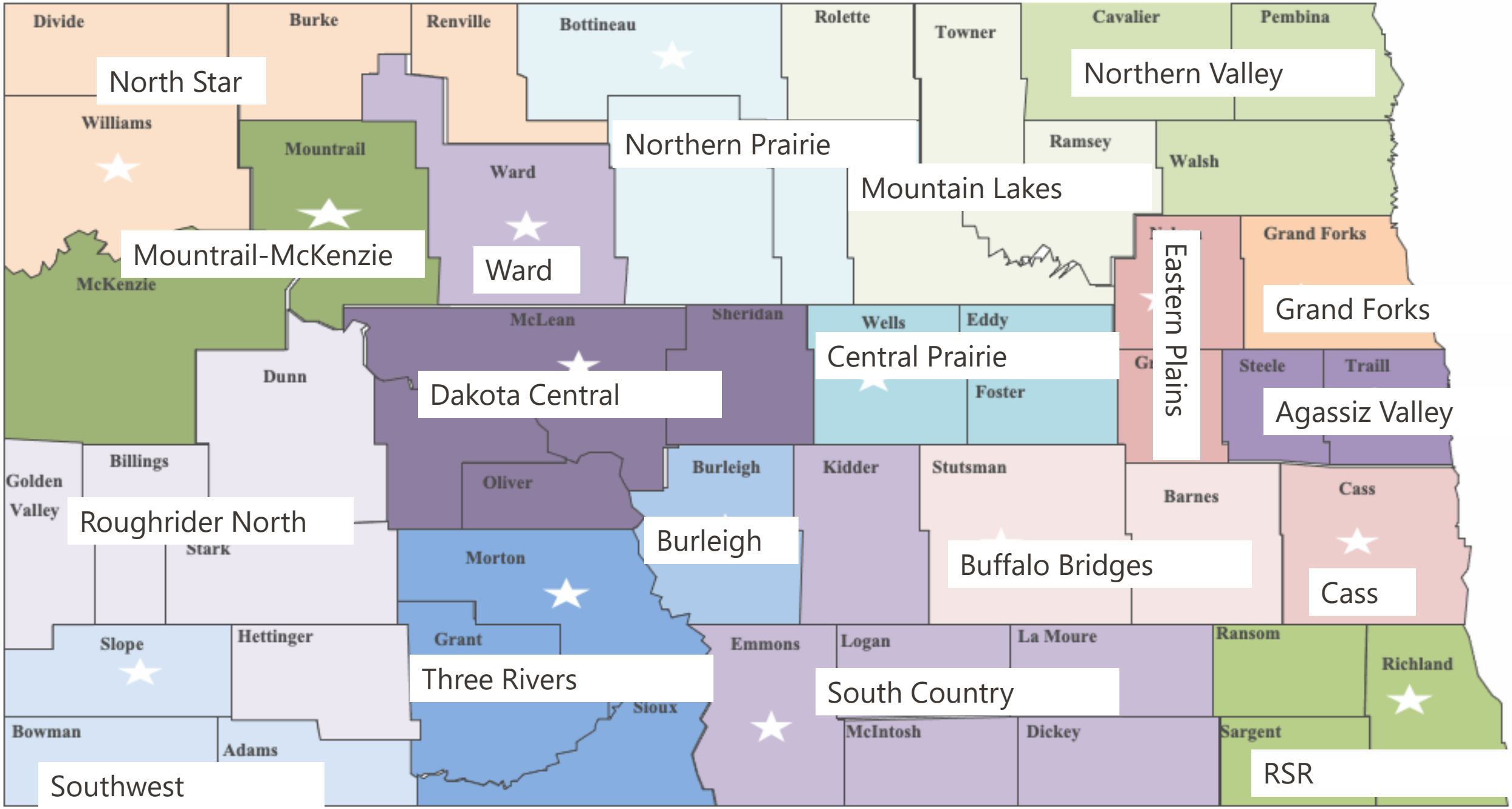
Program Operations

- Consistent General Assistance policy and process*
- Consistent Indigent Burial Criteria*
- Opt In – State Study*
- Multiple Redesign
  - Child Welfare
  - Eligibility*
  - Central Background Check
  - Institutional CPS
  - Foster Eligibility*
  - Sub Adopt Negotiations*
  - ADRL
  - QSP Enrollment*

*These projects are currently in process.

COVID IMPACT

- Increased SNAP and Medicaid applications with fewer eligibility workers
- Hybrid office closures – continued to serve clients
- Experienced more clients using electronic means for verification
- Maintained child and family visits
- Federal waivers that provided flexibility in how eligibility workers engaged with clients


Divide
Burke
Renville
Bottineau
Rolette
Towner
Cavalier
Pembina
North Star
Northern Valley
Williams
Mountrail
Ward
Northern Prairie
Ramsey
Walsh
Mountain Lakes
Mountrail-McKenzie
Ward
McKenzie
Grand Forks
Eastern Plains
Grand Forks
McLean
Sheridan
Wells
Eddy
Central Prairie
Dunn
Dakota Central
Steele
Traill
Agassiz Valley
Foster
Billings
Golden Valley
Burleigh
Kidder
Stutsman
Oliver
Barnes
Cass
Roughrider North
Burleigh
Stark
Morton
Buffalo Bridges
Cass
Slope
Hettinger
Grant
Emmons
Logan
La Moure
Ransom
Richland
Three Rivers
South Country
Sioux
Bowman
Adams
McIntosh
Dickey
Sargent
Southwest
RSR

Total Full Time Equivalents



Counties were authorized 1,207 FTE



DHS budgeted for 985 FTEs in the zones



222 positions under reevaluation

ZONE DIRECTORS



Social Service Directors 2019

37

17+2



Human Service Zone Directors

18



Program + Direct Service Staff

HUMAN SERVICE ZONE ADMINISTRATION

Executive Policy

Leads Family Stability and Community Inclusion strategy and policy to guide service delivery in zones.

Chief Operating Officer

Leads DHS and zone operations and program redesign efforts for the zones.



Dir Zone Operations

Works to guide zones, build collaboration and lead zone operations.

Project Manager

Leads the DHS Office of Transformation supporting redesign projects, change management and process improvement across DHS and Human Service Zones.

FTE TRANSITIONS FROM COUNTY TO STATE



HCBS CASE MANAGERS

- Provide case management for older adults & individuals with physical disabilities receiving state and federally funded home and community-based services and basic care
- Became state employees 1/1/2020

Major Initiatives

- Specialized role of HCBS Case Manager
- Standardized training required for position
- Implemented a statewide centralized intake system for HCBS referrals and informed choice visits to ensure consumers understand their long-term service and support options
- 64 FTE provide support to 3057 unduplicated individuals
- Average 283 referrals and 54 new cases per month

CFS QUALITY ASSURANCE UNIT

SUPERVISOR: LEANNE MILLER



Continuous Quality Improvement Efforts (TBD in 2021)



Facility Licensure Visits



Case Record Reviews



Child & Family Service Reviews

Safety, Permanency, and Well-Being

EARLY CHILDHOOD SERVICES UNIT



2020 Big Wins

- Childcare Licensors are now state employees
- Made progress on the Early Childhood Services (ECS) online application system

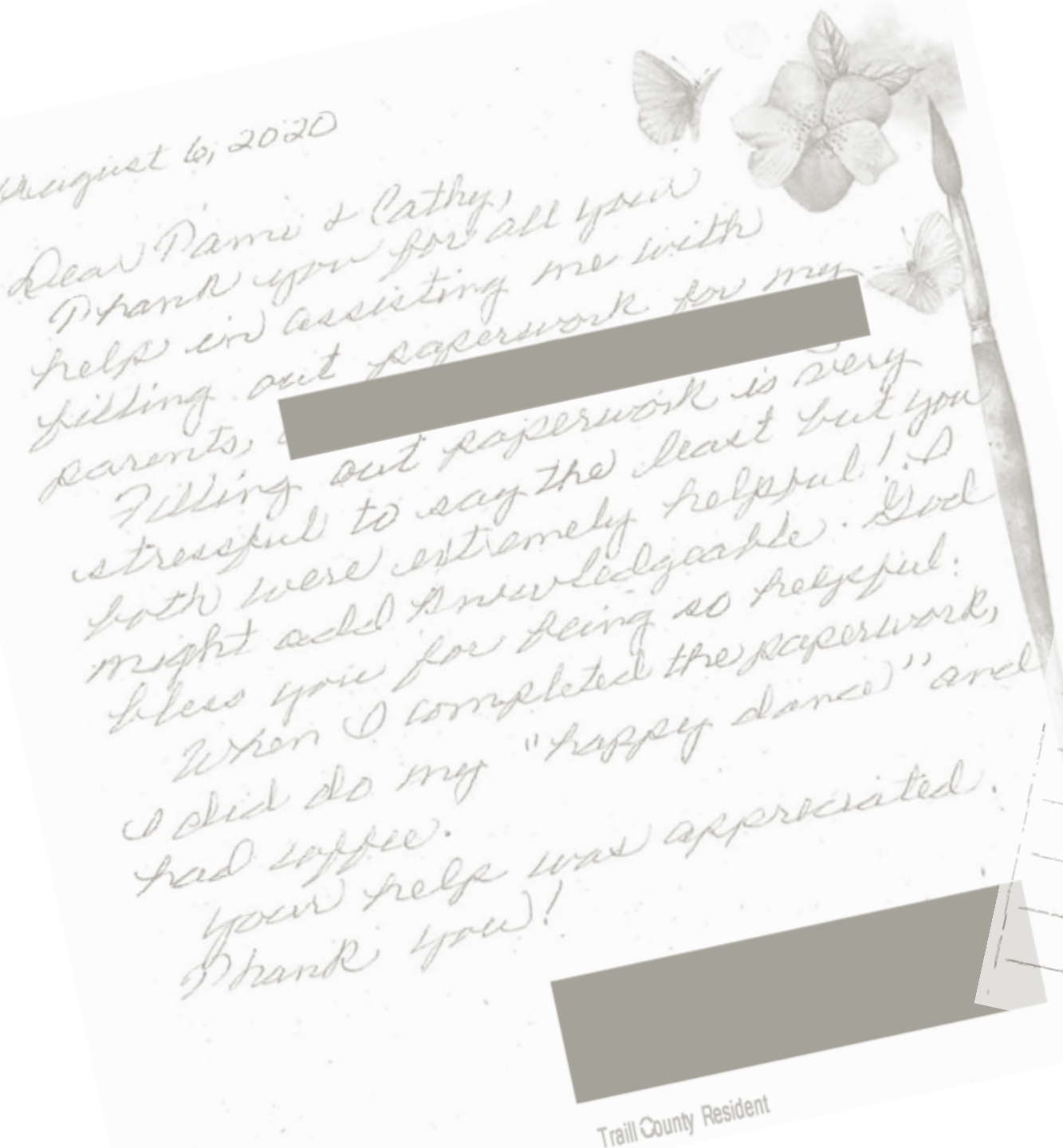


Goals for 2021

- Successfully complete the Child Care and Development Fund (CCDF) Monitoring Visit in Spring 2021
- Continue to work towards completion of the Early Childhood Services (ECS) online application system

MEDICAID LONG TERM CARE ELIGIBILITY UNIT

- Processed and maintain LTC Medicaid applications according to federal timeliness standards
- 16 FTE transferred from Human Service Zones
- Established Q1 2020
- Went live May 11, 2020



December 6, 2020

Dear Pami & Cathy,

Thank you for all your help in assisting me with filling out paperwork for my parents, [redacted]

Filling out paperwork is very stressful to say the least but you both were extremely helpful! I might add knowledgeable. God bless you for being so helpful: When I completed the paperwork, I did do my "happy dance" and had coffee.

Your help was appreciated.

Thank you!

[redacted]

Traill County Resident

12-11-20

Dear Ms. Brevik

This is just a quick note to say THANK YOU for your compassionate demeanor in handling our case.

It was a much needed emphatic ear you gave me on the phone at a time of my peak stress over this unexpected "worrier" matter. Such an attitude is very rare in my experience.

Happy Holidays

Sincerely

Pierce County Resident

FOSTER ELIGIBILITY + SUB ADOPT

- Authorized for 14 FTE to transfer from the HSZ to the State for a specialty foster eligibility unit
- Authorized for 2 FTE to transfer from the HSZ to the state to support subsidized adoption negotiation
- Unit launches in March 2021
- Will process all foster eligibility, Medicaid determinations for all foster and adopted children and negotiate subsidy for special needs adoptions

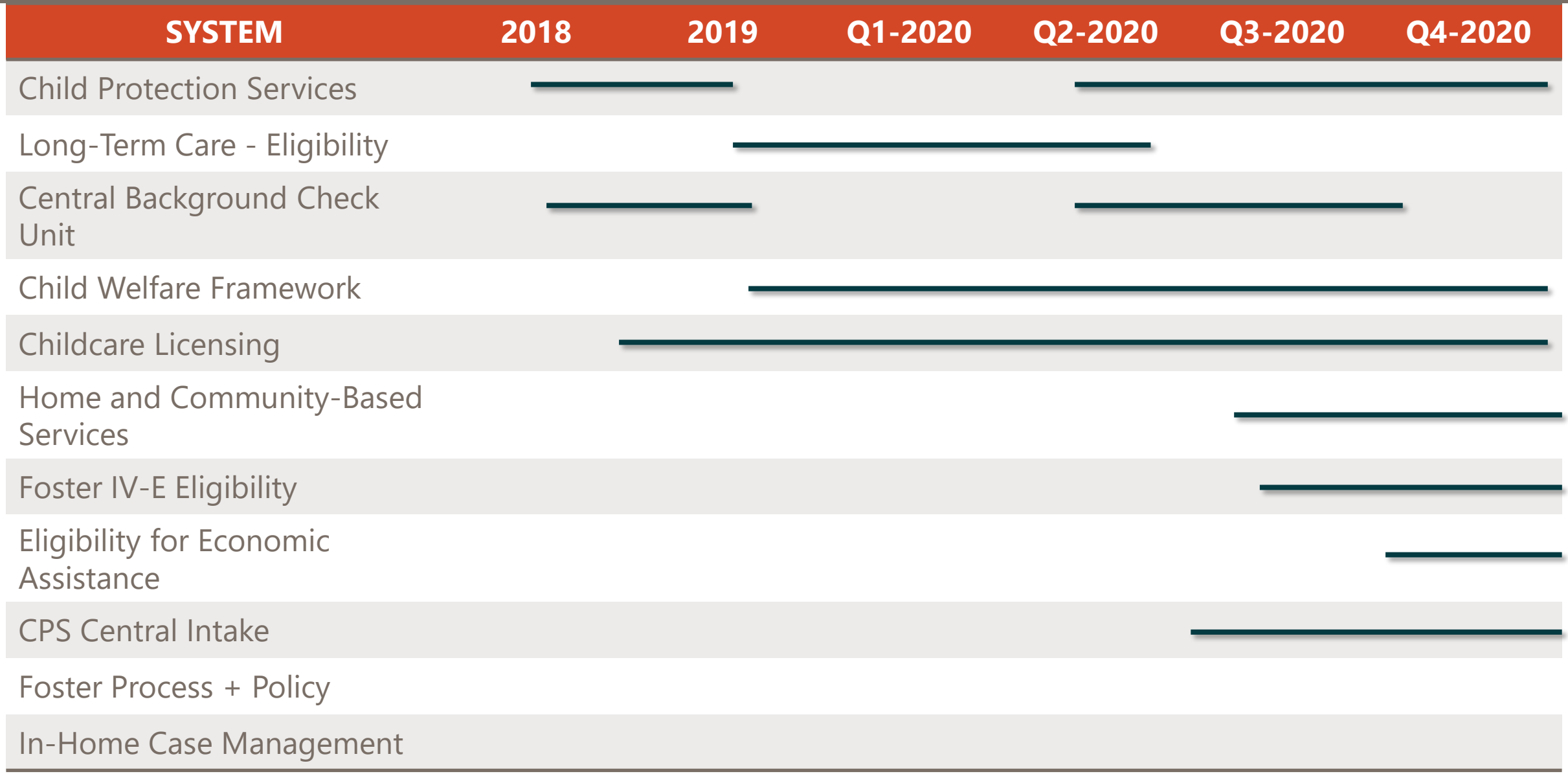
FOSTER CARE LICENSING

- Request for up to 16 FTE to for a specialized foster care licensing unit to provide foster care licensing and renewals to foster homes in ND
- Create consistency and a leveled approach to managing foster licenses

IN PROGRESS

- Request for 16 FTE to transfer from the county to state to form a specialty foster care licensing team
- Consistent indigent burial criteria
- Consistent General Assistance policies, criteria and appeals process
- Study for zones to opt in to State employment

SYSTEM REDESIGN TIMELINE



OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries & Benefits	24,186,261	2,934,741	27,121,002
Operating	4,621,303	(432,414)	4,188,889
Grants	144,892,436	956,411	145,848,847
Total	173,700,000	3,458,738	177,158,738
General Fund	0	1,323,223	1,323,223
Federal Funds	0	1,176,874	1,176,874
Other Funds	173,700,000	958,641	174,658,641
Total	173,700,000	3,458,738	177,158,738
Full Time Equivalent (FTE)	140	3	143

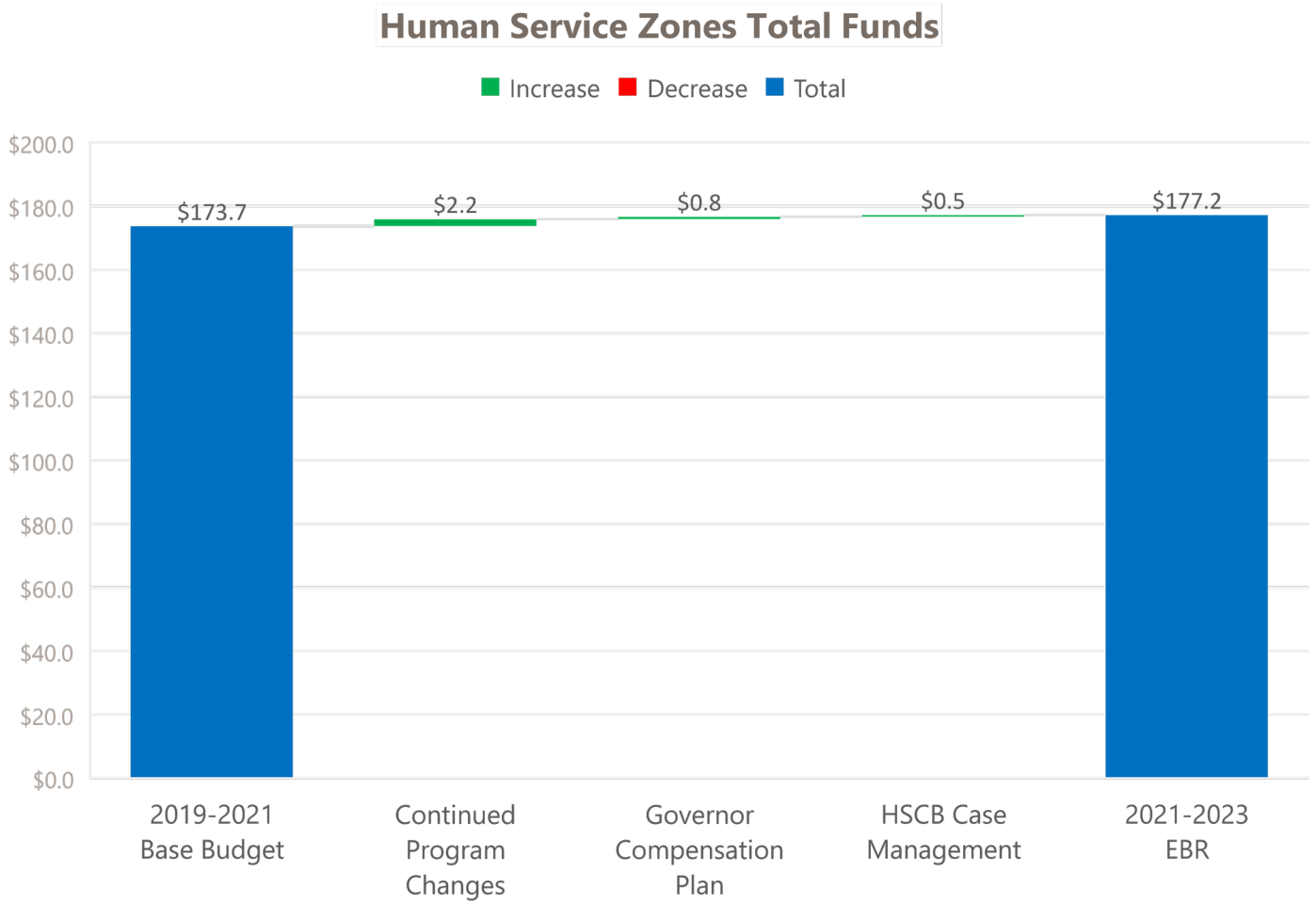
21-23 BUDGET REQUEST

	21-23 Request
19-21 Base	173,700,000
3 FTE HCBS	498,673
Comp + Benefits – 140 State FTE	2,436,068
Operating	(432,414)
Grants	956,411
Subtotal	**177,158,738**
Proposed Legislative Increase of 2/2	3,468,215
21-23 Zones Uncovered Need	9,089,381
Total Increase Requested	**12,557,596**
Total Proposed 21-23 Budget	**189,716,334**

EQUITY ADJUSTMENTS

Zone Directors	Compensation equity to align all zone directors within the range
Zone Employee Benefits	Employees shifting to host county benefits which were often more robust
Zone Transfers to State Team	140 FTE that transferred to state were made whole if moving to state caused them to go backwards in salary and benefits

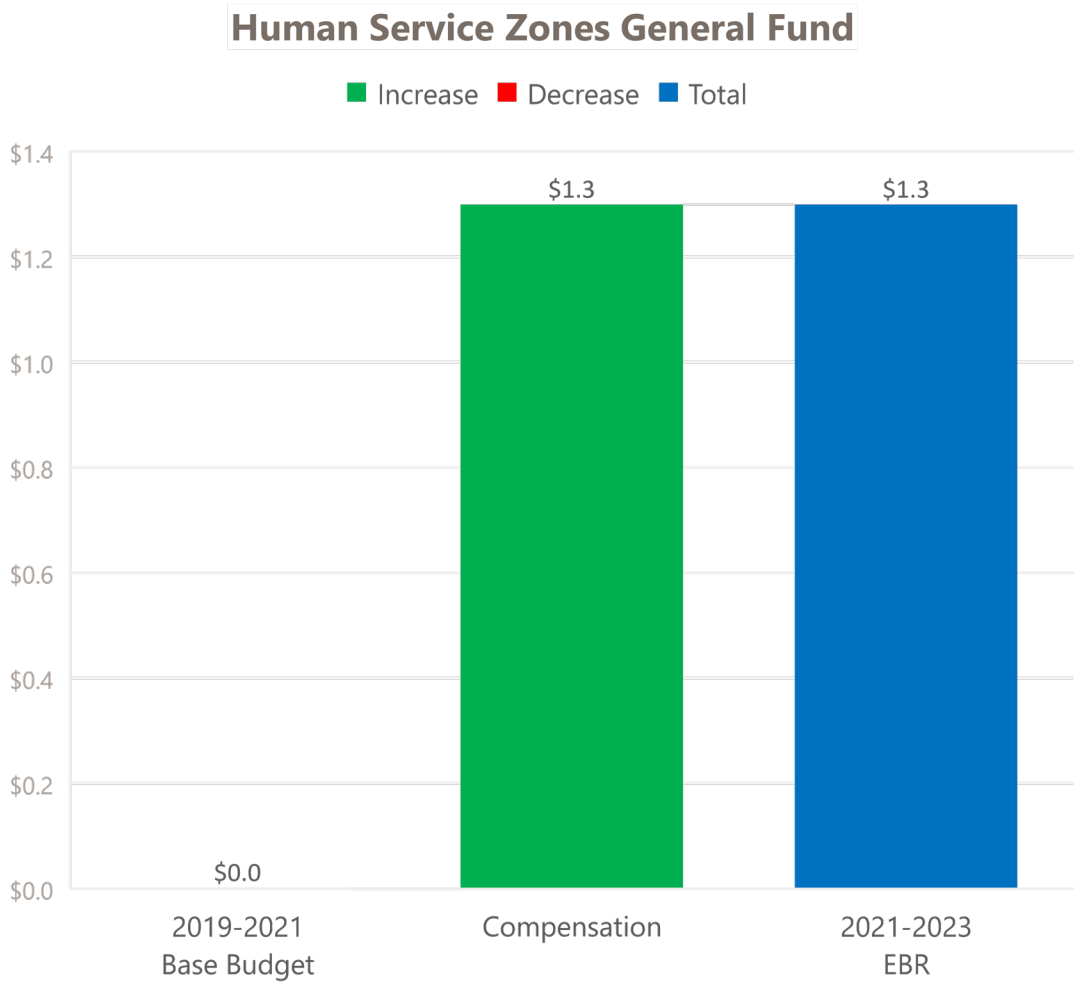
OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



Continued Program Costs

- Salary & Benefits Changes $1.6 million
- Zone Payment Change $1 million
- Other cost changes ($0.4) million

GENERAL FUND CHANGES (IN MILLIONS)



Compensation

- Expend revenue for collected fees for associated FTEs



Contact Information

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3rd Floor, Judicial Wing
Bismarck, ND 58505

Phone: 701-328-1891
E-mail: sarastolt@nd.gov



NORTH Dakota

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HOUSE BILL 1012 #1114

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

ADMINISTRATIVE SUPPORT BUDGET OVERVIEW

Arnie Strebe, Chief Administrative Officer / Chief Financial Officer

NORTH Dakota | Human Services

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DHS MISSION AND OPERATING PRINCIPLES

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

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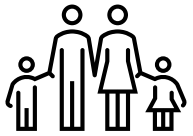
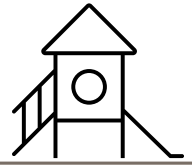
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



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- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



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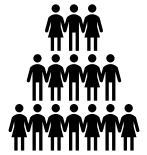
- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

WHO WE ARE

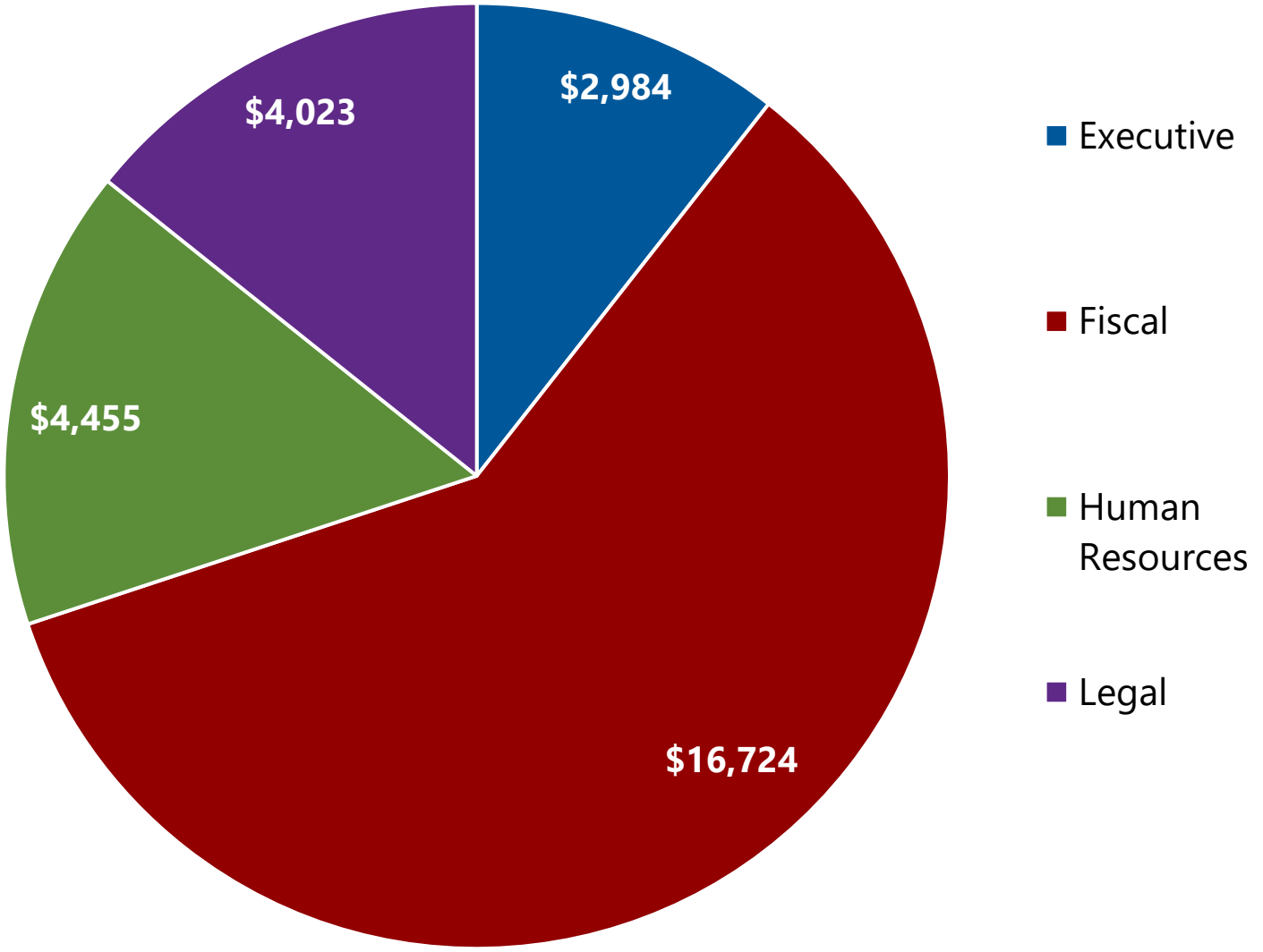


Administration Support

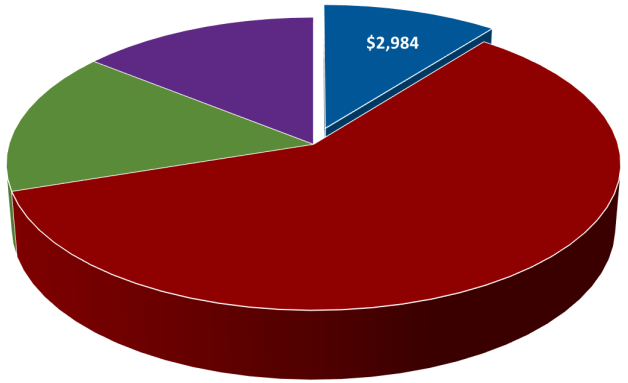
- Human Resources
- Legal Services
- Fiscal
- Logistics Management – New 19-21
- Strategic Communications – New 19-21

We support the people who serve the people

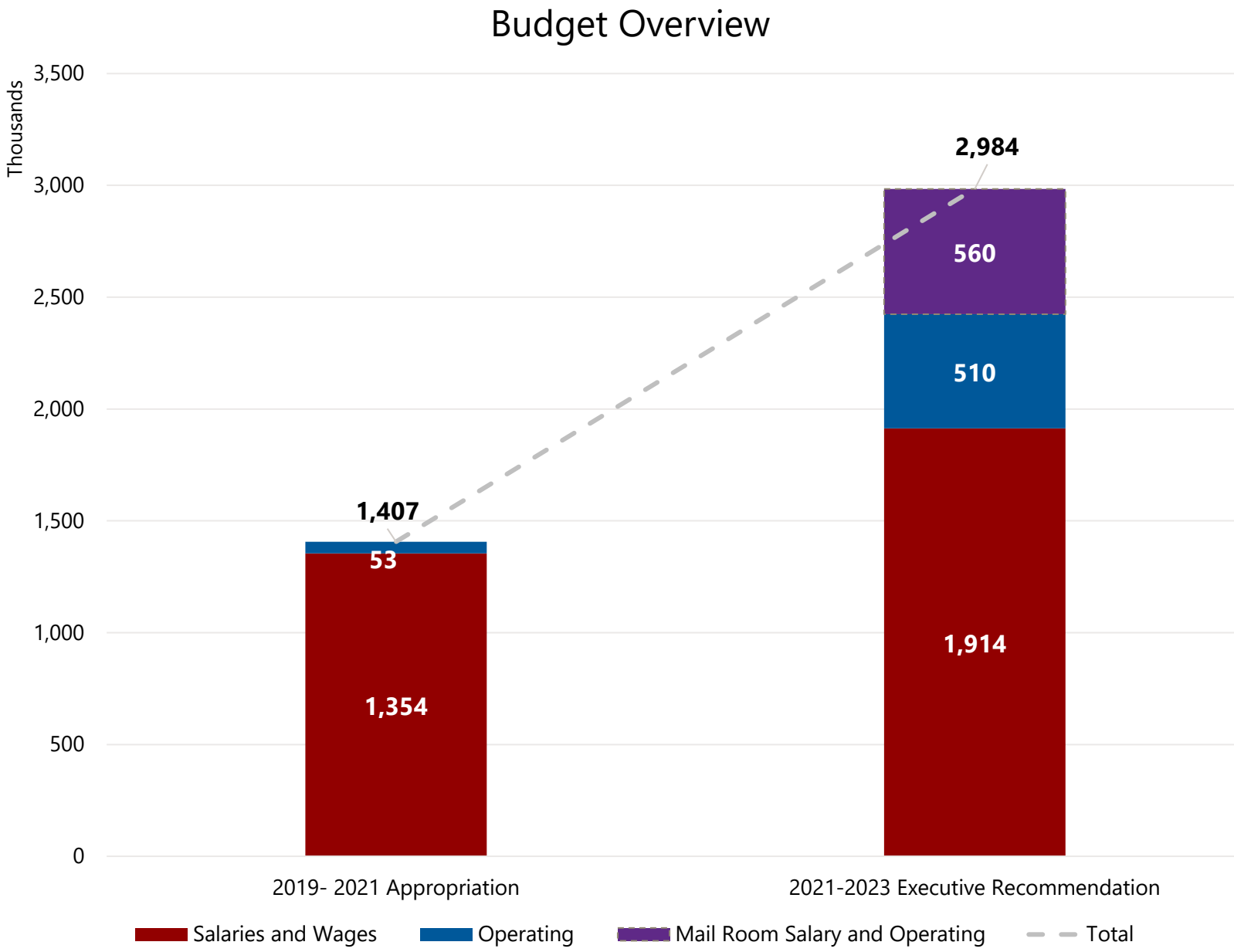
2021-2023 EXECUTIVE RECOMMENDATION ADMINISTRATION-SUPPORT (THOUSANDS)



EXECUTIVE OFFICE



- 11.0 FTE
- Provides programmatic direction and oversees operation of:
  - Program and Policy
  - Medical Services
  - Behavioral Health
  - Administration Support
    - Mailing services
- Provides guidance and/or information to:
  - Governor
  - Legislators
  - Congress
  - Political subdivisions and
  - Tribes
  - Public and Mass Media

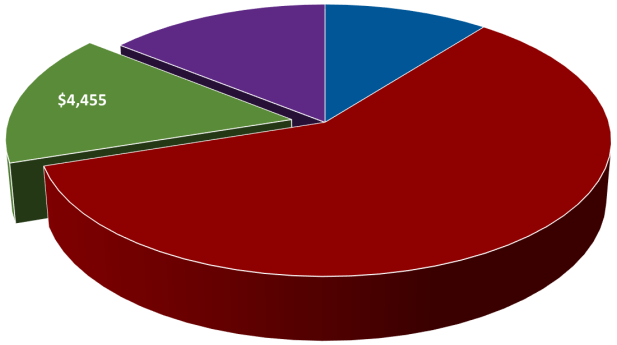


HUMAN RESOURCES – GOALS

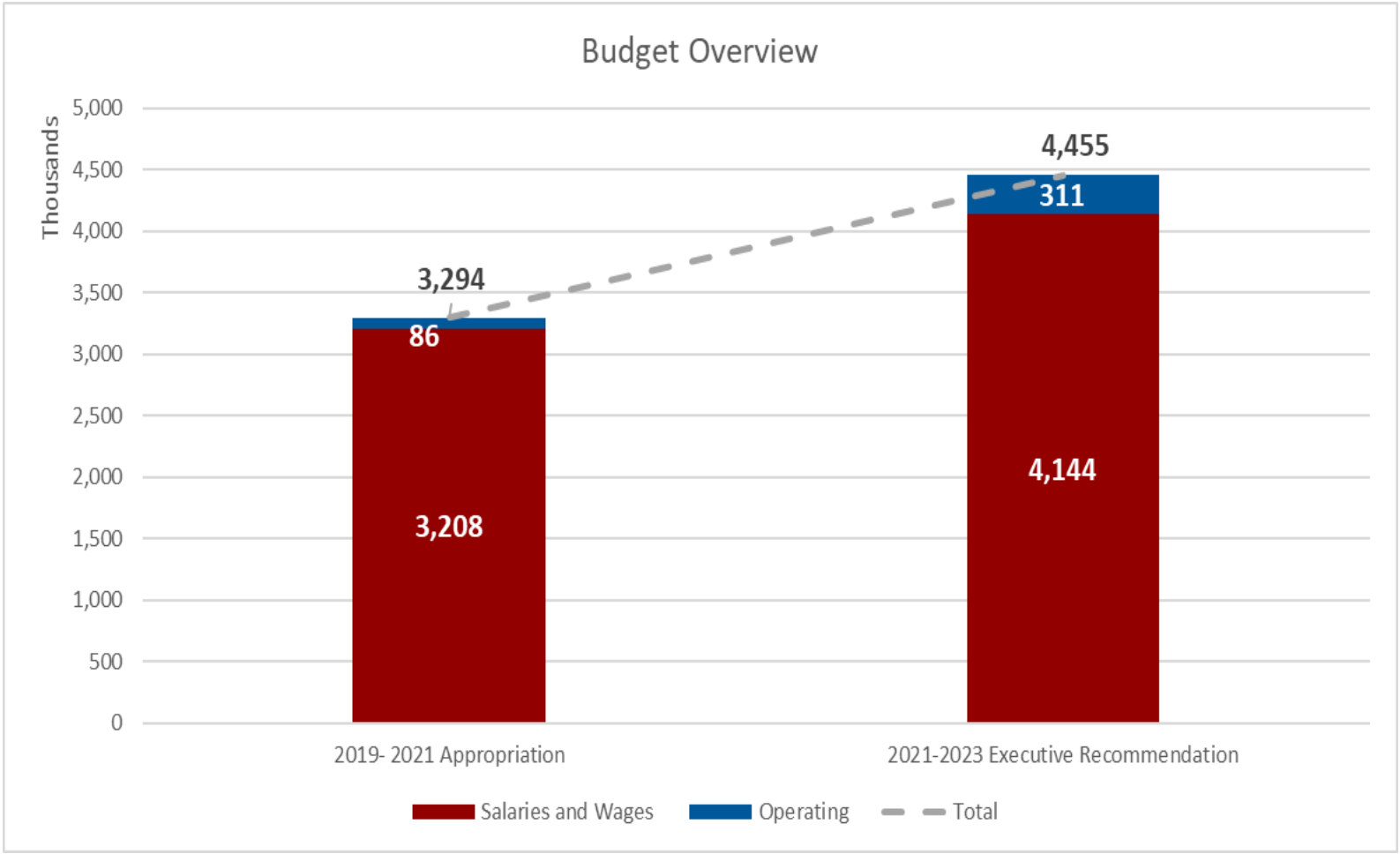
- New Workplace
- Employee engagement
- Recruitment / staffing
- Succession planning
- Automation of processes



HUMAN RESOURCES



- 21.80 FTE
- Talent Acquisition
- Performance Development/ Management
- Classification/Compensation
- Position/FTE Management
- Payroll/Data Management
- Learning & Development
- Compliance/Regulation
- Employee Relations
- Risk Management/Safety/Wellness
- Disaster Preparedness
- County Social Service/Zone HR support

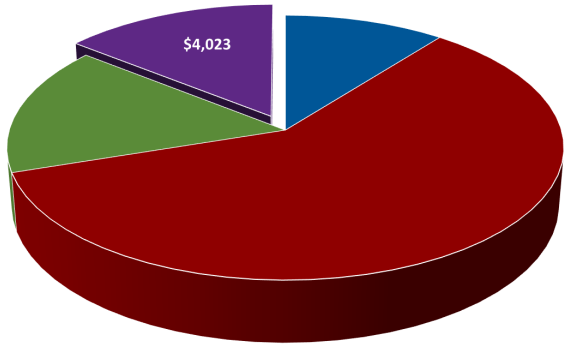


LEGAL – GOALS

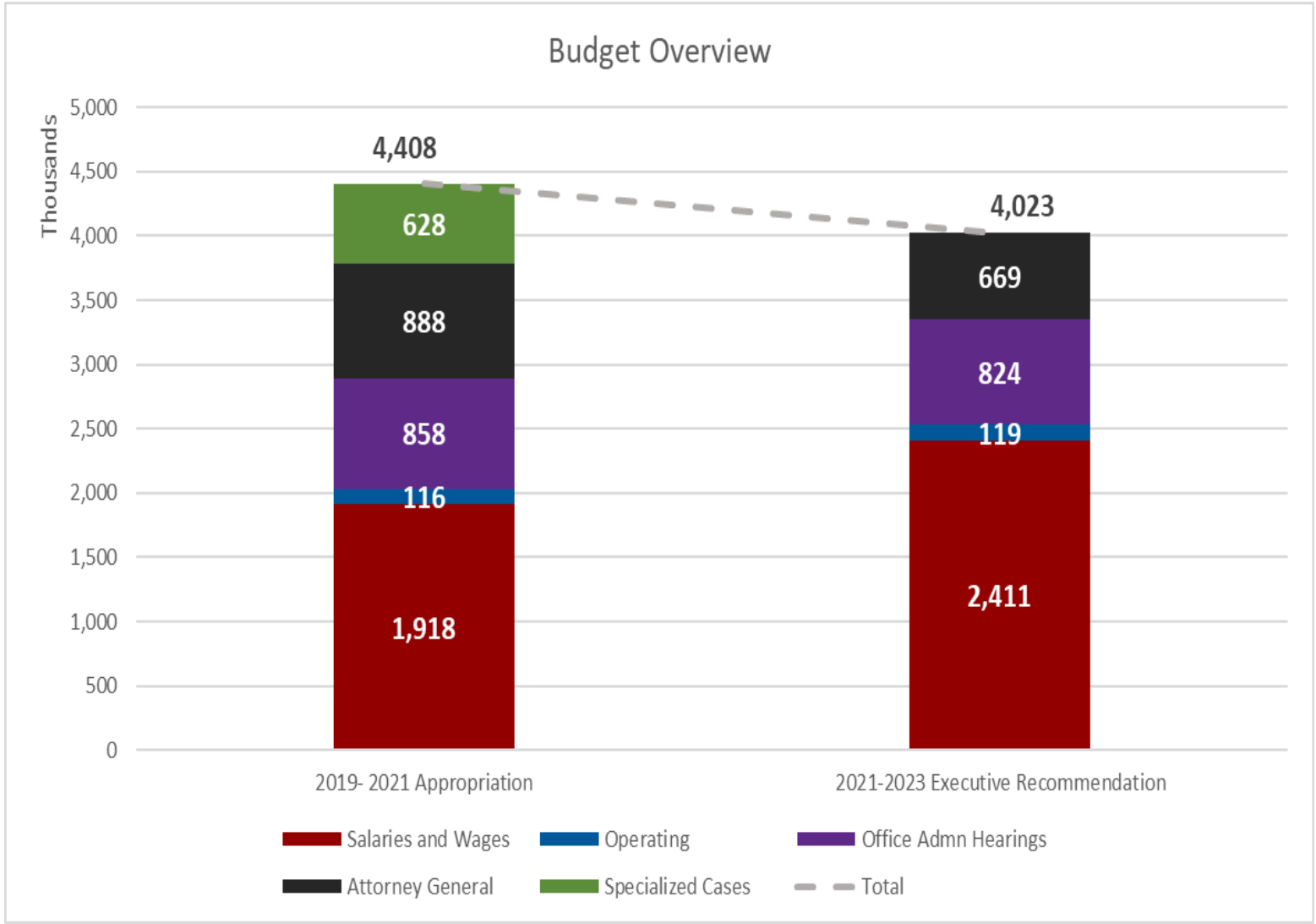
- Provide general counsel and policy analysis
- Process administrative appeals
- Assist with, plan and develop administrative rules
- Implement administrative and program policy
- Draft proposed legislation



LEGAL UNIT-ADVISORY

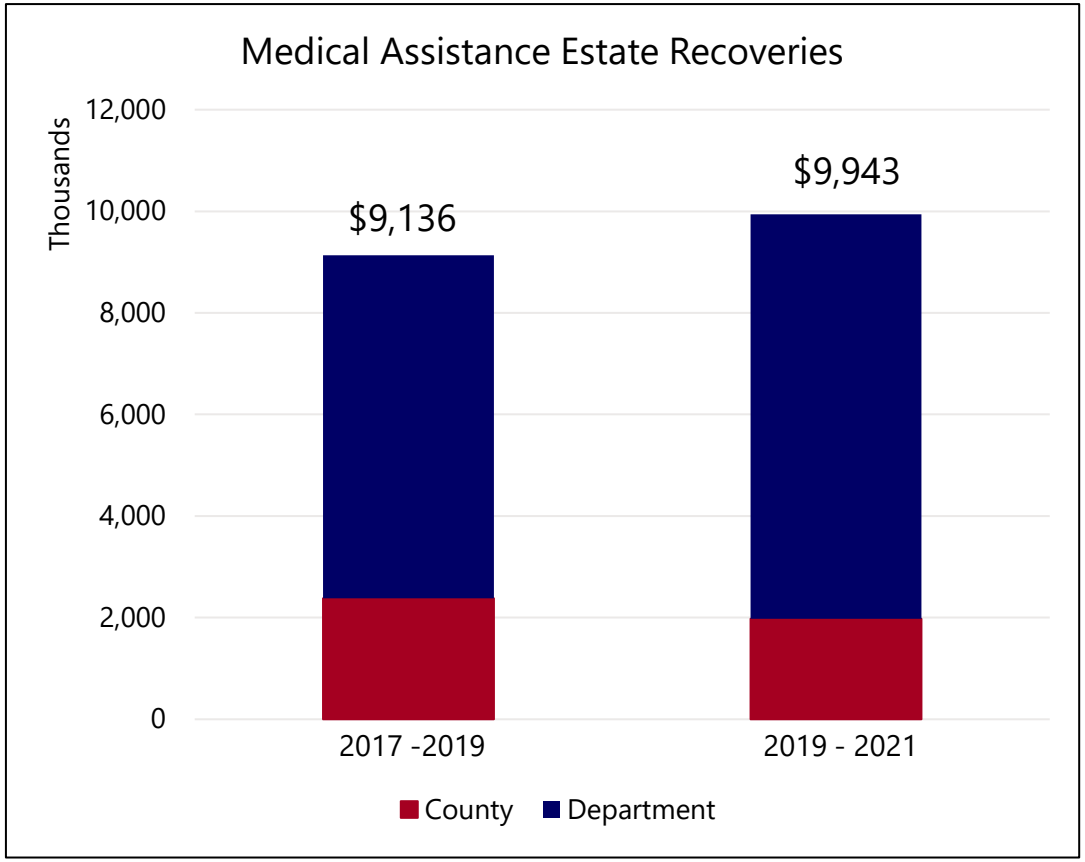


- 10.75 FTE
- Provides assistance in policy analysis, interpretation, development, training, and information
- Provides legal advice to the Department as authorized by the Attorney General
- Coordinates the appeals process for DHS clients and providers so they can obtain final decisions
- Facilitates estate recovery
- Serves as the Department's Civil Rights Office, ADA Compliance Office, and HIPAA Privacy Office
- Draft proposed legislation



LEGAL UNIT-ADVISORY

Number of:	SFY 2019	SFY 2020
Request for Fair Hearings	306	265
Provider Appeals	384	626
Intentional Program Violation	280	173
Civil Rights	18	13
Administrative Rules/ Legislative Process	4	42
Trust Review Files	87	84

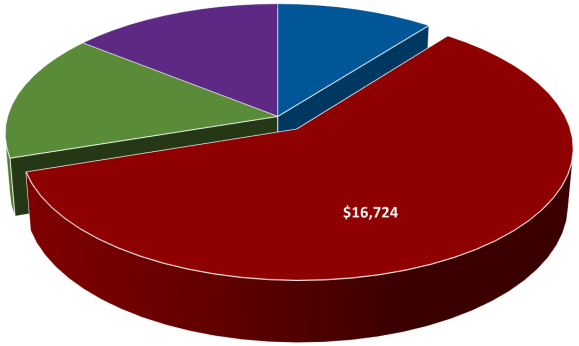


FISCAL ADMINISTRATION – GOALS

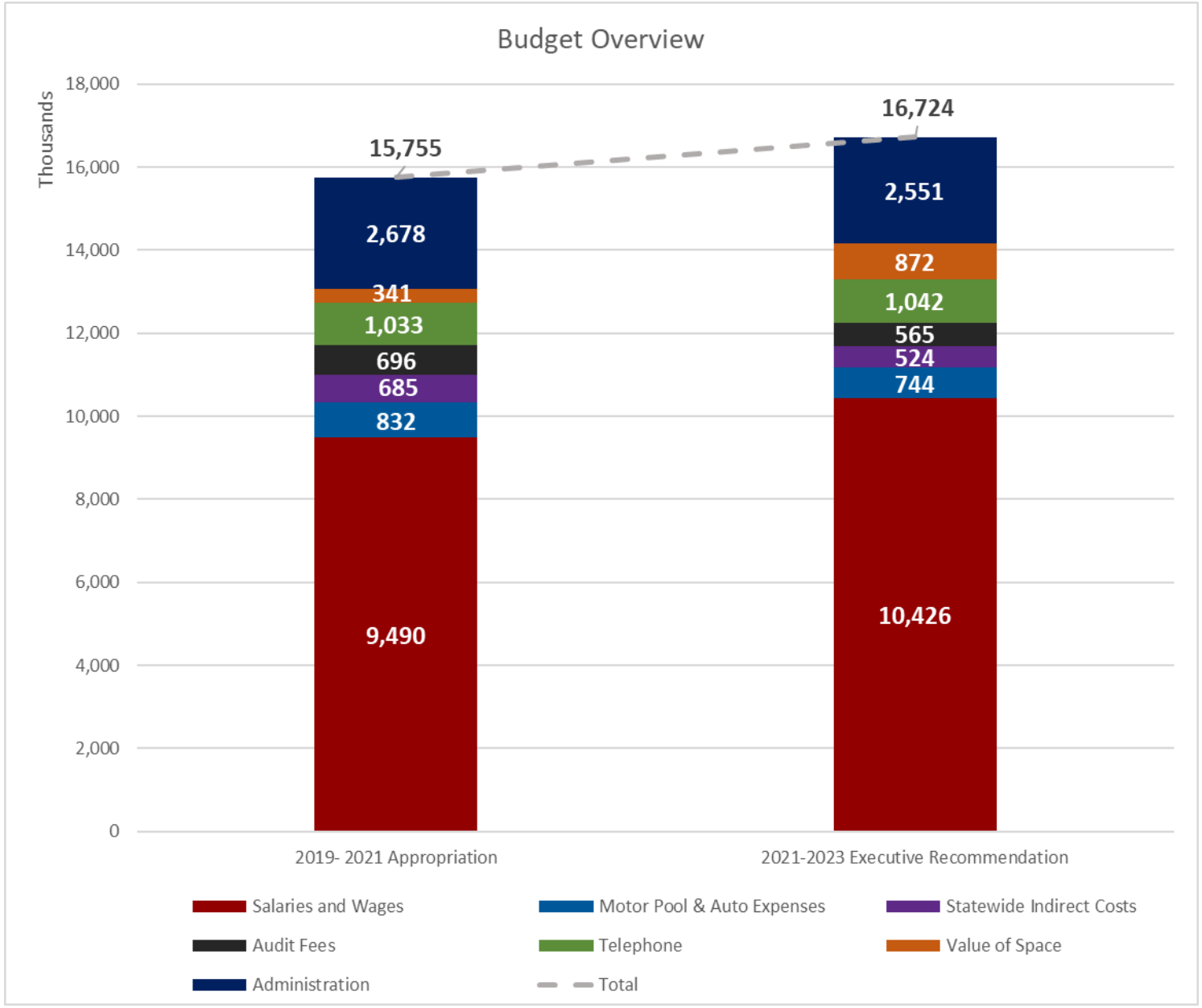
- Train and develop the fiscal team
- Improve fiscal effectiveness and efficiencies
- Develop a fiscal business scorecard
- Improve the fiscal acumen of the department
- Streamline fiscal processes
- Develop logistics



FISCAL ADMINISTRATION



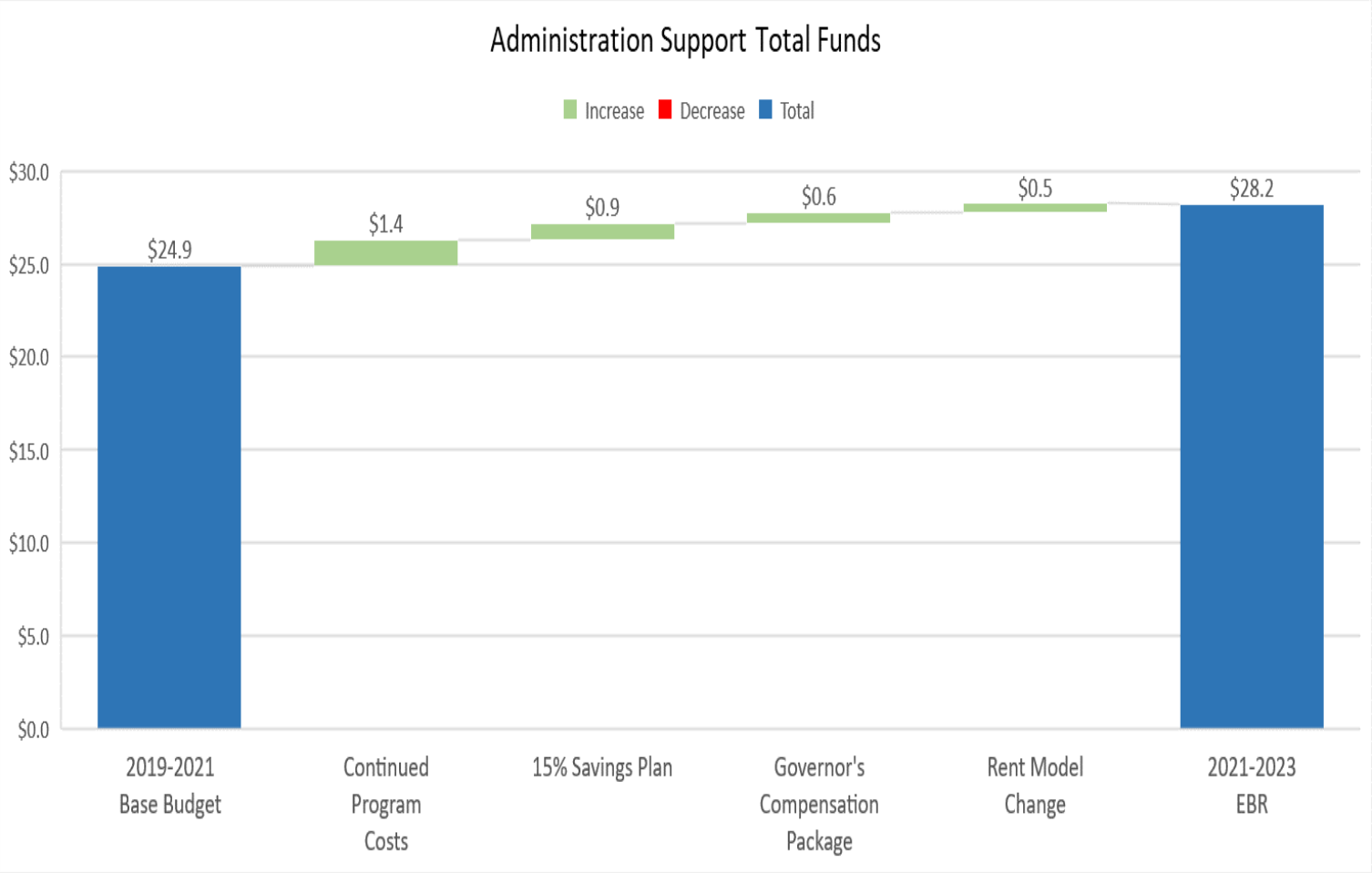
- 54.30 FTE
- Provides the following to program administrators to manage and achieve program results:
  - Budgeting and projection reports
  - Reporting
  - Cash management services
  - Procurement
  - Contract drafting and monitoring
  - Facility management
  - Centralized billing and receivable tracking for field services
  - Internal Controls
  - Audit review assistance
  - Sub-recipient Monitoring



OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Wages	16,939,176	2,509,310	19,448,486
Operating	7,925,303	812,231	8,737,534
Capital			-
Total	24,864,480	3,321,540	28,186,020
			-
General Fund	16,861,917	1,208,046	18,069,964
Federal Funds	6,581,522	3,322,296	9,903,817
Other Funds	1,421,040	(1,208,801)	212,239
Total	24,864,479	3,321,540	28,186,020
Full Time Equivalent (FTE)	89.85	8.00	97.85

OVERVIEW OF BUDGET CHANGES



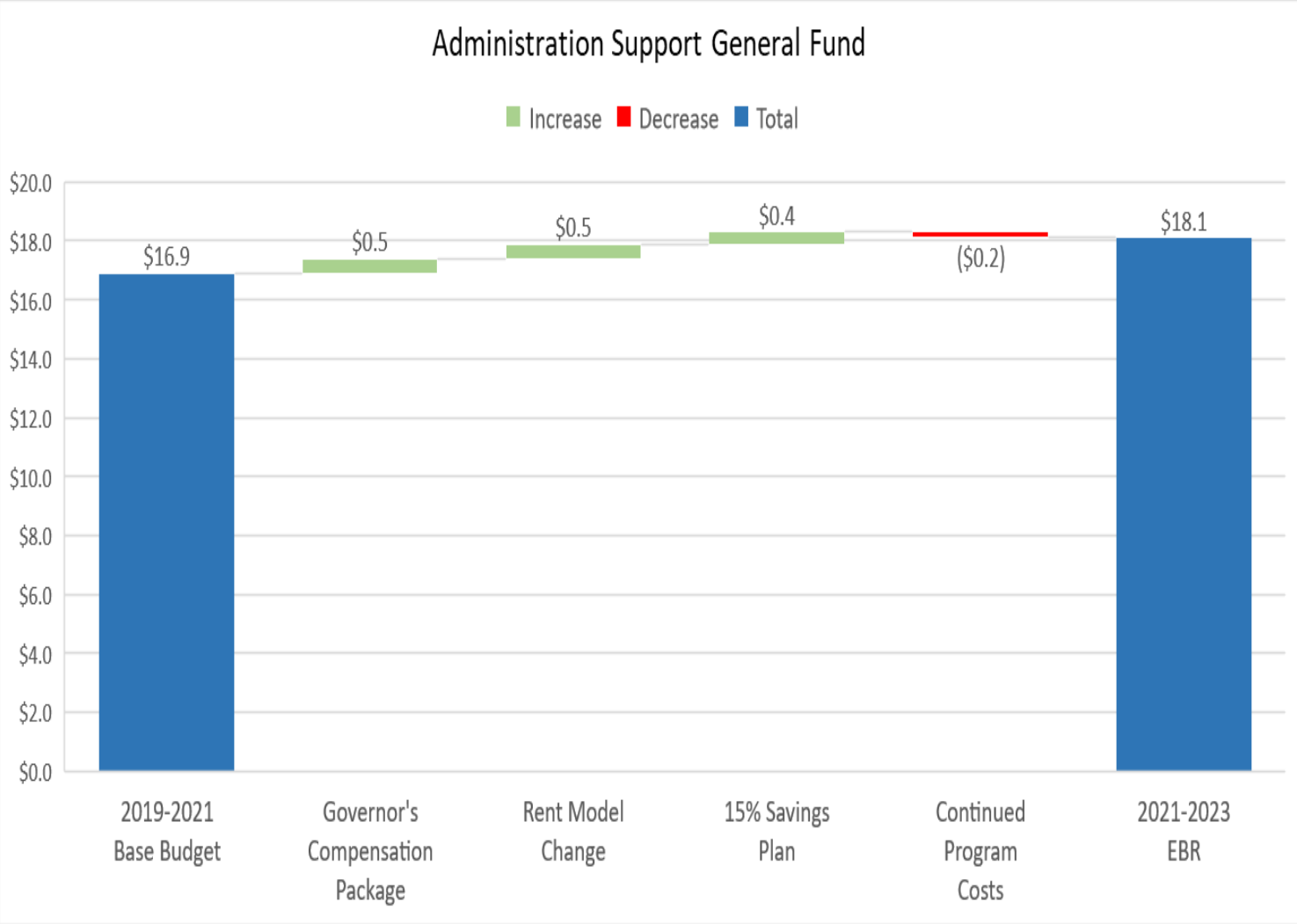
Continued Program Costs

- Wage Adjustments and Lump Sum Payouts for Retirement $1.2 Million
- Operational Changes $.2 Million
  - Increases:
    - Kanban Subscription
    - Nexus contract
  - Decreases:
    - Removal of Provider Audit Division
    - Lower audit fees
    - Less motor pool use
    - Lower legal costs for Attorney General and Office of Admin Hearings

15% Savings Plan

- Increases:
  - Addition of 8 FTE $1.6Million
- Decreases:
  - Removal of funding for Specialized Lawsuits $628,000
  - Use of State DOT rate vs Federal Rate for Personal Vehicle Travel $40,000

OVERVIEW OF GENERAL FUND CHANGES



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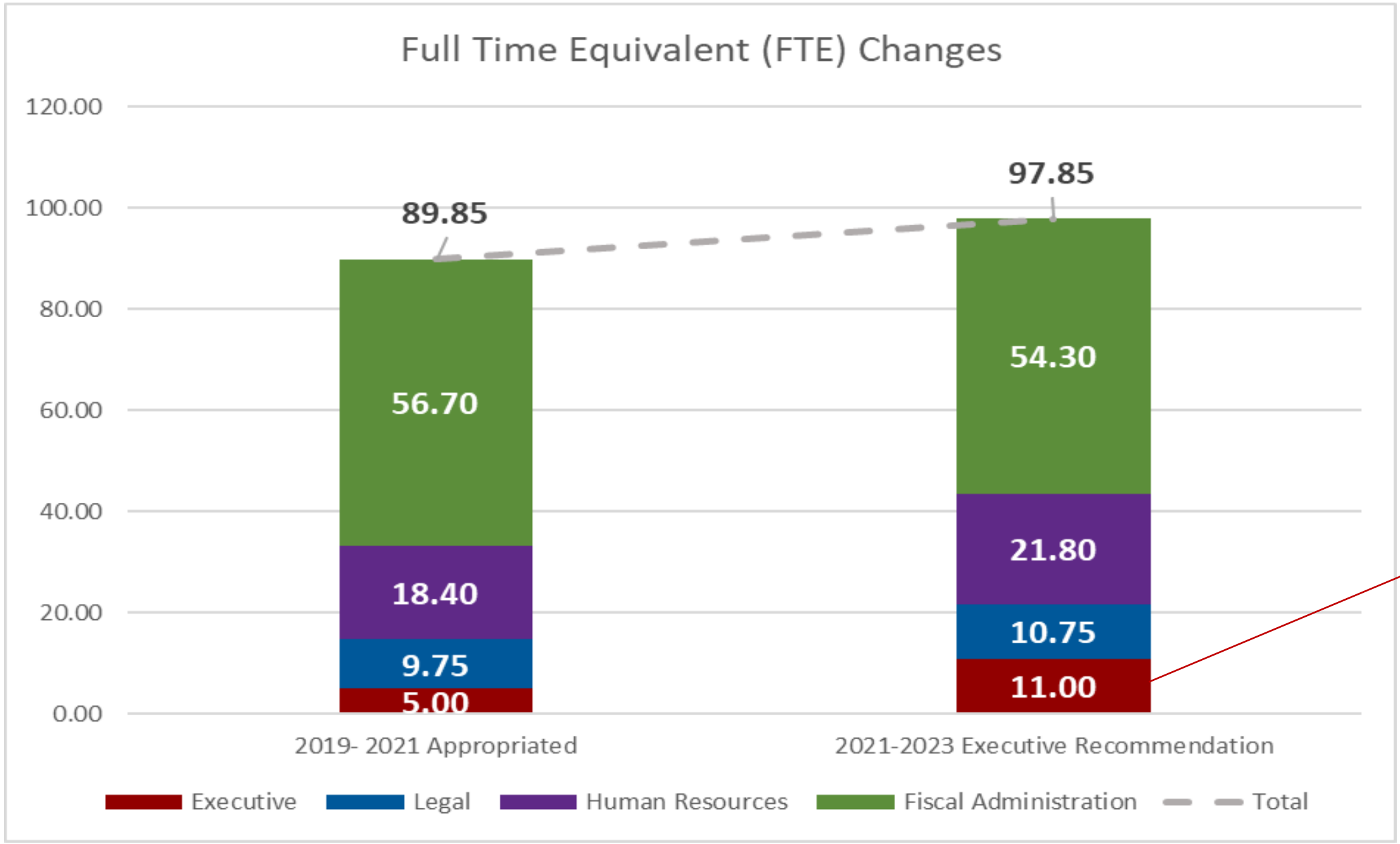
    - Nexus contract
- Decreases:
    - Removal of Provider Audit Division
    - Lower audit fees
    - Less motor pool use
    - Lower legal costs for Attorney General and Office of Admin Hearings

15% Savings Plan

- Increases:
    - Addition of 8 FTE $1 Million
- Decreases:
    - Removal of funding for Specialized Lawsuits $628,000
    - Use of State DOT rate vs Federal Rate for Personal Vehicle Travel $16,000



Large increase due to Mailroom staff moving from Fiscal to Executive Office

LOGISTICS – GOALS

- Manage procurement of personal protective equipment (PPE) and critical supplies
- Centralized purchasing for DHS facilities
- Develop logistics program for internal audit and analysis for spending processes
- Develop logistics capability for procurement activities
- Provide liaison with partner agency logistics POCs and programs
- Develop logistics capabilities for management of property and facilities



STRATEGIC COMMUNICATIONS – GOALS

- Develop communication strategy in support of DHS's key priorities
- Enhance and strengthen internal communications processes and tools, with a focus on manager support
- Build awareness and capabilities related to change management
- Streamline and drive efficiencies in standard processes and measure results
- Update citizen-facing DHS website
- Improve the communication and change management acumen of the department



IT SERVICES

HUMAN SERVICES AND IT PARTNERSHIP

As a collaborative team, we work together to:

- Improve the citizen experience
- Enable and support our team members
- Focus on continuous improvement
- Deliver return on investment

- **Our approach to the human services IT budget:**
- Improving technology is a critical action now – not in a distant future state
- IT services and projects have been under-funded in past sessions
- IT enables us to do our work
- IT is a force multiplier



IT SERVICES PROVIDED

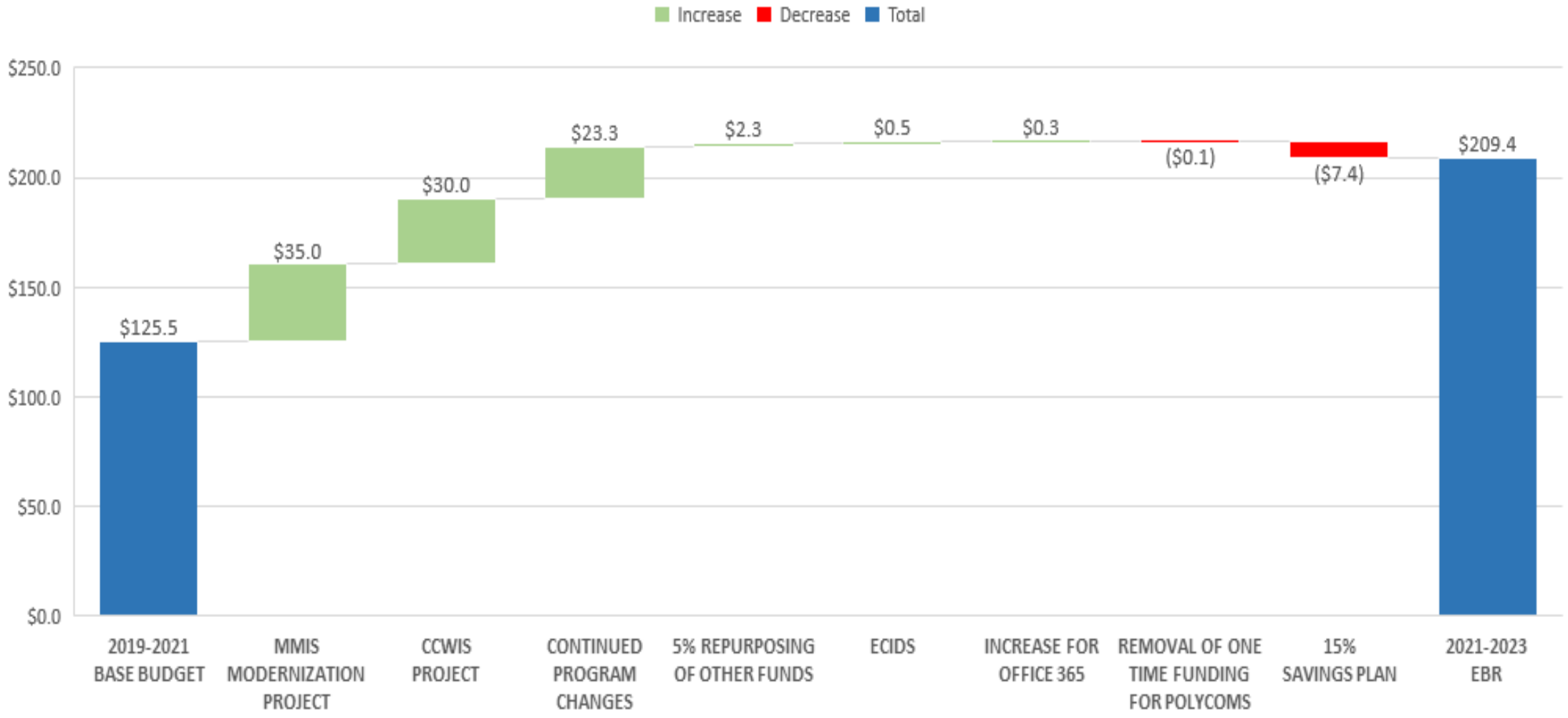


- **Information Technology Strategic Planning**
  - Customer Success
  - Strategic Planning, Direction
- **Business Applications**
  - Business Analysis
  - Project Management
  - Business Application Support
  - Application Development
- **Security**
  - Governance, Risk, Compliance
  - Operations
- **Information Management**
  - Business Intelligence
  - Electronic Document Management
- **Infrastructure**
  - Desktop | Hosting | Network
- **Communication**
  - Voice and video

OVERVIEW OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Operating	125,404,448	83,876,845	209,281,293
Capital	50,000	25,000	75,000
Total	125,454,448	83,901,845	209,356,293
General Fund	46,989,576	34,464,456	81,454,032
Federal Funds	74,426,552	51,056,184	125,482,736
Other Funds	4,038,320	(1,618,795)	2,419,525
Total	125,454,448	83,901,845	209,356,293
Full Time Equivalent (FTE)	0.00	0.00	0.00

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



IT DIFFERENCES (IN MILLIONS)

- **Medicare Management Information System (MMIS) Modernization Project - $35.0**
  - Collaborated with other states that have a mature modularization model for the estimated budget.
  - Budget includes estimates for systems integrator, solution vendors, project management and CMS IV&V.



- **Comprehensive Child Welfare Information System (CCWIS) Project - $30.0**
  - Collaborated with other states that recently implemented for the estimated budget.
  - Budget includes estimates for solution vendor and project management.

- **Continued Program Changes - $23.3**
  - $17.3 for SPACES M&O
  - $3.4 for Field Services M&O
  - $2.2 for NDHIN
  - $1.5 for MMIS M&O
  - $1.0 for Child Support M&O
  - $1.0 for Aging M&O
  - ($1.9) for CFS M&O
  - ($1.2) for other

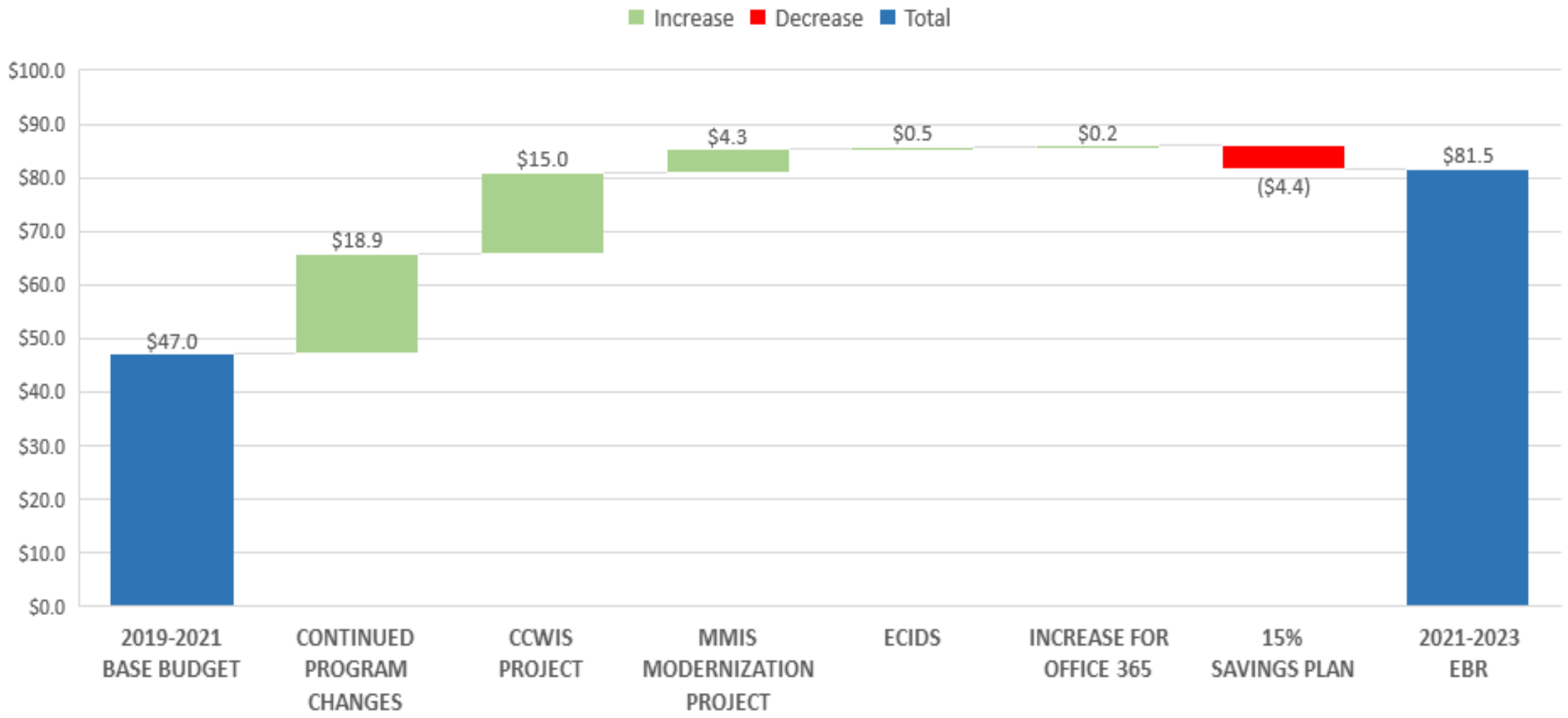
IT DIFFERENCES (IN MILLIONS)

- **5% Repurposing of other funds – $2.3**
  - Other funds were reduced from Basic Care Room and Board and were repurposed to Information Technology Services for supporting SPACES Maintenance and Operations (M&O).

- **15% Savings plan – ($7.4)**
  - ($4.7) related to NDIT
    - ($3) for Application Development and Support
    - ($1.7) for Mainframe Processing
  - ($2.3) for SPACES G.F. due to 5% Other Funds Increase
  - ($0.4) DHS North Rent



GENERAL FUND CHANGES (IN MILLIONS)



INFORMATION TECHNOLOGY CONTRACTS

Division	Project	19-21 Budget	21-23 Budget	Inc/(dec)
Medical	Advantage Suite/Datawarehouse	$3,031,626	$3,172,618	$140,992
Medical	Postproduction support for MMIS (M&O)	26,824,581	30,889,658	4,065,077
EA	Deloitte- M&O	15,952,342	12,816,150	(3,136,192)
SH/HSC	Netsmart - Hosting	1,678,080	1,720,032	41,952
SH/HSC	Netsmart - Subscription	1,337,384	1,913,559	576,175
SH/HSC	Davinci - Data Warehouse	0	1,000,000	1,000,000
DD	Therap	1,652,679	2,047,316	394,637
Multiple	Other contracts less than $1,000,000	7,085,143	5,007,854	(2,077,289)
	Total	$57,561,835	$58,567,186	$1,005,351



Contact Information

Arnie Strebe, Chief Administrative Officer / CFO
Department of Human Services
Phone: 701.328.3695
Email: astrebe@nd.gov



2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/14/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report

Chair Nelson called the meeting to order at 1:53 p.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Medical Services
- Key Priorities
- Values
- Who they serve
- Covid-19 impact
- Executive Request
- Budget Savings

Dr. Caprice Knapp, Dir. of the Medical Services Division (1:54 pm) testified about

Medicaid expansion#1115

Chair Nelson closed the meeting at 3:47 p.m.

Cole Fleck, Committee Clerk



Medical Services Budget- House Bill 1012
Traditional and Expansion #1115

House Appropriations – Human Resources Division, Chairman Nelson

Caprice Knapp, PhD Medical Services Director

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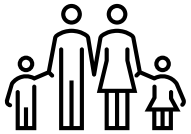
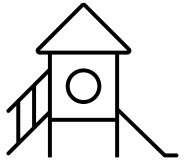
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



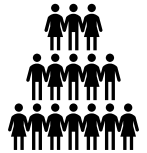
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

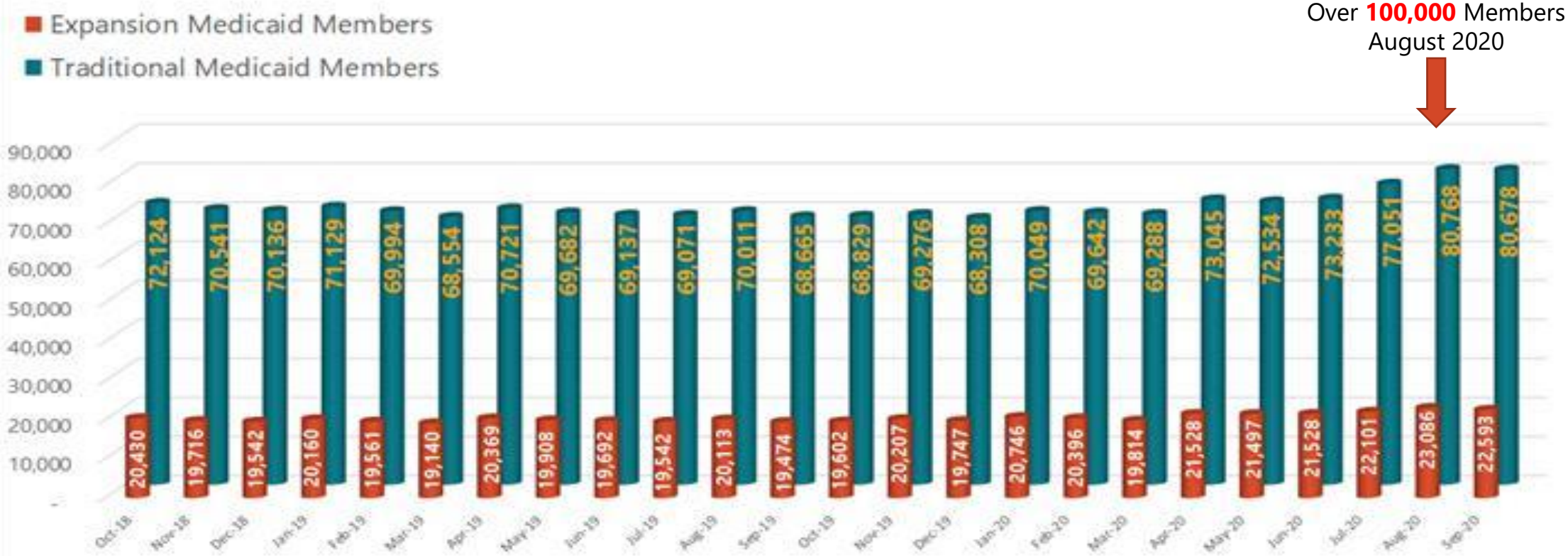
MEDICAL SERVICES DIVISION

Who We Serve

Traditional and Expansion Medicaid Members

24 Month Period

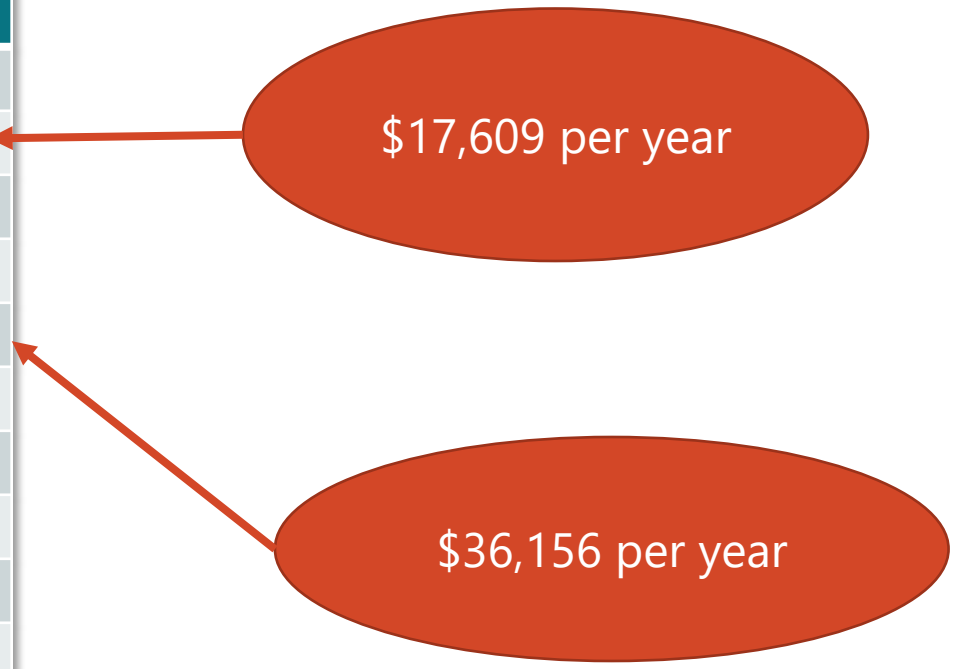
October 2018 - September 2020



Note: Children's Health Insurance Program numbers prior to January 1, 2020 are included in the Traditional Medicaid Members count.
Effective January 1, 2020, Healthy Steps children transitioned to Traditional Medicaid and are included in the Traditional Medicaid Members count.

Medicaid Expansion Eligibility for Adults

Family Size	Medicaid Expansion 138% of PL
	Monthly
1	$ 1,468
2	$ 1,983
3	$ 2,498
4	$ 3,013
5	$ 3,529
6	$ 4,044
7	$ 4,559
8	$ 5,074
9	$ 5,589
10	$ 6,105
+1	$ 516



MEDICAL SERVICES DIVISION

How We Pay

Contracted Services 1915(b) Waiver

- States design an Alternative Benefit Plan that describes the services and must include Essential Health Benefits
- Medicaid Expansion **does not** cover:
  - Skilled Nursing Facility Services*
  - Dental Care Office Visits**
  - Routine Eye Care**
  - Any waivered services
  - Long Term Care services
  - Room and Board for Residential Treatment Services**

** Only covers up to 30 days and only covers a skilled level of care*
*** Only covered for 19- and 20-year-olds*

Medicaid Expansion

Managed Care Organization:

- Risk Based Capitation paid on a per member, per month basis
- Current Vendor: Sanford Health Plan (SHP)
- Contract is currently being re-bid
  - Notice of Intent to Award will be issued approximately 5/21/2021
  - Contract Start will be approximately 1/1/2022

Medicaid Expansion:

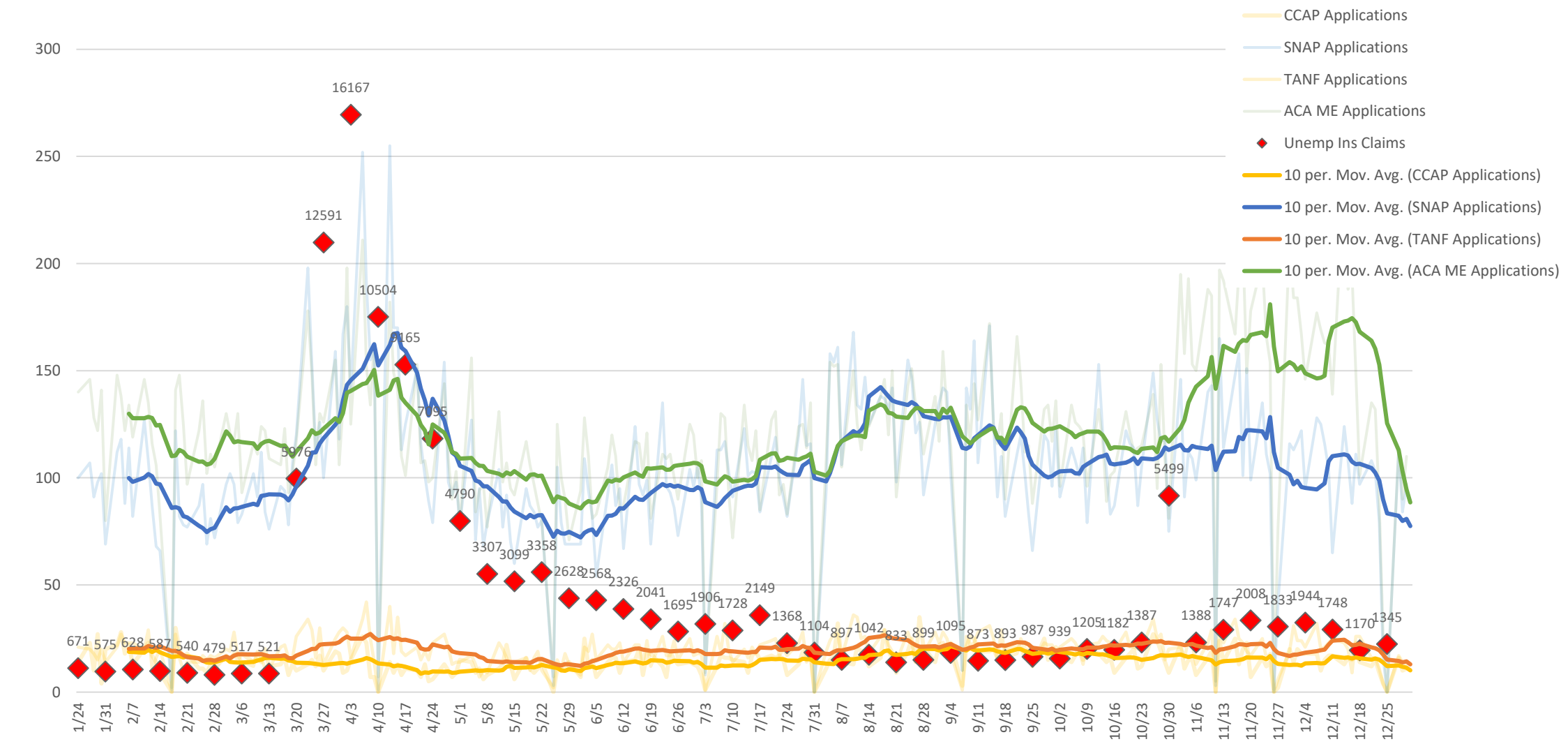
http://www.nd.gov/dhs/medicaidexpansion/



FMAP 6.2%

Maintenance of Effort

ECONOMIC ASSISTANCE APPLICATIONS DURING 2020



COVID-19: **FMAP 6.2% IMPACT**

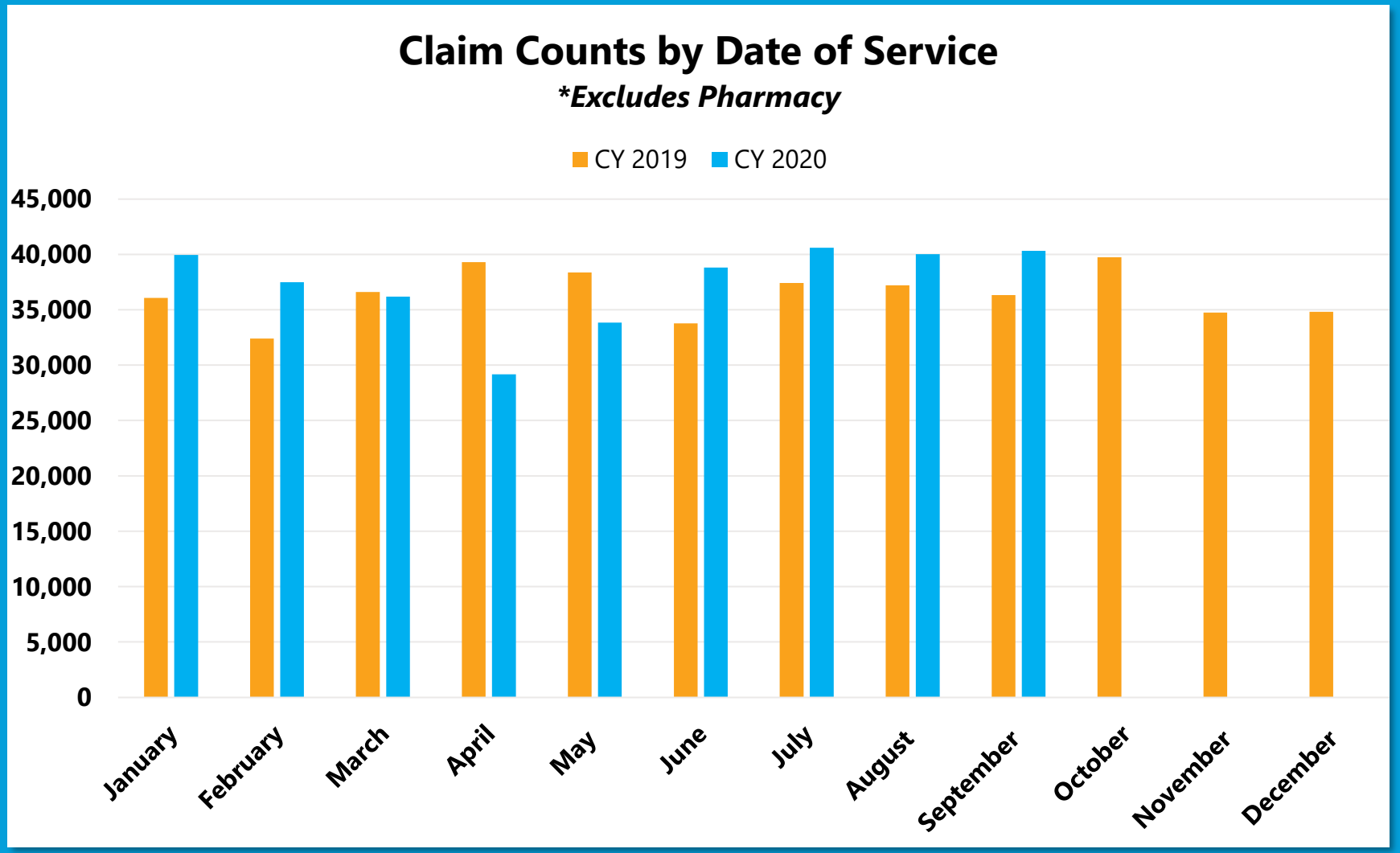
Average General Fund Expenditures

	DD	LTC	Traditional	Expansion
August 2019 - March 2020	$13,315,738.78	$15,054,484.62	$11,719,483.00	$2,775,323.00
April 2020 - September 2020	$10,541,758.98	$12,856,855.67	$10,801,010.83	$3,285,486.83
Difference of Average	-$2,773,979.80	-$2,197,628.95	-$918,472.17	$510,163.83
Total Average Difference	**-$5,379,917.09**	Average General Fund Expenditures for Months April 2020 – September 2020 were less than months August 2019 - March 2020		



COVID-19: **MEDICAID EXPANSION UTILIZATION**

Utilization Comparison 2019 v. 2020



** For September 2020 data, the CY2020 data is provided through 09/30/2020 (3rd Quarter 2020), as claims are still being submitted for the remainder of 2020 and utilization data based on claims is incomplete due to claims run-out.



EXECUTIVE REQUEST 2021-2023



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OVERVIEW OF BUDGET

Description	2013-2015 Appropriation	2015-2017 Appropriation	2017-2019 Appropriation	2019-2021 Appropriation	Changes	2021-2023 Executive Budget
Salary and Wages	9,361,167	11,006,399	9,217,240	17,623,821	839,862	18,471,683
Operating	39,355,085	44,241,160	53,320,237	48,290,789	8,712,126	57,002,915
Grants						
Medical Grants	806,717,552	1,215,896,867	1,303,690,959	1,352,417,879	49,551,425	1,401,969,304
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**59,111,413**	**1,477,443,902**
General Fund	289,891,636	313,547,595	284,162,440	342,465,788	42,758,835	385,224,623
Federal Funds	514,107,184	914,467,704	962,268,730	977,292,683	30,619,126	1,007,911,809
Other Funds	51,434,984	43,129,127	119,797,266	98,574,018	(14,266,548)	84,307,470
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**59,111,413**	**1,477,443,902**
Full Time Equivalent (FTE)	**59.50**	**59.50**	**48.00**	**86.50**	**12.00**	**98.50**



BUDGET SAVINGS ITEMS

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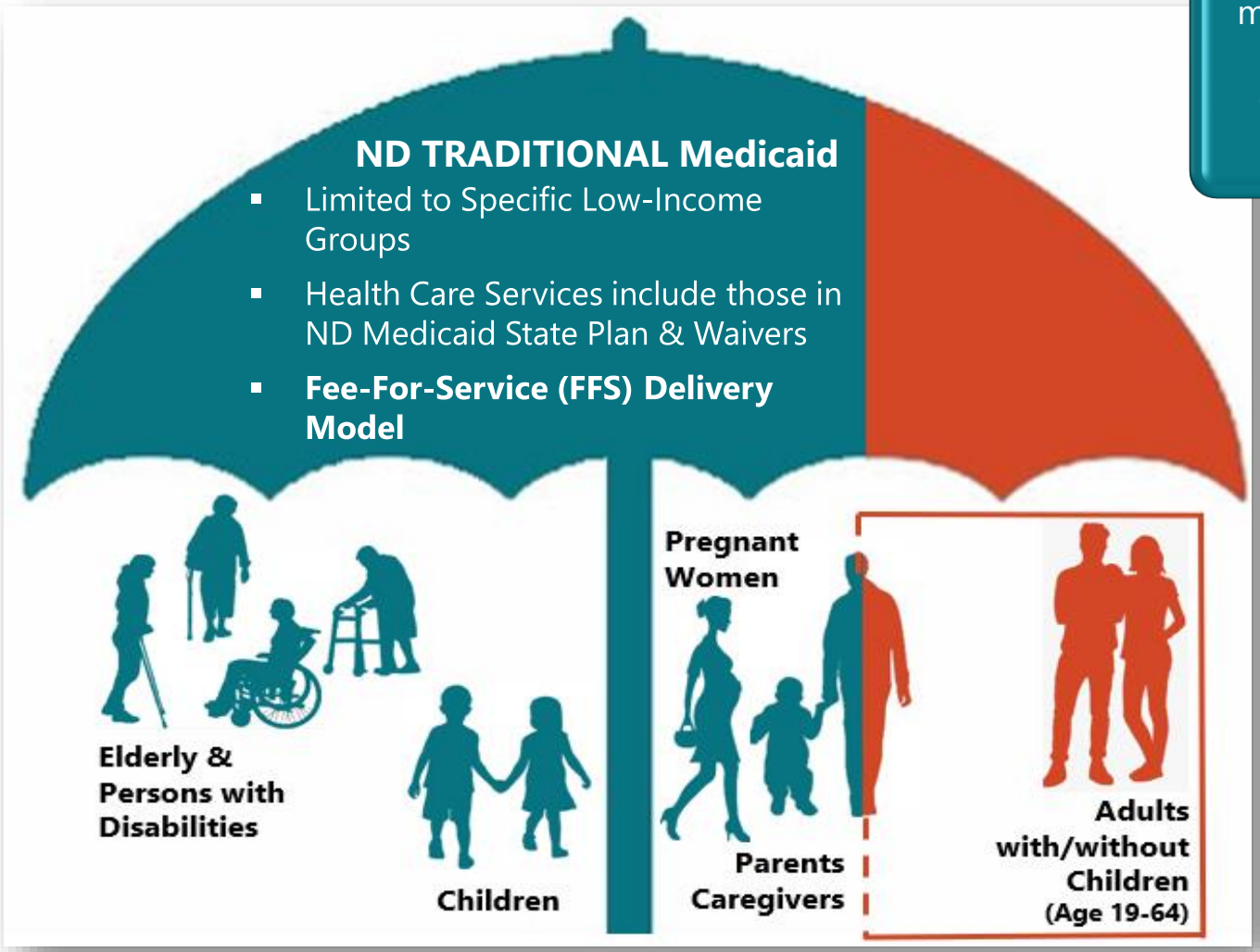
NORTH DAKOTA MEDICAID



The 2013 ND Legislative Assembly (HB 1362) directed DHS to expand medical assistance as authorized by the federal Patient Protection and Affordable Care Act.

This included implementing the expansion by bidding through private carriers or utilizing the health insurance exchange

ND Medicaid Expansion

Limited to individuals age 19-64 with income below 138% of the Federal Poverty Level (FPL)

Health Care Services include those in ND Alternative Benefit Plan

Managed Care (MC) Delivery Model

NORTH DAKOTA LEGISLATION TO DATE

Since the initial implementation, each subsequent session of the ND Legislative Assembly has reauthorized ND Medicaid Expansion as administered and managed through a **Private Carrier**.

The 2019 ND Legislative Assembly (SB 2012) did make the following updates to the ND Medicaid Expansion Program:

- Directed the Department to continue the utilization of a private carrier for the administration and management **except for pharmacy services**, effective January 1, 2020.
- Directed the Managed Care Organization (MCO), while under contract with the Department, to
  - **Develop and implement a uniform provider reimbursement methodology**
  - **Add 1915(i) Behavioral Health Services through the MCO**



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

Medicaid Expansion Reimbursement Comparison Per Capita Costs Per State

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Note
Enrollment from the Medicaid Budget and Expenditure System (MBES) is reported for each month. In an effort to take into account that some beneficiaries are enrolled for only part of the year, maximum monthly enrollment for each state is used to estimate total enrollment over the period.

Source
Kaiser Family Foundation analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES)

Medicaid Expansion Reimbursement Comparison

Provider Reimbursement % of Medicaid

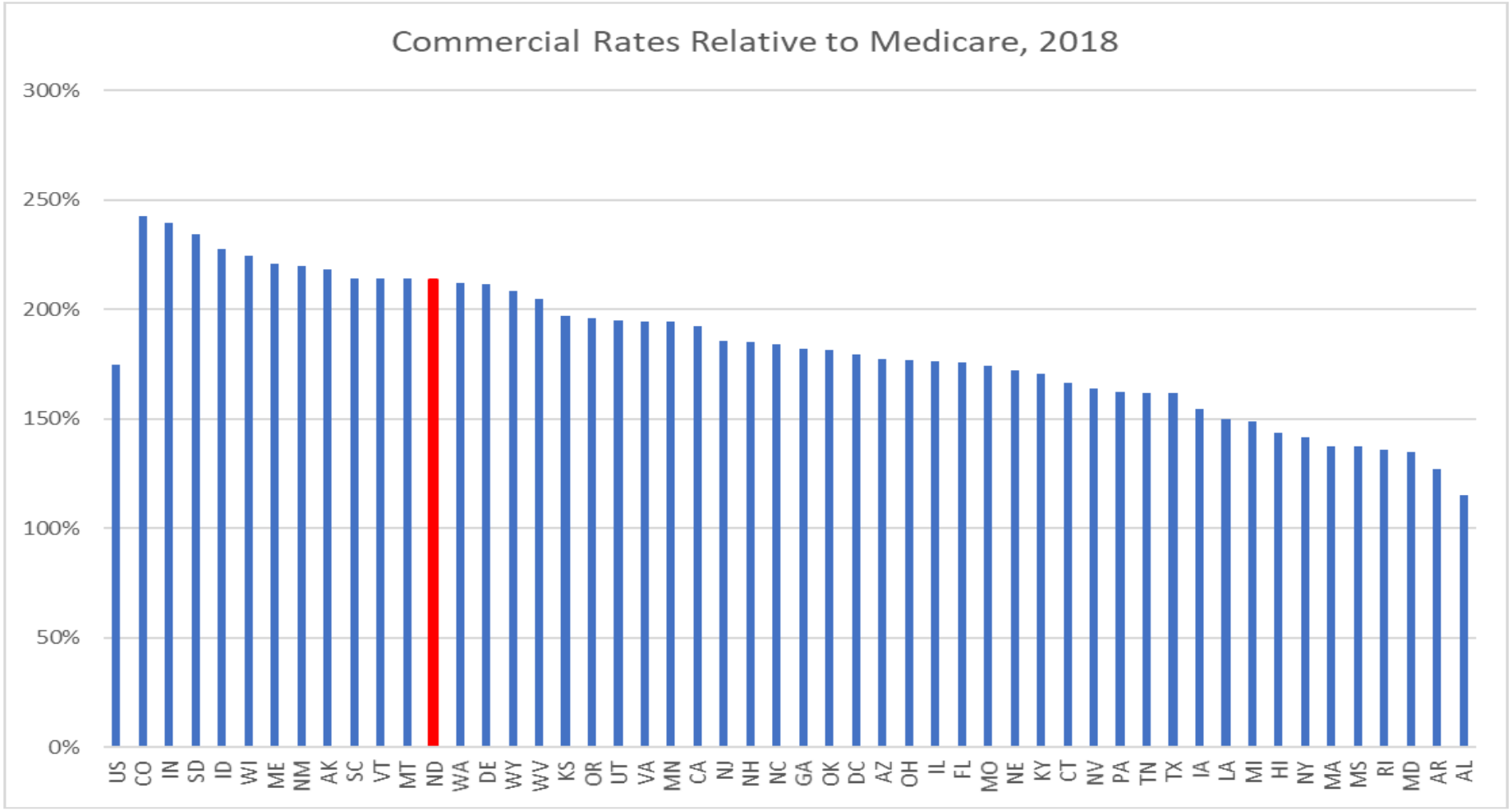
Actual % of Medicaid*

Type of Service	CY17	CY18	CY19
Inpatient	158.7%	165.8%	151.7%
Outpatient	209.8%	208.0%	204.2%
Professional	168.2%	168.2%	165.4%
Total	**175.0%**	**177.8%**	**170.3%**

***Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures**

Medicaid Expansion Reimbursement Comparison

Commercial Insurance Payment Rates



- **Commercial payments** for hospital services in ND are **214%** of the Medicare rate.
- **ND's commercial-to-Medicare** rate ratio for hospital payments is the **12th highest** in the U.S.

Source: North Dakota Insurance Department, "North Dakota 66th Legislative Assembly Interim Health Care Study," August 12, 2020

Medicaid Expansion Reimbursement Comparison

Medicaid FFS Physician Services

NORTH DAKOTA'S FFS MEDICAID PHYSICIAN FEE INDEX COMPARED TO NEIGHBORING OR SIMILAR STATES

STATE	ALL MD SERVICES	PRIMARY CARE SERVICES	OTHER SERVICES (EXCLUDING OB-GYN)
North Dakota	**1.35**	**1.52**	**1.15**
Minnesota	1.04	1.19	0.92
Montana	1.56	1.65	1.36
South Dakota	1.10	1.06	1.34
Wyoming	1.38	1.44	1.27

Source: Kaiser Family Foundation State Health Facts, based on Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees After the ACA Primary Care Fee Bump," Urban Institute, March 2017.



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration



Comparison Medicaid Expansion Financial Arrangement

Why do State Medicaid Programs use MCOs?

1. Managed Care Organization Takes on the Risk versus the State
2. Budget Predictability
3. Budget Savings
4. Improved Outcomes

Risk & Predictability

- As in any risk-based model the more people in the risk pool the more likely the managed care organization can spread the risk across health and less health individuals
- The larger the risk pool, the more predictable and stable premiums will be.
- Premiums also rely on the average health care costs of the enrollees
- Adverse selection occurs when the insurer attracts individuals when they have greater health care needs
- In **North Dakota**, the
  - **risk pool** is the **smallest** in the **entire country** using managed care
  - **premiums** have **not** been **predictable** or **stable**
  - **churn rate** indicates that **adverse selection** is probably occurring

Medicaid Expansion Comparison: under 100K People Delivery of Care Model

Medicaid Expansion Population

No MCOs

- Maine 19,812
- Alaska 51,144
- Vermont 55,431
- Montana 98,741

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

- New Hampshire 53,424
- Delaware 62,534 **2 MCOs serve traditional and expansion ~199K*
- Rhode Island 66,641 **2 MCOs serve traditional and expansion ~250K*

Source: Medicaid Enrollment Report Updated 2/2020
https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html
https://www.kff.org/medicaid/stateindicator/totalmedicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

Month	Expansion SHP Members	Expansion SHP Members Non-Expansion Eligibility	Expansion SHP Members Any Medicaid Eligibility	Percent Remaining in Expansion SHP	Percent Remaining with Any Medicaid Eligibility
Jan 2019	20,719		20,719	100.0%	100.0%
Feb 2019	19,441	270	19,711	93.8%	95.1%
Mar 2019	18,399	436	18,835	88.8%	90.9%
Apr 2019	17,515	624	18,139	84.5%	87.5%
May 2019	16,594	812	17,406	80.1%	84.0%
Jun 2019	15,551	1,002	16,553	75.1%	79.9%
Jul 2019	14,672	1,155	15,827	70.8%	76.4%
Aug 2019	13,873	1,295	15,168	67.0%	73.2%
Sep 2019	13,117	1,372	14,489	63.3%	69.9%
Oct 2019	12,523	1,463	13,986	60.4%	67.5%
Nov 2019	11,937	1,532	13,469	57.6%	65.0%
Dec 2019	11,491	1,579	13,070	55.5%	63.1%



Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

- Alabama (Medical Homes to ACO)
- South Dakota (Health Homes Model)
- Connecticut (ASO model) in early 2020

South Dakota avoided $7.3 million in costs using Health Homes in 5 years

Feedback from North Dakota Medicaid Stakeholders

- Noted that **Health Homes** was the preferred model
- Subsequent meeting with outpatient stakeholders

2021-2023 Executive Request

- Authorizes DHS to plan for **Health Homes** and seek CMS approval
- Enhanced payment will offset some of the reduction in rates.



Proposed Solution
Health Homes

Medicaid Health Homes

- Established by the Affordable Care Act
- Created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for Medicaid members with chronic conditions
- For the first 2 years of the program, the state receives an **enhanced federal match (90%)** for the health home-specific services.
- Section 1945 of the SSA: https://www.ssa.gov/OP_Home/ssact/title19/1945.htm

Prior Testimony
Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals.
Handout shows the Medicaid percentage of payer mix for all hospitals. Average Medicaid is 8% of payer mix across all hospitals. According to enrollment data, about 20% of that is expansion enrollees.

HOSPITAL NAME	TOWN	HOSPITAL TYPE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ST ALEXIUS MEDICAL CENTER	BISMARCK	SHORT TERM		4%	4%	5%	4%	3%	1%	7%	7%	6%
TRINITY HOSPITALS/ST JOES	MINOT	SHORT TERM		0%	0%	0%	3%	4%	11%	11%	13%	13%
SANFORD MEDICAL CENTER - FARGO	FARGO	SHORT TERM		6%	4%	3%	4%	7%	9%	8%	8%	8%
SANFORD BISMARCK	BISMARCK	SHORT TERM		7%	7%	7%	5%	8%	7%	7%	8%	6%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	GRAND FORKS	SHORT TERM		10%	10%	10%	12%	8%	9%	9%	8%	
INNOVIS HEALTH	FARGO	SHORT TERM		5%	5%	5%	6%	7%	7%	8%	6%	6%
TIOGA MEDICAL CENTER	TIOGA	CRITICAL ACCESS HOSPITALS		0%	0%	0%	1%	1%	1%	1%	1%	1%
MOUNTRAIL COUNTY MEDICAL CENTER	STANLEY	CRITICAL ACCESS HOSPITALS		0%	0%	1%	2%	2%	2%	3%	3%	2%
MCKENZIE COUNTY HEALTHCARE SYSTEM	WATFORD CITY	CRITICAL ACCESS HOSPITALS		1%	1%	1%	3%	4%	6%	5%	4%	4%
GARRISON MEMORIAL HOSPITAL	GARRISON	CRITICAL ACCESS HOSPITALS		19%	20%	17%	26%	25%	25%	23%	22%	24%
TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	CRITICAL ACCESS HOSPITALS		9%	23%	25%	28%	30%	34%	30%	11%	26%
KENMARE COMMUNITY HOSPITAL	KENMARE	CRITICAL ACCESS HOSPITALS		0%	0%	0%	25%	33%	26%	25%	19%	17%
COOPERSTOWN MEDICAL CENTER	COOPERSTOWN	CRITICAL ACCESS HOSPITALS		1%	1%	3%	9%	0%	4%	3%	6%	6%
ST ANDREWS HEALTH CENTER	BOTTINEAU	CRITICAL ACCESS HOSPITALS		12%	13%	14%	18%	16%	14%	14%	17%	13%
NELSON COUNTY HEALTH SYSTEMS-HO	MCVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	1%	0%	1%	1%	3%
SANFORD MAYVILLE	MAYVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	3%	1%	2%	3%	3%	3%	3%
DAKAKAWEA MEDICAL CENTER	HAZEN	CRITICAL ACCESS HOSPITALS		5%	2%	2%	4%	3%	1%	5%	6%	5%
LISBON AREA HEALTH SERVICES	LISBON	CRITICAL ACCESS HOSPITALS		6%	8%	11%	9%	11%	10%	4%	7%	8%
NORTHWOOD DE												5%
SOUTHWEST HEAL												1%
JACOBSON MEMO												19%
OAKES COMMUNI												9%
PRESENTATION M												20%
CARRINTON HEAL												6%
PEMBINA COUNTY MEMORIAL HOSPITAL	CAVALIER	CRITICAL ACCESS HOSPITALS		2%	1%	1%	4%	4%	2%	14%	2%	1%
UNITY MEDICAL CENTER	GRAFTON	CRITICAL ACCESS HOSPITALS		4%	4%	3%	3%	3%	6%	5%	4%	5%
WISHEK COMMUNITY HOSPITAL	WISHEK	CRITICAL ACCESS HOSPITALS		3%	3%	2%	1%	1%	2%	2%	2%	2%
ASHLEY MEDICAL CENTER	ASHLEY	CRITICAL ACCESS HOSPITALS		33%	11%	11%	1%	1%	1%	2%	2%	2%
CAVALIER COUNTY MEMORIAL HOSPITAL	LANGDON	CRITICAL ACCESS HOSPITALS		1%	8%	2%	3%	3%	1%	8%	1%	4%
MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	CRITICAL ACCESS HOSPITALS		2%	4%	3%	4%	6%	7%	4%	1%	9%
ST LUKES HOSPITAL	CROSBY	CRITICAL ACCESS HOSPITALS		5%	1%	1%	1%	0%	2%	1%	4%	3%
FIRST CARE HEALTH CENTER	PARK RIVER	CRITICAL ACCESS HOSPITALS		3%	3%	2%	2%	4%	3%	3%	3%	3%
ST ALOISIUS MEDICAL CENTER	PARVEY	CRITICAL ACCESS HOSPITALS		0%	0%	0%	4%	3%	5%	5%	4%	4%
LINTON HOSPITAL	LINTON	CRITICAL ACCESS HOSPITALS		0%	2%	1%	1%	3%	2%	3%	4%	2%
SANFORD HILLSBORO	HILLBORO	CRITICAL ACCESS HOSPITALS		28%	27%	31%	43%	3%	2%	2%	3%	4%
WEST RIVER REGIONAL MEDICAL CENTER	HETTINGER	CRITICAL ACCESS HOSPITALS		28%	1%	2%	1%	3%	1%	3%	3%	
TOWNER COUNTY MEDICAL CENTER	CANDO	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	2%	3%	3%	3%	2%
HEART OF AMERICA MEDICAL CENTER	RUGBY	CRITICAL ACCESS HOSPITALS		1%	21%	26%	21%	2%	25%	30%	3%	14%
MERCY HOSPITAL OF VALLEY CITY	DEVILS LAKE	CRITICAL ACCESS HOSPITALS		12%	16%	15%	20%	23%	26%	10%	14%	34%
MERCY MEDICAL CENTER	WILLISTON	CRITICAL ACCESS HOSPITALS		4%	3%	4%	5%	4%	6%	6%	3%	6%
JAMESTOWN REGIONAL MEDICAL CENTER	JAMESTOWN	CRITICAL ACCESS HOSPITALS		9%	9%	8%	9%	10%	13%	13%	7%	10%
ST JOSEPHS HOSPITAL AND HEATLH CENTER	DICKINSON	CRITICAL ACCESS HOSPITALS		5%	6%	5%	5%	8%	8%	7%	2%	8%

Average estimated expansion payer mix for CAHs is 1.58% and 1.3% for PPS

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

Prior testimony implied that DHS does not have demonstrated results in management

- In 2019, both CHIP and expansion Pharmacy was moved to DHS administration.

Estimated total pharmacy savings is $17.26 million

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

Administrative Costs

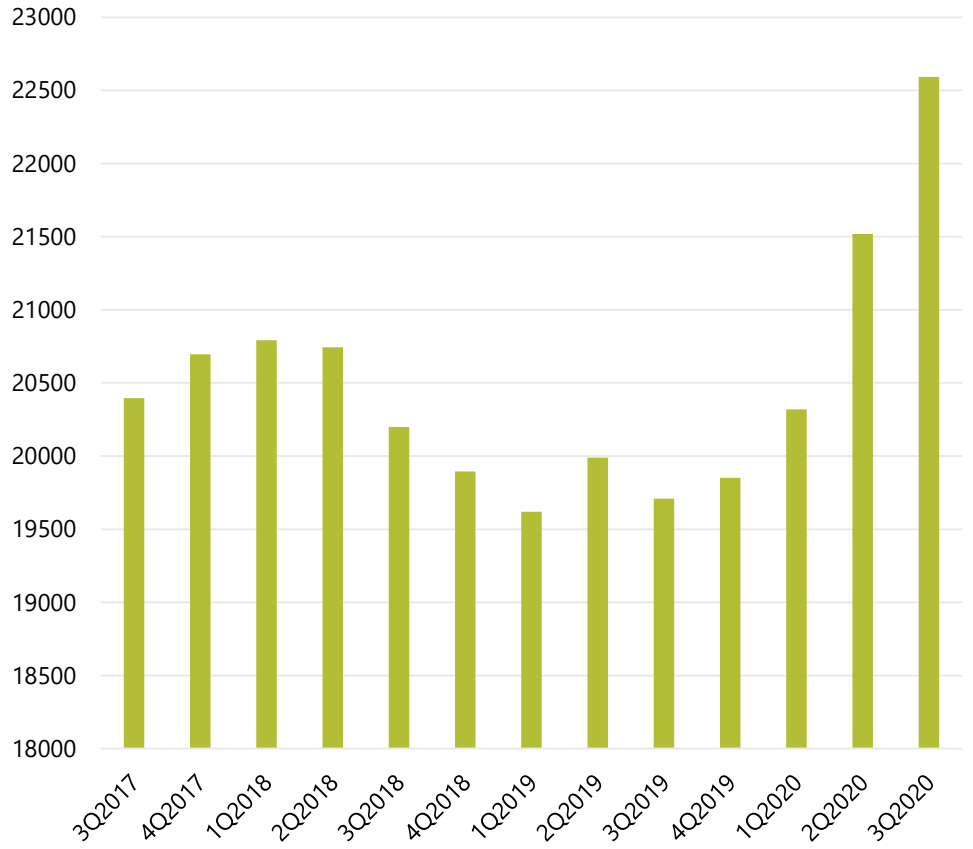
- As discussed during the 2019 session, DHS estimated $3.991 million in net administrative savings
  - Avoidance of paying $4.554 million to Sanford Health Plan for administrative costs (admin, profit, and the Health Insurance Provider Fee (CY 2020 plus first six months of CY 2021))
  - Incurring additional $562,347 in administrative costs by bringing the pharmacy claims in-house
    - Health Insurance Provider Fee will now not exist in 2021, so that removes $550,000 of expected admin savings

Pharmacy Claims Costs

- As discussed during the 2019 session, DHS estimated $2.1 million in pharmacy claim cost savings from additional utilization management efficiencies
  - Faster changes in coverage criteria
  - Management of non-Preferred Drug List (PDL) medications
  - More robust, Medicaid population centered claims processing system
  - Closer management and control of state claims system within MMIS

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

Average Number of Recipients by Quarter



COVID resulted in increasing number of eligibles for Medicaid Expansion

- Pre-COVID **average of 20,166**
- Post-COVID
  - 2Q20 = **21,518**
  - 3Q20 = **22,593**

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

RX Claims- Net Costs By Quarter

Quarter	Spend	Per Member Per Month
3Q 2019	$3,030,829.88	$51.26
4Q 2019	$2,934,056.57	$49.27
1Q 2020	$2,419,967.44	$39.70
2Q 2020	$2,591,717.60	$40.15
3Q 2020	$2,794,276.77	$41.23

RX Claims Savings

- Rx Average PMPM 4Q17 – 4Q19
  - $48.16
- Rx average quarterly spend 4Q17 – 4Q19
  - $2.91 million
- Rx Average PMPM 1Q20 – 3Q20
  - $40.36
- Rx average quarterly spend 1Q20 – 3Q20
  - $2.6 million

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

Summary – Claims Savings

PMPM dropped 16%

- Average of $48.16 (4Q17 – 4Q19)
- Average of $40.36 (1Q20 – 3Q20)

$1.509 million savings (1Q20 – 3Q20)

- If PMPM would not have changed from $48.16 average, net spend would have projected to be $9.315 million
- Net spend since carve out has been $7.806 million

With 3 quarters left, we are on track for total savings of $3.018 million

- Which is above the 2019 legislative testimony estimate of $2.1 million in claims savings



Prior Testimony ND Medicaid Demonstrated Results in Pharmacy Management

Savings From RX Carve Out- IHS

- **IHS claims are now 100% FMAP**
  - Prior to carve out, claims simply part of the rate
- **$3.6 million saved (1Q20 – 3Q20)**
  - Currently trending at $1.2 million per quarter
  - $3.8 million projected for next three quarters for total of $7.4 million in savings
- **Expansion contract included contractor being responsible for ensuring Medicaid Expansion was the payer of last resort**
- With DHS paying Rx claims, we have now included Expansion population in our processes for finding other coverage
- **A minimum of 190 recipients have been found to have Medicare coverage**
  - Premium ranges from roughly $900 to $1400 per month for different expansion recipients
  - 190 recipients X $1052 per month = $200,000 per month
- **$2.2 million in premium savings (Feb 2020 through Jan 2020)**
  - $1.2 million expected for next six months to total $3.4 million

Prior Testimony
ND Medicaid Demonstrated Results in Pharmacy Management

RX Carve Out Savings

	Realized Savings	Expected Total Savings
Claims	$ 1,509,000	$ 3,018,000
IHS	$ 3,600,000	$ 7,400,000
Premiums	$ 2,200,000	$ 3,400,000
Administration	$ 2,641,000	$ 3,441,000
Total	**$ 9,950,000**	**$ 17,259,000**

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- IHS = $7.4 million **(*New savings)**
- Premiums = $3.4 million **(*New savings)**
- Admin = $3.441 million (< $3.991 million projected in 2019 session due to HIPF going away in 2021)

Total = $17.259 million (> $6.091 projected in 2019 session)



Prior Testimony
ND Medicaid Demonstrated Results in CHIP Management

CHIP Savings (1Q20-3Q20)

- Expected CHIP cost = $6,706,332
  - Average 2377.77 kids per month x Average $313.38 premium per month
- Actual CHIP cost = $1,932,582
  - Actual Provider Payments = $2,872,734
  - Drug rebates = $940,152
- Savings = $4,773,750
- % reduction = 71.18%

Prior Testimony Federal Funds

During revenue downturns, 100% state-funded programs and **traditional Medicaid providers are disproportionately targeted for savings** versus expansion providers due to the funding split. Again, this creates a **non-equitable** Medicaid system.

100% General Fund	50%/50%	90%/10%
Autism Voucher Basic Care	Developmental Disabilities, HCBS, Nursing Homes, Dental, Vision Pediatrics	Expansion



Developmental Disability providers and **Nursing Homes** have put in the hard work to have **more equitable reimbursement**, reducing the financial burden on the State

MEDICAL SERVICES
Medicaid Expansion Transition

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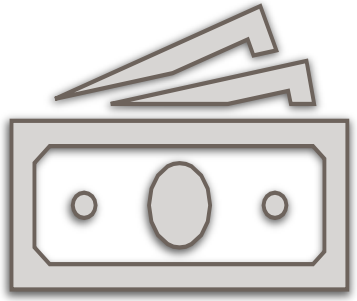
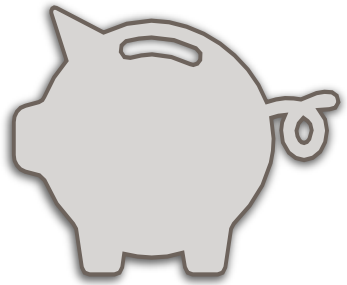
From MCO Administration to DHS Administration

SAVINGS



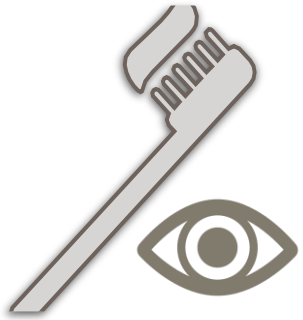
Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)



MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00



DHS Administrative Expenses

Staff Costs	$568,234.00
Contracts	$ 79,520.00
Other (Notices)	$ 23,332.00

$(10,749,572.00) Amendment

FUNDING REQUEST
2021-2023



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OVERVIEW OF BUDGET CHANGES
TOTAL FUNDS (IN MILLIONS)



OVERVIEW OF BUDGET CHANGES GENERAL FUND (IN MILLIONS)



Thank you!

North Dakota Medicaid



Caprice Knapp, PhD
Division Director

Phone: (701) 328-1603
E-Mail: cknapp@nd.gov

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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/15/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson opened the meeting at 9:00 a.m.

Representative	Present	Absent
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Discussion Topics:

- Long Term care
- Nursing Home Facilities
- Basic Care Facilities
- Home and Community based services
- Overview of Waivers
- Executive Request

Caprice Knapp, Dir. Med. Services (9:01 am) testified about long term care #1146

Nancy Nicholas Maier, Aging Services Dir. (9:15 am) testified about aging services #1146

Caprice Knapp, Dir. Med. Services (9:31 am) testified about nursing home payment reform & autism waivers #1146

Chris Jones, DHS (10:02 am) closing remarks

Shelly Peterson, ND Long Term Care Association (10:08 am) testified about the ND

long term care Association #1146

Chair Nelson closed the meeting at 10:19 a.m.

Cole Fleck, Committee Clerk



Long-Term Care Budget- House Bill 1012

House Appropriations, Chairman Nelson

Caprice Knapp, PhD Medical Services Director
Nancy Nikolas-Maier Aging Services Director

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DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION
Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Overview of Long-Term Care Services: Institutions



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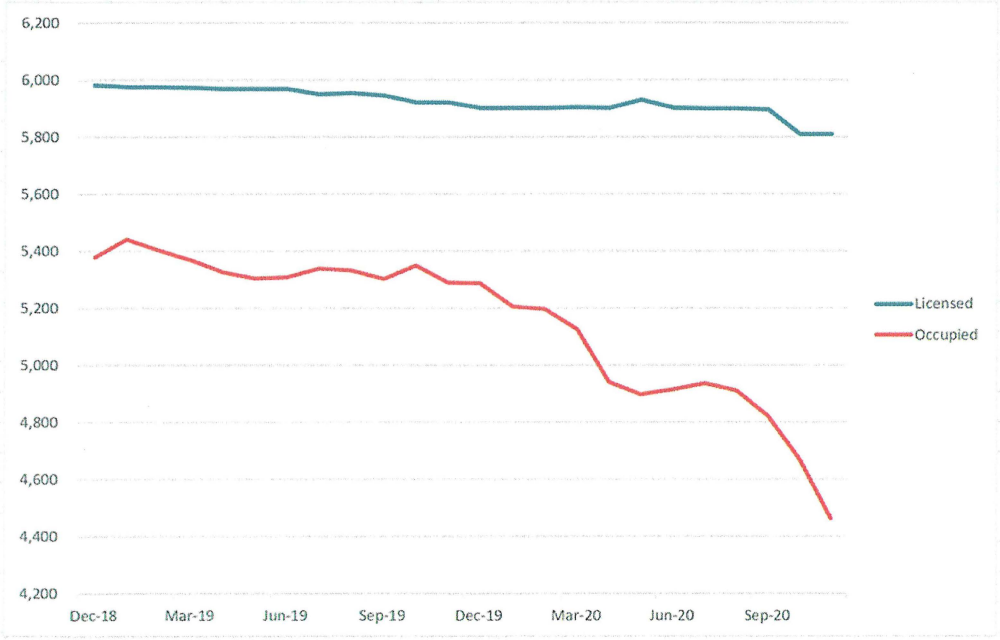
Bed Occupancy For Nursing Home Facilities

Nursing Facility Occupancy

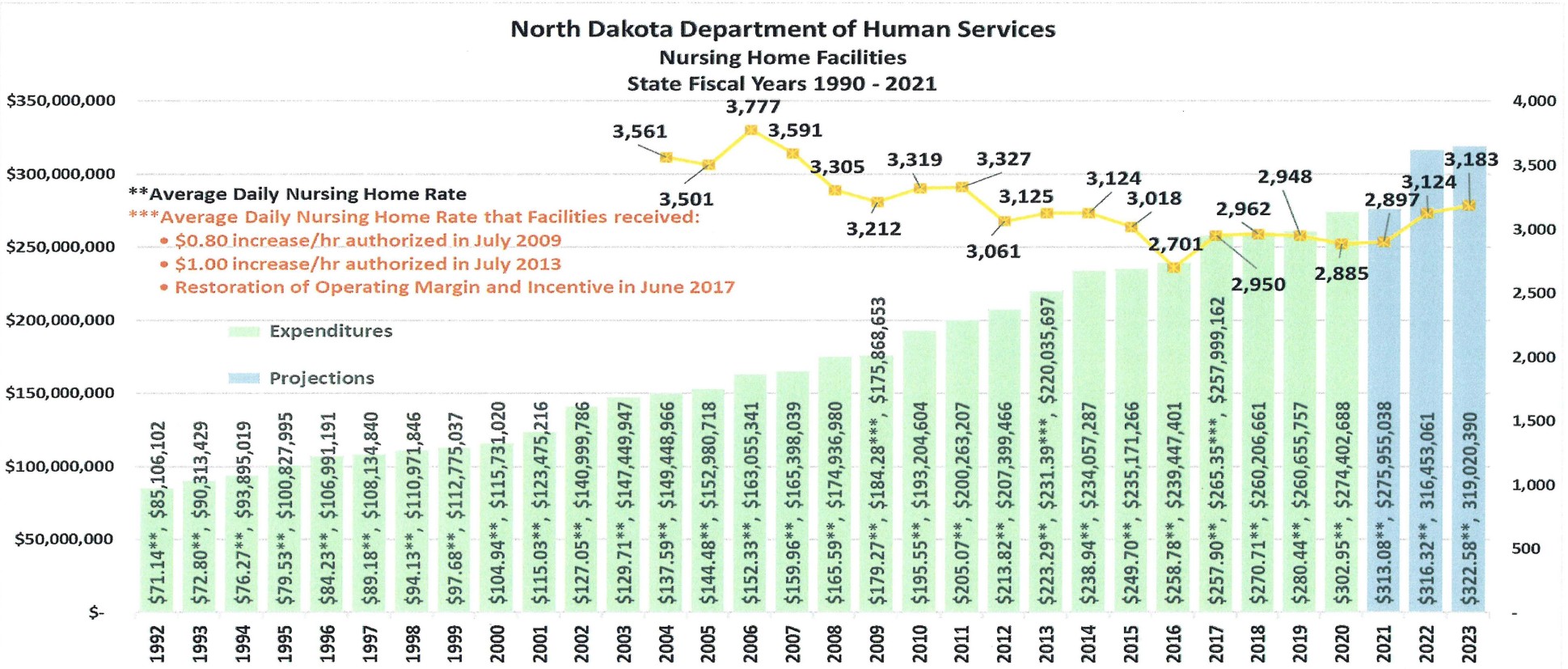


Nursing Facility Medicaid Occupancy



Nursing Home Facilities

State Fiscal Years 1990 - 2023



Data is based on paid date

*1992 - 2020 represents actual expenditures

2022 and 2023 represents estimated expenditures in the Executive Budget

The average daily nursing home rate is effective January 1 of each year unless otherwise indicated

Burleigh/Morton

224

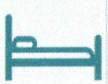
Medicaid beds



Cass

264

Medicaid beds



Grand Forks

163

Medicaid beds



Ward

25

Medicaid beds



Basic Care Facilities

Basic Care Payment Two Components

Personal Care Rate

- Medicaid funded
- For ADL and IADL assist
- Salaries and fringe benefits only
- Must be provide for at least 15 minutes per day
- No bed hold payment

Room and Board Rate

- **State Funded**
- Supplies and Property costs
- Allocated costs for non-hands-on care
- Bed hold payment applicable

Overview of Long-Term Care Services: HCBS



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Home & Community-Based Services (HCBS)

Adults & Individuals with Physical Disabilities

- Service Payments for the Elderly and Disabled (SPED)
- Expanded SPED (Ex-SPED)
- Medicaid 1915-(c) Waivers
  - Aged and Disabled
  - Tech Dependent

Medicaid Programs

- Medicaid State Plan Personal Care (MSP-PC)
- Money Follows Person Grant – (MFP)
- Supervise HCBS Case Managers
- PACE

HCBS SUPPORTS INDIVIDUALS WITH DISABILITIES

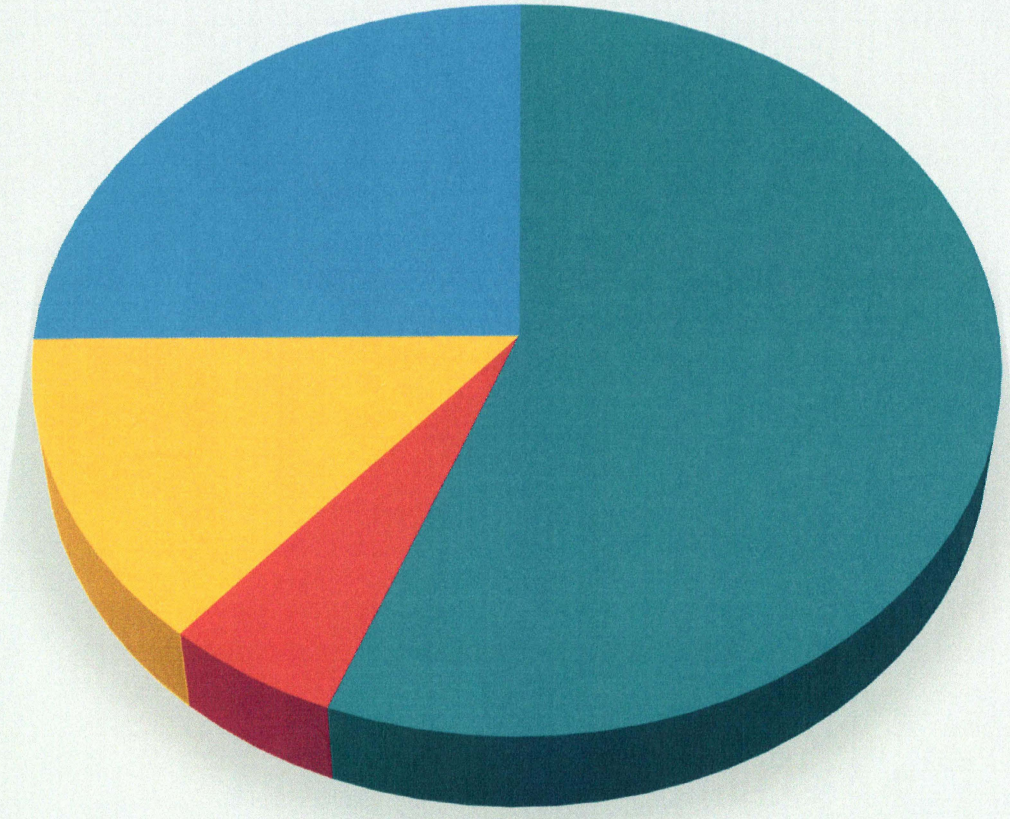
Olmstead Decision

- The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual.
- In 1999 the Federal Supreme Court Olmstead decision affirmed the ADA requirements.
- Increasing access to HCBS will assist the State in meeting this requirement.

Benefits of HCBS

- Most integrated setting means, a setting where individuals with disabilities can fully interact with individuals with non-disabilities and take advantage of community living as much as possible.
  - Usually, a private residence owned or leased by the individual or their family.
- Most integrated setting for each individual is determined through person centered planning and informed choice.

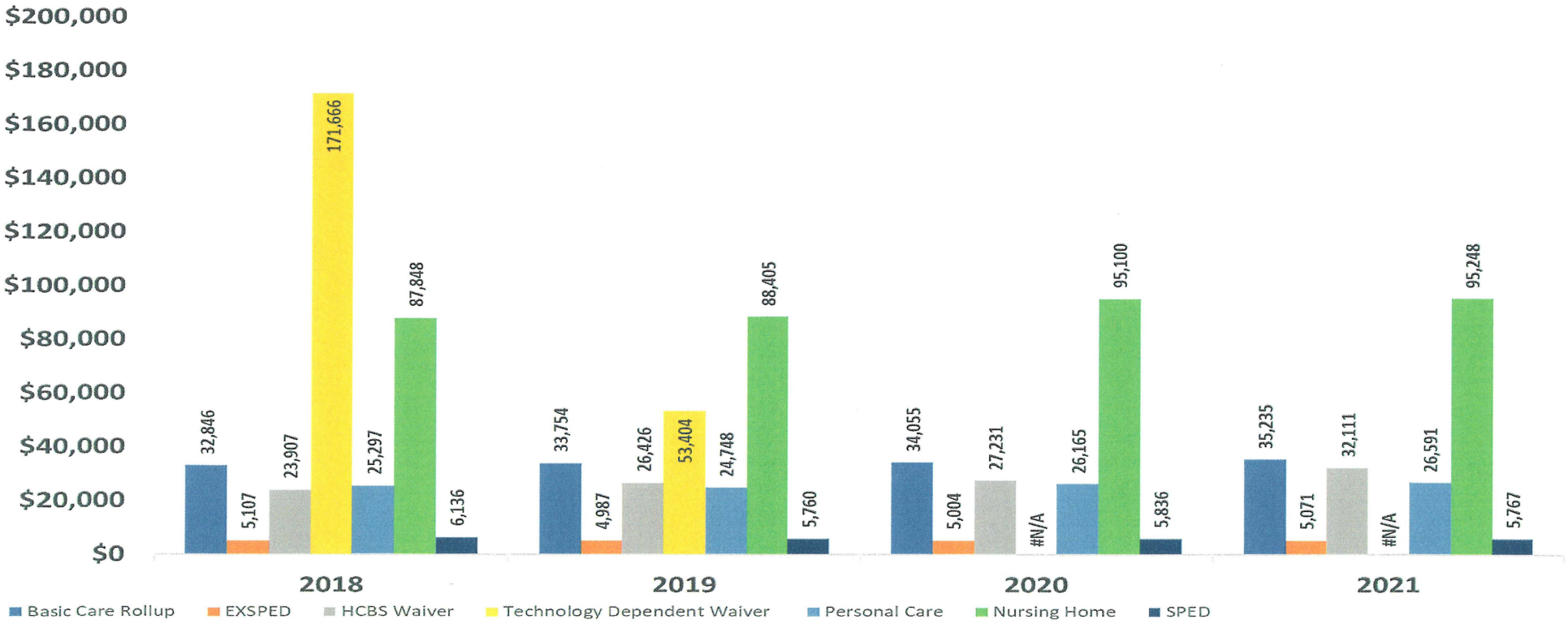
CURRENT ACTIVE CLIENT CASES AS OF NOVEMBER 2020



- SPED: 1,450
- Ex-SPED: 141
- HCBS WAIVER: 355
- MSP-PC: 654

Source: DHS HCBS Caseload Data Nov 2020

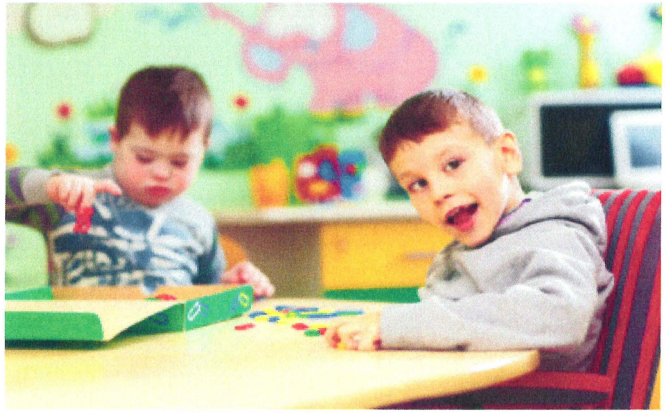
Aging Average Recipient Cost Per Year
State Fiscal Years 2018 - 2021



Data is based on paid date
2021 based on estimated expenditures, remaining years are based on actual paid claims
HCBS does not include room and board

Overview of Long-Term Care Services: Autism and Other Waivers







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Overview of Autism & Other Waivers

Waiver & Voucher Services

- Children's Autism Spectrum Disorder Voucher

Medicaid 1915 (c) Waivers

- Children's Autism Spectrum Disorder 96 slots
- Children's Medically Fragile 25 slots
- Children's Hospice 30 slots



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Funding Requests

Nursing Home Payment Reform

- Reform of both care and property rate methodology
- Interim report submitted October 1, 2020
- Policy testimony will be presented in **Human Services Committee**
- DHS sponsored bill- House Bill 1090
- $7.2 million ($3.3m General; $3.8m Federal)

Nursing Home Bed Buy Back

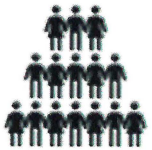
- Request to purchase beds out of the current nursing home system and layaway
- State plans to pay between $12,000-$15,000 per bed
- Taking beds out of the system reduces future State liability
- $3.3m in General Funds



Services Closer to Home

Create pathways that help people access the right service at the right time

Engage proactively with providers to expand access to services



High-Performing Organization

Develop an adaptable, capable and mission driven workforce

Balance resources to achieve strategic goals

REDUCE PACE RATES & ENROLLMENT



Estimated Total Potential Savings **$1,914,734**

Reduce PACE Rates & Enrollment

	Total	Federal	State
PACE Capitated Rate Reduction	$ (1,385,545)	$ (740,194)	$ (645,351)
PACE Enrollment Reduction	$ (529,189)	$ (282,709)	$ (246,480)
TOTAL POTENTIAL SAVINGS	**$ (1,914,734)**	**$ (1,022,903)**	**$ (891,831)**

BASIC CARE REDUCTION

Estimated Total Potential Savings **$7,300,000**

Basic Care Reduction			
	Total	**Federal**	**State**
Basic Care	$ (7,300,000)	$ (0)	$ (7,300,000)

SUMMARY OF AUTISM CHANGES



Estimated Total Potential General Fund Savings **$623,000**

- **Autism Voucher** = **$1.358 million** general fund savings by eliminating
- **Autism Waiver** = **$830,000 increase** in general funds for **increase of 54 slots** and state plan services
- **Autism Training funds** = **$93,000** in general fund savings by eliminating

ELIMINATION OF TECHNOLOGY DEPENDENT WAIVER

Estimated Total Potential Savings **$596,112**

Elimination of TECH DEPENDENT WAIVER

	Total	Federal	State
Tech Dependent Waiver	**$ (596,112)**	$ (318,560)	$ (277,552)

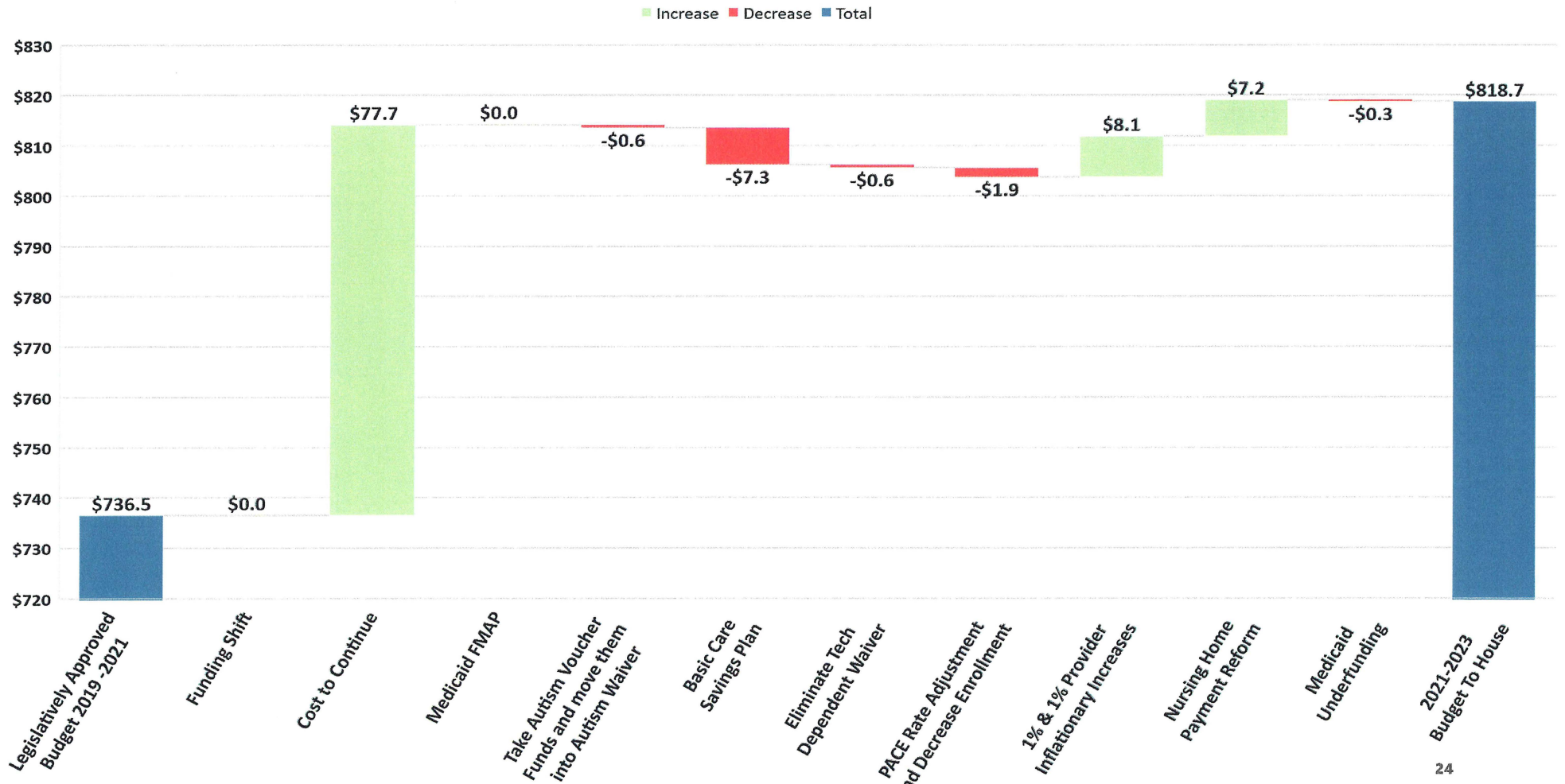
OVERVIEW OF LONG-TERM CARE BUDGET CHANGES

Description	Budget 2019-2021	Increase/ (Decrease)	Executive Budget 2021-2023
Grants	853,200	(330,000)	523,200
Medical Grants	736,510,531	85,531,242	822,041,773
Total	**737,363,731**	**85,201,242**	**822,564,973**
General Fund	377,567,931	26,612,730	404,180,661
Federal Funds	356,199,438	61,872,874	418,072,312
Other Funds	3,596,362	(3,284,362)	312,000
Total	**737,363,731**	**85,201,242**	**822,564,973**
Full Time Equivalent (FTE)	**0.00**	**0.00**	**0.00**

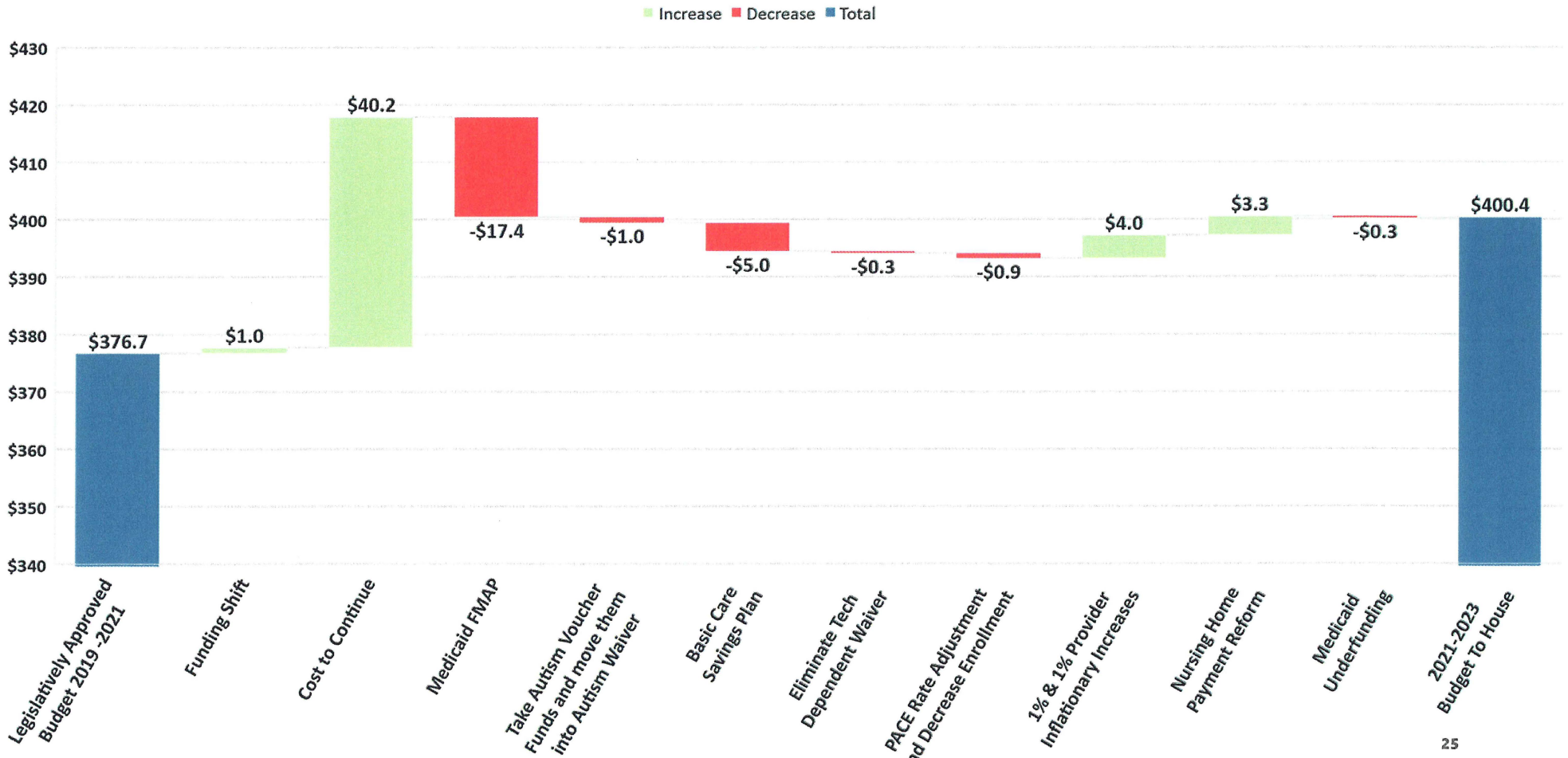
LONG-TERM CARE WALKTHROUGH

Service Description	Legislatively Approved Budget 2019 - 2021	Funding Shift	Cost to Continue	Medicaid FMAP	Take Autism Voucher Funds and move them into Autism Waiver	Basic Care Savings Plan	Eliminate Tech Dependent Waiver	PACE Rate Adjustment and Decrease Enrollment	Total Changes	2021-2023 Budget To OMB	1% & 1% Provider Inflationary Increases	Nursing Home Payment Reform	Medicaid Underfunding	Total Governor Changes	2021-2023 Budget To House
Nursing Facilities	582,849,867		39,676,637						39,676,637	622,526,504	5,646,947	7,200,000		12,846,947	635,373,451
Underfunding	(20,000,000)		20,000,000						20,000,000	0			(330,000)	(330,000)	(330,000)
Total Nursing Facilities	**562,849,867**	**0**	**59,676,637**	**0**	**0**	**0**	**0**	**0**	**59,676,637**	**622,526,504**	**5,646,947**	**7,200,000**	**(330,000)**	**12,516,947**	**635,043,451**
Basic Care	49,555,981		5,717,765			(7,300,000)			(1,582,235)	47,973,746	439,126			439,126	48,412,872
Home & Community Based Services	**124,104,683**	**0**	**12,304,310**	**0**	**(645,673)**	**0**	**(596,112)**	**(1,914,734)**	**9,147,791**	**133,252,474**	**2,032,976**	**0**	**0**	**2,032,976**	**135,285,450**
SPED	17,799,841		2,020,479			0			2,020,479	19,820,320	298,683			298,683	20,119,003
Ex-SPED	1,844,963		(10,073)			0			(10,073)	1,834,890	27,782			27,782	1,862,672
Personal Care Services	34,483,377		(3,206,937)			0			(3,206,937)	31,276,440	470,710			470,710	31,747,150
Targeted Case Management	1,917,742		(1,763,206)			0			(1,763,206)	154,536	2,326			2,326	156,862
Home & Comm Based Service Waiver	30,104,751		14,492,777			0			14,492,777	44,597,528	683,636			683,636	45,281,164
Children's Medically Fragile Waiver	544,416		(154,680)			0			(154,680)	389,736	5,866			5,866	395,602
Technology Dependent Waiver	591,288		4,824			0	(596,112)		(591,288)	0	0			0	0
PACE	32,866,676		1,946,562			0		(1,914,734)	31,828	32,898,504	509,262			509,262	33,407,766
Children's Hospice Waiver	61,848		10,224			0			10,224	72,072	1,085			1,085	73,157
Autism Waiver	2,564,772		(1,068,804)		712,480				(356,324)	2,208,448	33,626			33,626	2,242,074
Autism Voucher	1,325,009		33,144		(1,358,153)				(1,325,009)	0				0	0
	0		0												
Excess Federal Authority	0		0						0	0				0	0.00
Total	**736,510,531**	**0**	**77,698,712**	**0**	**(645,673)**	**(7,300,000)**	**(596,112)**	**(1,914,734)**	**67,242,193**	**803,752,724**	**8,119,049**	**7,200,000**	**(330,000)**	**14,989,049**	**818,741,773**
General Fund	**376,744,734**	**1,000,000**	**40,249,973**	**(47,377,698)**	**(1,026,852)**	**(5,045,639)**	**(277,552)**	**(894,834)**	**46,630,402**	**393,345,433**	**3,994,328**	**3,348,000**	**(330,000)**	**7,942,328**	**400,357,464**

LONG-TERM CARE TOTAL FUND CHANGE (IN MILLIONS)



LONG-TERM CARE GENERAL FUND CHANGE (IN MILLIONS)



Thank You!

Caprice Knapp, PhD
Division Director

Phone: (701) 328-1603
E-Mail: cknapp@nd.gov

Nancy Maier
Aging Services Director

Phone: (701) 328-4607
E-Mail: nmaier@nd.gov

NORTH Dakota | Human Services
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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB1012
1/18/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of **human services; to provide an exemption; and to provide for a report.**

9:01am start time

	Present	**Absent**
Rep Nelson	P	
Rep Kreidt	P	
Rep Anderson	P	
Rep Mitskog	P	
Rep Schobinger	P	
Rep Strinden	P	

Discussion Topics:
Budget Detail
Fact Based decision making
1915i overview
Human Service Centers

- Arnie Strebe , Chief Administrative Officer (9:04 am) testified about the budget overview #1622
- Pam Sagness, Executive Policy Director (9:16 am) testified about Behavioral Health Human Services #1633
- Rosalie Etherington, Chief Clinics Officer (9:43 am) testified about behaioral health #1633
- Laurie Gotvaslee, Regional Director (10:33 am) testified about the North Central Human Service Center #1629
- Charlotte Ferrel, Regional Director (11:20 am) testified about the Northwest Human Service Center #1627

11:58am – end time

Cole Fleck, Committee Clerk



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

INTRODUCTION TO BUDGET DETAIL REVIEWS

Arnie Strebe, Chief Administrative Officer / Chief Financial Officer

NORTH Dakota | Human Services

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This week's budget detail agenda

Monday a.m.
- Intro and overview
- 1915i presentation
- Human service centers

Monday p.m.
- Human service centers

Tuesday a.m.
- Child support
- Aging services

Tuesday p.m.
- Vocational rehabilitation
- Disability determination services
- DD council

Wednesday a.m.
- Life Skills and Transition Center
- Developmental disabilities
- Economic assistance

Wednesday p.m.
- Human services zones

Thursday a.m.
- Behavioral health
- Administrative support

Slide 2

BLM8 Bargmann, Lynn M., 1/17/2021

DHS MISSION AND OPERATING PRINCIPLES

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

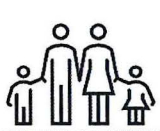
   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

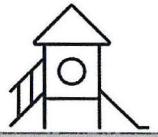
   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



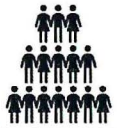
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

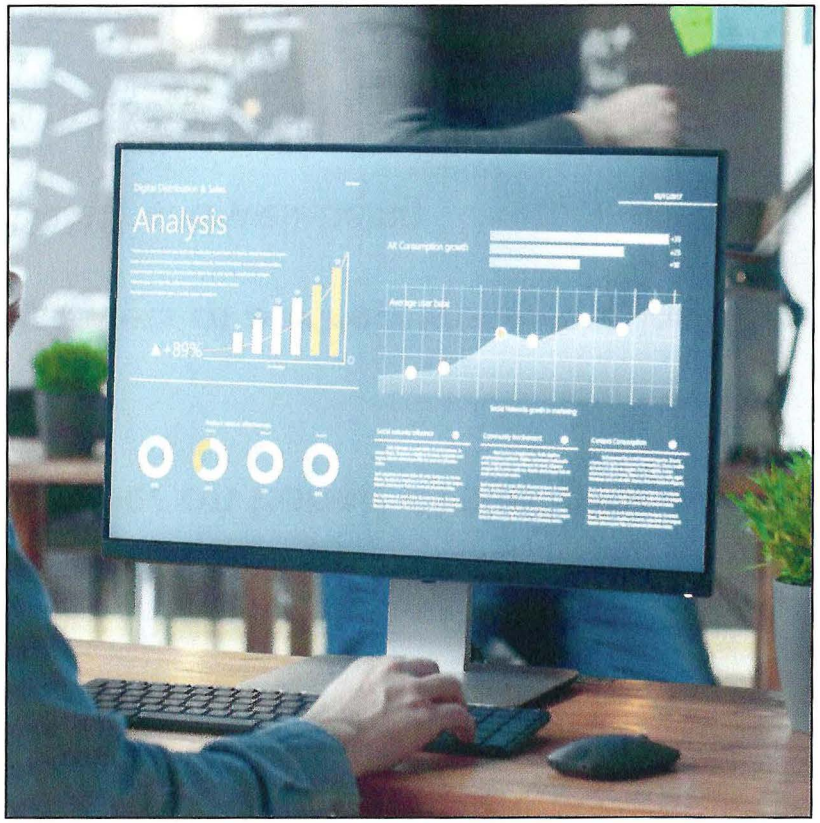
Economic Health | Behavioral Health | Physical Health

Fact-based decision making ensures solutions make the biggest impact on those we serve

Change and continuous improvement are standard operations across DHS.

We successfully lead and manage through it by:

1. Staying focused on our DHS mission and key priorities, and
2. Using fact-based decision making.



DHS's new workplace represents more than a work location

Its about defining how way we work and win together on behalf of those we serve

FACT

100% of field services team members work onsite:

- Human service centers
- Life Skills and Transition Center
- State Hospital

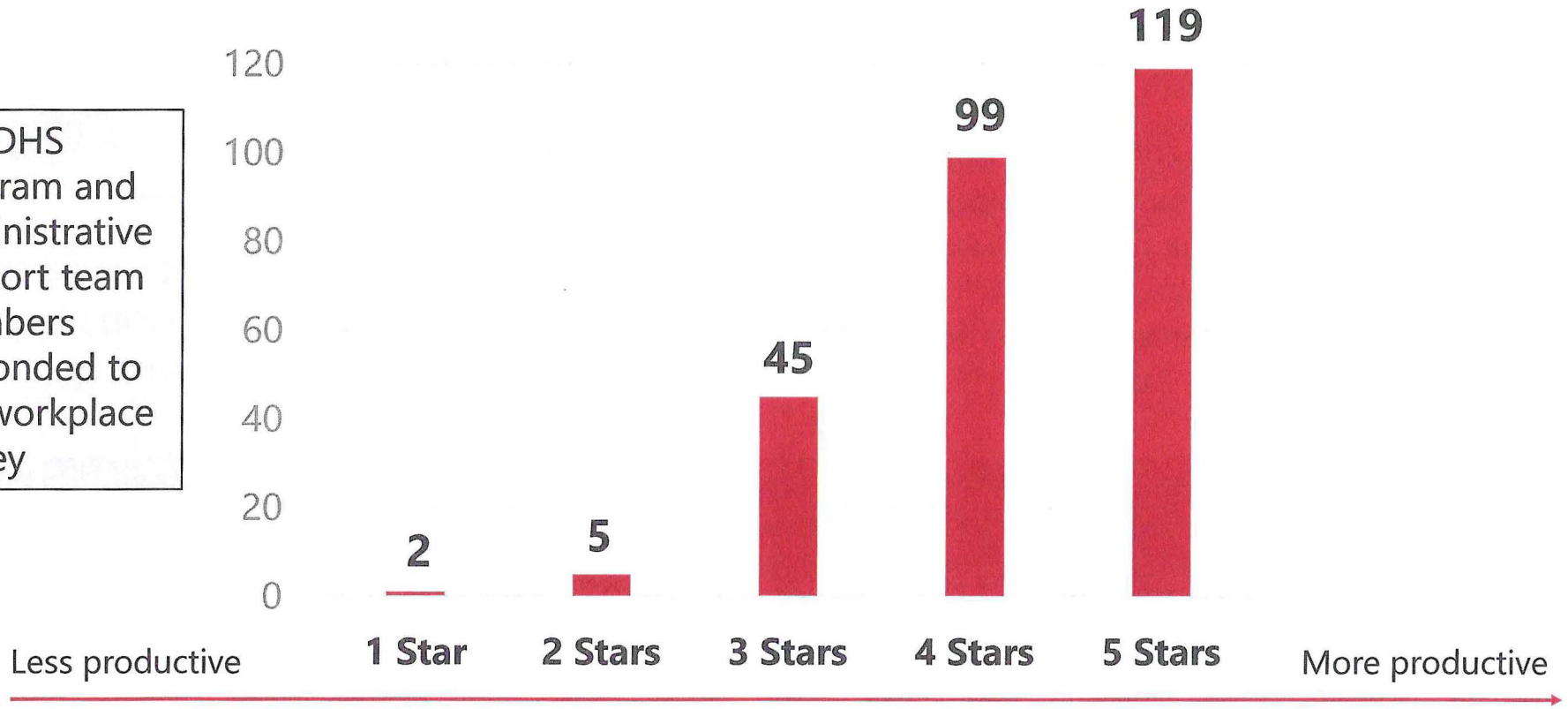
80% of program administration and support teams work remotely.

Key tenets of our new workplace include:

- Safety and well-being
- Continuity of critical human services
- Taxpayer value
- Flexibility, technology, teamwork and innovation

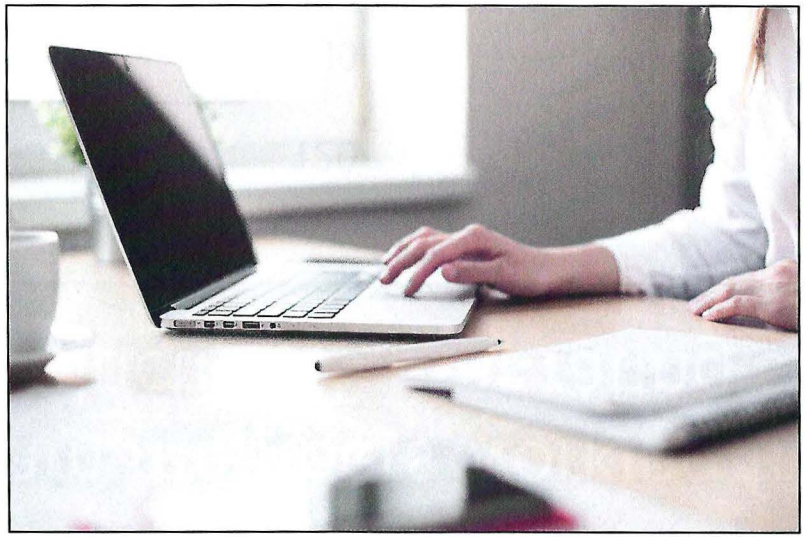
Team members working from home say they are more productive (5-star rating scale)

270 DHS program and administrative support team members responded to our workplace survey



You asked about our work-from-home approach ...

We carefully reviewed every job function from a work-from-home perspective. Here's what we learned:



- Most of our clients are best served in a direct, face-to-face environment.
- While many program administration and administration support jobs can be done from home, some roles still need to be office-based.
- Team members may not always have the necessary space or functional setup to work from home.
- While some team members prefer to work from home, others prefer an office setting with appropriate health and safety precautions (e.g.; sanitization, masks).

Divisions will share detailed FTE updates in the format shown here

DIVISION NAME

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
00.00	00.00	00.00	0.0	0%	Administration	0
				0%	Client Facing Administration	0
				0%	Behavioral Health	00

COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount	
Pre-COVID	Current
0	0

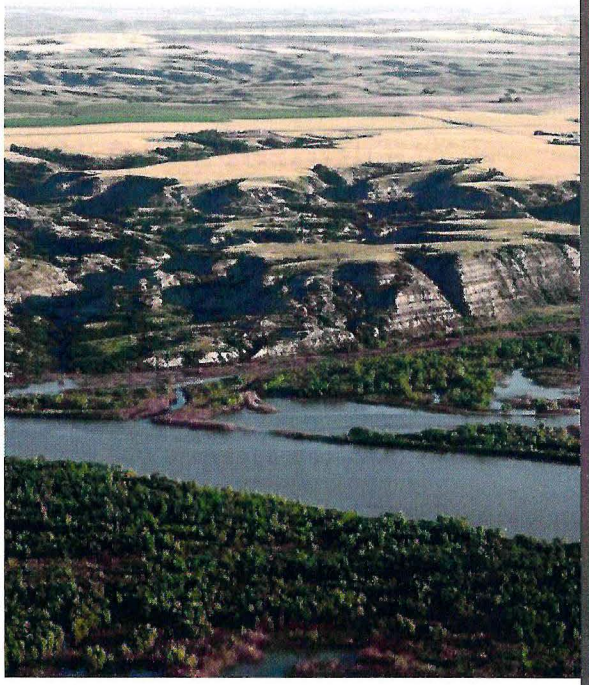
Divisions will share detailed budget information in the format shown here

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	-	-	-	-	-
52x Travel	-	-	-	-	-
53x Supply	-	-	-	-	-
54x Postage & Printing	-	-	-	-	-
55x Equipment Under $5,000	-	-	-	-	-
56x Utilities	-	-	-	-	-
57x Insurance	-	-	-	-	-
58x Rent/Leases - Bldg./Equip	-	-	-	-	-
59x Repairs	-	-	-	-	-
61x Professional Development	-	-	-	-	-
62x Fees - Operating & Professional	-	-	-	-	-
67x Non Operating Expenses	-	-	-	-	-
60x IT Expenses	-	-	-	-	-
68x Land, Building, Other Capital	-	-	-	-	-
69x Equipment Over $5,000	-	-	-	-	-
71x Grants, Benefits, & Claims	-	-	-	-	-
72x Transfers	-	-	-	-	-
Total	-	-	-	-	-

This week's Amendments process

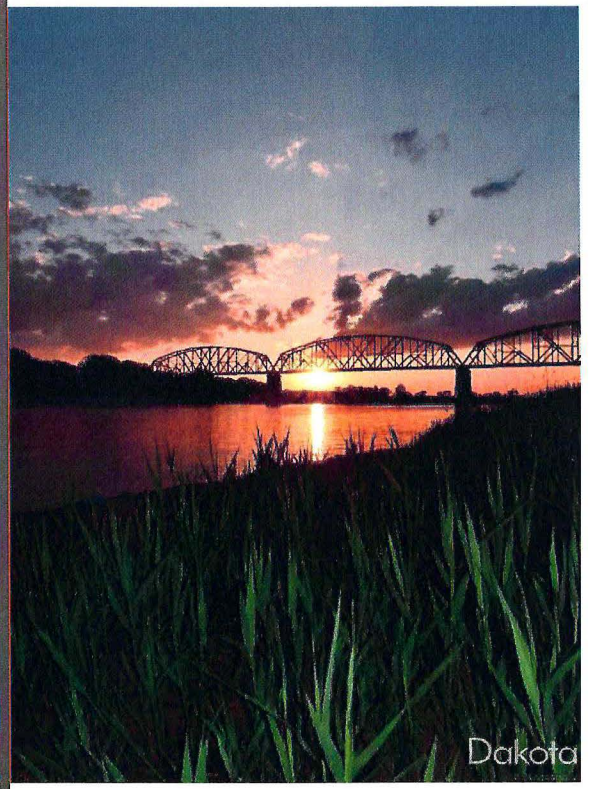
- We will present a green sheet review.
- You will receive a summary of our amendments.
- Divisions will cover their amendments during their testimony.
- We will collect and summarize them.
- We will review them during the administrative support discussion on Thursday.





Contact Information

Arnie Strebe, Chief Administrative Officer / CFO
Department of Human Services
Phone: 701.328.3695
Email: astrebe@nd.gov



#1633

NORTH Dakota | Behavioral Health
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House Bill 1012
House Appropriations
Representative Nelson, Chairman

1915i State Plan Amendment Overview
Pamela Sagness, Executive Policy Director

1

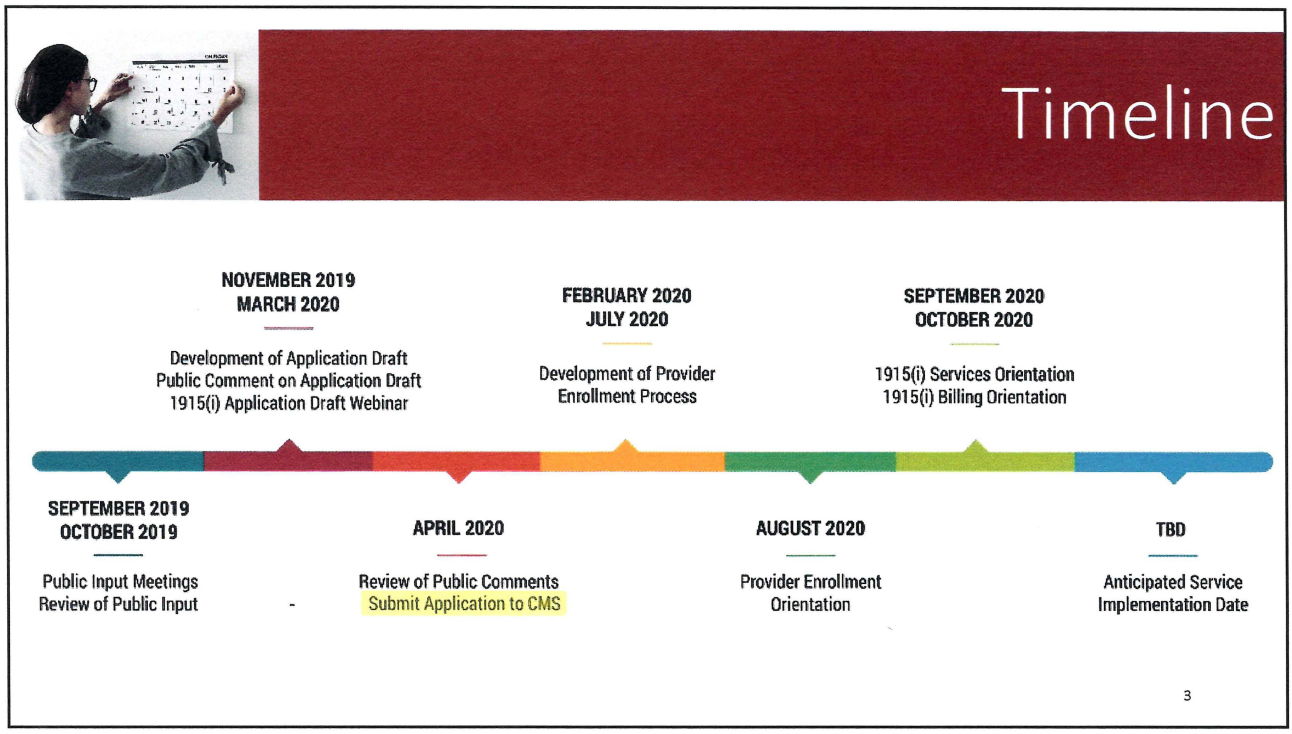
1



During the 2019 legislative session, North Dakota lawmakers authorized the Department of Human Services (Department) to create a Medicaid 1915(i) State Plan Amendment.

The amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.

2


Timeline
NOVEMBER 2019
MARCH 2020
Development of Application Draft
Public Comment on Application Draft
1915(i) Application Draft Webinar
FEBRUARY 2020
JULY 2020
Development of Provider Enrollment Process
SEPTEMBER 2020
OCTOBER 2020
1915(i) Services Orientation
1915(i) Billing Orientation
SEPTEMBER 2019
OCTOBER 2019
Public Input Meetings
Review of Public Input
APRIL 2020
Review of Public Comments
Submit Application to CMS
AUGUST 2020
Provider Enrollment Orientation
TBD
Anticipated Service Implementation Date
3

3


www.behavioralhealth.nd.gov/1915i
4

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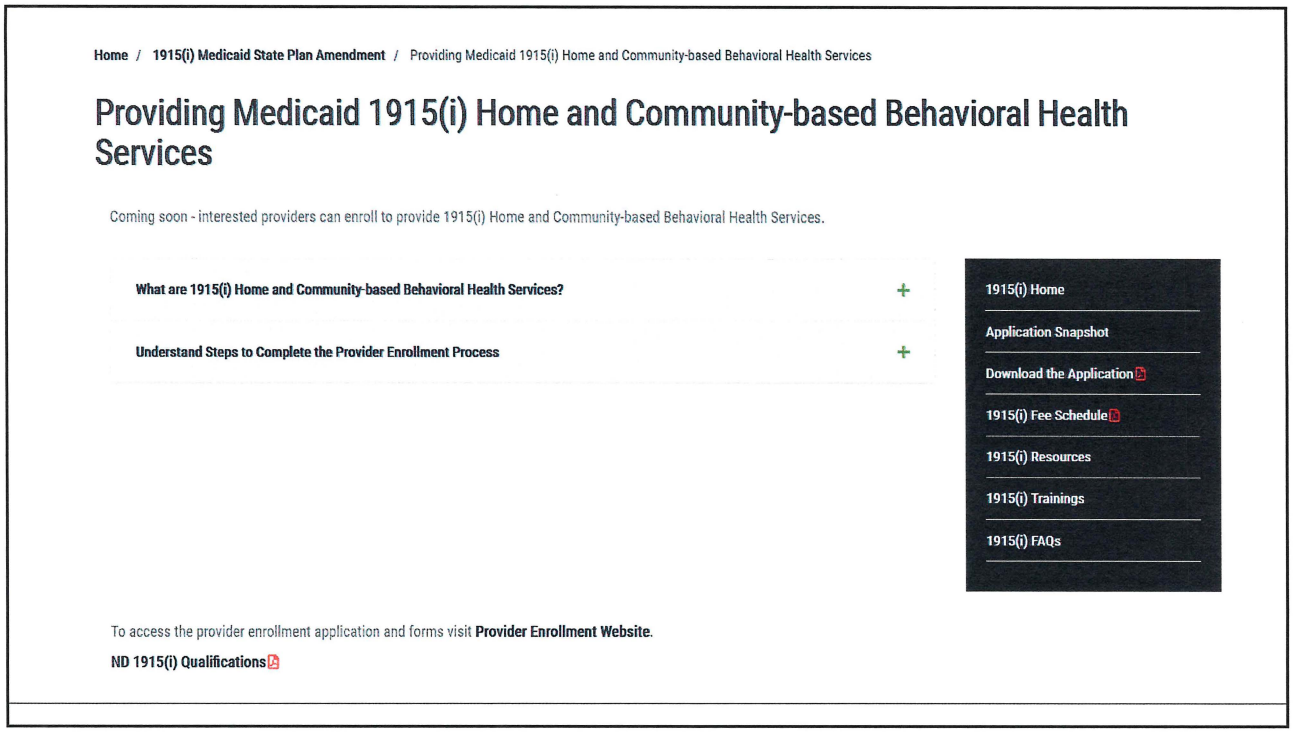

Home / 1915(i) Medicaid State Plan Amendment / Providing Medicaid 1915(i) Home and Community-based Behavioral Health Services

Providing Medicaid 1915(i) Home and Community-based Behavioral Health Services

Coming soon - interested providers can enroll to provide 1915(i) Home and Community-based Behavioral Health Services.

What are 1915(i) Home and Community-based Behavioral Health Services? +

Understand Steps to Complete the Provider Enrollment Process +

1915(i) Home
Application Snapshot
Download the Application
1915(i) Fee Schedule
1915(i) Resources
1915(i) Trainings
1915(i) FAQs

To access the provider enrollment application and forms visit **Provider Enrollment Website**.

ND 1915(i) Qualifications

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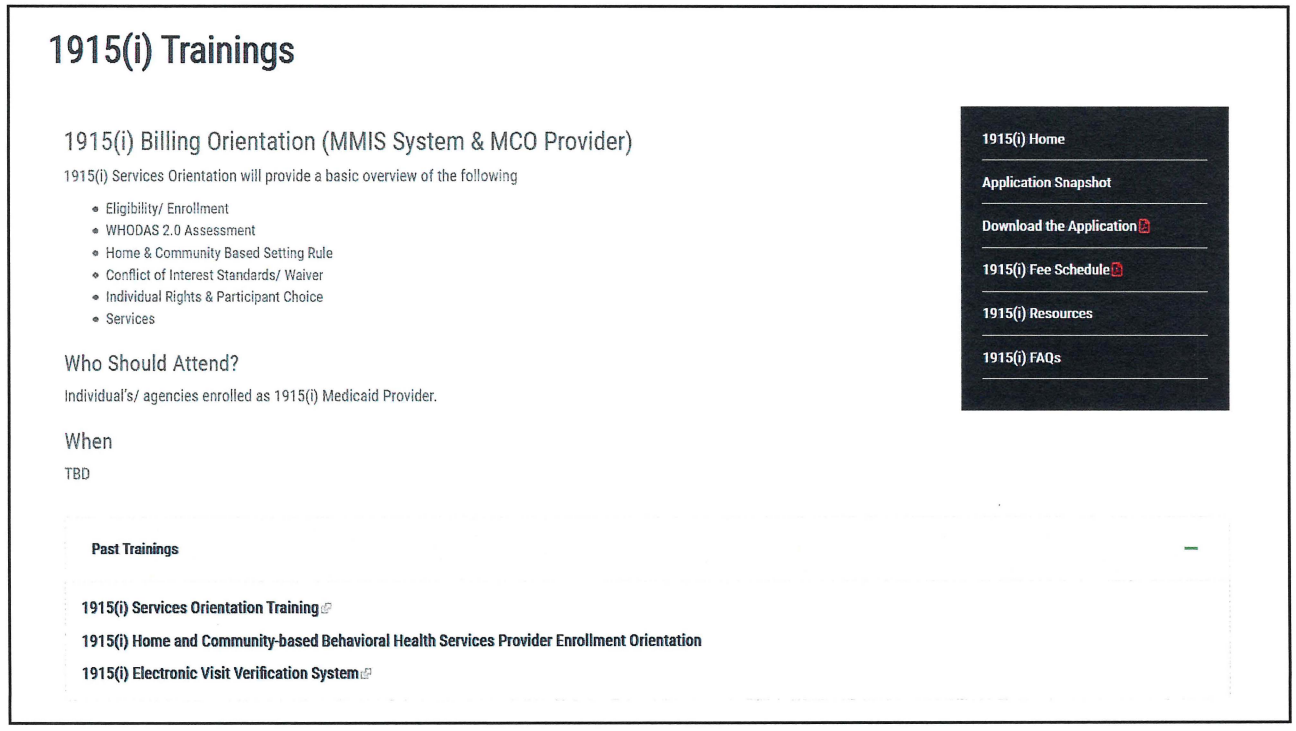

1915(i) Trainings

1915(i) Billing Orientation (MMIS System & MCO Provider)

1915(i) Services Orientation will provide a basic overview of the following

- Eligibility/ Enrollment
- WHODAS 2.0 Assessment
- Home & Community Based Setting Rule
- Conflict of Interest Standards/ Waiver
- Individual Rights & Participant Choice
- Services

Who Should Attend?

Individual's/ agencies enrolled as 1915(i) Medicaid Provider.

When

TBD

1915(i) Home
Application Snapshot
Download the Application
1915(i) Fee Schedule
1915(i) Resources
1915(i) FAQs

Past Trainings −

1915(i) Services Orientation Training
1915(i) Home and Community-based Behavioral Health Services Provider Enrollment Orientation
1915(i) Electronic Visit Verification System

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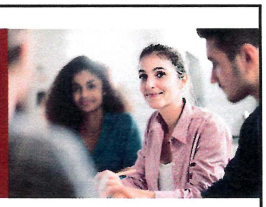
Individual Eligibility



- The individual is age 0+; and
- The individual is currently enrolled in ND Medicaid or Medicaid Expansion; and
- The individual resides in and will receive services in a setting meeting the federal home and community-based setting requirements, and
- The individual has a mental illness, substance use disorder or traumatic brain injury diagnosis, and
- The individual has a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting, as evidenced by a complex score of 50 or higher on the WHODAS 2.0.

7

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Services

SERVICE TYPE	DESCRIPTION	AGE
Care Coordination	Coordinates participant care, develops Person-centered Plan of Care plan of care and assists individuals with gaining access to needed1915(i) and other services.	0+
Training and Supports for Caregivers	Service directed to individuals providing unpaid support to a recipient of 1915(i) services. Services are provided for the purpose of preserving, educating, and supporting the family and/ or support system of the individual.	0+
Community Transitional Services	Non-recurring basic household set-up expenses for individuals transitioning from certain institutions to a private residence where the person is directly responsible for his or her own living expenses. Transition Coordination services are also available	0+
Benefits Planning	Assists individuals considering employment with making informed decisions regarding public benefits and work incentives. Counselors are knowledgeable on public benefits, including Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid etc.	0+
Non-Medical Transportation	Assists participants with transportation needs to gain access to services, activities and resources, as specified by their plan of care.	0 to 21
Respite	Provided to participants unable to care for themselves. Furnished on a short-term basis because of the absence or need for relief of persons who normally provide care for the participant.	0 to 21
Prevocational Training	Assists participants with developing general, non-job-task-specific strengths and skills that contribute to paid employment	18+
Supported Education	Assists participants who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment.	5+
Supported Employment	Assists participants with obtaining and keeping competitive employment at or above the minimum wage.	14+
Housing Support Services	Assists participants with accessing and maintaining stable housing in the community.	Six months prior to 18th birthday
Peer Support	Trained and certified individuals with lived experience as recipients of behavioral health services promote hope, self-determination, and skills to participants to achieve long-term recovery from a behavioral health disorder.	18+
Family Peer Support	FPSS provide a structured, strength-based relationship between a Family Peer Support provider and the parent/family member/caregiver for the benefit of the child/youth.	Families with children under age 18

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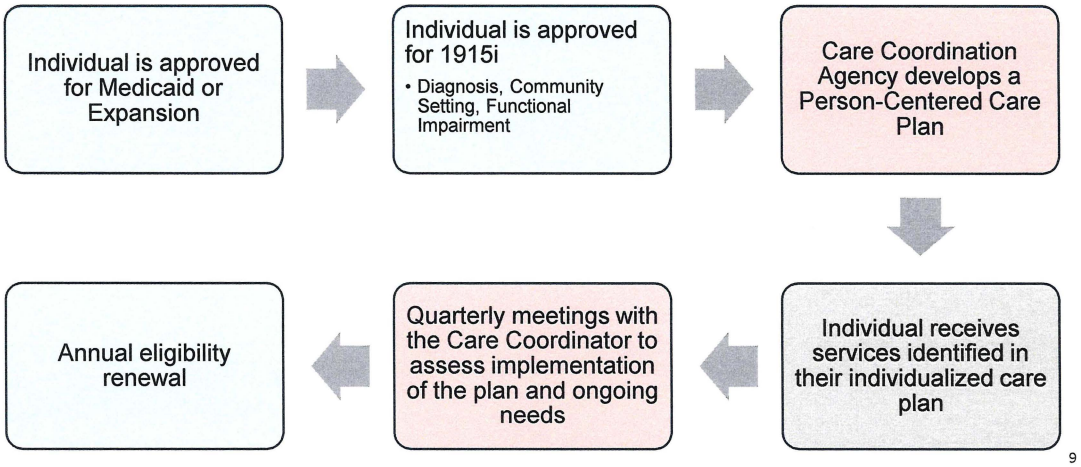
Process



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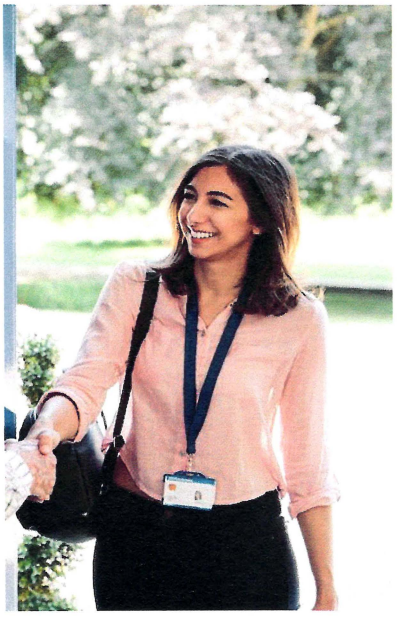
9 blue - services in human service zones.

The Care Coordination Role

- 1915(i) Care Coordination Service are provided by enrolled 1915(i) Care Coordination Providers. Care Coordinators could be employed by the state, private providers/ community organizations.
- The Care Coordination Role is responsible for the development of the Person-centered Plan of Care and supporting the individual with accessing the greater community to meet the individual's overall needs. This includes:
  - Ensuring continuity of care including collaborating with existing systems and services.
  - Connecting individual to additional 1915(i) Services through the development of the person-centered plan of care.
  - Building informal supports network in the individual's community.
  - Providing services that are equitable and culturally competent.
  - Empowering individuals by upholding practice that promotes individual choice, rights and responsibilities.



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CARE COORDINATION

- Coordinates participant care and assists individuals with gaining access to needed 1915(i) and other services.
- The Care Coordinator is responsible for the facilitation and oversight of:
  - Comprehensive Assessment and Reassessment of Activities
  - Development of an individualized Person-centered Plan of Care (POC), including a Crisis Plan component.
  - Plan Development Implementation and Monitoring.
  - Referral Collateral Contacts & Related Activities

Service Type	Age	Limits
Care Coordination	0+	8 hours per day; Remote Support up to 25% of the time.

Care Coordination Provider Qualifications

Organization/ Agency Standards

A provider of this service must meet all the following:
- Complete the Medicaid Provider Enrollment Agreement & Attestations.
- Meet individual practitioner qualifications/ and competencies
- Services are provided within the scope of practice.
- Agency conducts training in accordance to state policies and procedures
- Agency adheres to all 1915(i) standards and requirements.
- agency policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation, use of restraints and reporting procedures are written and available for NDDHS review upon request

Individual Practitioner

The individual providing the service must:
- be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and
- have a bachelor's degree in social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation. With accompanying transcript, the NDDHS, at their discretion, may approve other degrees in a closely related field.

Proof of training/ competency in The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or
The Case Management Society of America standards of practice.

11

11

Example 1: Community Behavioral Health Provider

NOW

- $1,000,000 **general** fund/biennium
- 60 individuals served at any one time/biennium
  - 50% qualify for Medicaid
  - 25% qualify for 1915i (15)
- Individuals receive support services 24/7

FUTURE

- 15 individuals (qualify for 1915i) - Provider reimbursed for person-centered services based on individuals need

EXAMPLE →

- *An individual receives 2 hours of Care Coordination/3 days a week/biennium = $50,918.40*
  - *For 15 individuals = **$763,776***
- *An individual receives Peer Support 4 hours/week/biennium = $12,280.32*
  - *For 13 individuals = **$159,644.16***
- *An individual receives Supported Housing 1 hour/day/5 days a week = $21,819.20*
  - *For 12 individuals = **$261,830.40***
- *An individual receives Supported Employment 3 hours/week/biennium = $13,091.52*
  - *For 4 individuals = **$52,366.08***
- *Total amount billed to the provider = **$1,237,616.64***
  - *$618,808.32 general funds/biennium for the 15 individuals serviced*

In current budget most providers continue to receive 50% of the original amount - $500,000

12

12

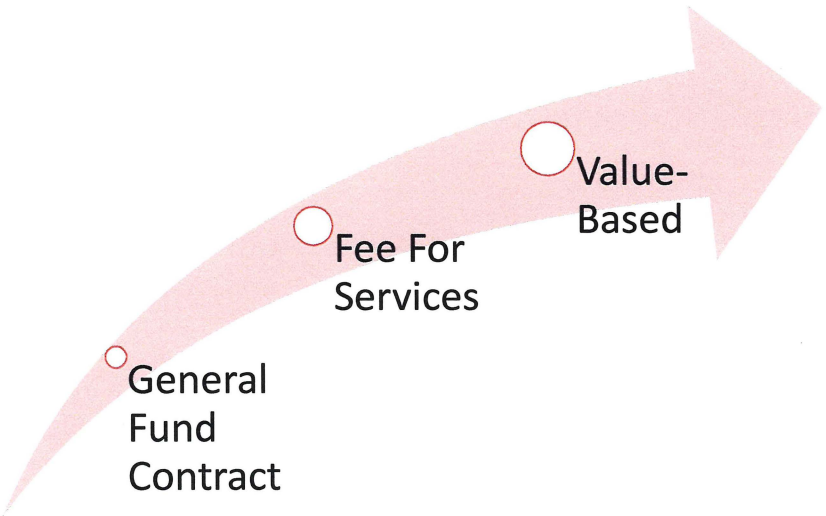
Outcomes of 1915i Implementation

- Individuals with highest need receive services that are more robust and targeted to their specific needs (person-centered).
- State is investing less funding yet providing more service to individuals with a behavioral health condition and providing opportunities to providers to expand services.
- Providers are able to bill for the specific services they are providing which allows greater opportunity to expand services and increase revenue.
- Behavioral health on par with health & sustainable.

13

13

Reimbursement Roadmap



14

14

Example 2: School

FUTURE

EXAMPLE →

- *School-Based Care Coordinator*
  30 hours/40 weeks/biennium =
  $195,840

→ *Family Peer Support*
→ *Respite*
→ *Supported Education*
→ *Supported Employment*

School social worker could qualify as school-based C.C. and can be reimbursed for these services. - possible example.

15

15

Supporting Families

FUTURE

- ***Student struggles are often related to family issues.***
- ***Connecting family members to services can be significant for student success.***

EXAMPLE →

A family experiences homelessness due to parental mental illness. Connecting to care coordination providers of adult services will be vital.

16

16

Expanded Behavioral Health Workforce

- 1915i services are provided by non-traditional behavioral health professionals
- Potential to improve access for workforce in rural areas
- Effectiveness of lived experience
- Career growth opportunities

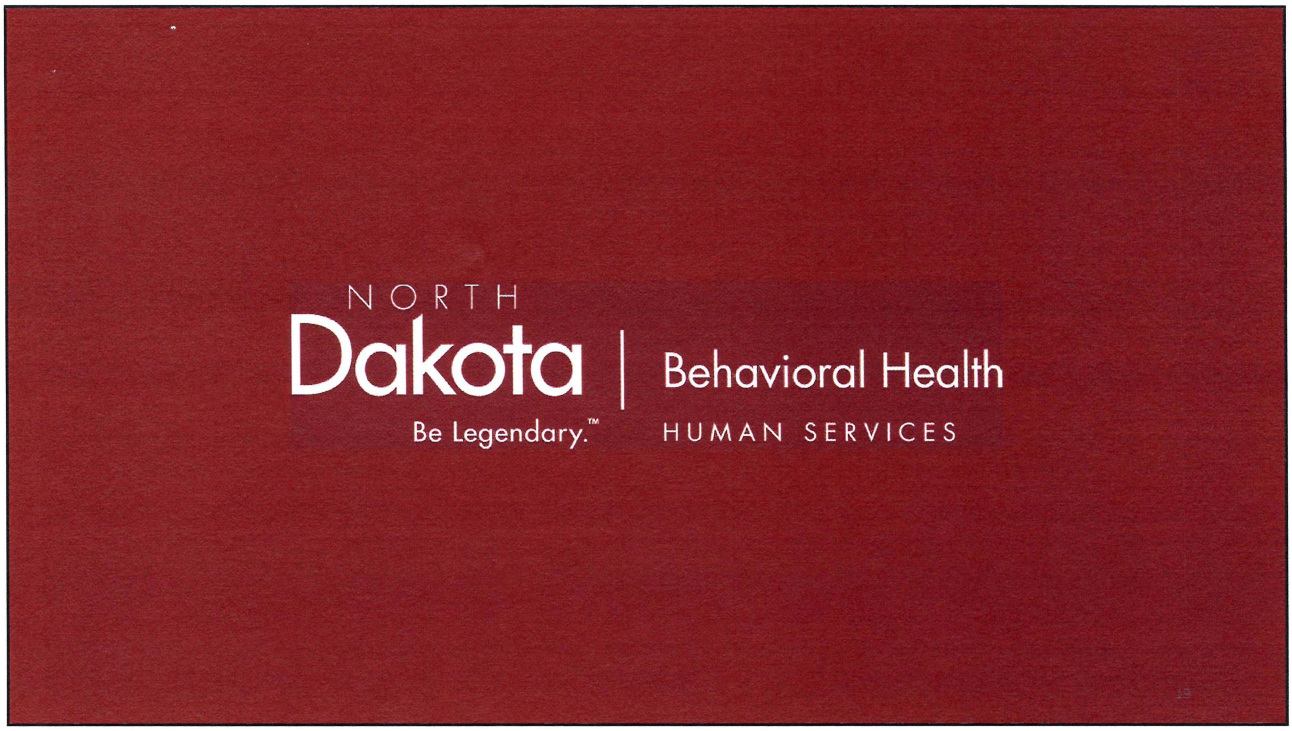
17

17

Providers Needed!

18

18


NORTH
Dakota
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Behavioral Health
HUMAN SERVICES
19

19



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTH CENTRAL HUMAN SERVICE CENTER OVERVIEW

Laurie Gotvaslee, Regional Director

NORTH Dakota | Human Services

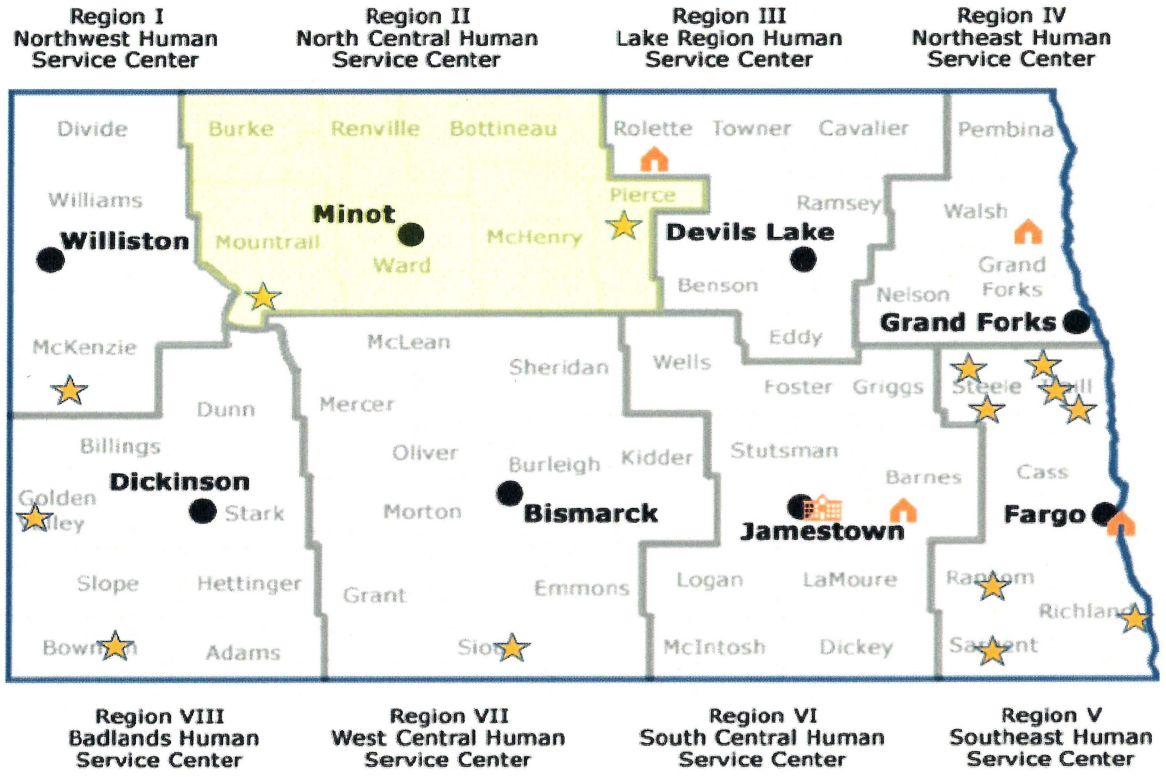
Be Legendary.™

North Central Human Service Center
Region II



Public Behavioral Health System

8 Regional Human Service Centers
14 Outreach Offices
4 Satellite Clinics
1 North Dakota State Hospital



Department of Human Services

NCHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
				7%	Administration	7
125	95.50	95.50	7	12%	Client Facing Administration	11.6
				81%	Behavioral Health	77.9

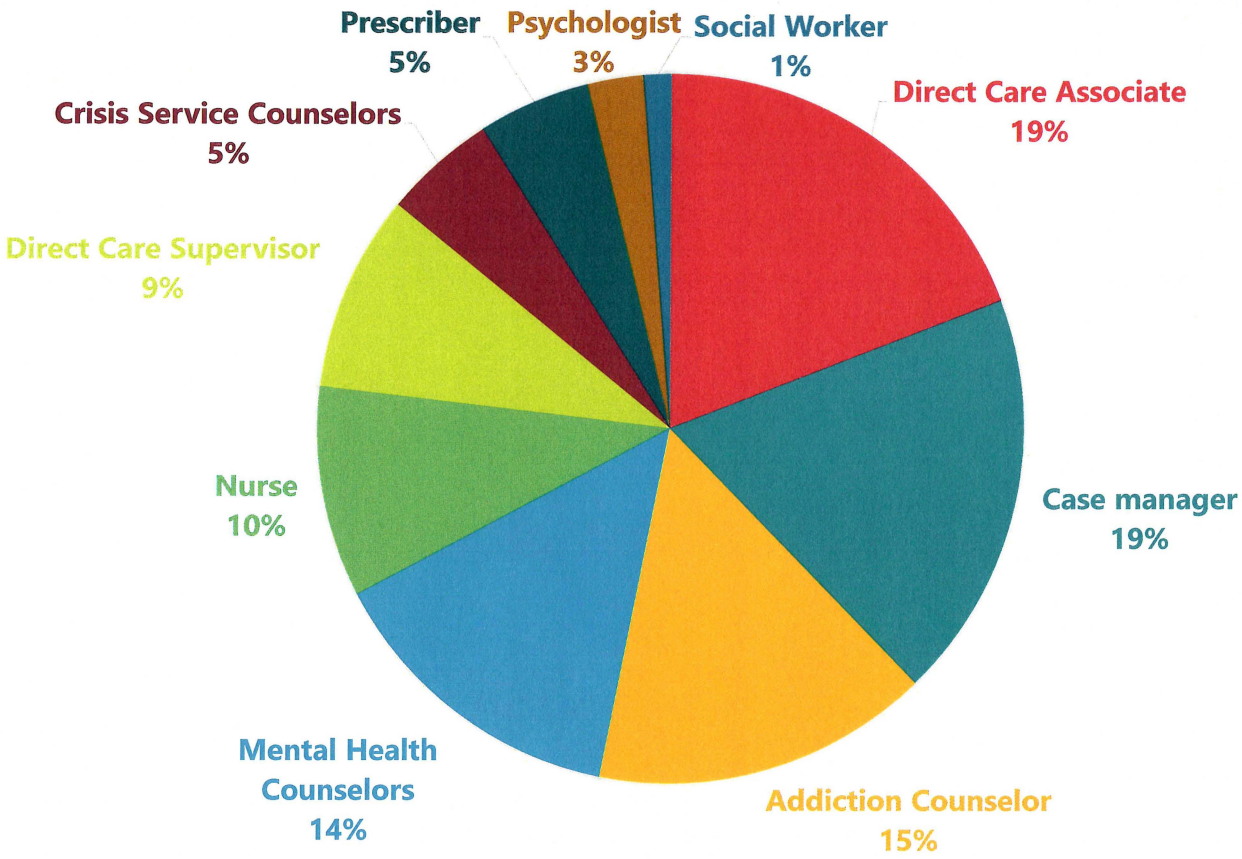
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
7	8

North Central Human Service Center
Behavioral Health FTE Breakdown



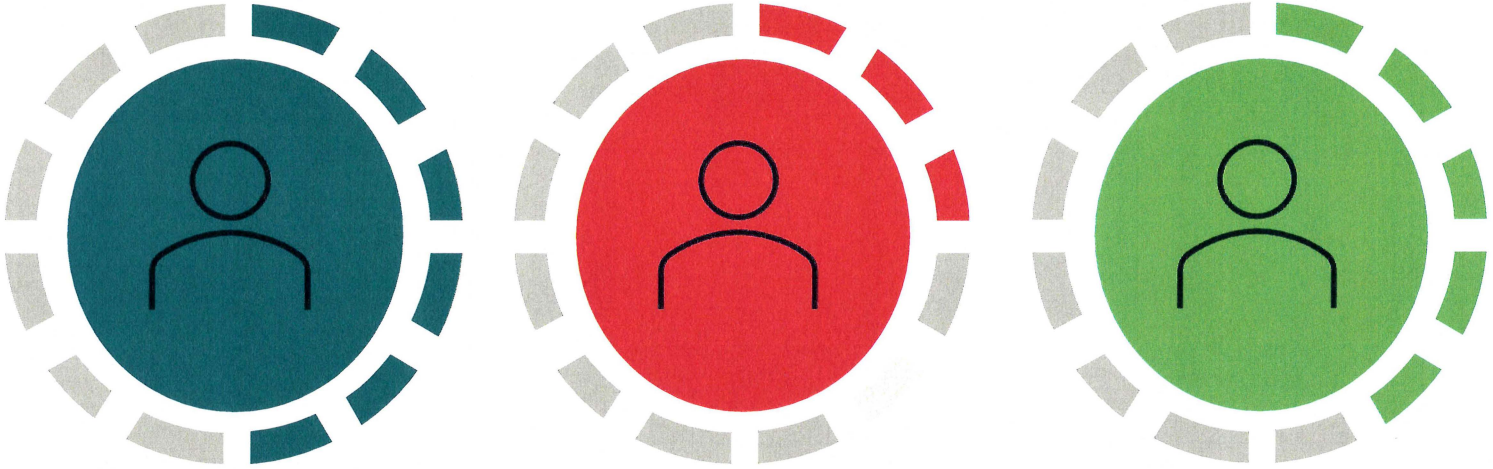
North Central Human Service Center
Crisis Services Staffing

NCHSC	Filled	Vacant
New Crisis Staff FTE (4)	4	0
Existing Crisis Staff FTE	N/A	N/A

North Central Human Service Center

Our Clients

The North Central HSC provided services to 2,946 clients between March 2019 and Nov. 2020.



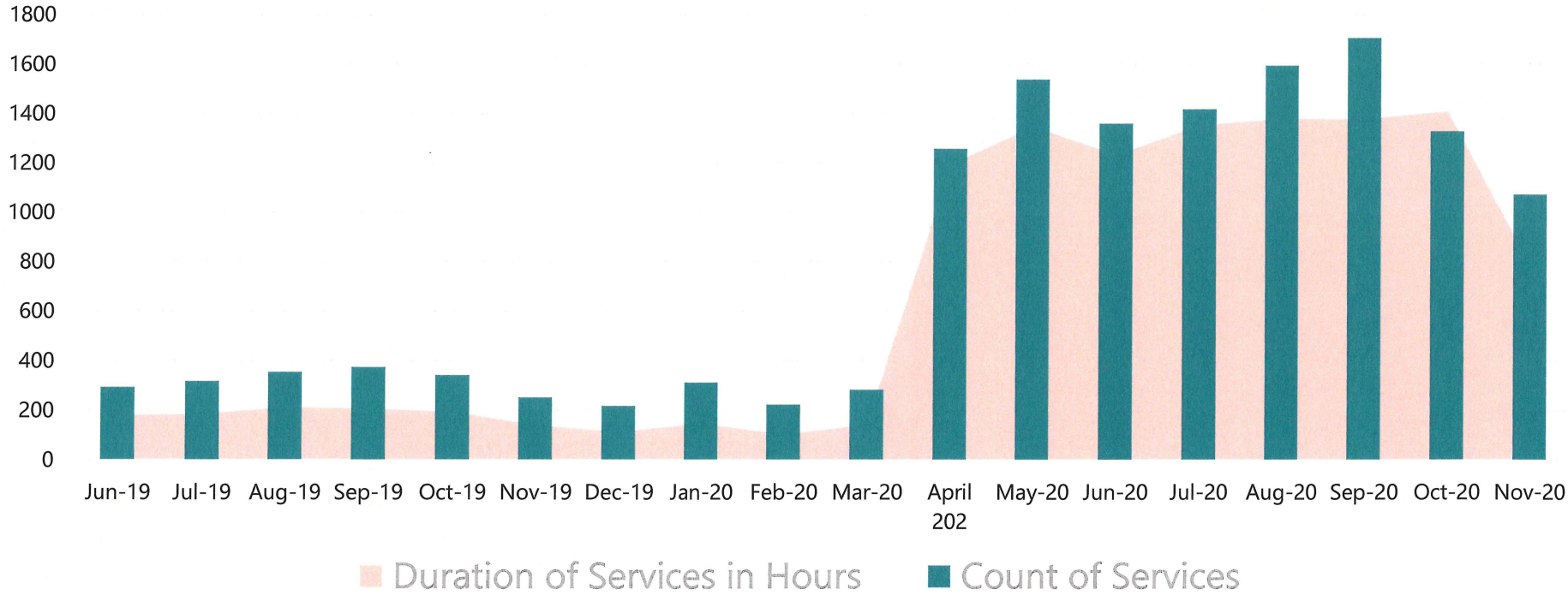
47% Serious Mental Illness (SMI) Primary Diagnosis

25% Substance Use Disorder (SUD) Primary Diagnosis

41% Co-Diagnosis of SUD and Mental Health Disorder

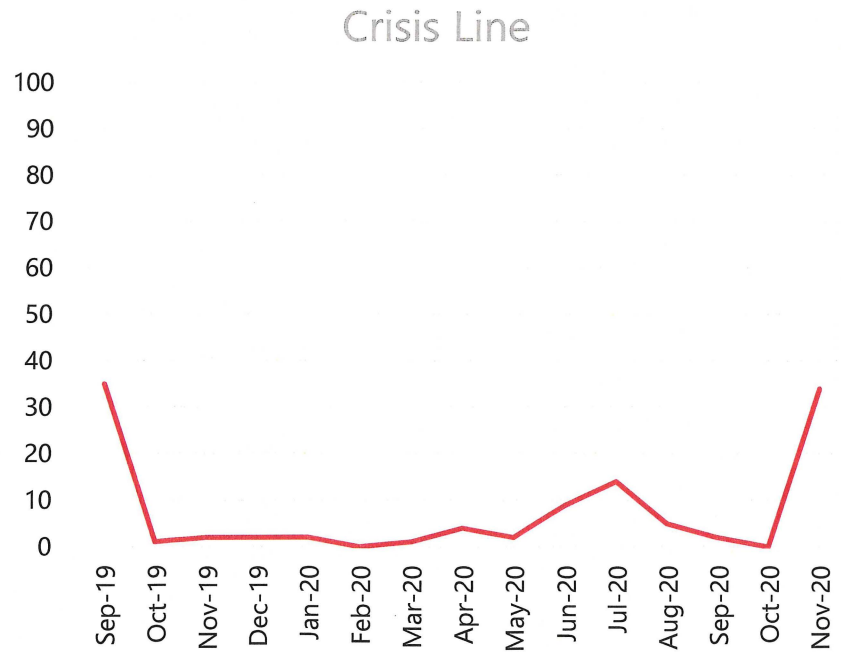
North Central Human Service Center
Telehealth Services

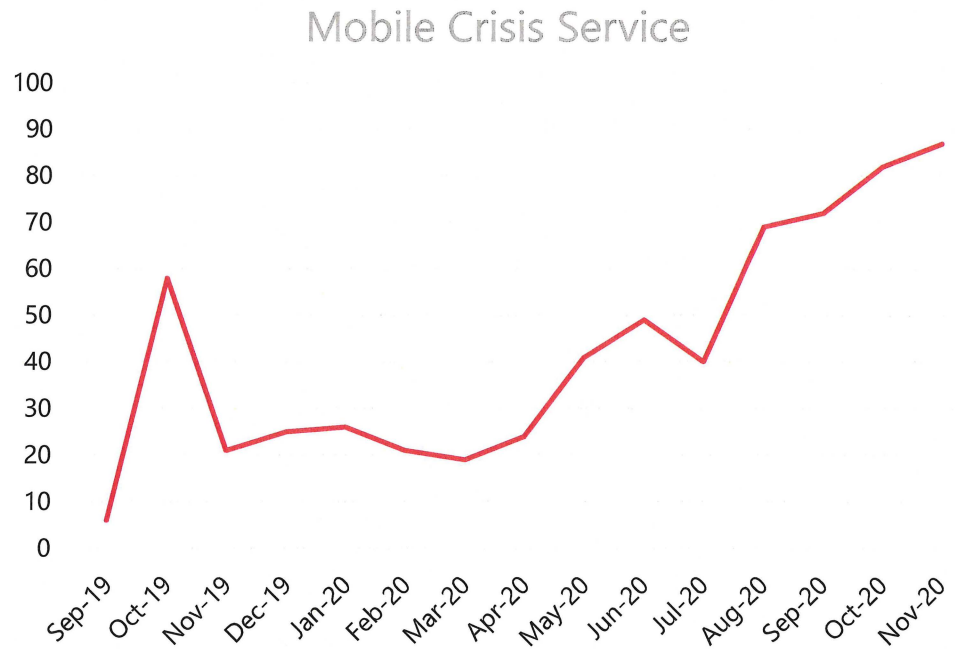
North Central HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



North Central Human Service Center
Crisis Services

North Central HSC provided 753 crisis services from September 2019 through November 2020.

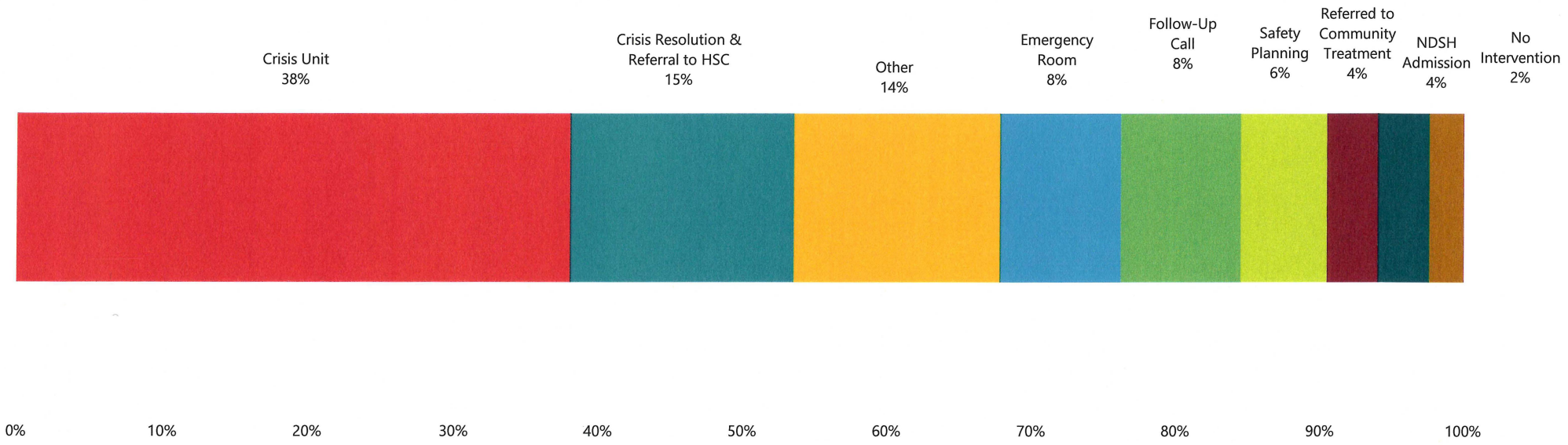




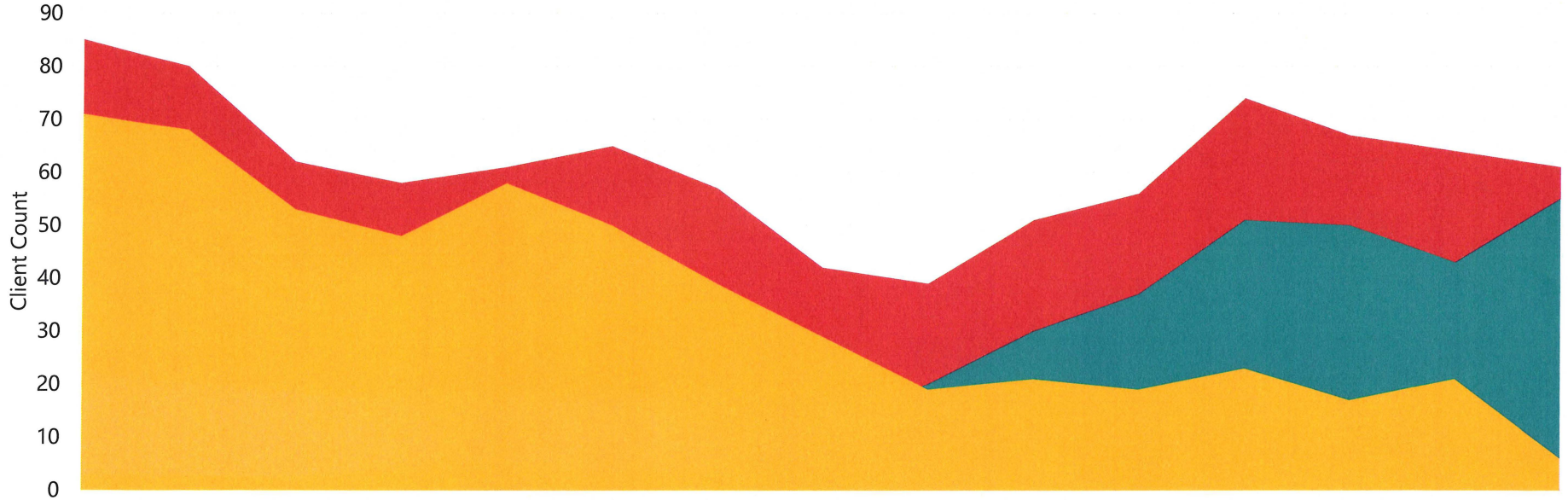
North Central Human Service Center

Disposition following Screening and Triage of Crisis Services

Between September 2019 through November 2020, North Central HSC triaged and screened 101 individuals for crisis services. Of those individuals, 67% were either referred to Crisis Unit, Crisis Resolution.



North Central Human Service Center
Open Access

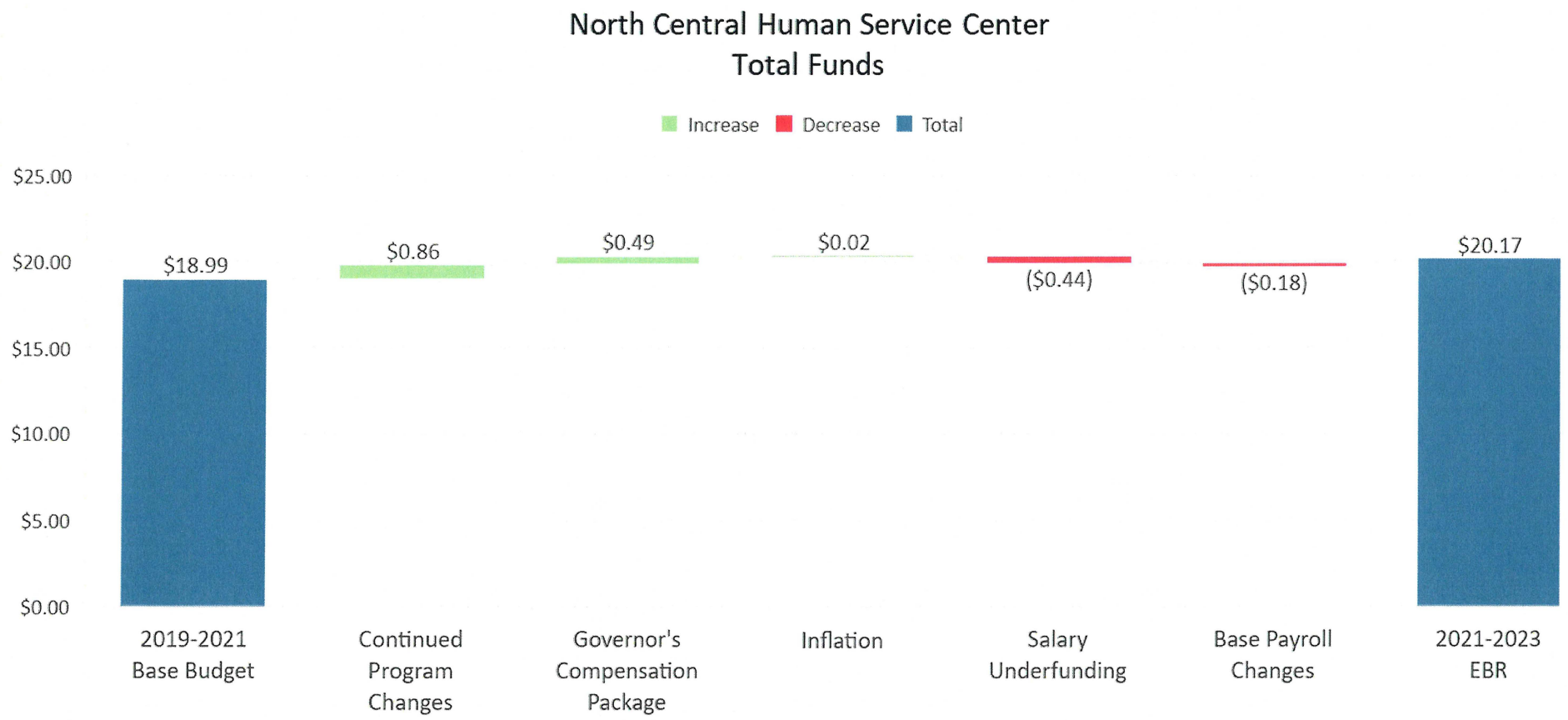


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	85	80	62	58	61	65	57	42	39	51	56	74	67	64	61
Referred To HSC	14	12	9	10	3	15	18	13	20	30	37	51	50	43	55
Referred Out	71	68	53	48	58	50	39	29	19	21	19	23	17	21	6

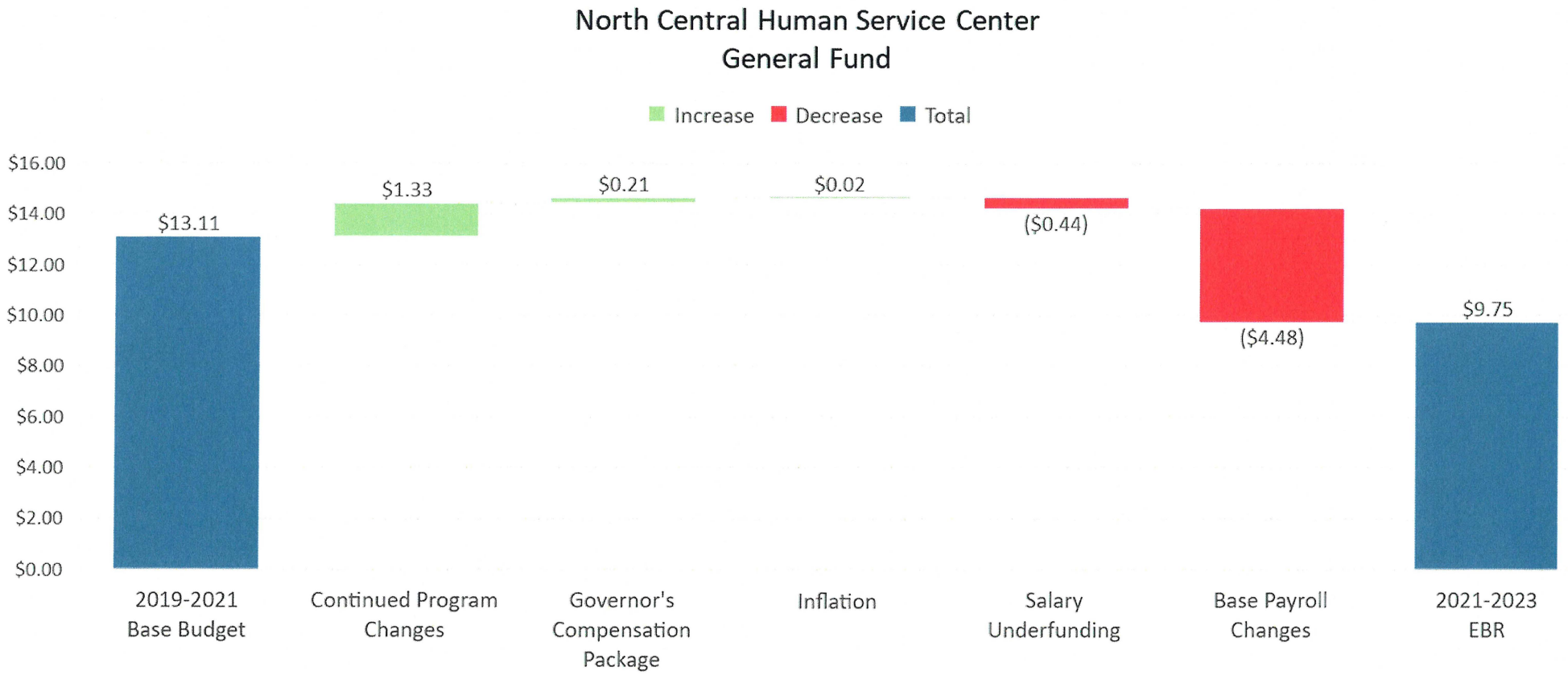
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Wages	16,799,013	312,778	17,111,791
Operating	1,737,729	222,651	1,960,380
Grants	451,470	650,679	1,102,149
Total	18,988,212	1,186,108	20,174,320
General Fund	13,111,157	(3,361,670)	9,749,487
Federal Funds	3,445,763	2,957,424	6,403,187
Other Funds	2,431,292	1,590,354	4,021,646
Total	18,988,212	1,186,108	20,174,320
Full Time Equivalent (FTE)	95.50	0	95.50

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	13,284,016	16,799,013	7,519,816	312,778	17,111,791
52x Travel	182,005	210,046	76,631	(69,217)	140,829
53x Supply	129,481	122,969	87,156	45,495	168,464
54x Postage & Printing	21,605	21,800	1,998	11,934	33,734
55x Equipment Under $5,000	14,156	30,230	2,419	(20,000)	10,230
56x Utilities	1,237	1,200	537	-	1,200
58x Rent/Leases - Bldg./Equip	1,058,797	1,030,173	625,647	229,386	1,259,559
59x Repairs	125,798	109,098	59,522	-	109,098
61x Professional Development	20,368	12,240	25,959	29,067	41,307
62x Fees - Operating & Professional	49,120	109,384	23,737	(4,014)	105,370
60x IT Expenses	94,259	90,589	45,448	-	90,589
71x Grants, Benefits, & Claims	1,103,680	451,470	196,398	650,679	1,102,149
Total	16,084,522	18,988,212	8,665,268	1,186,108	20,174,320

Overview Of Budget Changes By Funding Source

Expense Category	2017 - 2019 Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	9,198,181	13,111,157	5,888,153	(3,361,670)	9,749,487
Federal	4,684,476	3,445,763	1,475,441	2,957,424	6,403,187
Other	2,201,868	2,431,292	1,301,678	1,590,354	4,021,646
Total	16,084,525	18,988,212	8,665,272	1,186,108	20,174,320



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTHWEST HUMAN SERVICE CENTER OVERVIEW

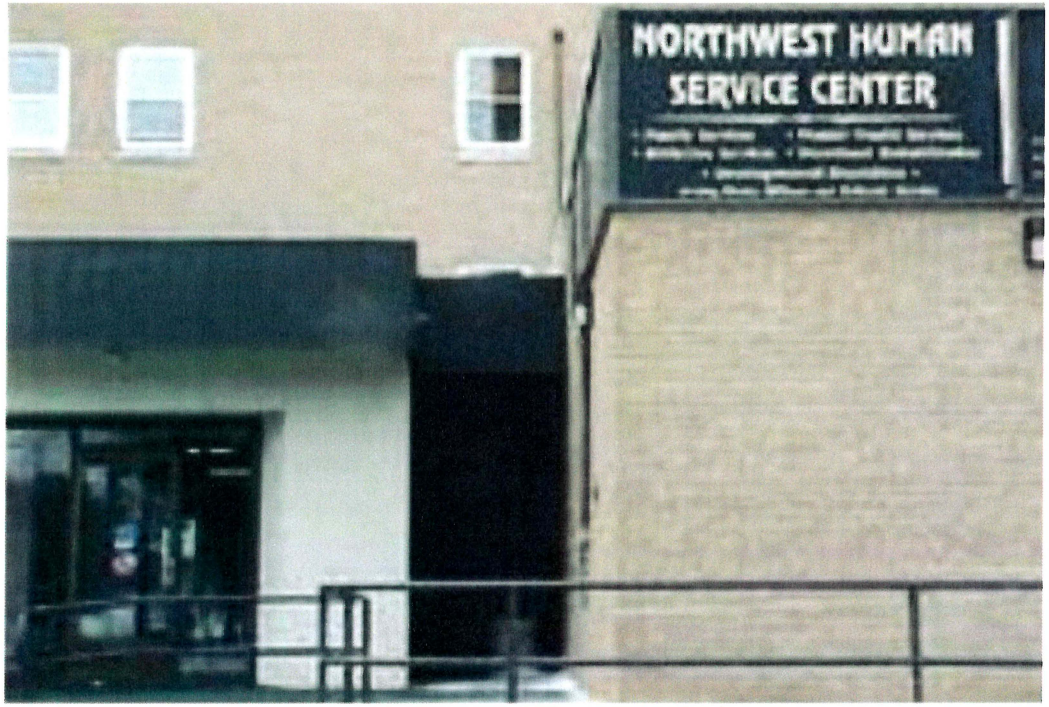
Charlotte Ferrell, Regional Director

NORTH Dakota | Human Services

Be Legendary.™

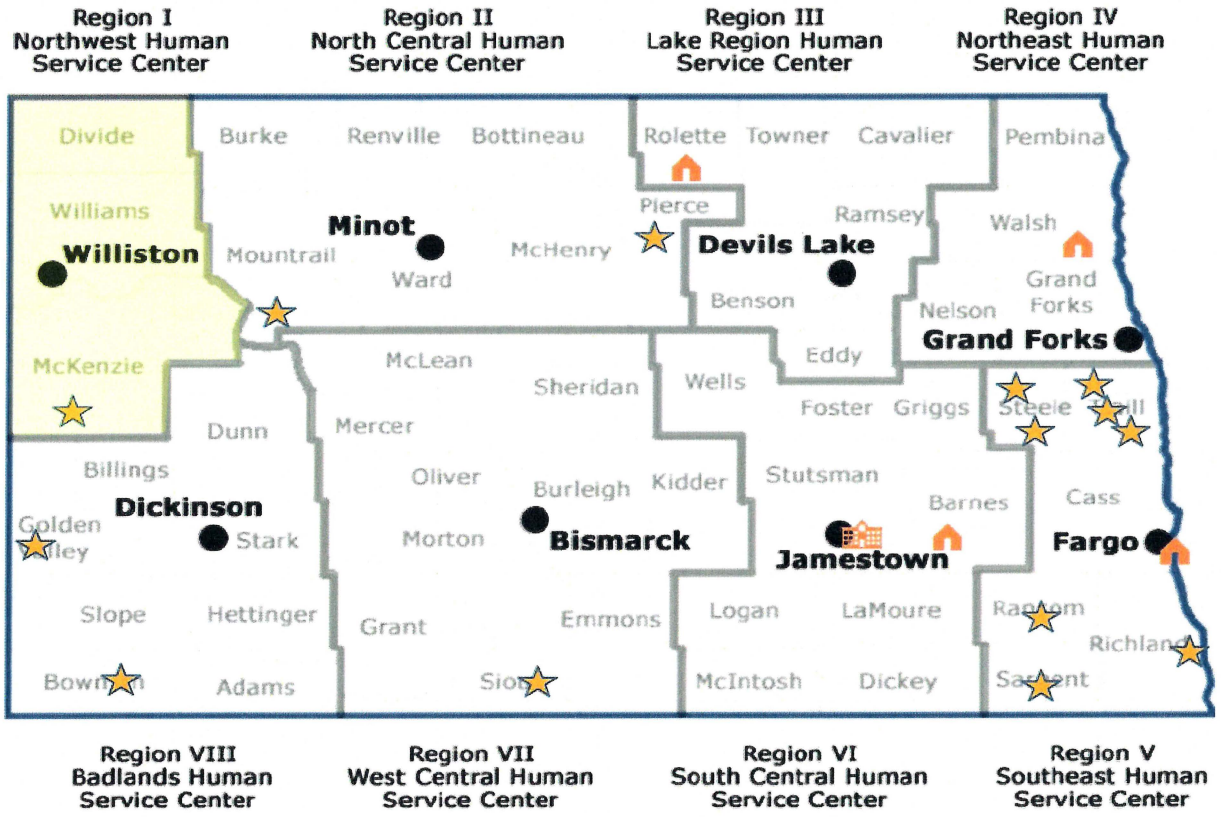
Northwest Human Service Center

Region I



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

NWHSC

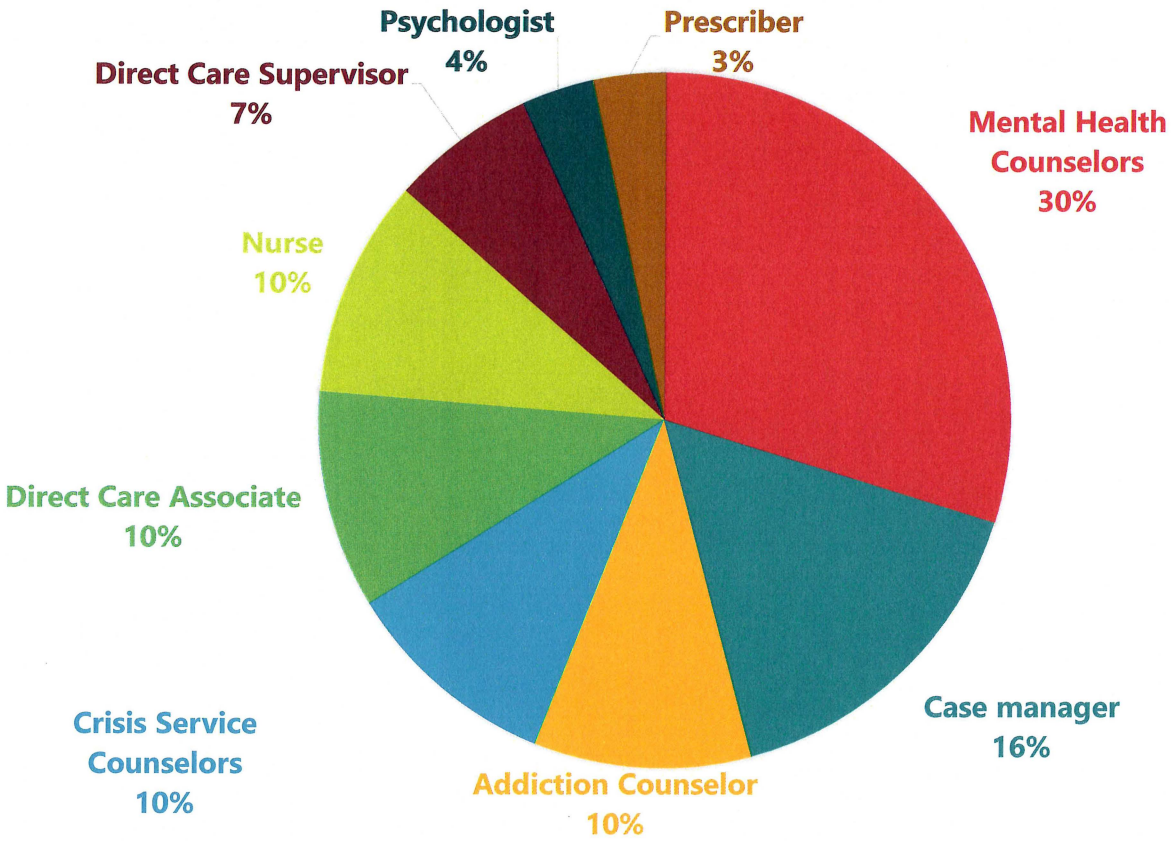
19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
47.30	35.55	35.55	9.55	17% 83%	Client Facing Administration Behavioral Health	6 29.55

COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount	
Pre-COVID	Current
0	2

Northwest Human Service Center
Behavioral Health FTE Breakdown

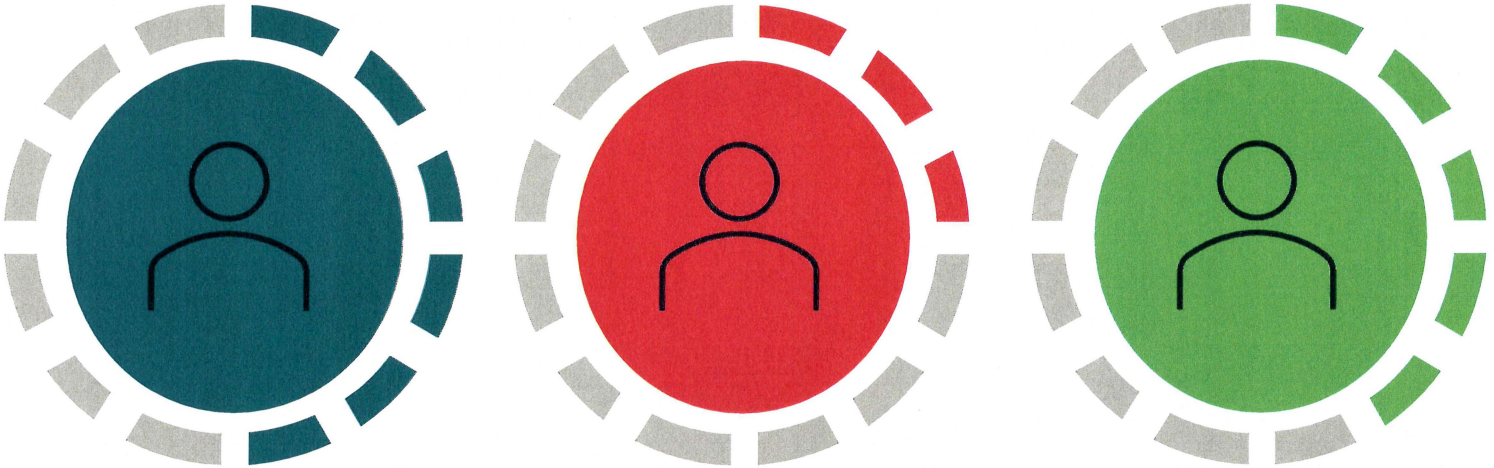


Northwest Human Service Center
Crisis Services Staffing

NWHSC	Filled	Vacant
New Crisis Staff FTE (3)	1	2
Existing Crisis Staff FTE	N/A	N/A

Northwest Human Service Center
Our Clients

The Northwest HSC provided services to 1,947 clients between March 2019 and Nov. 2020.



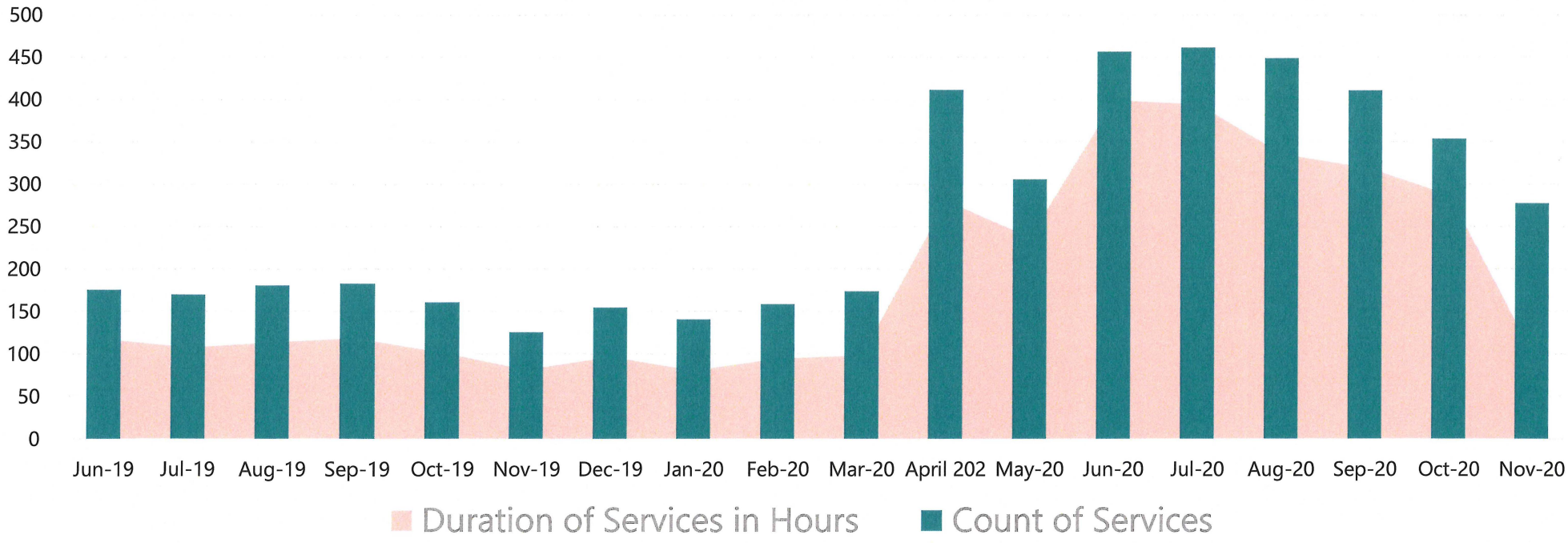
51% Serious Mental Illness (SMI) Primary Diagnosis

20% Substance Use Disorder (SUD) Primary Diagnosis

39% Co-Diagnosis of SUD and Mental Health Disorder

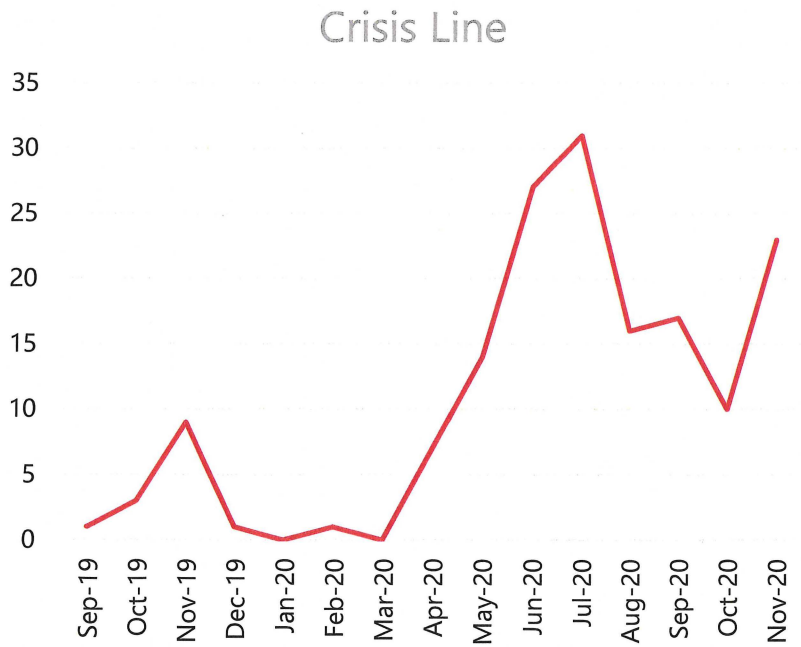
Northwest Human Service Center
Telehealth Services

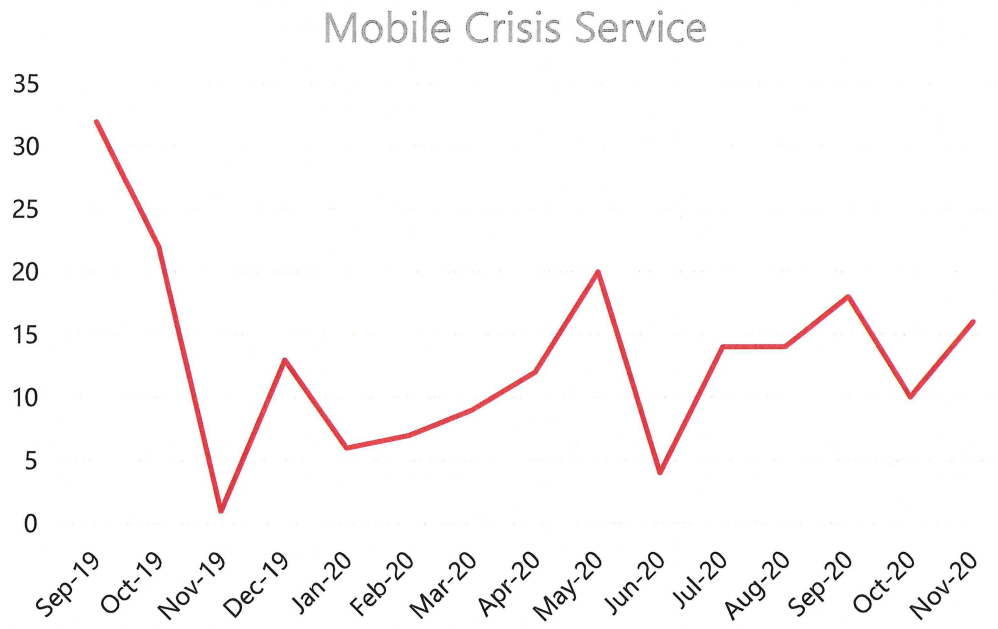
Northwest HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



Northwest Human Service Center
Crisis Services

Northwest HSC provided 358 crisis services from September 2019 through Nov. 2020.

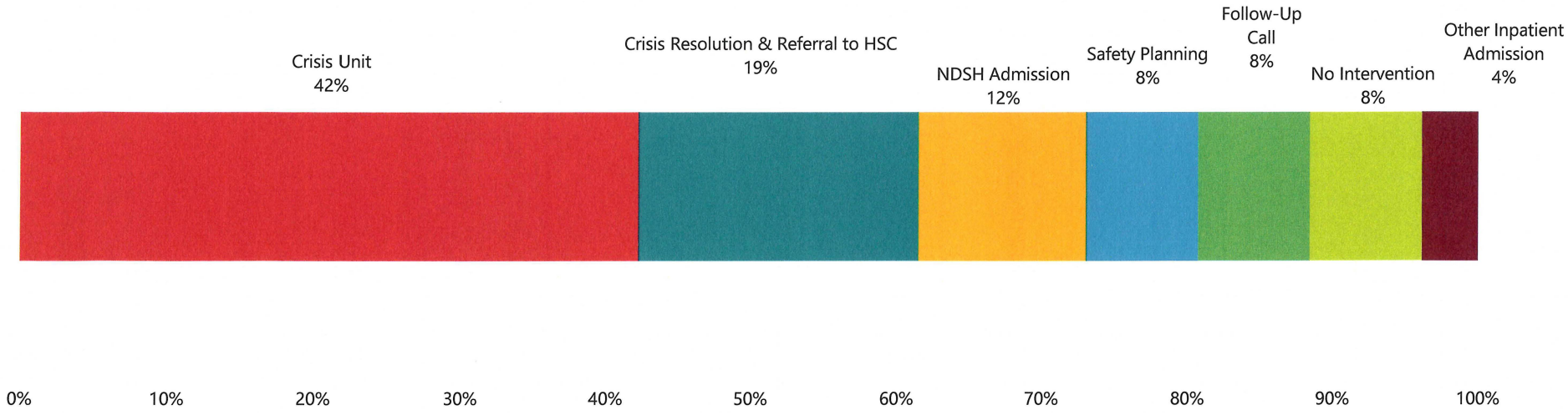




Northwest Human Service Center

Disposition following Screening and Triage of Crisis Services

Between September 2019 through November 2020, Northwest HSC triaged and screened 27 individuals for crisis services. Of those individuals, 73% were either referred to Crisis Unit, Crisis Resolution & Referral to HSC, or North Dakota State Hospital.



Northwest Human Service Center
Open Access

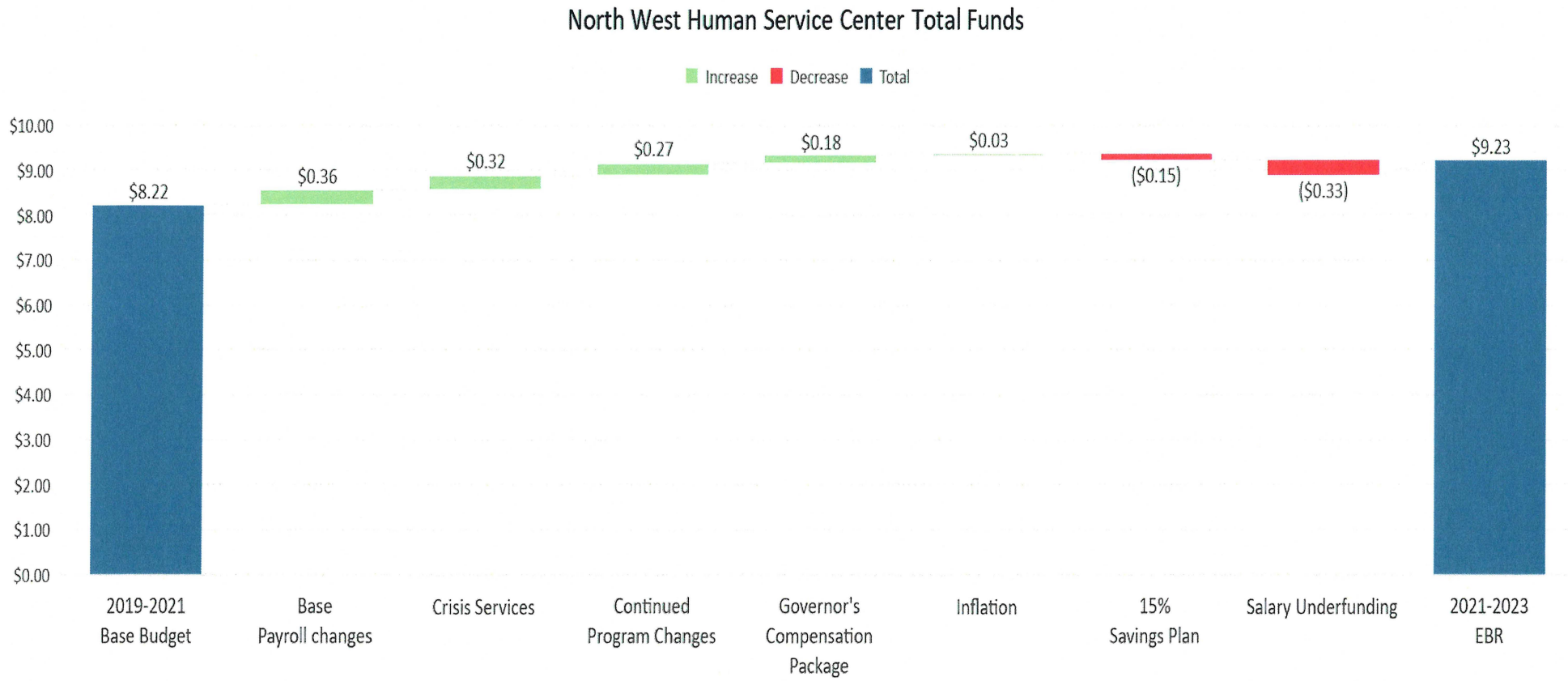


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	42	79	59	50	68	58	49	37	42	52	59	45	42	37	32
Referred To HSC	9	23	19	14	33	27	30	13	26	36	34	30	25	25	28
Referred Out	33	56	40	36	35	31	19	24	16	16	25	15	17	12	4

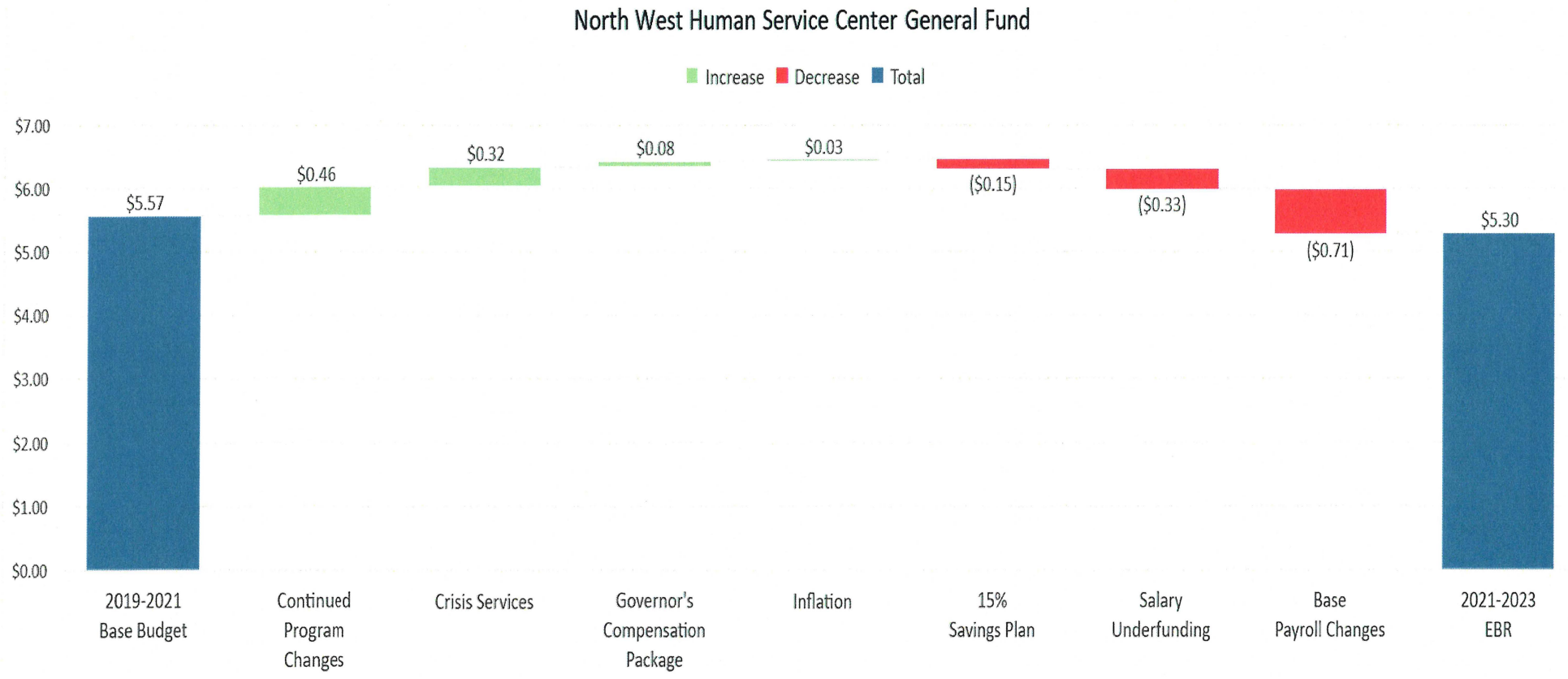
Overview Of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Wages	5,442,034	542,202	5,984,236
Operating	1,247,057	10,203	1,257,260
Grants	1,529,884	457,942	1,987,826
Total	8,218,975	1,010,347	9,229,322
General Fund	5,565,421	(299,266)	5,266,155
Federal Funds	1,735,897	538,265	2,274,162
Other Funds	917,657	771,348	1,689,005
Total	8,218,975	1,010,347	9,229,322
Full Time Equivalent (FTE)	35.55	0	35.55

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



Overview Of Budget Changes By Expense Category

Expense Category	2017 – 2019 Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 – 2023 Executive Budget Request
51x Salary & Benefits	4,453,580	5,442,034	2,103,339	542,202	5,984,236
52x Travel	95,782	70,359	36,252	-	70,359
53x Supply	34,209	46,960	16,969	(3,963)	42,997
54x Postage & Printing	9,668	15,440	4,012	1,686	17,126
55x Equipment Under $5,000	20,960	1,840	474	1,660	3,500
58x Rent/Leases - Bldg./Equip	944,428	997,737	491,552	-	997,737
59x Repairs	20,723	2,400	5,452	7,820	10,220
61x Professional Development	9,035	5,240	4,406	3,000	8,240
62x Fees - Operating & Professional	17,118	62,654	14,580	-	62,654
60x IT Expenses	44,488	44,427	27,043	-	44,427
71x Grants, Benefits, & Claims	1,321,138	1,529,884	698,712	457,942	1,987,826
Total	6,971,129	8,218,975	3,402,791	1,010,347	9,229,322

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	4,284,393	5,565,421	1,945,233	(299,266)	5,266,155
Federal	2,165,883	1,735,897	1,121,106	538,265	2,274,162
Other	520,851	917,657	336,452	771,348	1,689,005
Total	6,971,127	8,218,975	3,402,791	1,010,347	9,229,322

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/18/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 1:58 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Lake Region Human Service Center Overview
- South Central Human Service Center Overview
- Northeast Human Service Center Overview
- Southeast Human Service Center Overview

Julie Baumgarn, Regional Director (1:58 pm) testified about the Lake Region Human Service Center overview #1638

Clint Deveer, Fiscal Manager (2:08 pm) testified about the Lake Region Human Service Center Overview #1638

Julie Baumgarn, Regional Director (2:10 pm) testified about the Lake Region Human Service Center Overview #1638

Dr. Rosalie Etherington, Chief Clinics Officer (2:20 pm) testified about the Lake Region Human Service Center Overview #1638

Dan Cramer, Regional Director (2:21 pm) testified about the South Central Human Service Center Overview #1634

Randy Slavens, Regional Director (2:44 pm) testified about the Northeast Human Service Center Overview #1640

Lynn Bingham, Business Manage (3:07 pm) testified about the Northeast Human Service Center #1640

Jeff Stenseth, Regional Director (3:24 pm) testified about the Southeast Human Service Center #1635

Brad Brown, Regional Director (3:53 pm) testified about the West Central Human Service Center #1623

Jessica Odermann, Regional Director (4:14 pm) testified about the Badlands Human Service Center #1637

Chair Nelson closed the meeting at 4:50 p.m.

Cole Fleck, Committee Clerk



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

LAKE REGION HUMAN SERVICE CENTER OVERVIEW

Julie Baumgarn, Regional Director

NORTH Dakota | Human Services

Be Legendary.™

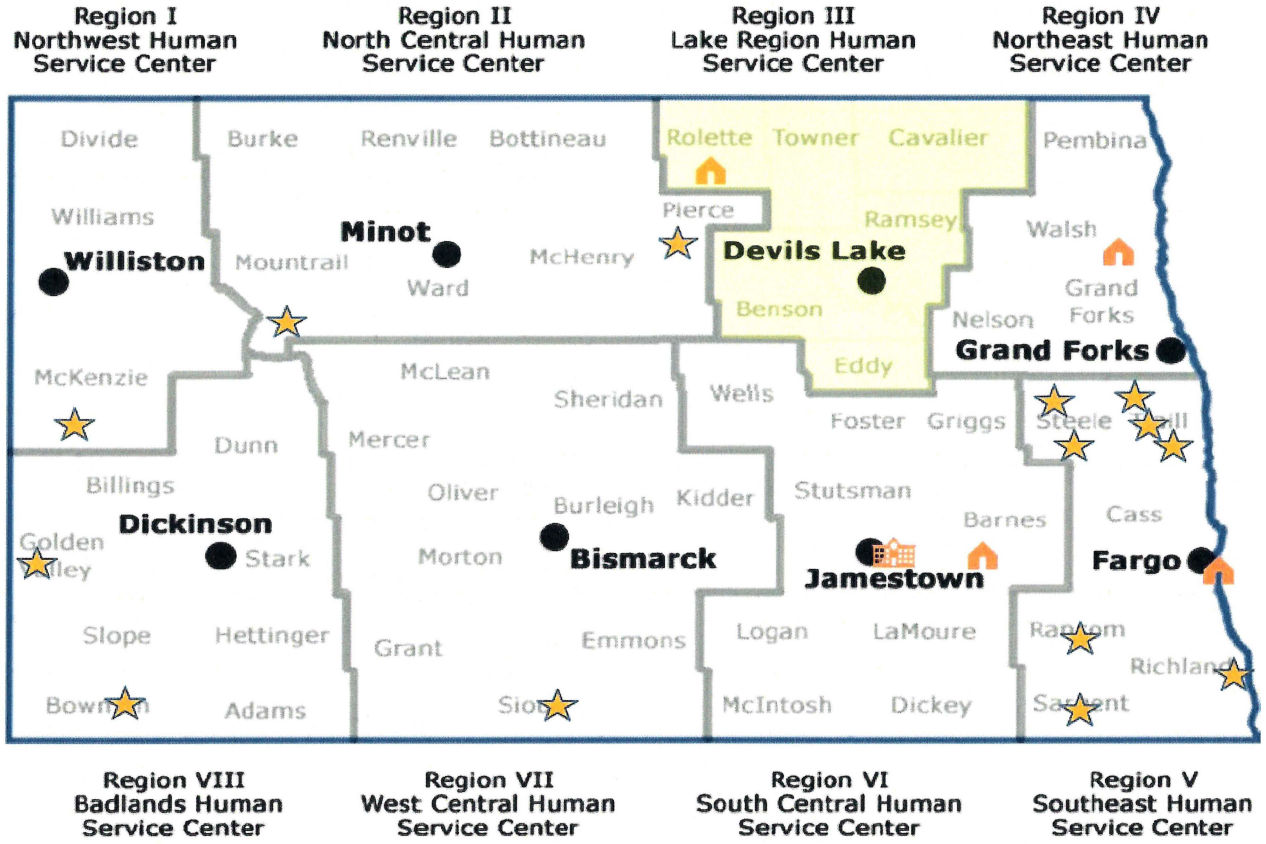
Lake Region Human Service Center

Region III



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

LRHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)
65.00	46.00	46.00	9

Assignment of Requested FTE

% of FTE	Descriptor	# of FTE
2%	Administration	1
22%	Client Facing Administration	10
76%	Behavioral Health	35

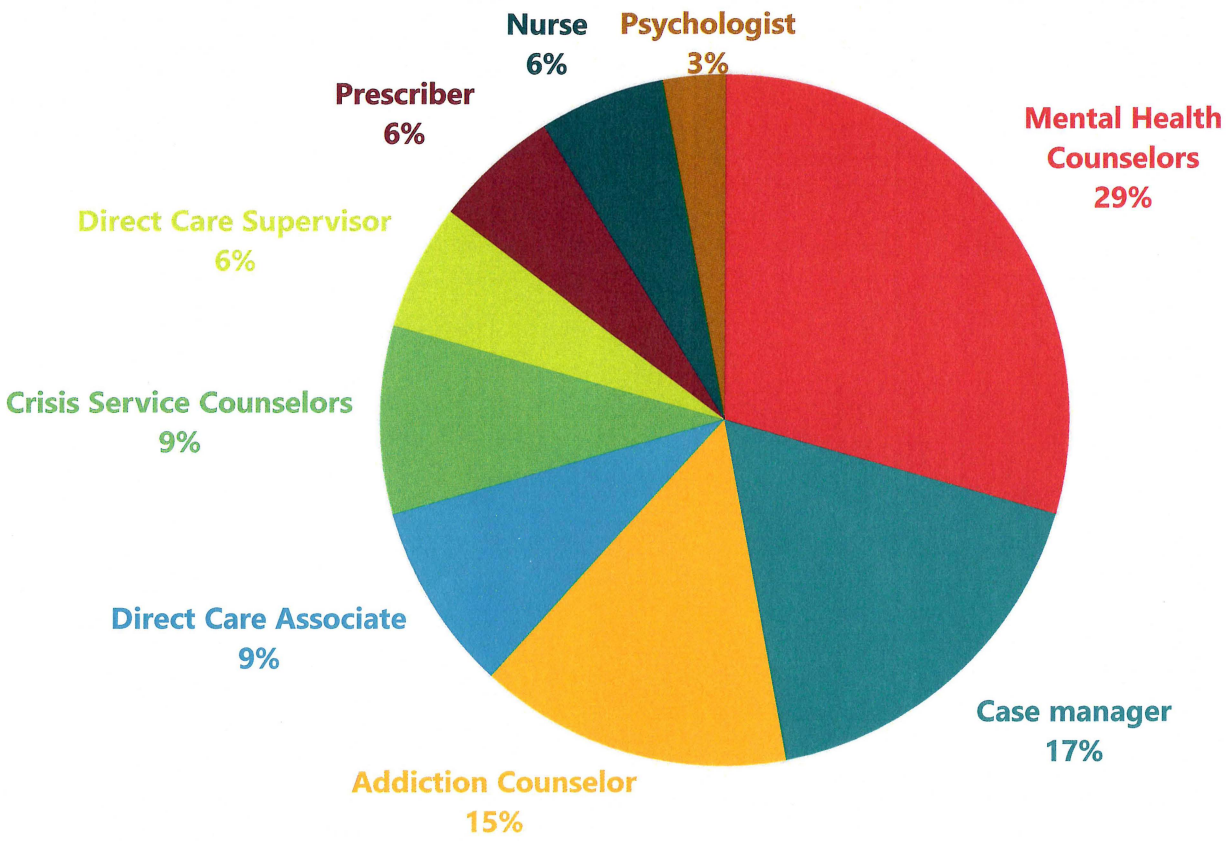
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
4	5

Lake Region Human Service Center
Behavioral Health FTE Breakdown



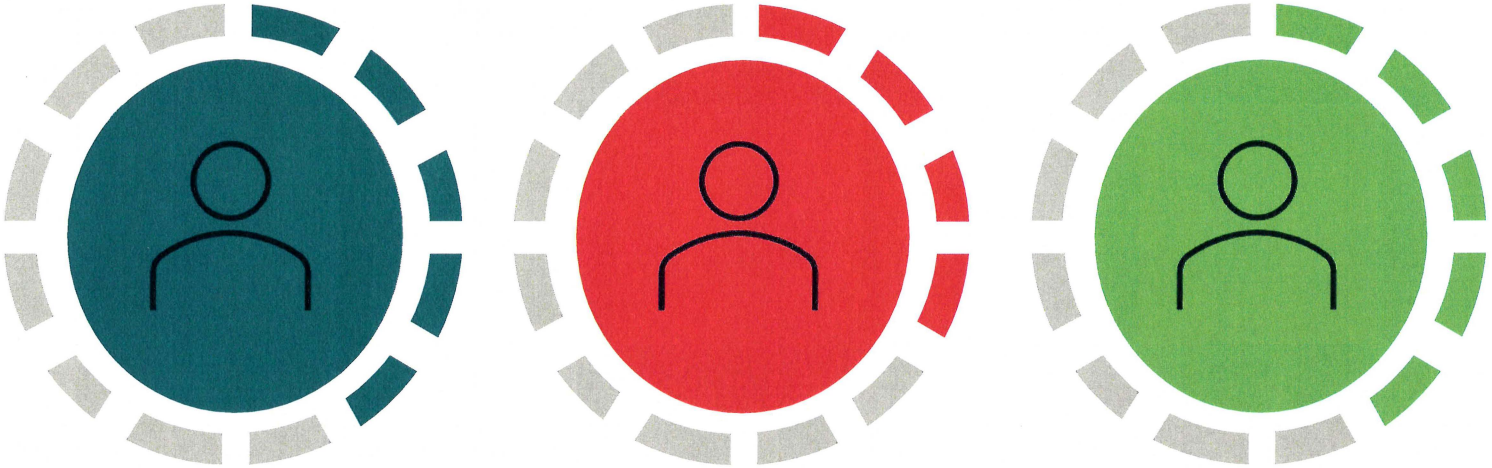
Lake Region Human Service Center
Crisis Services Staffing

LRHSC	Filled	Vacant
New Crisis Staff FTE (3)	3	0
Existing Crisis Staff FTE	N/A	N/A

Lake Region Human Service Center

Our Clients

The Lake Region HSC provided services to 2,144 clients between March 2019 and Nov. 2020.



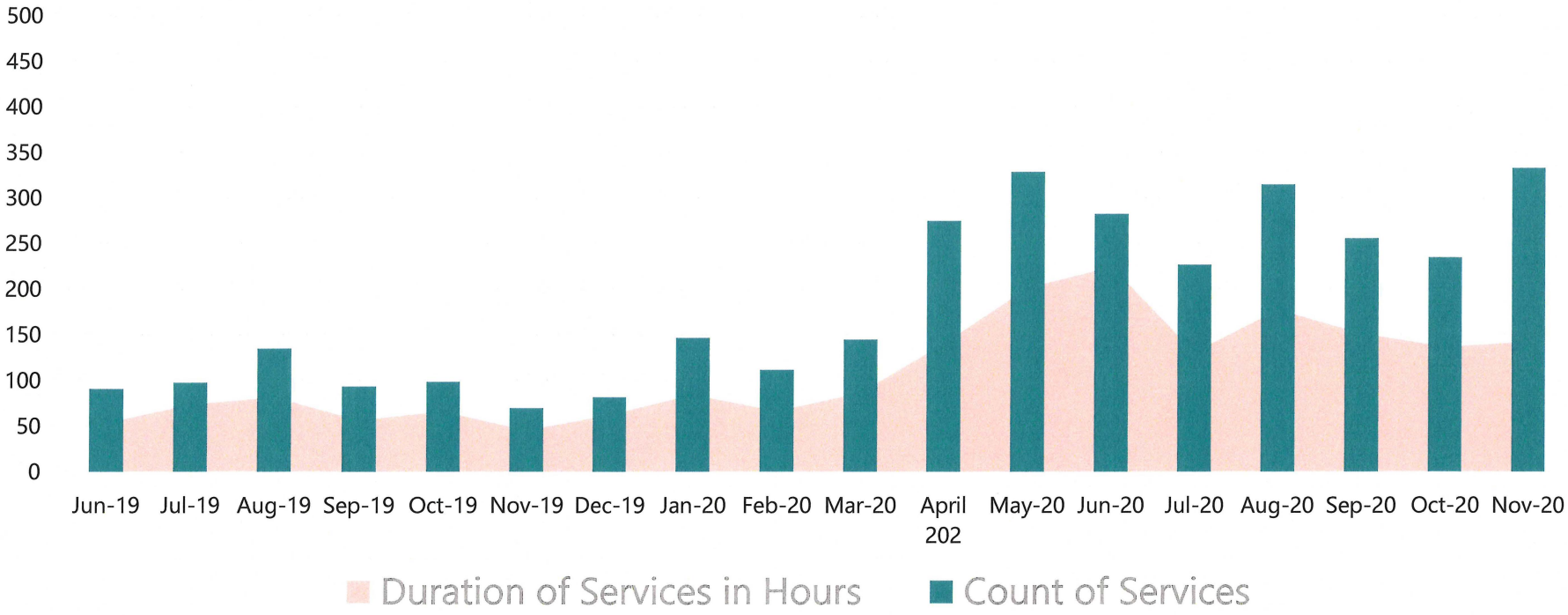
38% Serious Mental Illness (SMI) Primary Diagnosis

30% Substance Use Disorder (SUD) Primary Diagnosis

40% Co-Diagnosis of SUD and Mental Health Disorder

Lake Region Human Service Center
Telehealth Services

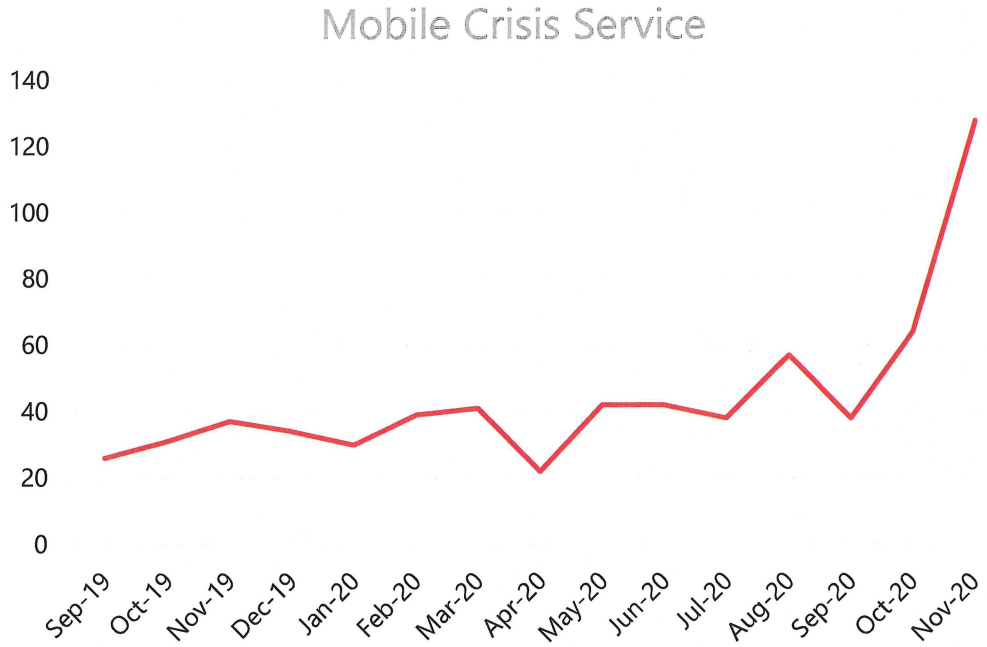
Lake Region HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



Lake Region Human Service Center
Crisis Services

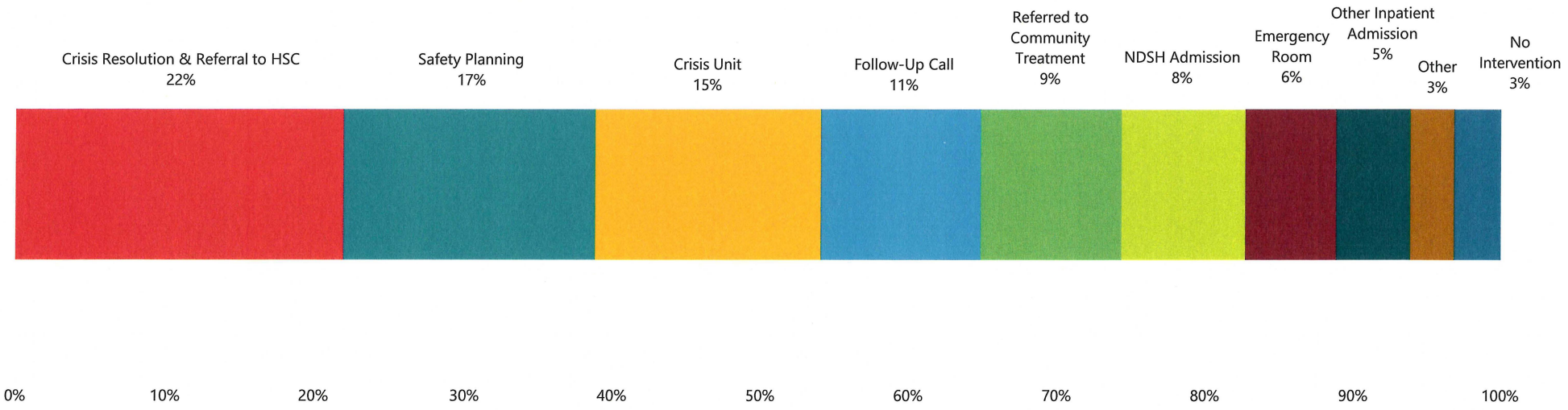
Lake Region HSC provided 935 crisis services from September 2019 through November 2020.



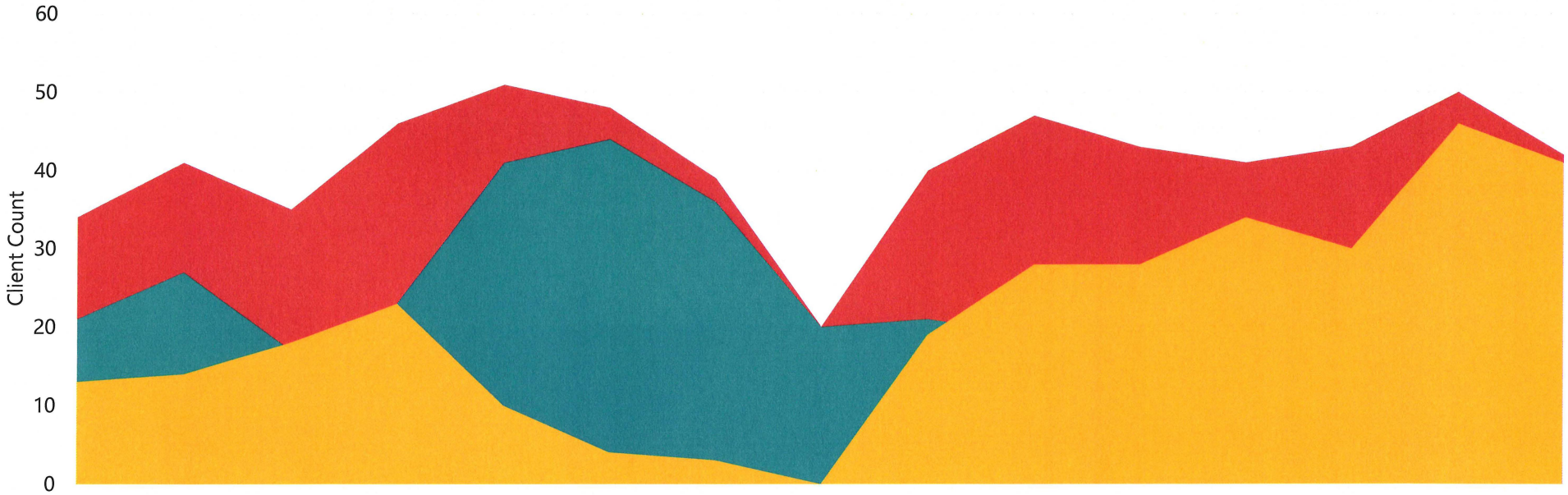


Lake Region Human Service Center
Disposition Following Screening and Triage of Crisis Services

Between September 2019 through November 2020, Lake Region HSC triaged and screened 462 individuals for crisis services. Of those individuals, 54% were either referred to Crisis Resolution and Referral to HSC, Safety Planning, or Crisis Unit.



Lake Region Human Service Center
Open Access

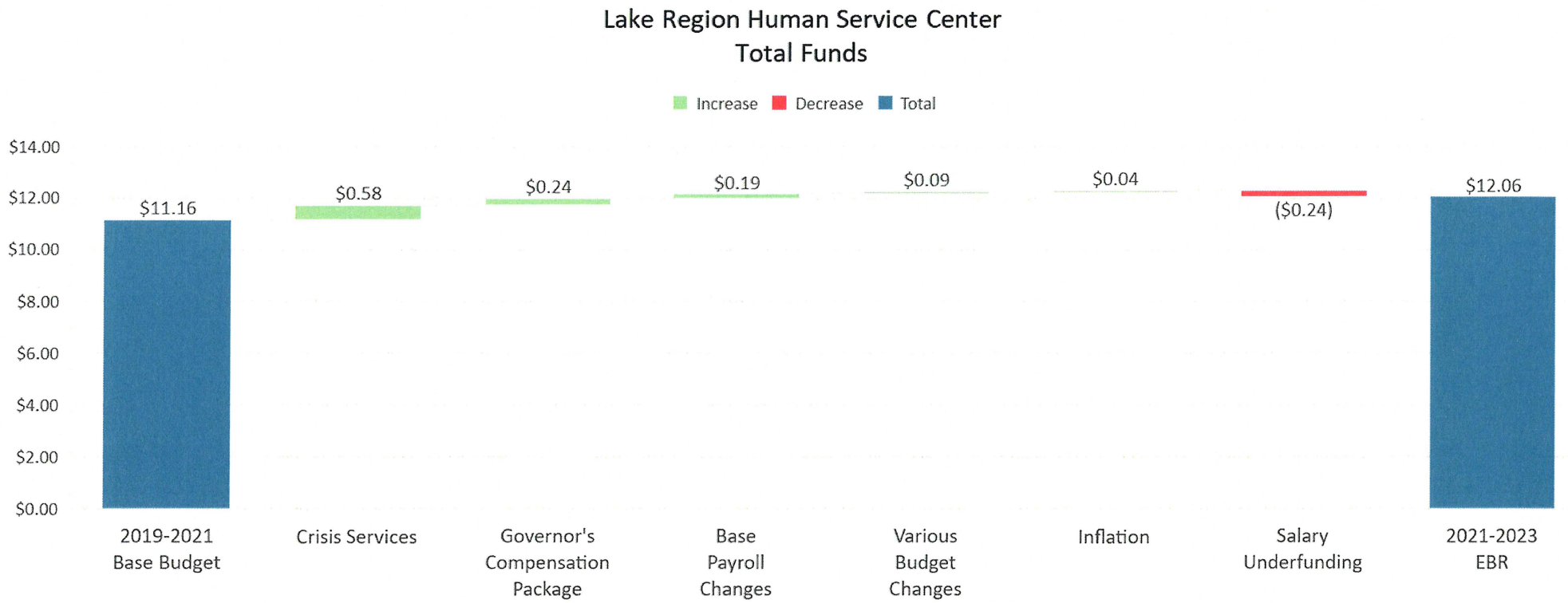


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	34	41	35	46	51	48	39	20	40	47	43	41	43	50	42
Referred Out	21	27	17	23	41	44	36	20	21	19	15	7	13	4	1
Referred To HSC	13	14	18	23	10	4	3	0	19	28	28	34	30	46	41

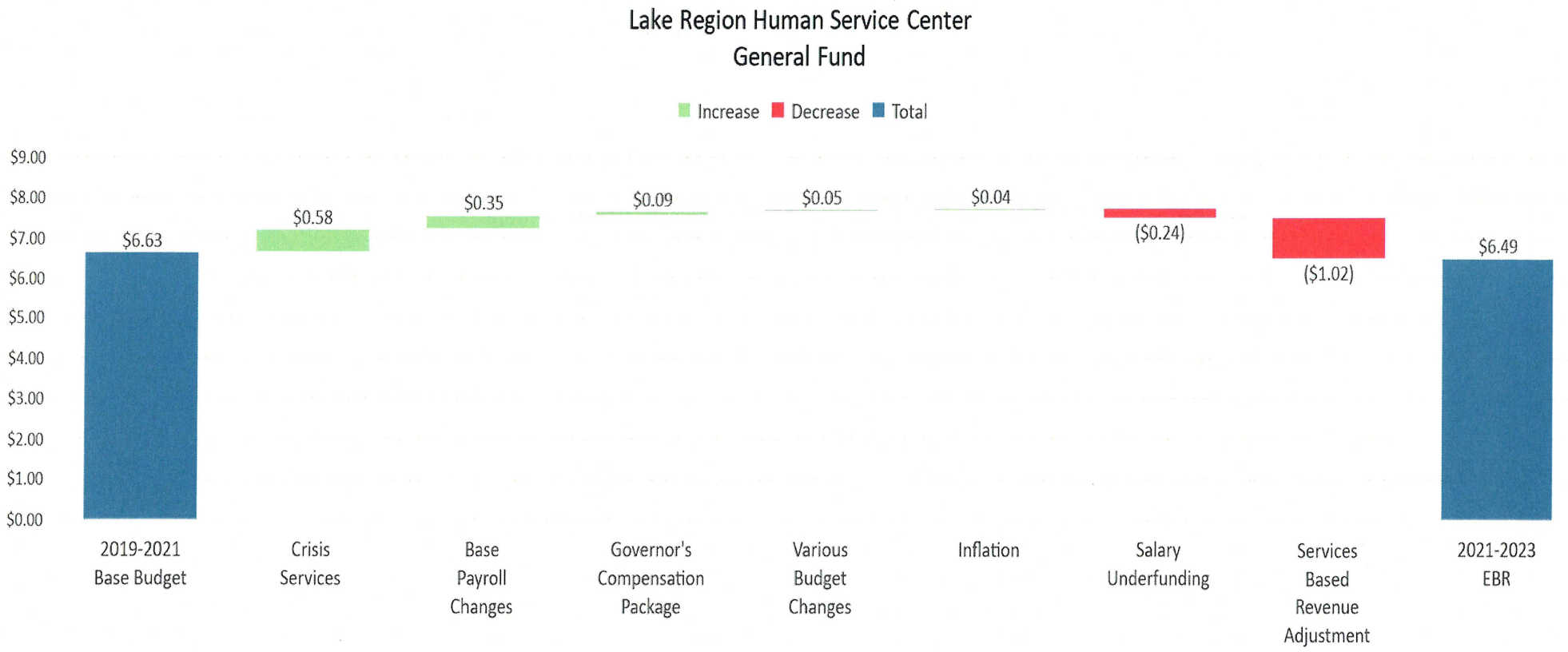
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	8,000,120	194,796	8,194,916
Operating	989,390	68,507	1,057,897
Grants	2,173,950	637,899	2,811,849
Total	11,163,460	901,202	12,064,662
General Fund	6,625,697	(139,802)	6,485,895
Federal Funds	3,156,118	723,356	3,879,474
Other Funds	1,381,645	317,648	1,699,293
Total	11,163,460	901,202	12,064,662
Full Time Equivalent (FTE)	46.00	0.00	46.00

Total Fund Change (IN MILLIONS)



General Fund Change (IN MILLIONS)



Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	6,545,287	8,000,120	3,346,431	194,796	8,194,916
52x Travel	108,380	132,696	47,616	14,445	147,141
53x Supply	85,754	89,872	41,283	(4,600)	85,272
54x Postage & Printing	11,073	20,500	682	(7,000)	13,500
55x Equipment Under $5,000	27,977	5,000	5,000	-	5,000
57x Insurance	5,169	5,100	3,717	476	5,576
58x Rent/Leases - Bldg./Equip	554,239	556,292	300,488	55,266	611,558
59x Repairs	25,302	20,500	4,335	(200)	20,300
61x Professional Development	10,024	11,192	2,867	-	11,192
62x Fees - Operating & Professional	24,626	78,203	28,144	1,000	79,203
60x IT Expenses	73,432	70,035	29,711	9,120	79,155
71x Grants, Benefits, & Claims	2,100,840	2,173,950	952,379	637,899	2,811,849
Total	9,572,103	11,163,460	4,762,653	901,202	12,064,662

Overview of Budget Changes by Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	6,498,933	6,625,697	3,371,449	(139,802)	6,485,895
Federal	1,862,037	3,156,118	791,587	723,356	3,879,474
Other	1,211,133	1,381,645	599,613	317,648	1,699,293
Total	9,572,103	11,163,460	4,762,649	901,202	12,064,662



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

SOUTH CENTRAL HUMAN SERVICE CENTER OVERVIEW

Dan Cramer, Regional Director

NORTH Dakota | Human Services

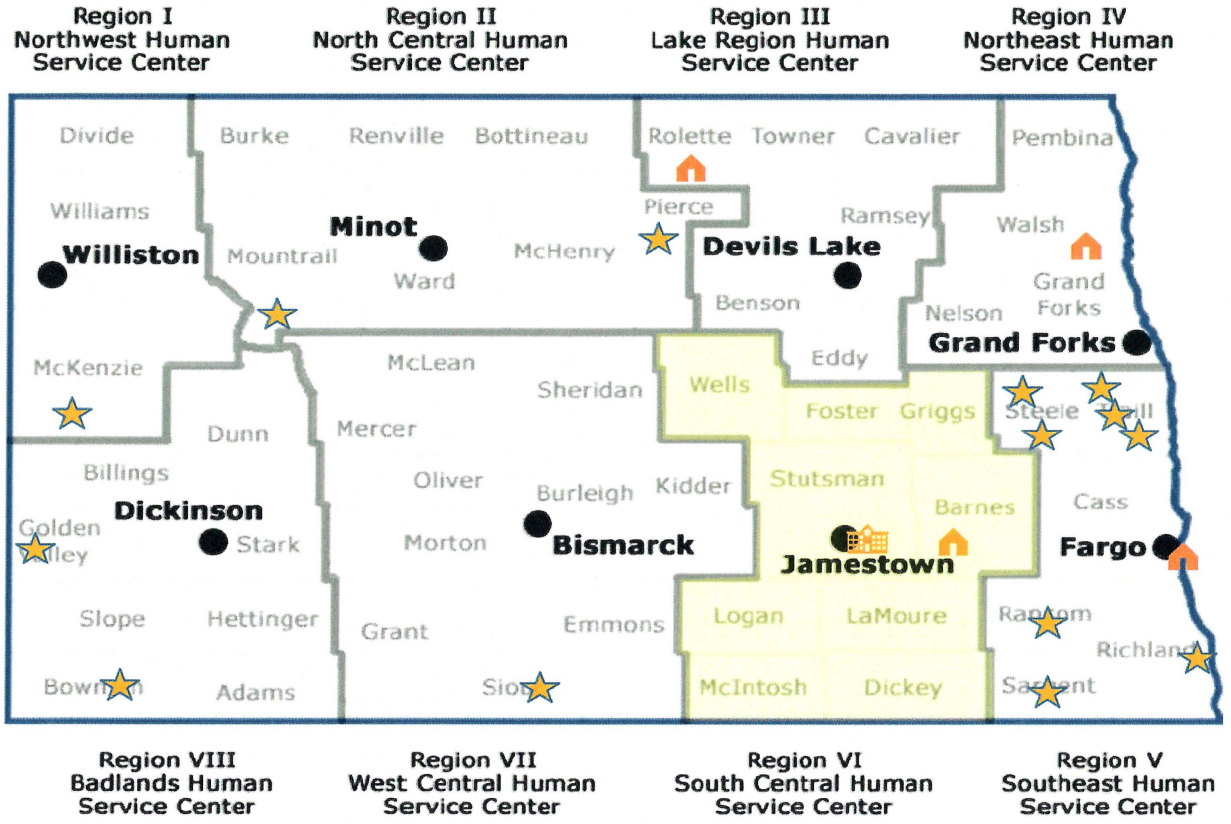
Be Legendary.™

South Central Human Service Center
Region VI



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

SCHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)
78.80	57.00	57.00	2.3

Assignment of Requested FTE

% of FTE	Descriptor	# of FTE
7%	Administration	4
7%	Client Facing Administration	4
86%	Behavioral Health	49

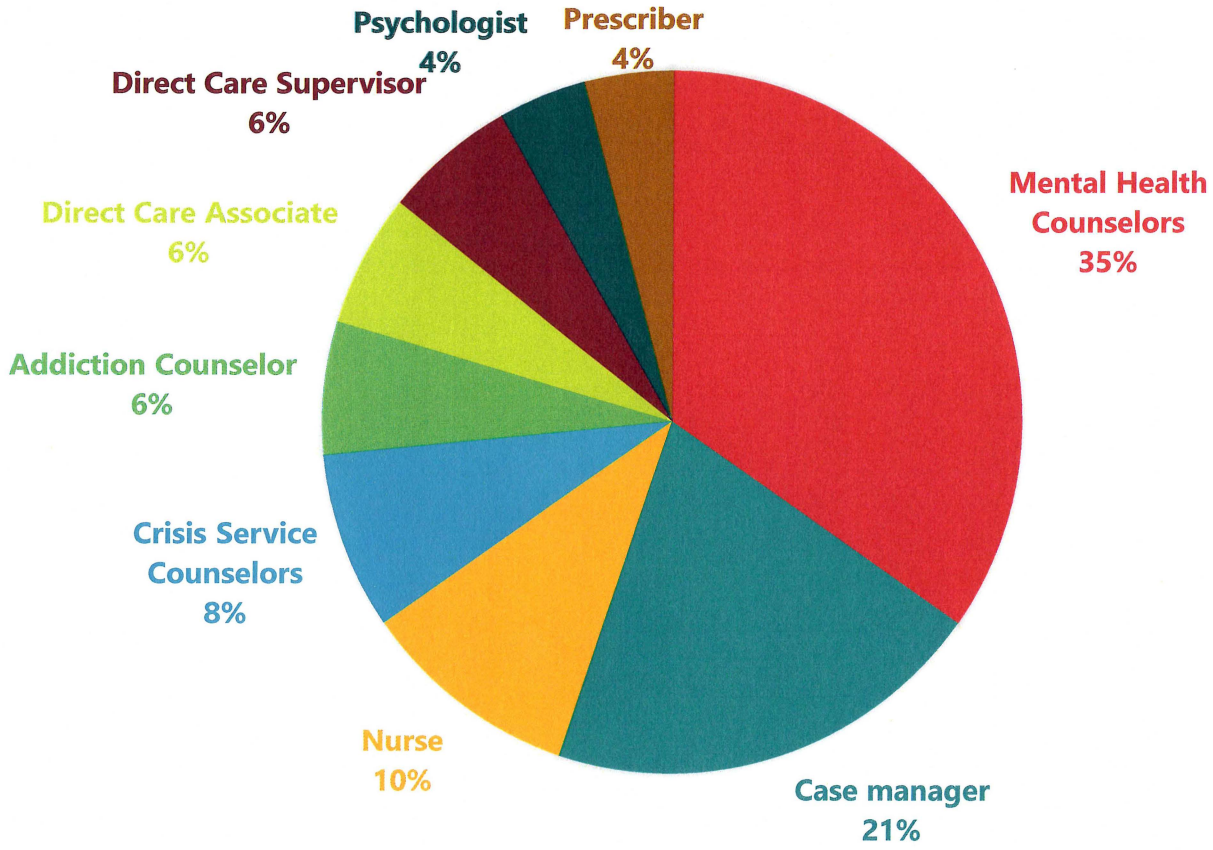
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
0	2

South Central Human Service Center
Behavioral Health FTE Breakdown



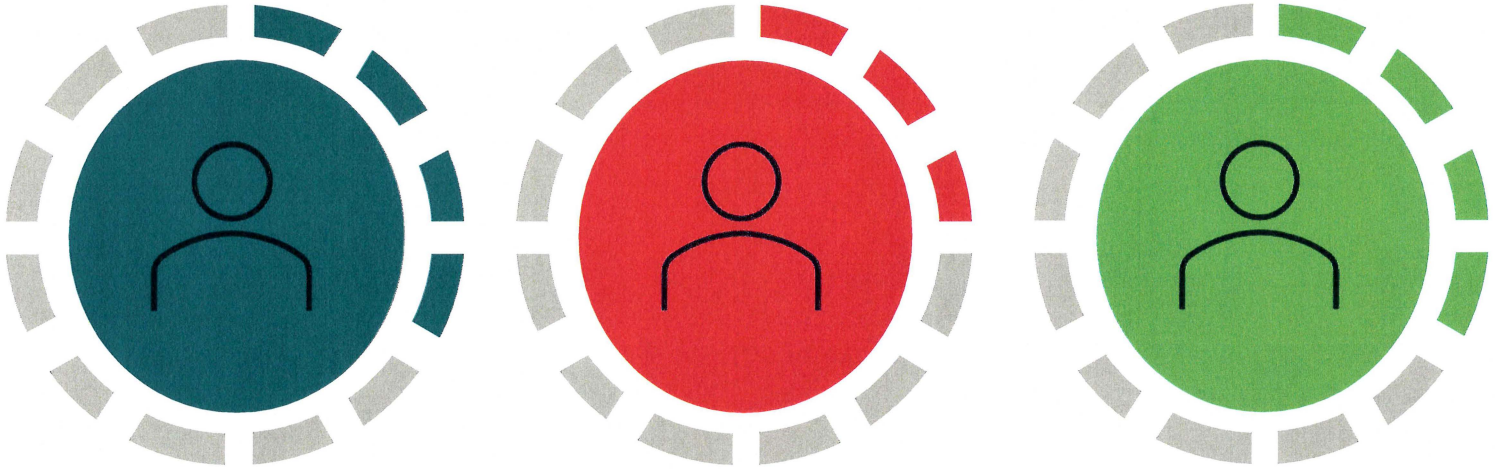
South Central Human Service Center
Crisis Services Staffing

SCHSC	Filled	Vacant
New Crisis Staff FTE	N/A	N/A
Existing Crisis Staff FTE	4	0

South Central Human Service Center

Our Clients

The South Central HSC provided services to 1,768 clients between March 2019 and Nov. 2020.



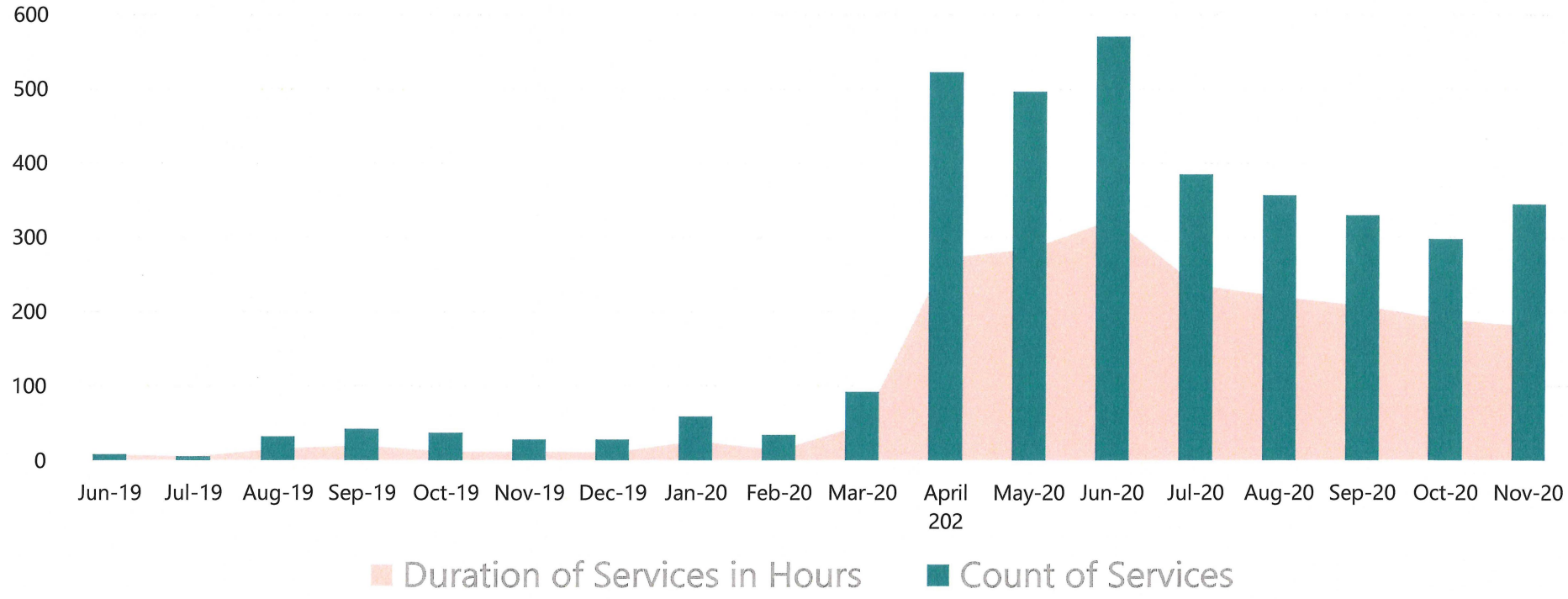
34% Serious Mental Illness (SMI) Primary Diagnosis

21% Substance Use Disorder (SUD) Primary Diagnosis

33% Co-Diagnosis of SUD and Mental Health Disorder

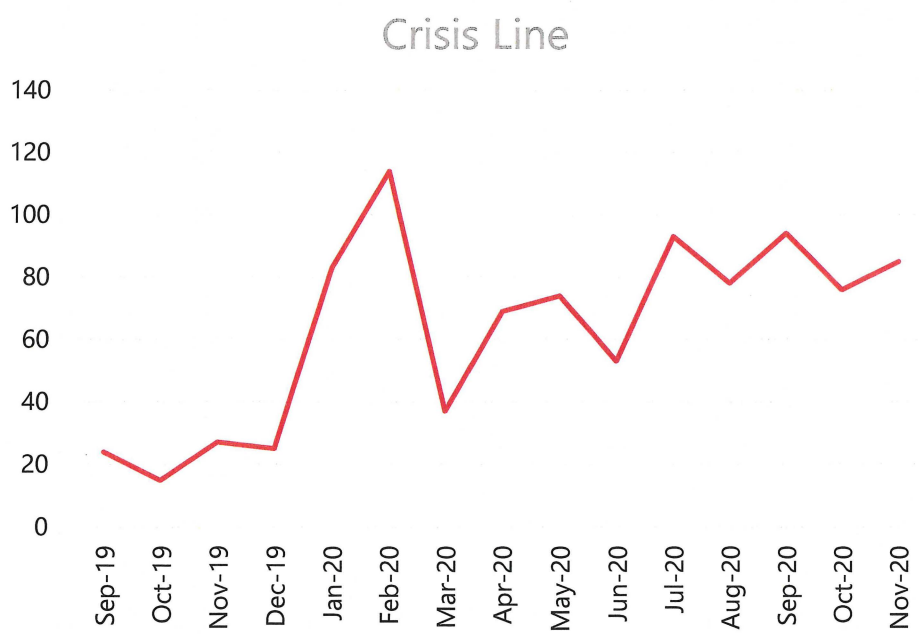
South Central Human Service Center
Telehealth Services

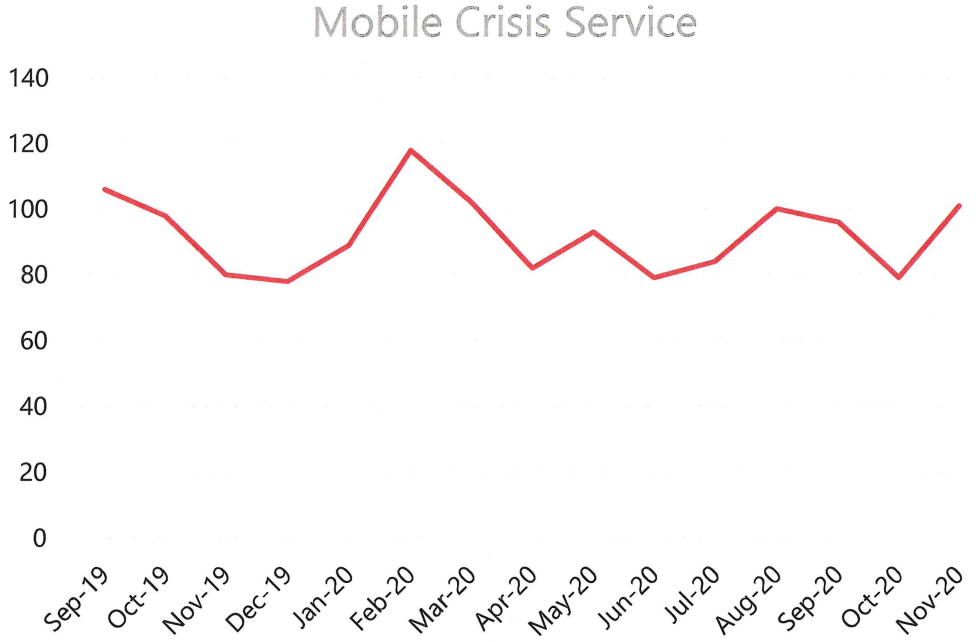
South Central HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



South Central Human Service Center
Crisis Services

South Central HSC provided 2,332 crisis services from September 2019 through November 2020.

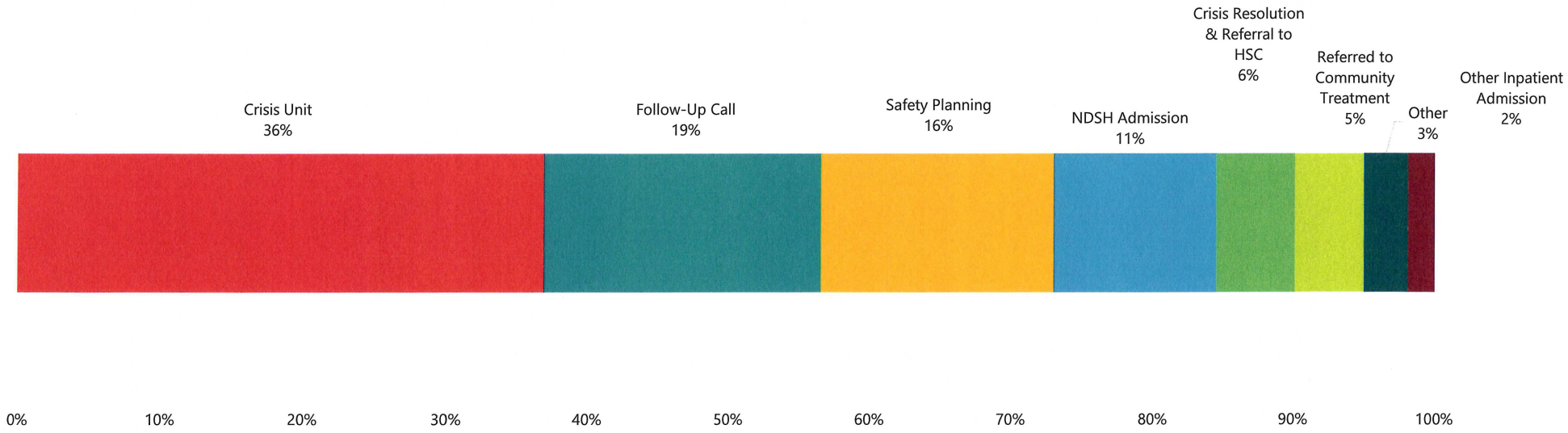




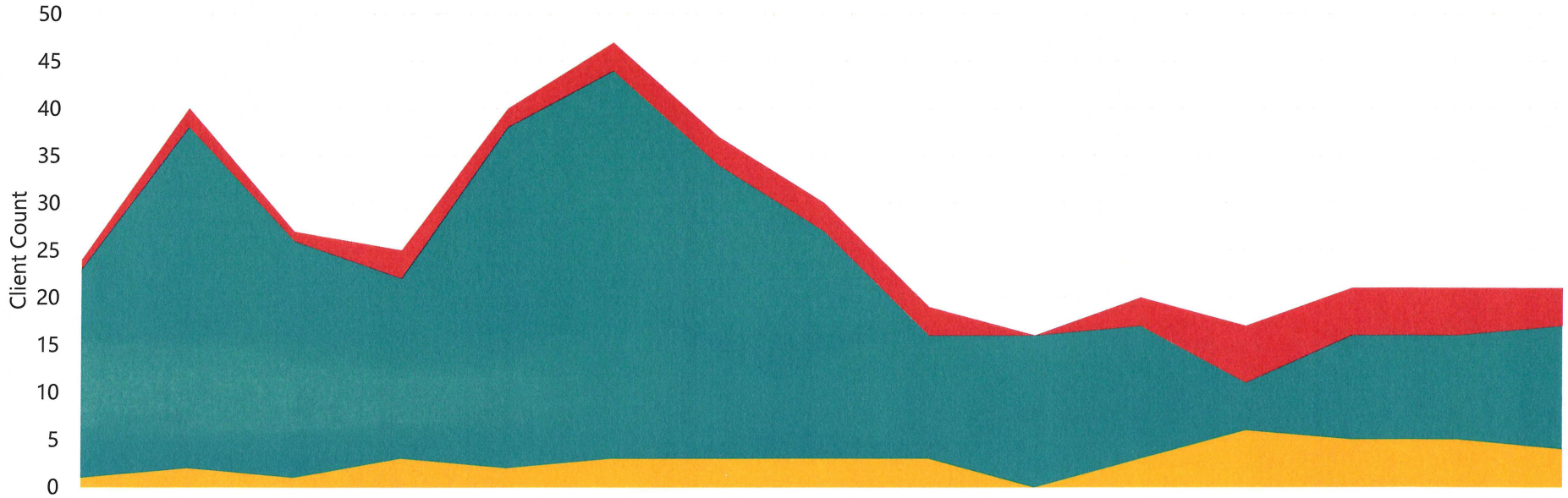
South Central Human Service Center

Disposition Following Screening and Triage of Crisis Services

Between September 2019 through November 2020, South Central HSC triaged and screened 1,309 individuals for crisis services. Of those individuals, 71% were either referred to Crisis Unit, Follow-up Call, or Safety Planning.



South Central Human Service Center
Open Access

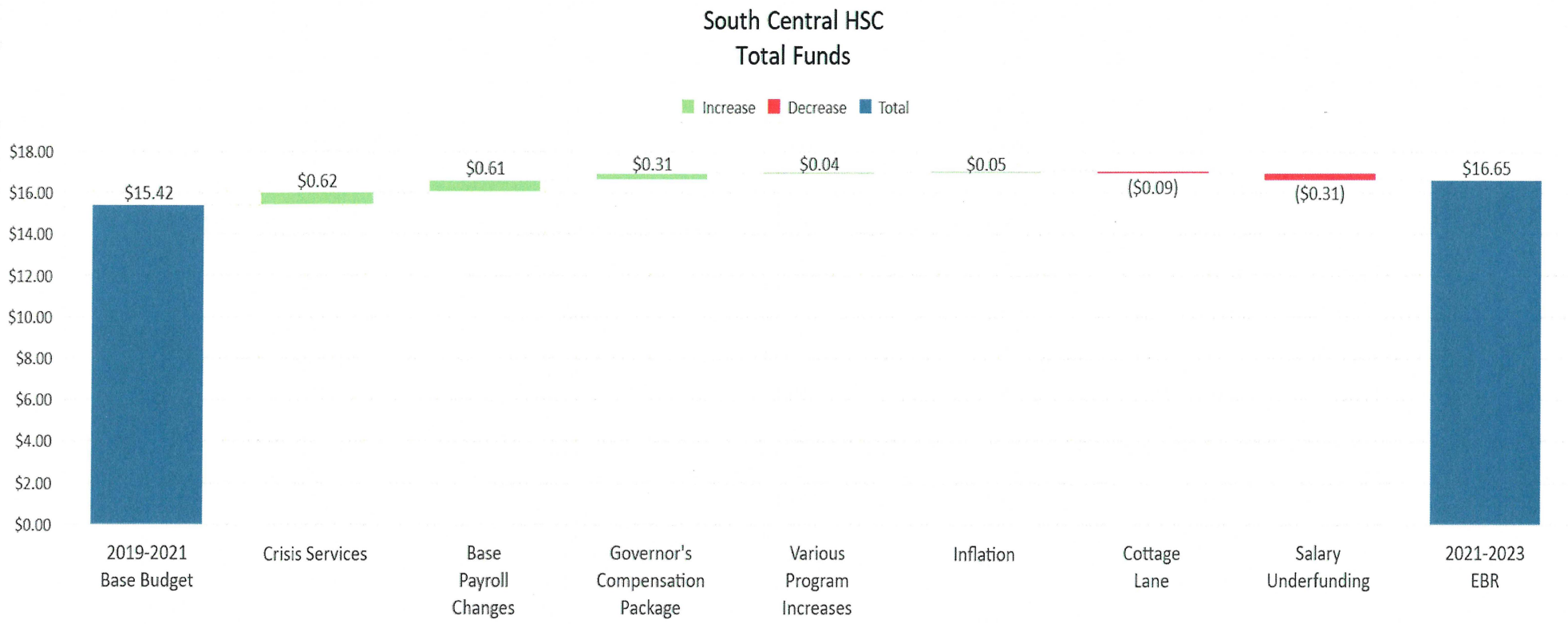


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	24	40	27	25	40	47	37	30	19	16	20	17	21	21	21
Referred To HSC	23	38	26	22	38	44	34	27	16	16	17	11	16	16	17
Referred Out	1	2	1	3	2	3	3	3	3	0	3	6	5	5	4

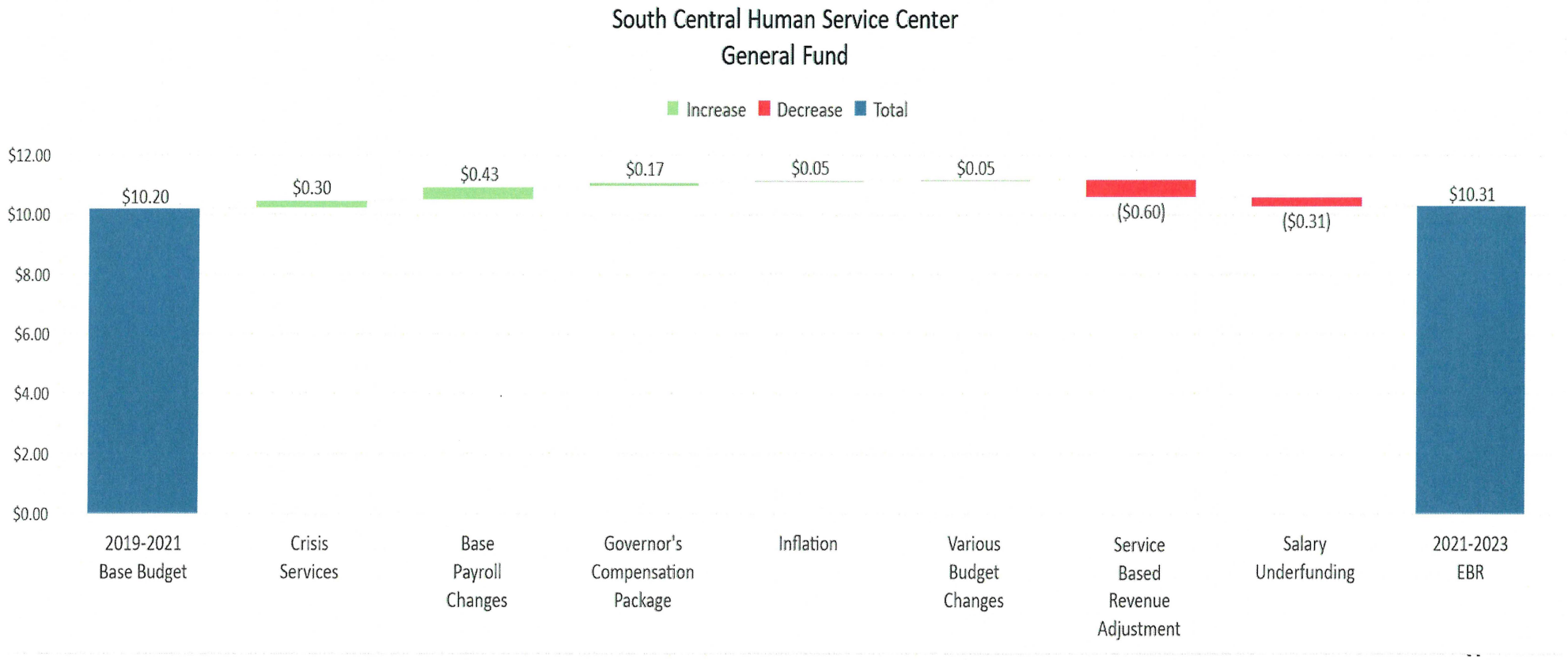
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	11,124,225	614,005	11,738,230
Operating	1,280,943	(81,032)	1,199,911
Grants	3,012,507	699,612	3,712,119
Total	15,417,675	1,232,585	16,650,260
General Fund	10,203,345	103,966	10,307,311
Federal Funds	3,928,948	29,505	3,958,453
Other Funds	1,285,382	1,099,114	2,384,496
Total	15,417,675	1,232,585	16,650,260
Full Time Equivalent (FTE)	57.00	0.00	57.00

Total Funds Changes (In Millions)



General Fund Changes (In Millions)



Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	9,856,693	11,124,225	5,349,212	614,005	11,738,230
52x Travel	128,606	202,238	63,961	7,145	209,383
53x Supply	85,509	92,106	22,301	(26,570)	65,536
54x Postage & Printing	13,551	29,916	3,661	(12,606)	17,310
55x Equipment Under $5,000	29,126	18,000	13,278	-	18,000
57x Insurance	-	50	-	-	50
58x Rent/Leases - Bldg./Equip	736,638	744,882	284,716	(51,261)	693,621
59x Repairs	14,095	18,621	1,649	(2,782)	15,839
61x Professional Development	12,447	11,550	6,011	-	11,550
62x Fees - Operating & Professional	31,540	60,653	25,055	15,250	75,903
60x IT Expenses	86,312	102,927	35,991	(10,209)	92,718
71x Grants, Benefits, & Claims	2,845,660	3,012,507	1,293,409	699,612	3,712,119
Total	13,840,177	15,417,675	7,099,244	1,232,584	16,650,259

Overview Of Budget Changes By Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	9,516,703	10,203,345	5,866,766	103,966	10,307,311
Federal	2,957,435	3,928,948	917,937	29,505	3,958,453
Other	1,366,039	1,285,382	345,314	1,099,114	2,384,496
Total	13,840,177	15,417,675	7,130,017	1,232,585	16,650,260



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTHEAST HUMAN SERVICE CENTER OVERVIEW

Randy Slavens, Regional Director

NORTH Dakota | Human Services

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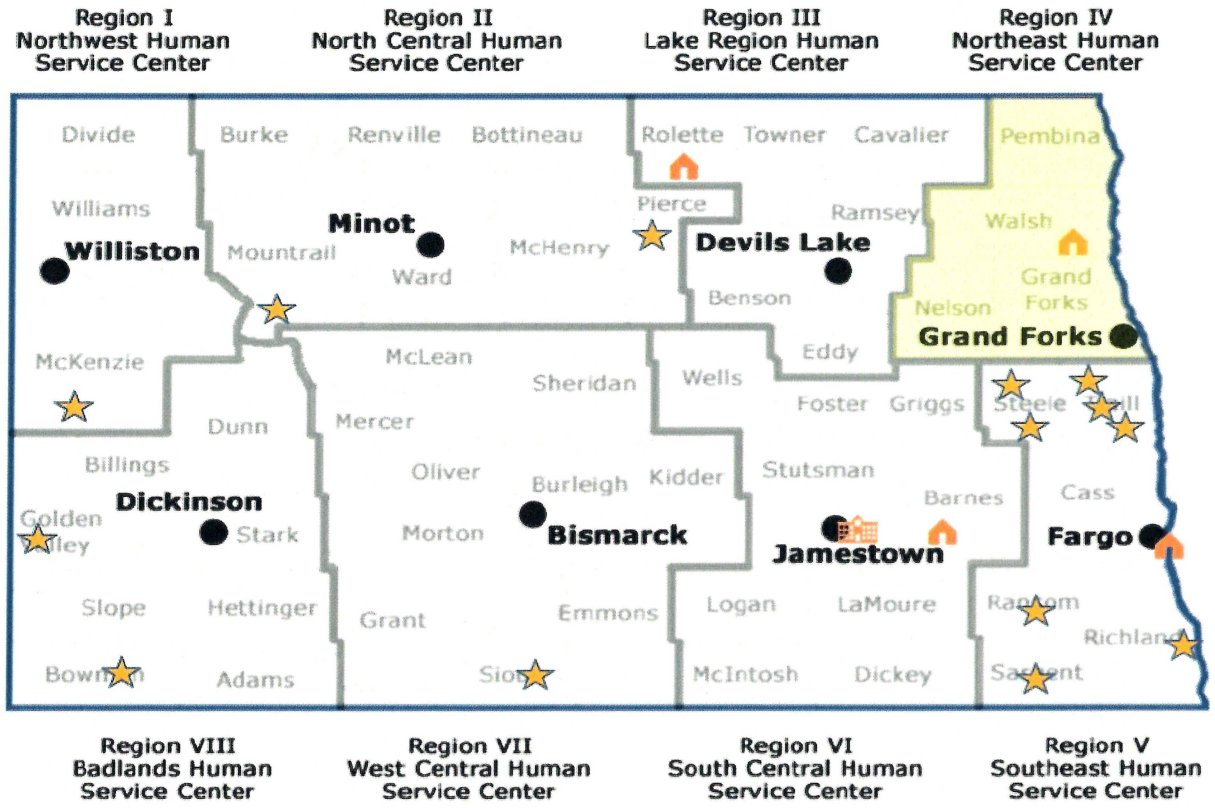
Northeast Human Service Center
Region IV



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

NEHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)
139.80	106.00	106.00	13

Assignment of Requested FTE

% of FTE	Descriptor	# of FTE
5%	Administration	5
13%	Client Facing Administration	13.3
83%	Behavioral Health	87.7

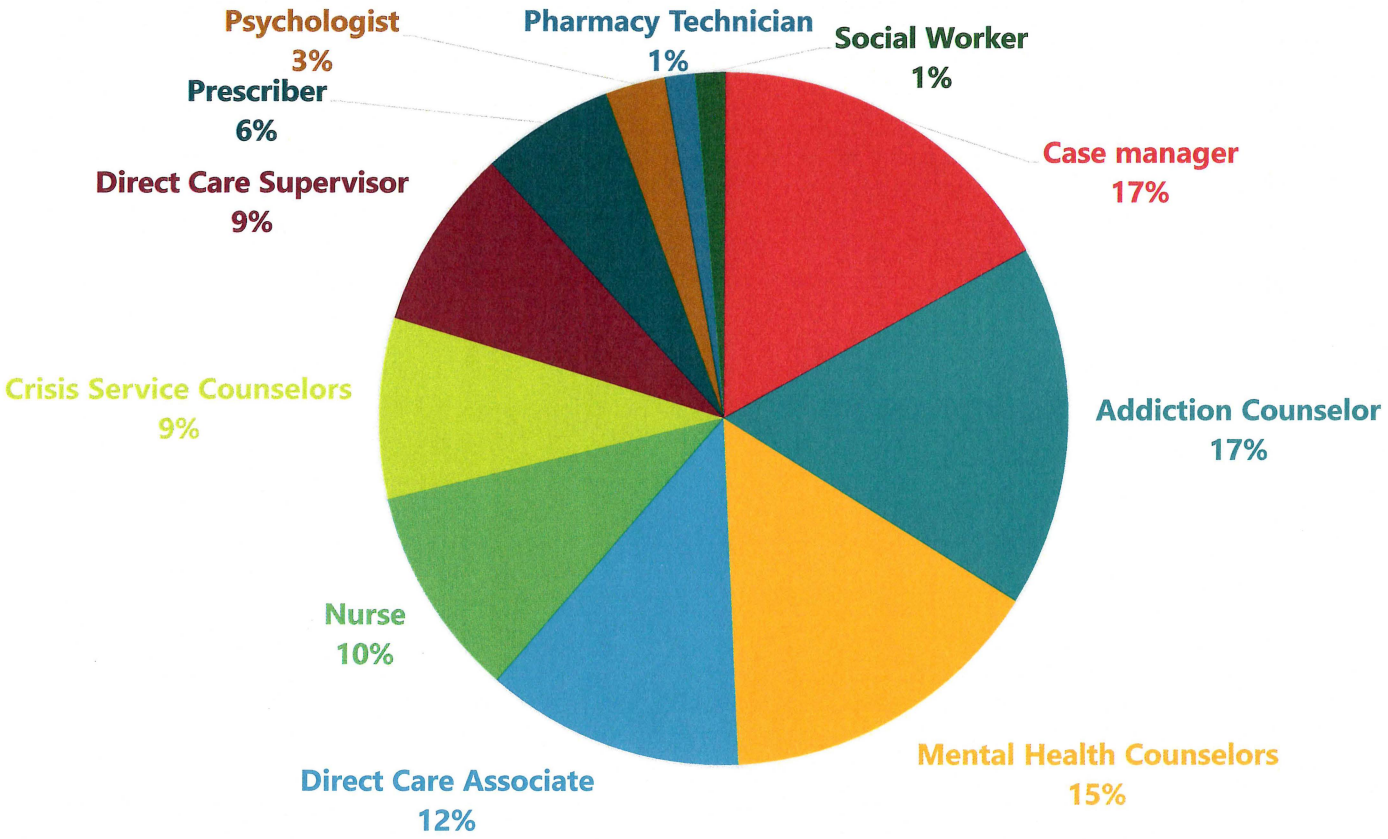
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

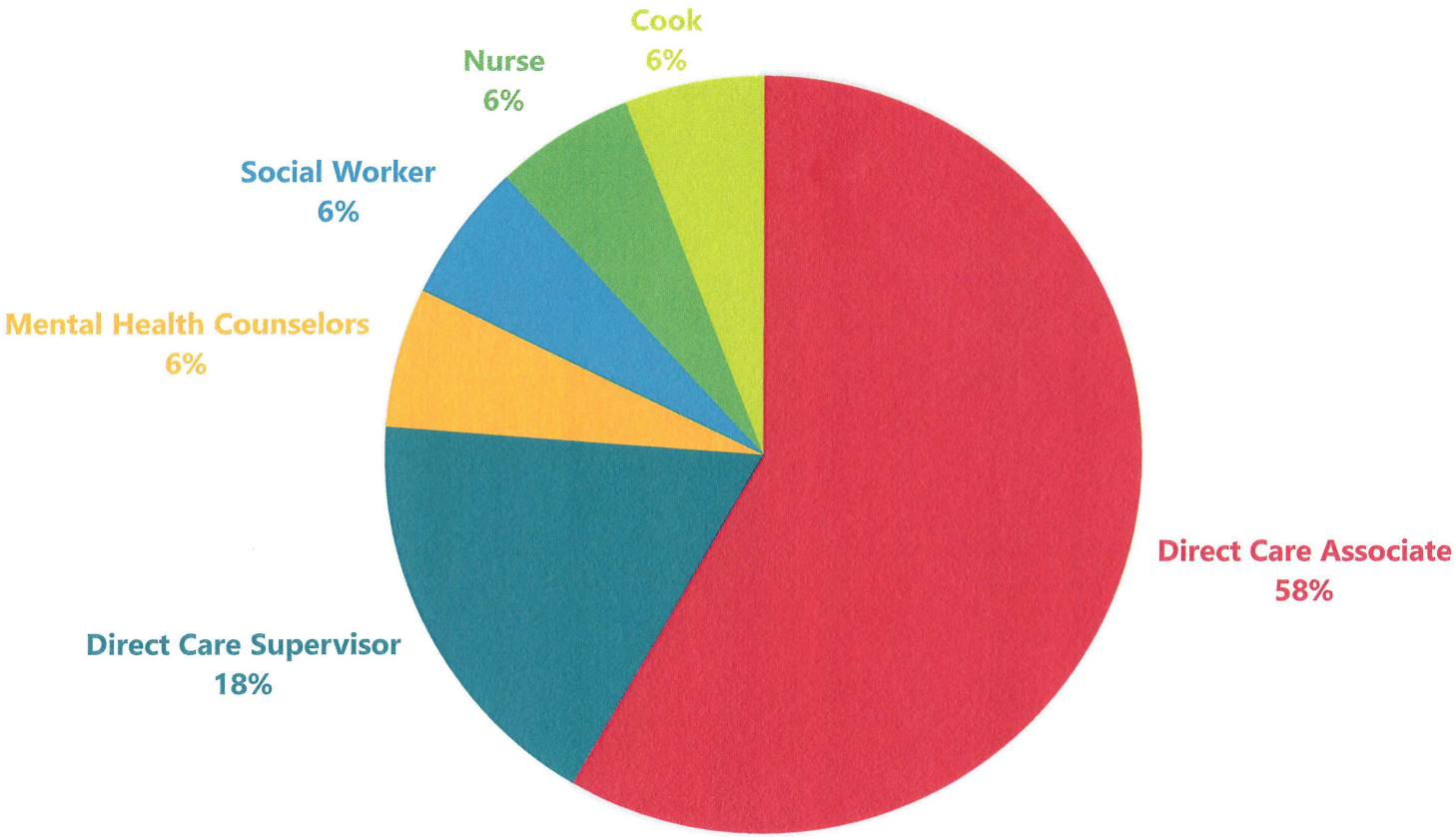
Pre-COVID	Current
0	3

Northeast Human Service Center
Behavioral Health FTE Breakdown, HSC



Northeast Human Service Center

Behavioral Health FTE Breakdown, Ruth Meiers Adolescent Treatment Center (RMAC)

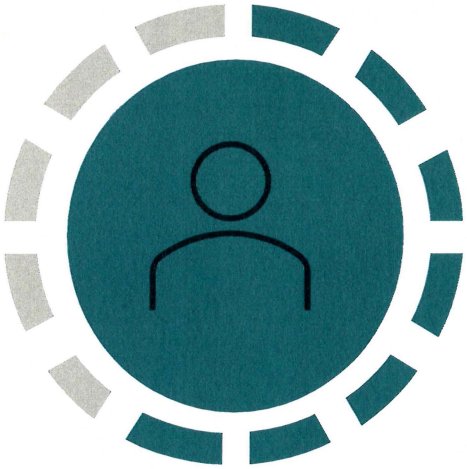


Northeast Human Service Center
Crisis Services Staffing

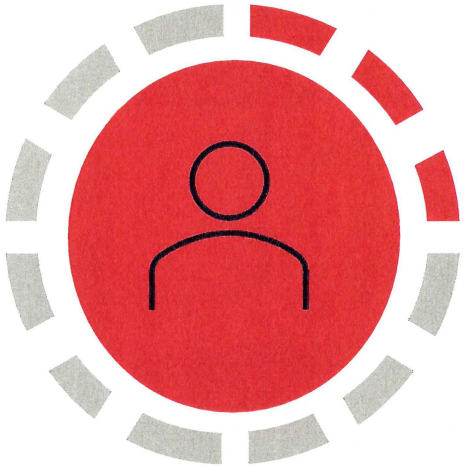
NEHSC	Filled	Vacant
New Crisis Staff FTE (4)	1	3
Existing Crisis Staff FTE	2	0

Northeast Human Service Center
Our Clients

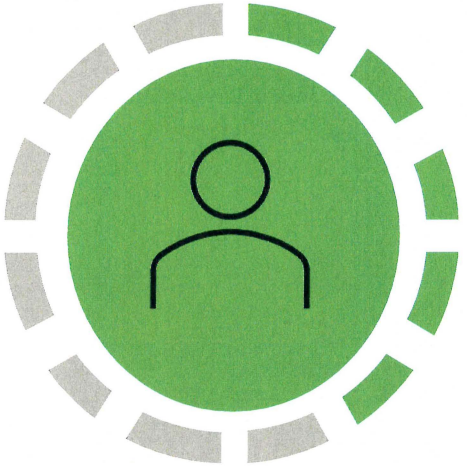
The Northeast HSC provided services to 2,485 clients between March 2019 and Nov. 2020.



54% Serious Mental Illness (SMI) Primary Diagnosis



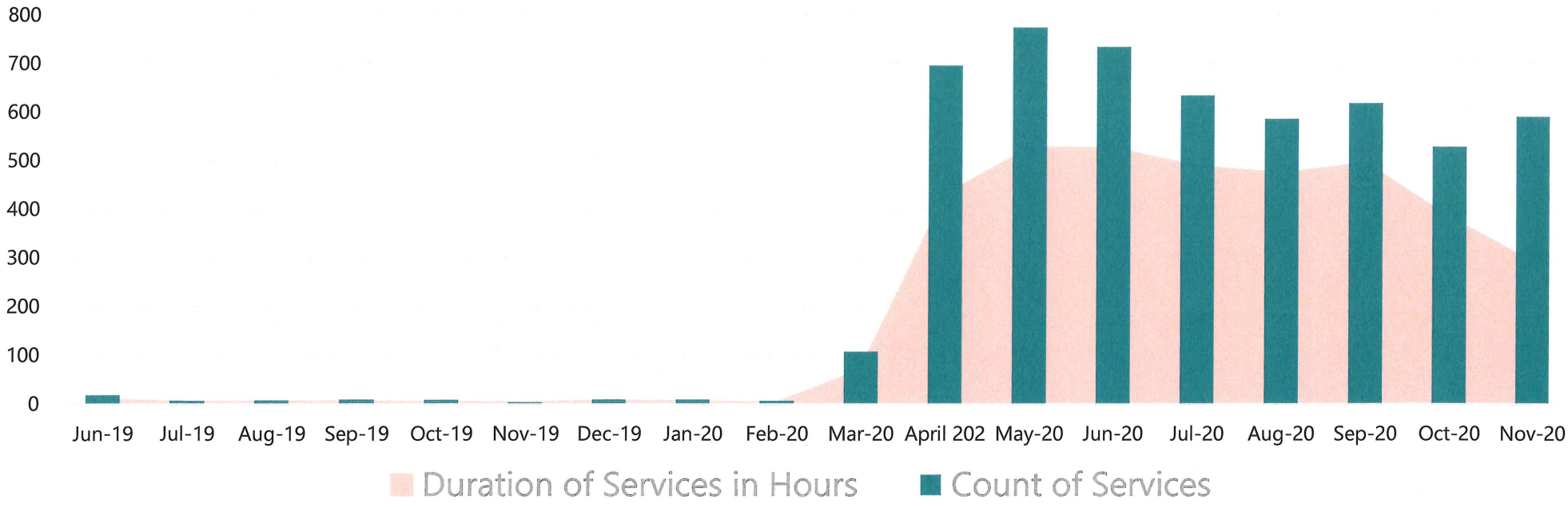
26% Substance Use Disorder (SUD) Primary Diagnosis



43% Co-Diagnosis of SUD and Mental Health Disorder

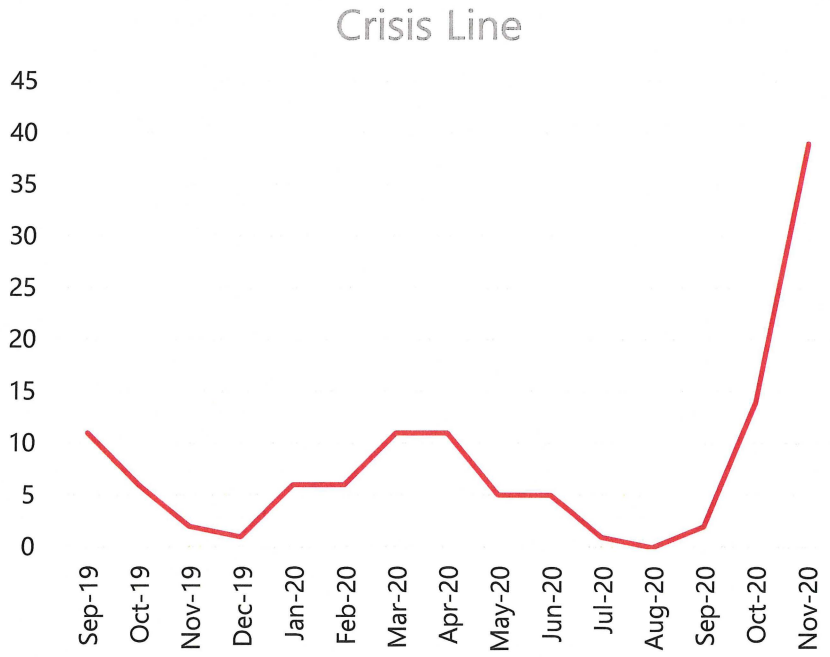
Northeast Human Service Center
Telehealth Services

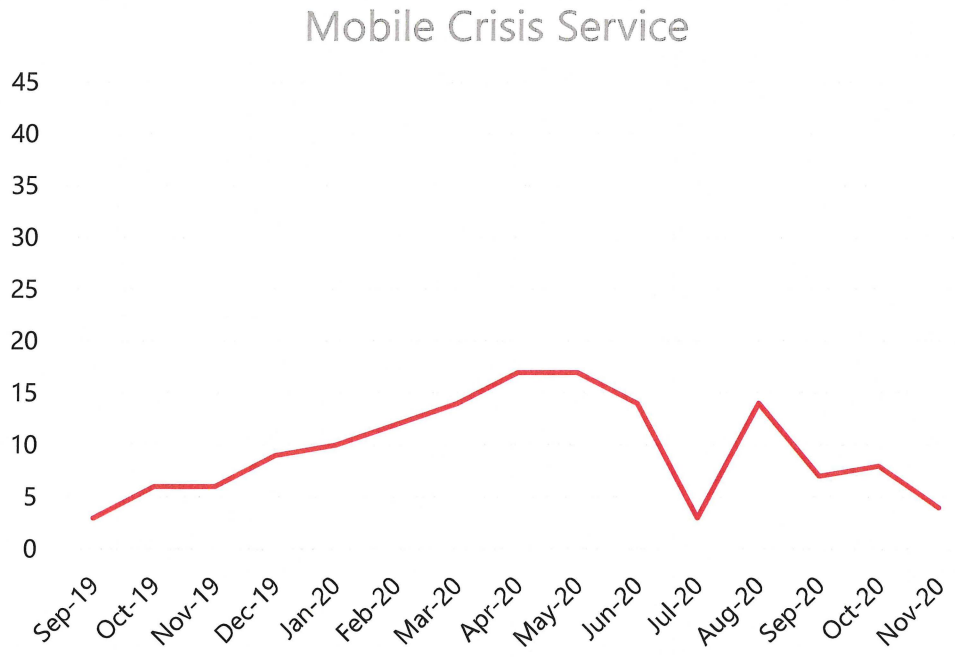
Northeast HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



Northeast Human Service Center
Crisis Services

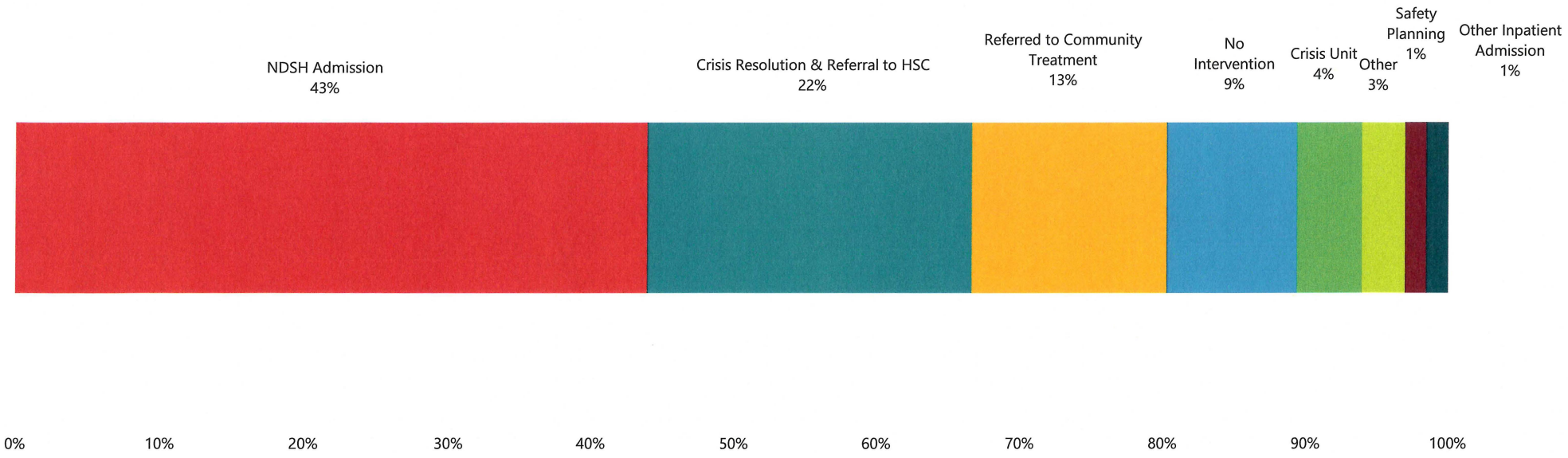
Northeast HSC provided 264 crisis services from September 2019 through November 2020.



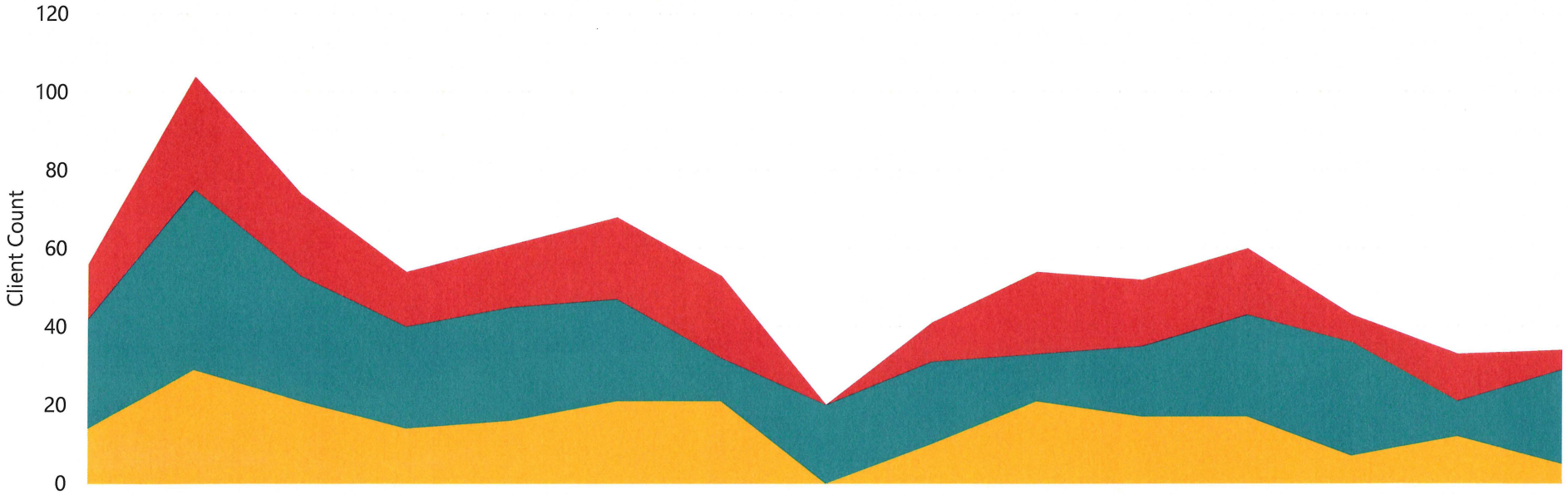


Northeast Human Service Center
Disposition Following Screening and Triage of Crisis Services

Between September 2019 through November 2020, Northeast HSC triaged and screened 68 individuals for crisis services. Of those individuals, 78% were either referred to North Dakota State Hospital, Crisis Resolution & Referral to HSC, or Referred to Community Treatment.



Northeast Human Service Center
Open Access

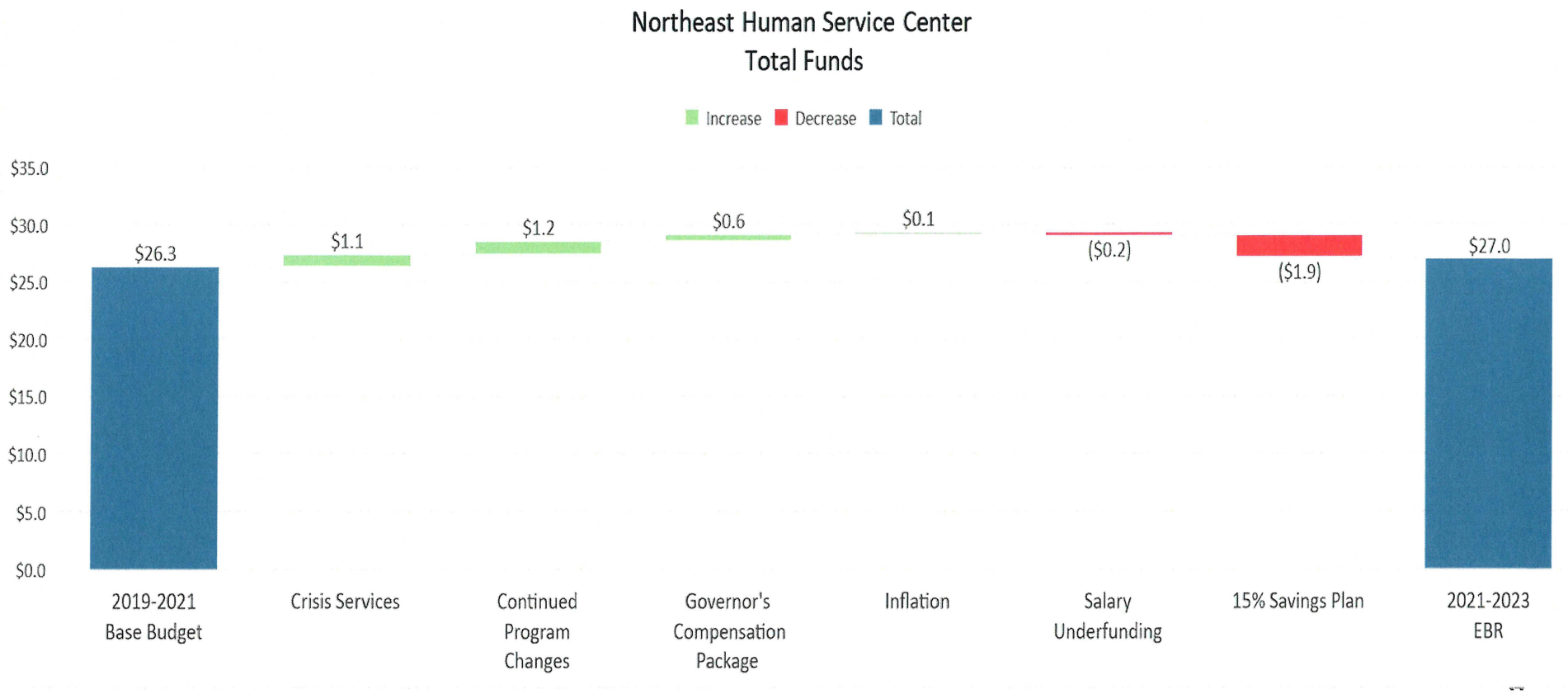


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	56	104	74	54	61	68	53	20	41	54	52	60	43	33	34
Referred To HSC	42	75	53	40	45	47	32	20	31	33	35	43	36	21	29
Referred Out	14	29	21	14	16	21	21	0	10	21	17	17	7	12	5

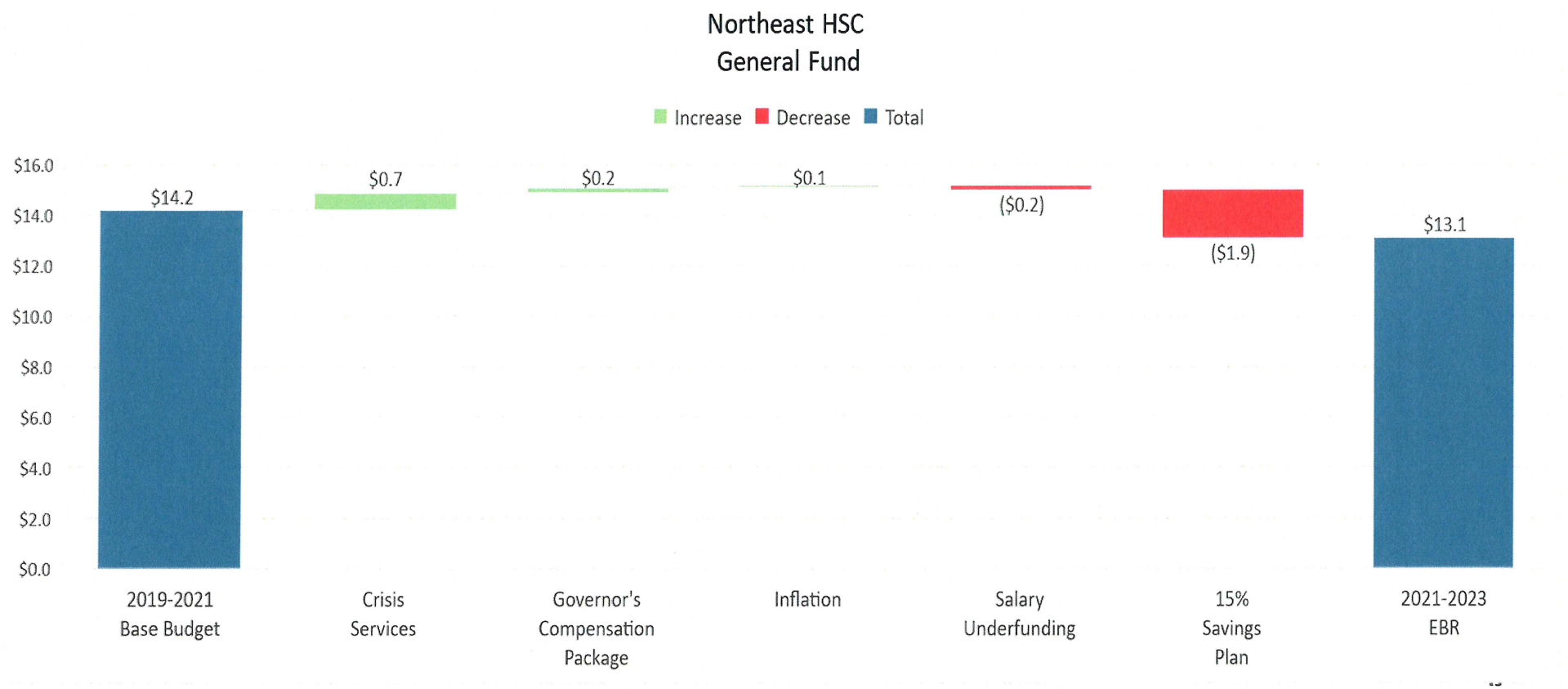
Overview of Budget Changes

Description	2019 - 2021 Budget	Increase/ (Decrease)	2021 - 2023 Executive Budget
Salaries and Benefits	19,241,822	1,696,539	20,938,361
Operating	2,502,425	(276,879)	2,225,546
Grants	4,518,936	(636,265)	3,882,671
Total	26,263,183	783,395	27,046,578
General Fund	14,234,704	(1,136,811)	13,097,893
Federal Funds	8,124,597	1,257,483	9,382,080
Other Funds	3,903,882	662,723	4,566,605
Total Funds	26,263,183	783,395	27,046,578
Full Time Equivalent (FTE)	106.00	(0.0)	106.00

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



15% Savings Plan

- Long-Term Residential Services - $1,414,800*
- Reducing LaGrave on First housing - $ 187,500*
- Reducing Main Office Rent by 25% - $280,000
- Support Services Operating - $20,000

*The Providers may be able to replace a portion of these funds with 1915i funding

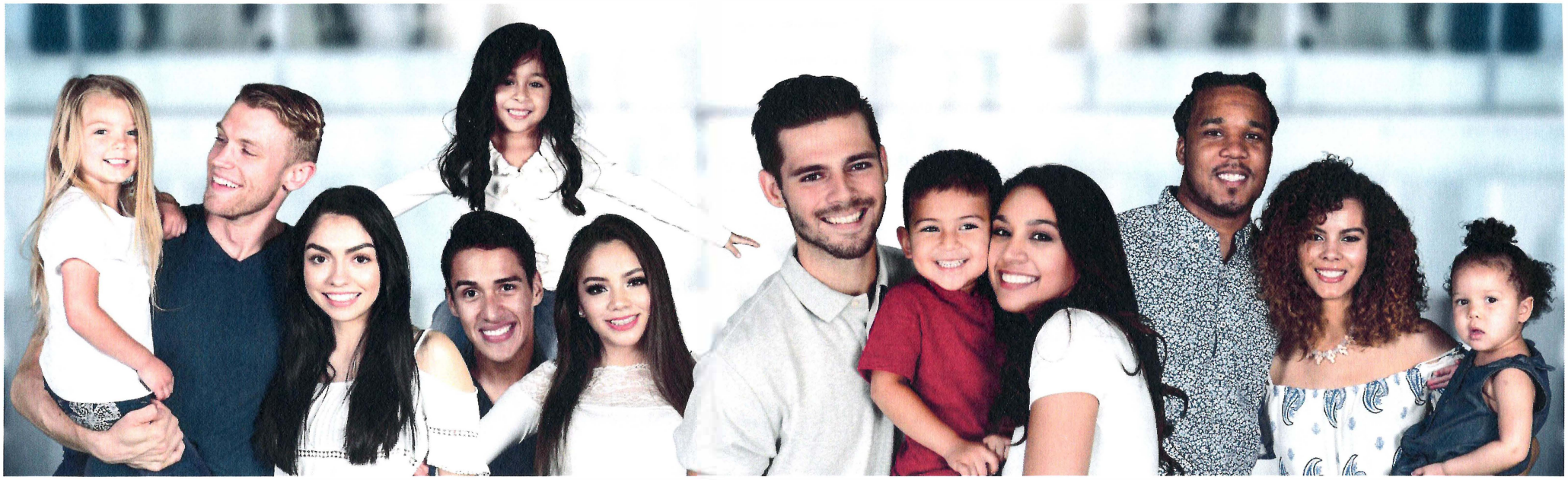
Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	16,264,584	19,241,822	8,834,031	1,696,539	20,938,361
52x Travel	251,049	249,583	79,783	(20,000)	229,583
53x Supply	265,641	222,433	129,235	14,000	236,433
54x Postage & Printing	31,983	9,510	10,882	20,000	29,510
55x Equipment Under $5,000	56,305	28,000	14,156	(20,000)	8,000
56x Utilities	28,949	29,160	11,163	(4,000)	25,160
58x Rent/Leases - Bldg./Equip	1,051,768	1,359,021	718,455	(280,000)	1,079,021
59x Repairs	38,092	39,529	38,412	-	39,529
61x Professional Development	23,557	22,678	6,726	-	22,678
62x Fees - Operating & Professional	442,925	411,166	143,964	(1,089)	410,077
60x IT Expenses	136,489	131,345	65,281	14,210	145,555
71x Grants, Benefits, & Claims	4,136,837	4,518,936	1,962,685	(636,265)	3,882,671
Total	22,728,179	26,263,183	12,014,773	783,395	27,046,578

Overview of Budget Changes by Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	13,276,509	14,234,704	8,732,004	(1,136,811)	13,097,893
Federal	5,871,082	8,124,597	2,381,903	1,257,483	9,382,080
Other	3,580,588	3,903,882	900,866	662,723	4,566,605
Total	22,728,179	26,263,183	12,014,773	783,395	27,046,578

#1635



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

SOUTHEAST HUMAN SERVICE CENTER OVERVIEW

Jeff Stenseth, Regional Director

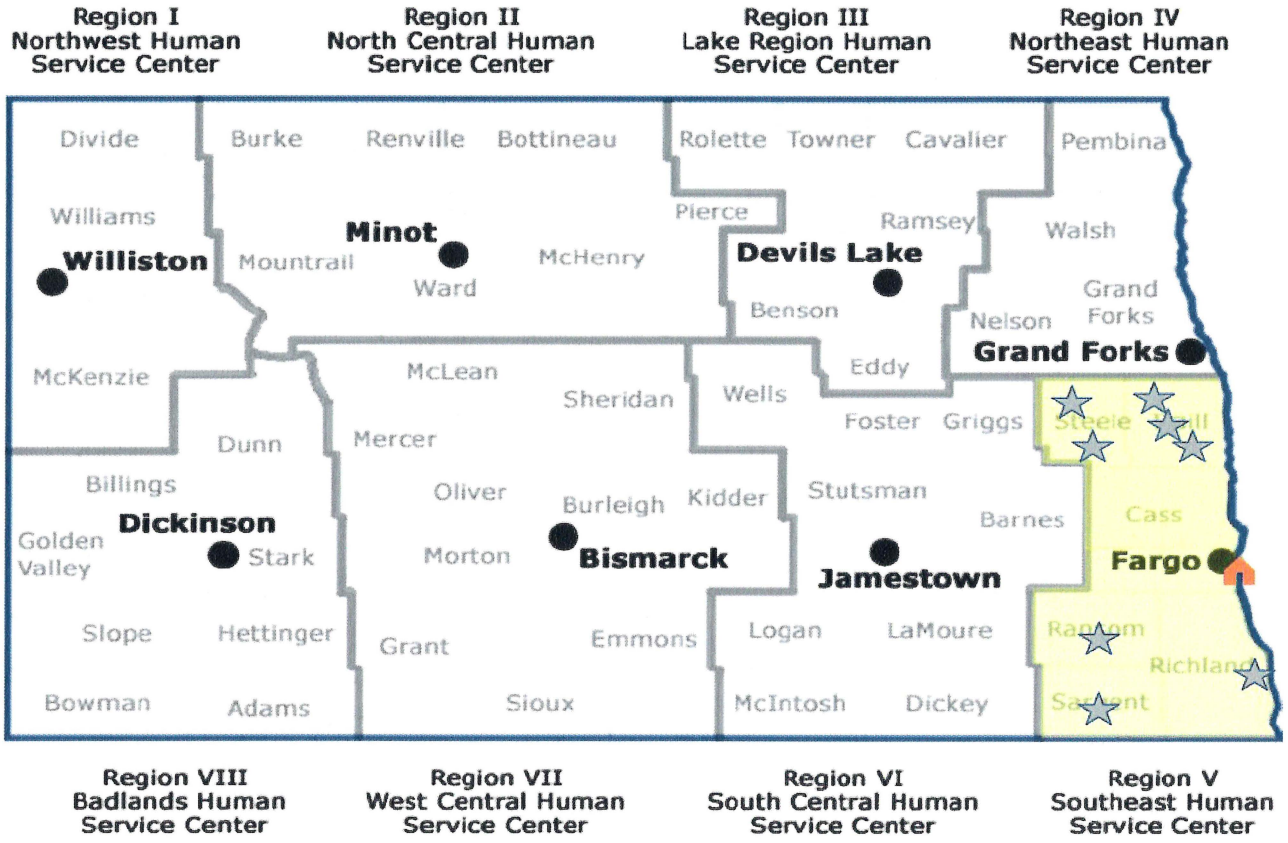
NORTH Dakota | Human Services

Be Legendary.™

Southeast Human Service Center
Region V



Public Behavioral Health System



Department of Human Services

SEHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
185.17	134.80	134.80	5	8%	Administration	10
				10%	Client Facing Administration	13.9
				82%	Behavioral Health	110.9

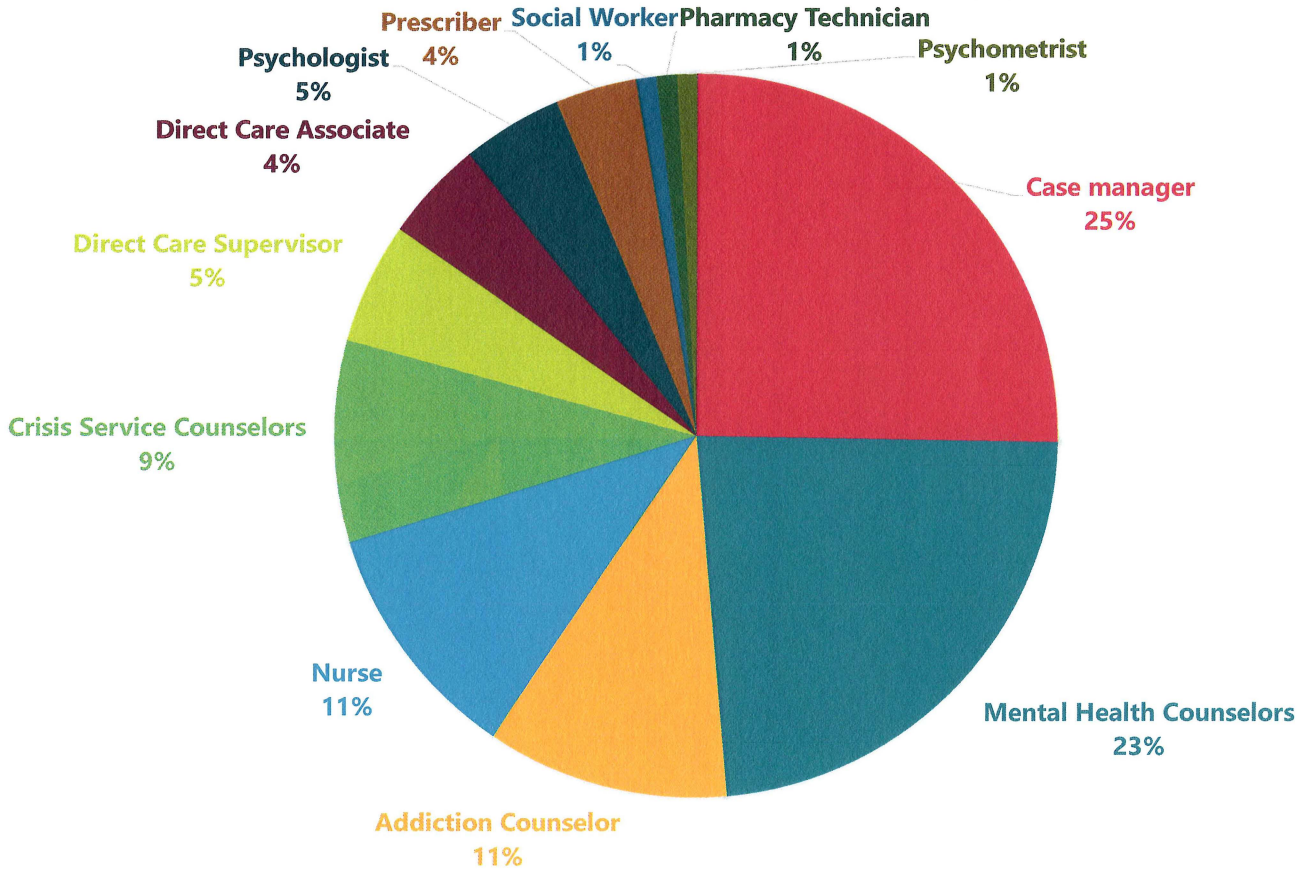
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
10	13

Southeast Human Service Center
Behavioral Health FTE Breakdown

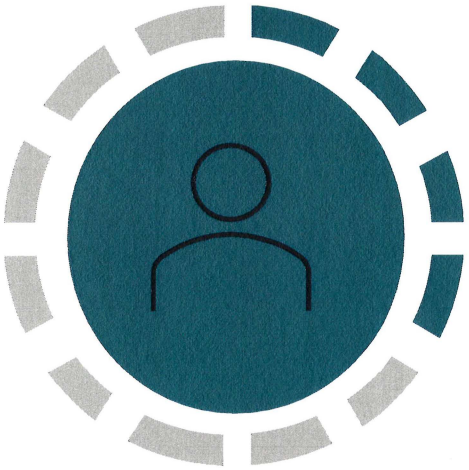


Southeast Human Service Center
Crisis Services Staffing

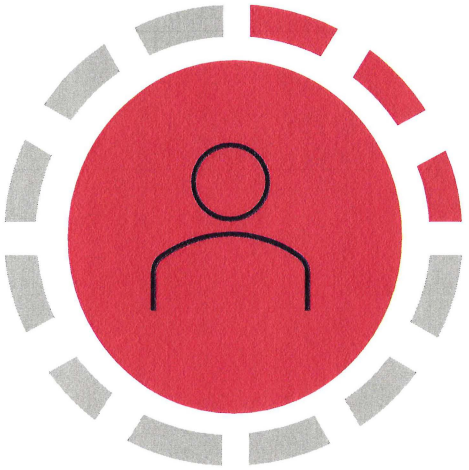
SEHSC	Filled	Vacant
New Crisis Staff FTE	N/A	N/A
Existing Crisis Staff FTE	8	2

Southeast Human Service Center
Our Clients

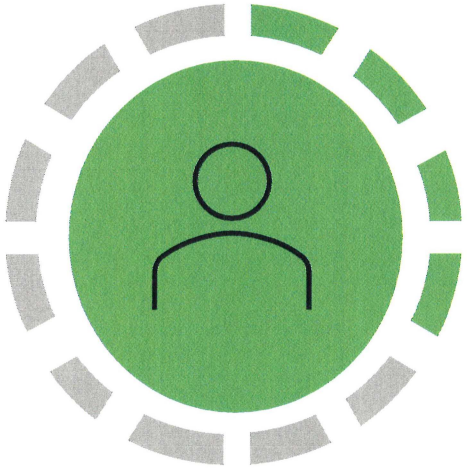
The Southeast HSC provided services to 4,243 clients between March 2019 and Nov. 2020.



44% Serious Mental Illness (SMI) Primary Diagnosis



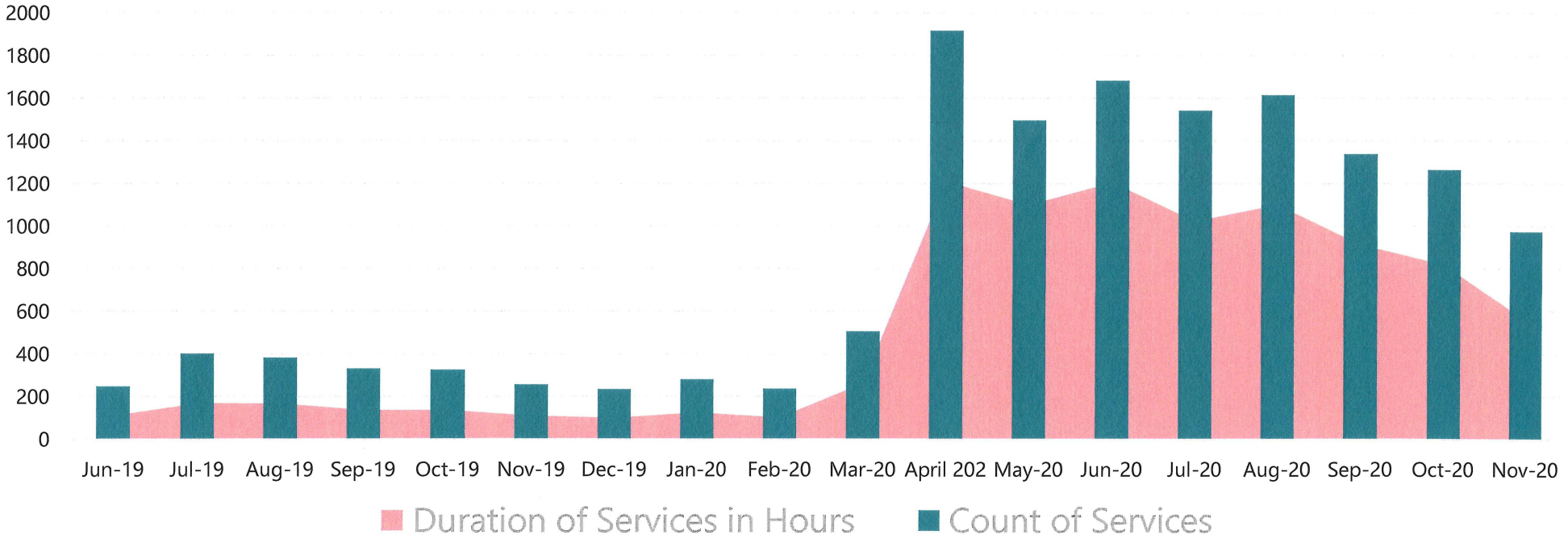
22% Substance Use Disorder (SUD) Primary Diagnosis



42% Co-Diagnosis of SUD and Mental Health Disorder

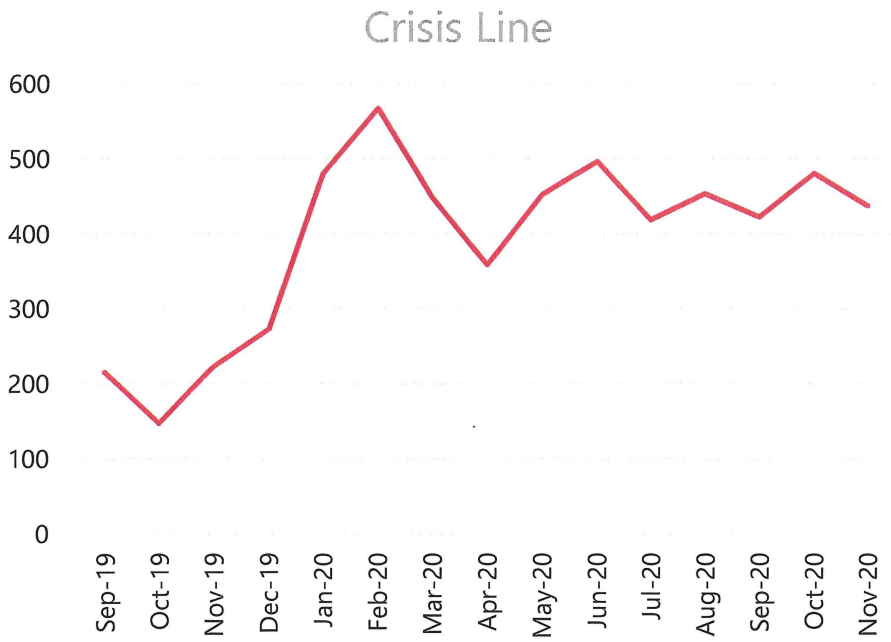
Southeast Human Service Center
Telehealth Services

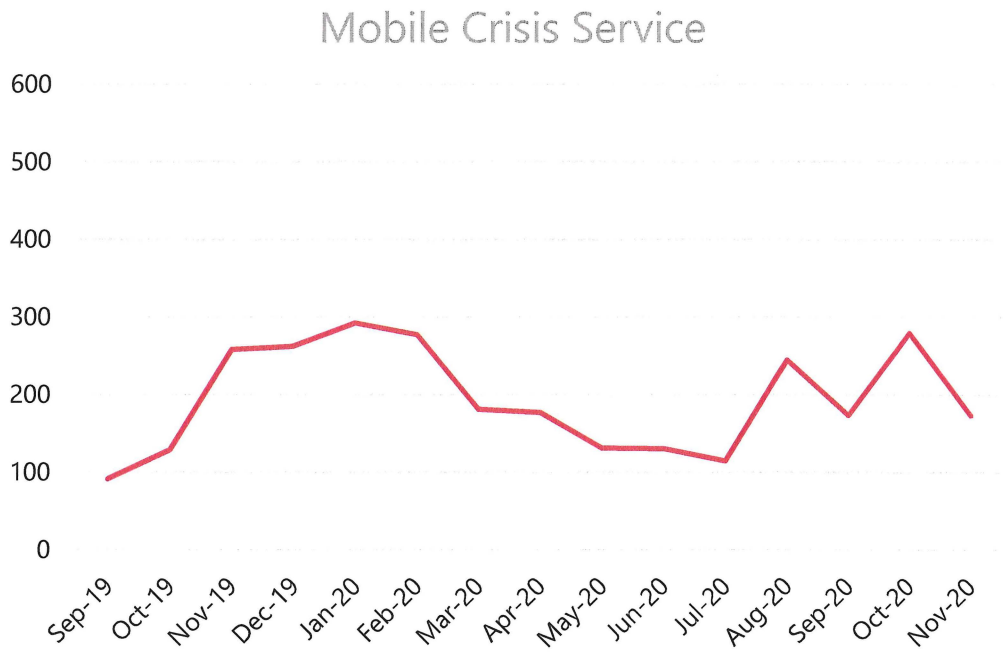
Southeast HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



Southeast Human Service Center
Crisis Services

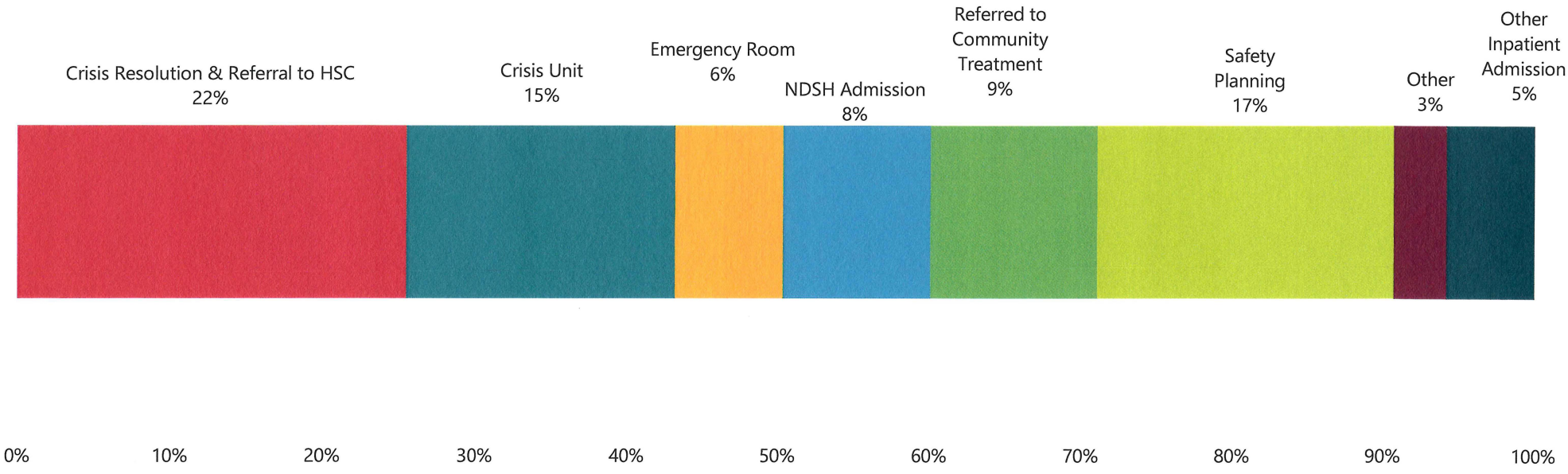
Southeast HSC provided 8,778 crisis services from September 2019 through November 2020.



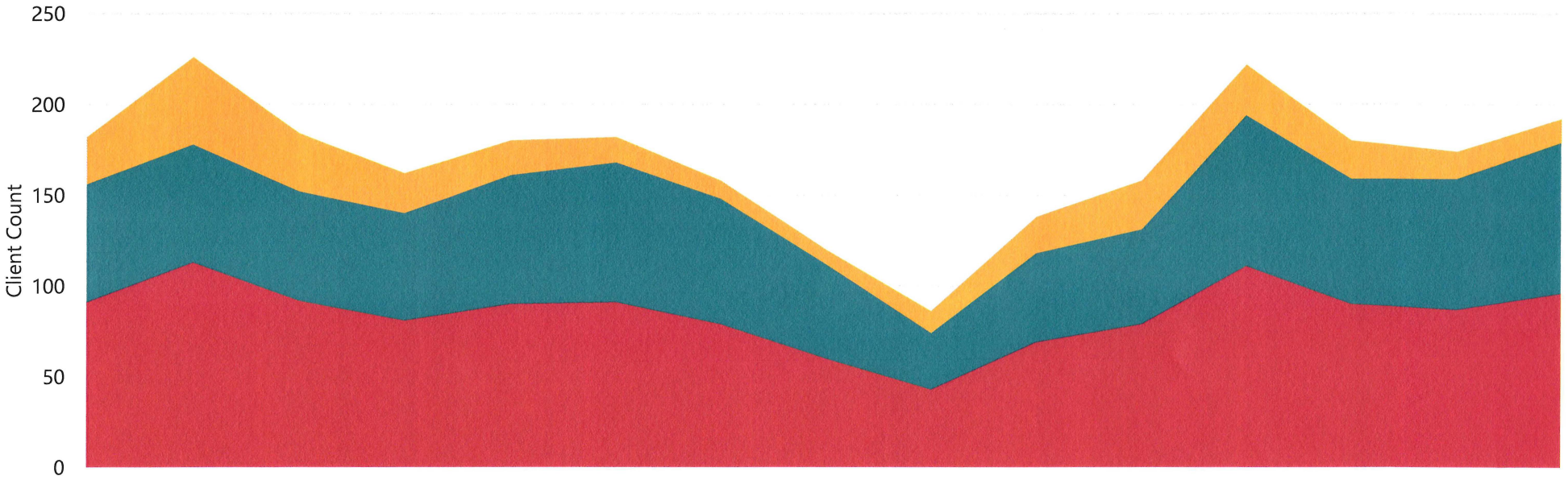


Southeast Human Service Center
Disposition Following Screening and Triage of Crisis Services

Between September 2019 through November 2020, Southeast HSC triaged and screened 2,297 individuals for crisis services. Of those individuals, 81% were either referred to Crisis Resolution and Referral to HSC, Crisis Unit, Emergency Room, or the North Dakota State Hospital.



Southeast Human Service Center
Open Access

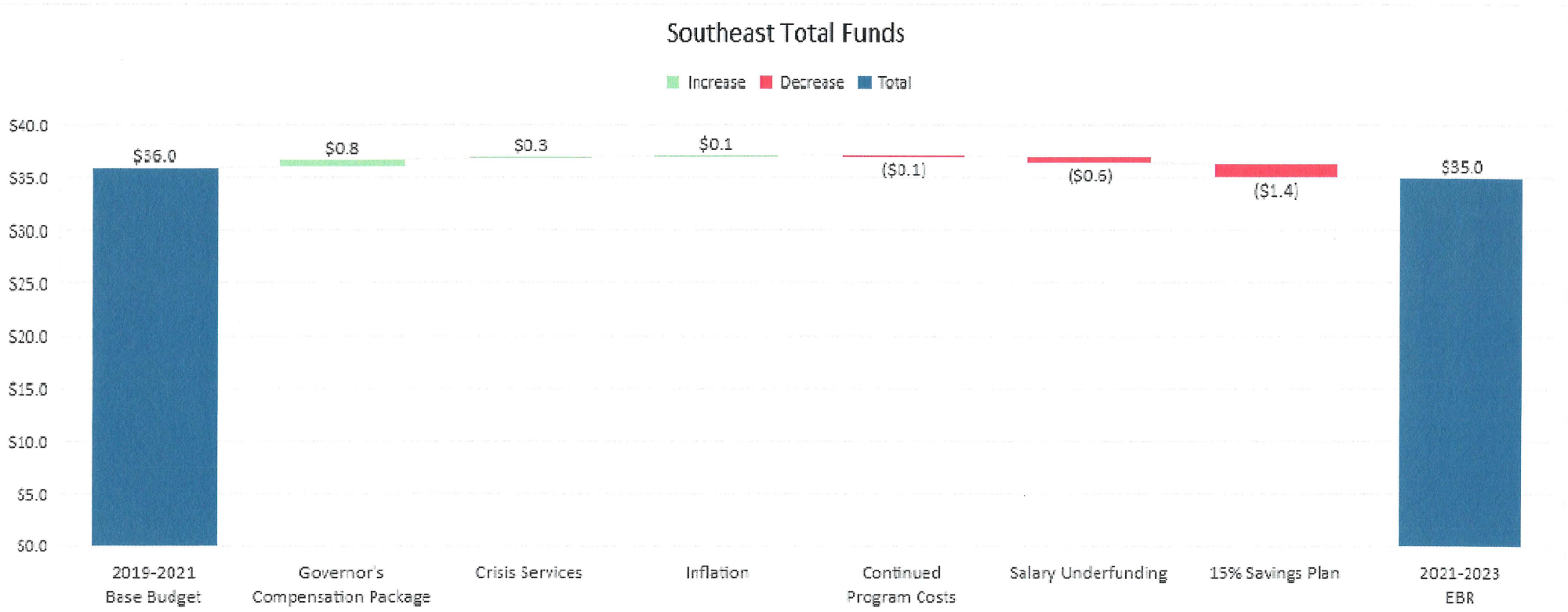


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	91	113	92	81	90	91	79	60	43	69	79	111	90	87	96
Referred to HSC	65	65	60	59	71	77	69	52	31	49	52	83	69	72	83
Referred Out	26	48	32	22	19	14	10	8	12	20	27	28	21	15	13

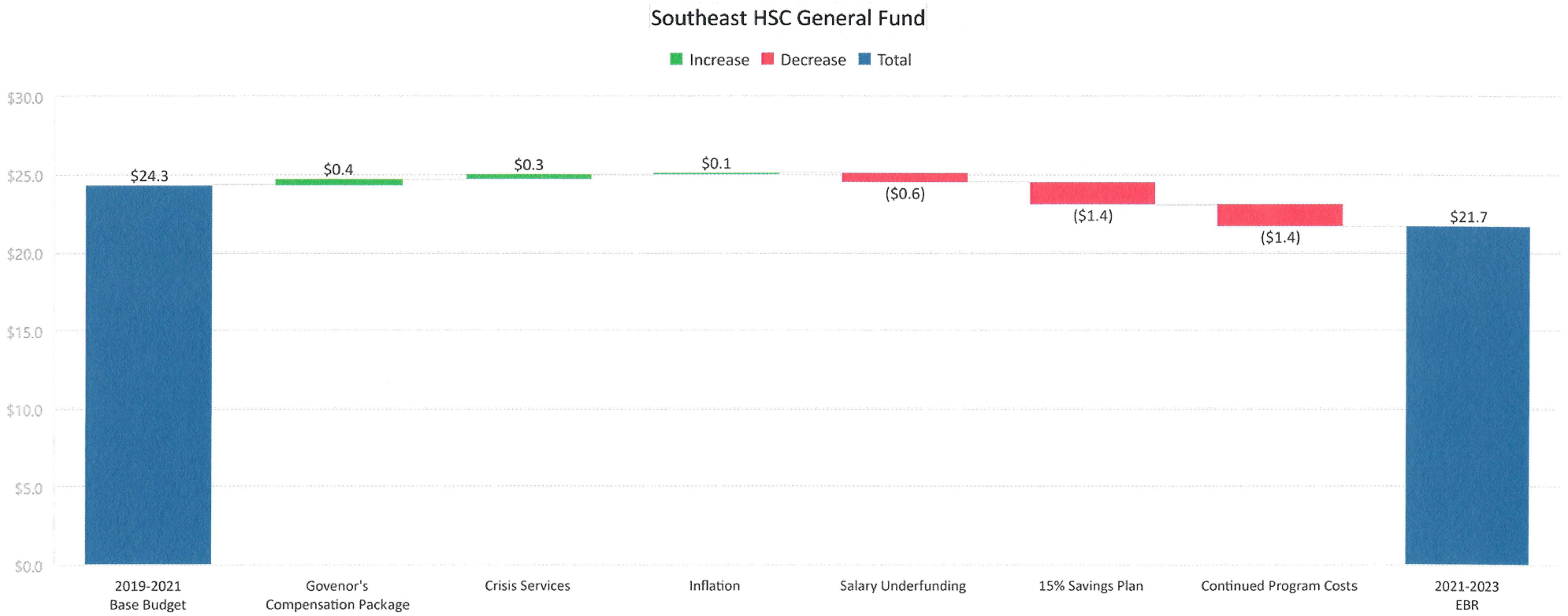
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	26,549,943	1,634,061	28,184,004
Operating	1,960,258	29,767	1,990,025
Capital	80,000	0	80,000
Grants	6,769,567	(2,049,775)	4,719,792
Total	35,359,768	(385,947)	34,973,821
General Fund	23,690,716	(2,016,605)	21,674,111
Federal Funds	7,596,866	(750,098)	6,846,768
Other Funds	4,072,186	2,380,756	6,452,942
Total	35,359,768	(385,947)	34,973,821
Full Time Equivalent (FTE)	134.80	0	134.80

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



Overview of Budget changes by Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	22,913,471	26,549,943	11,963,995	1,634,061	28,184,004
52x Travel	366,180	413,110	150,212	(16,714)	396,396
53x Supply	140,636	147,734	58,147	(3,294)	144,440
54x Postage & Printing	43,671	57,503	13,937	(11,442)	46,061
55x Equipment Under $5,000	28,568	18,272	21,596	4,328	22,600
56x Utilities	153,639	162,648	72,373	-	162,648
57x Insurance	1,251	2,380	-	51	2,431
58x Rent/Leases - Bldg./Equip	247,082	266,444	145,773	(8,119)	258,325
59x Repairs	234,580	250,506	114,357	2,130	252,636
62x Fees - Operating & Professional	309,679	452,851	212,571	21,074	473,925
60x IT Expenses	204,527	188,810	104,782	41,753	230,563
68x Land, Building, Other Capital	131,555	80,000	7,991	-	80,000
71x Grants, Benefits, & Claims	6,867,315	6,769,567	3,608,272	(2,049,775)	4,719,792
Total	31,642,152	35,359,768	16,474,006	(385,947)	34,973,821

Overview of Budget Changes by Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	19,998,256	23,690,716	12,879,852	(2,016,605)	21,674,111
Federal	9,623,510	7,596,866	2,333,811	(750,098)	6,846,768
Other	2,020,386	4,072,186	1,259,343	2,380,756	6,452,942
Total	31,642,152	35,359,768	16,473,006	(385,947)	34,973,821



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

WEST CENTRAL HUMAN SERVICE CENTER OVERVIEW

Brad Brown, Regional Director

NORTH Dakota | Human Services

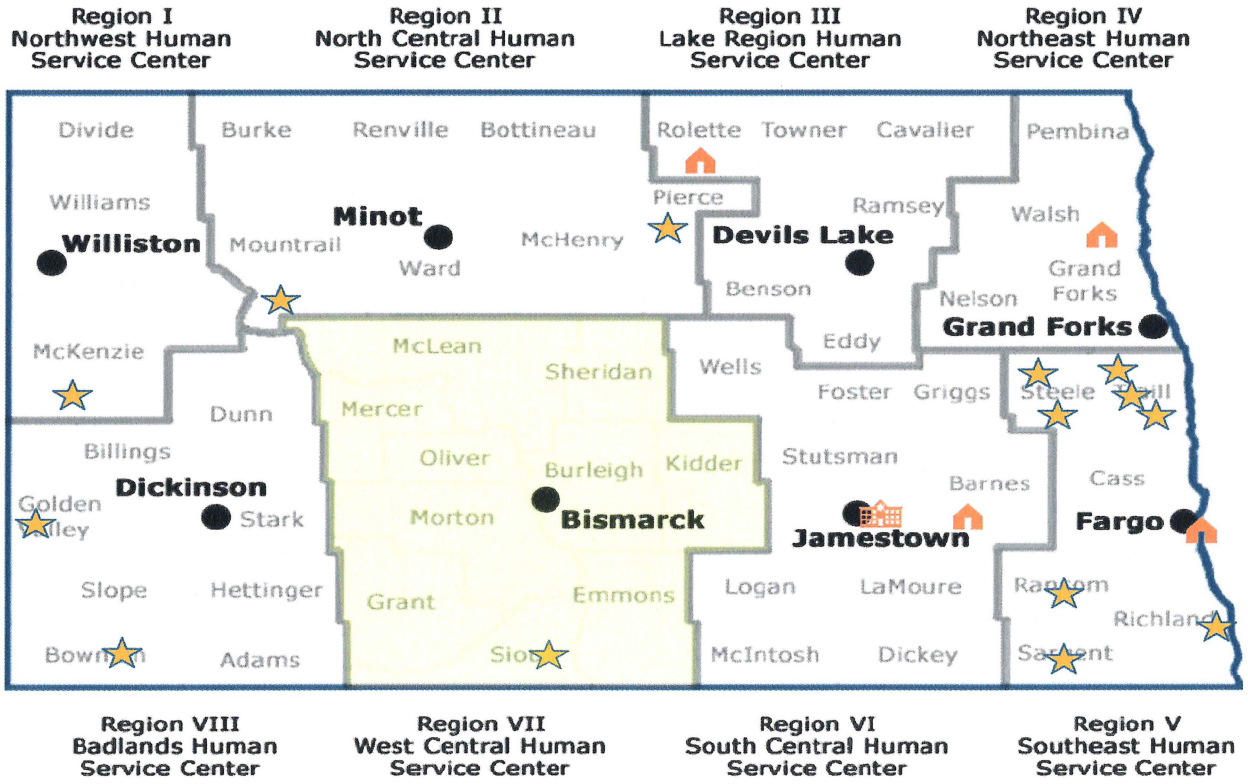
Be Legendary.™

West Central Human Service Center
Region VII



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

WCHSC

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
136.60	93.10	93.10	5	5%	Administration	4.6
				14%	Client Facing Administration	13
				81%	Behavioral Health	75.5

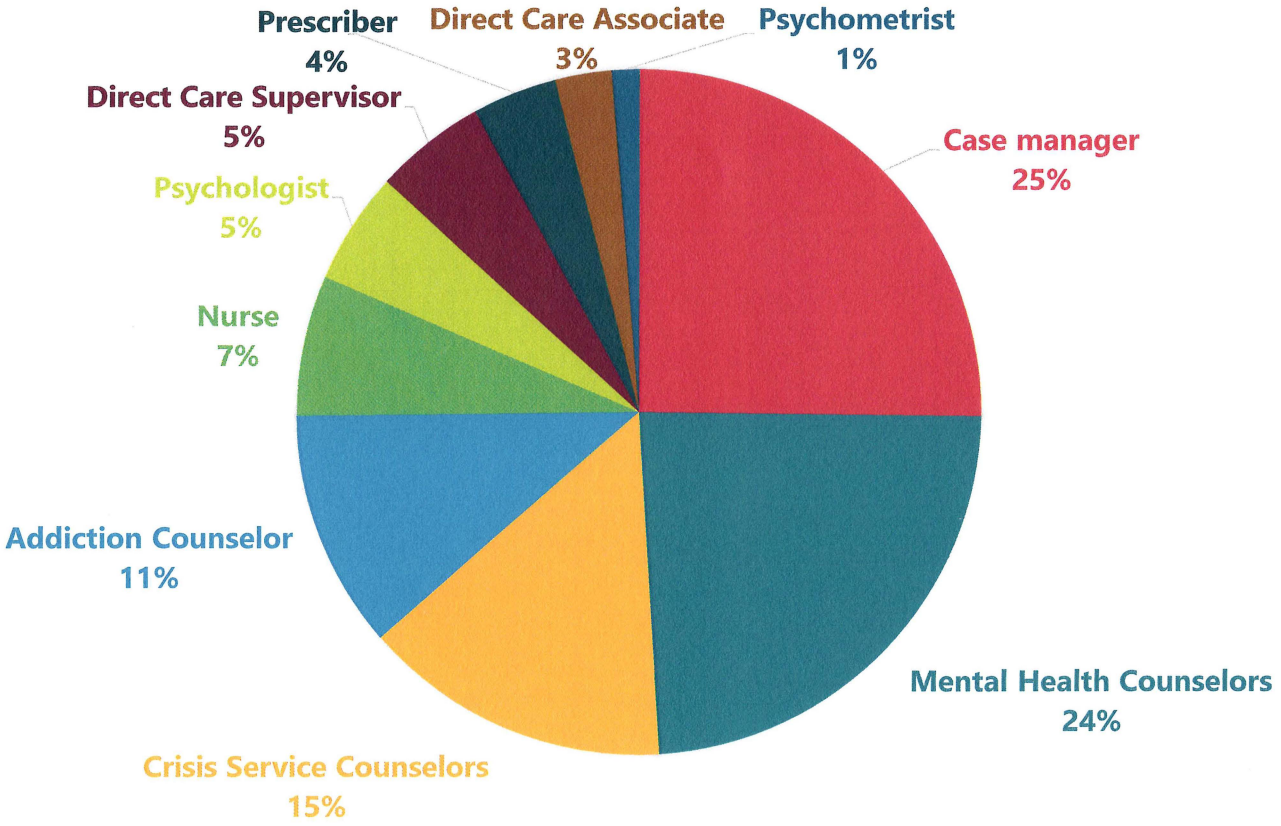
COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
4	6

West Central Human Service Center
Behavioral Health FTE Breakdown



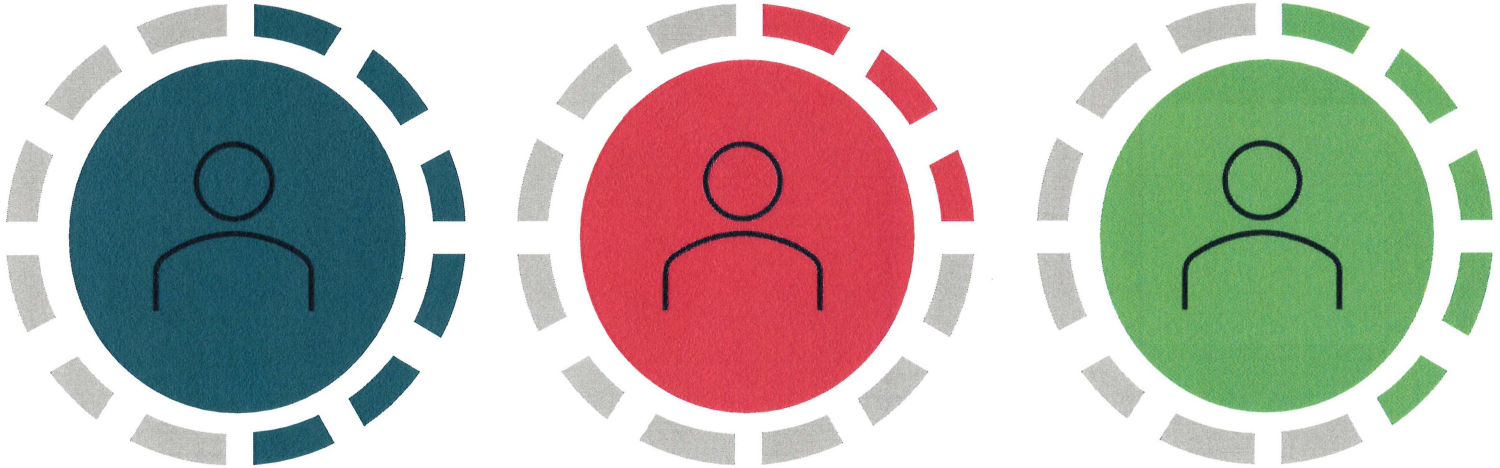
West Central Human Service Center
Crisis Services Staffing

WCHSC	Filled	Vacant
New Crisis Staff FTE (3)	3	0
Existing Crisis Staff FTE	8	0

West Central Human Service Center

Our Clients

The West Central HSC provided services to 4,369 clients between March 2019 and Nov. 2020.



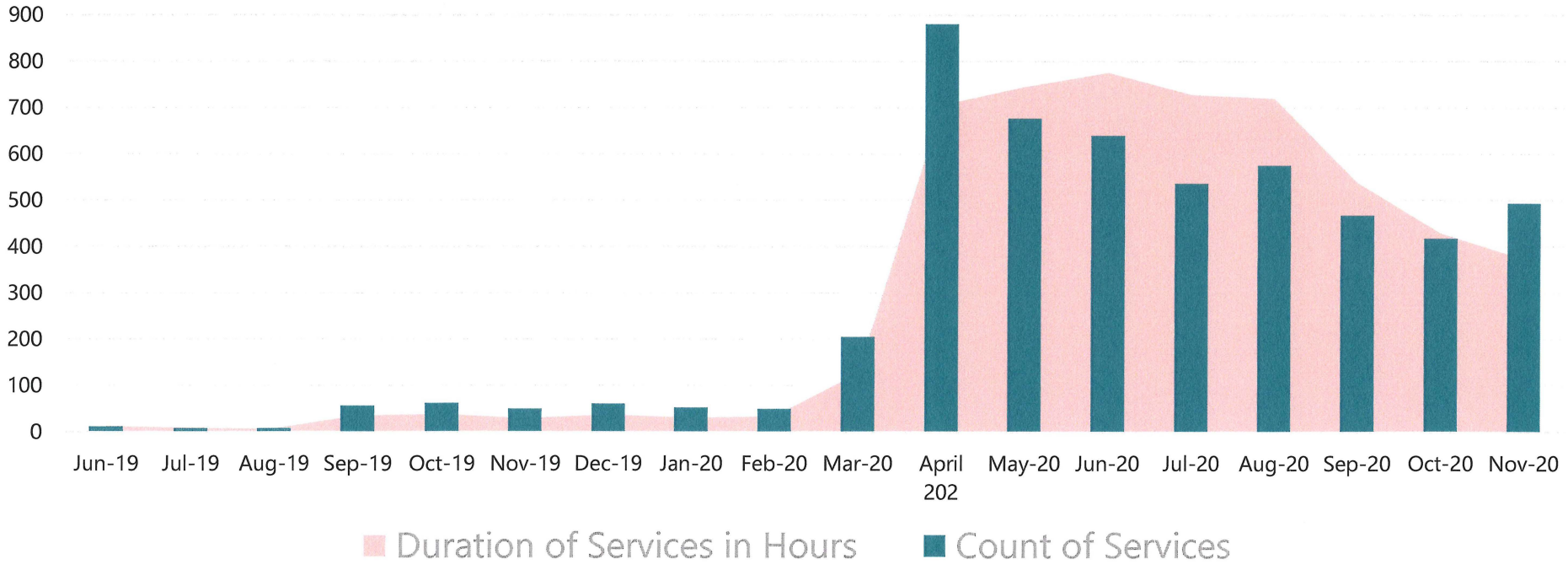
52% Serious Mental Illness (SMI) Primary Diagnosis

26% Substance Use Disorder (SUD) Primary Diagnosis

43% Co-Diagnosis of SUD and Mental Health Disorder

West Central Human Service Center
Telehealth Services

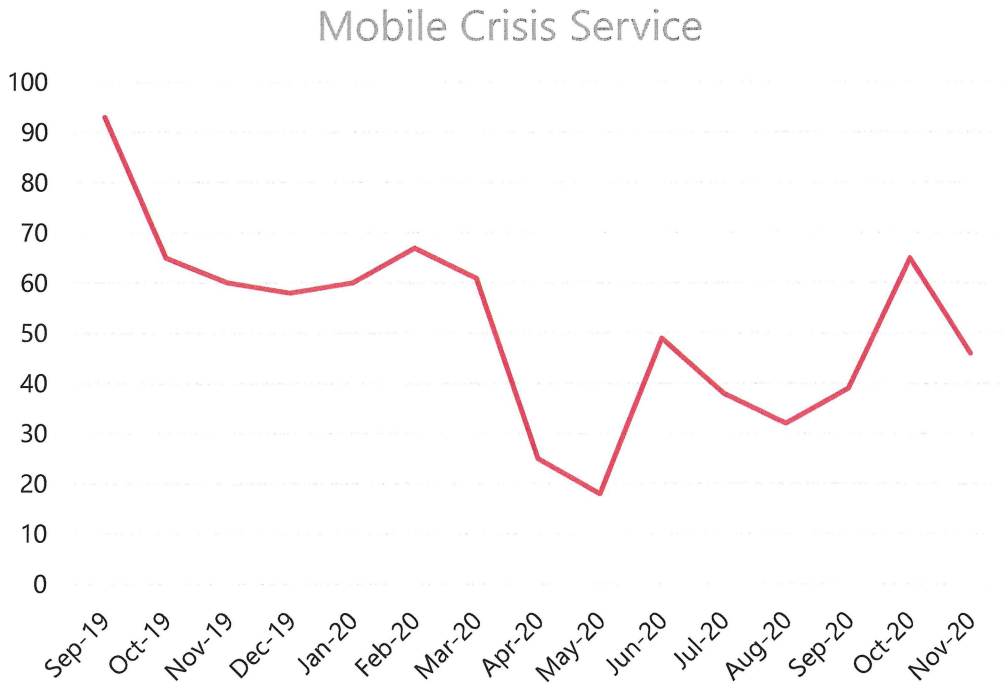
West Central HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



West Central Human Service Center
Crisis Services

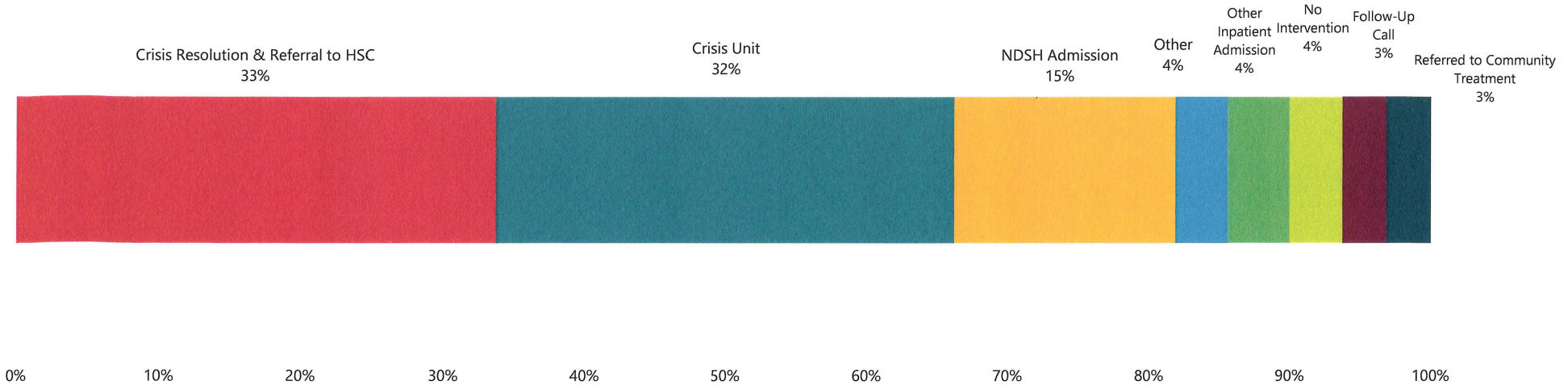
West Central HSC provided 1,415 crisis services from September 2019 through November 2020.



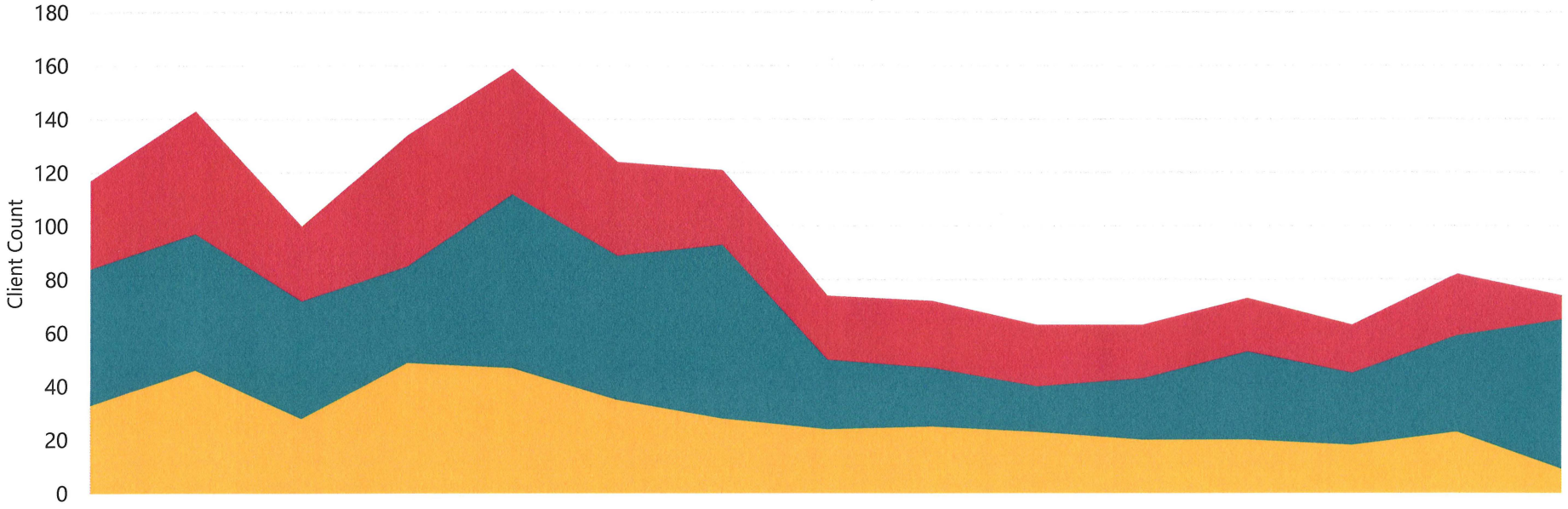


West Central Human Service Center
Disposition Following Screening and Triage of Crisis Services

Between September 2019 through November 2020, West Central HSC triaged and screened 159 individuals for crisis services. Of those individuals, 80% were either referred to Crisis Resolution and Referral to HSC, Crisis Unit, or the North Dakota State Hospital.



West Central Human Service Center
Open Access

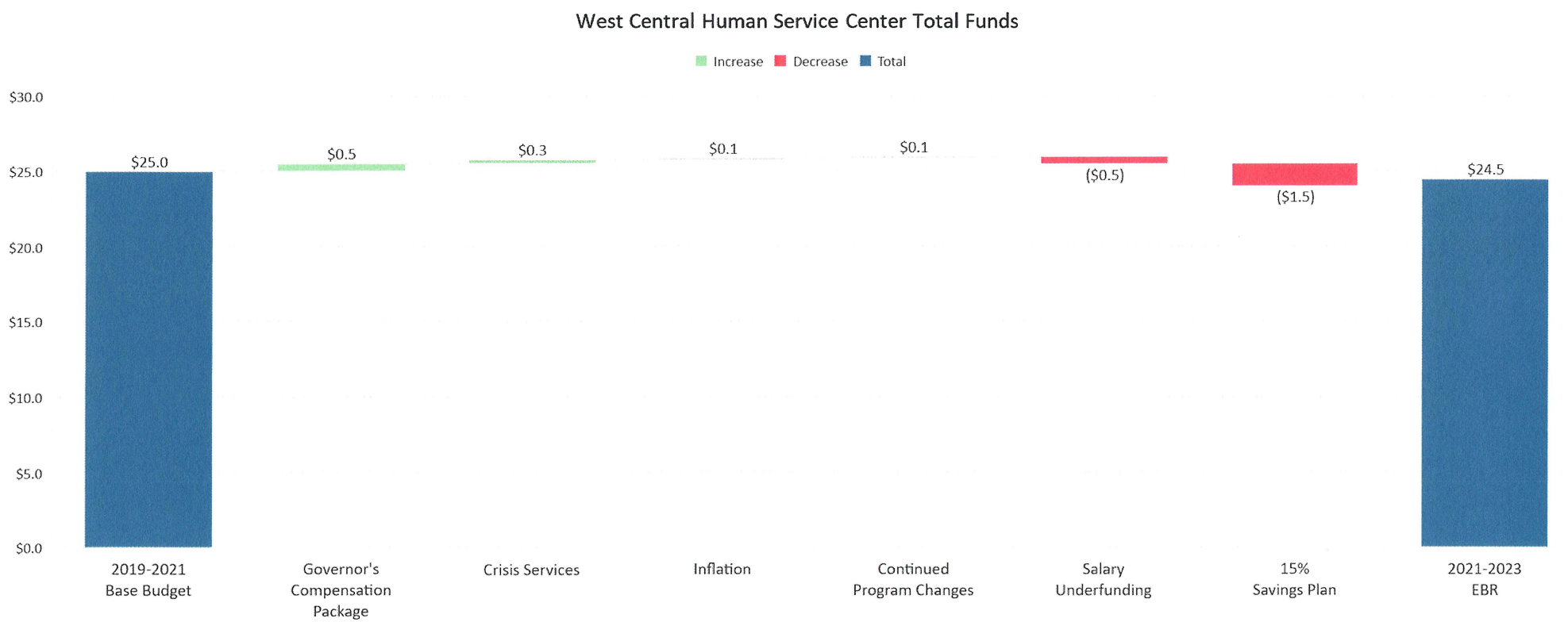


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	117	143	100	134	159	124	121	74	72	63	63	73	63	82	74
Referred To HSC	84	97	72	85	112	89	93	50	47	40	43	53	45	59	65
Referred Out	33	46	28	49	47	35	28	24	25	23	20	20	18	23	9

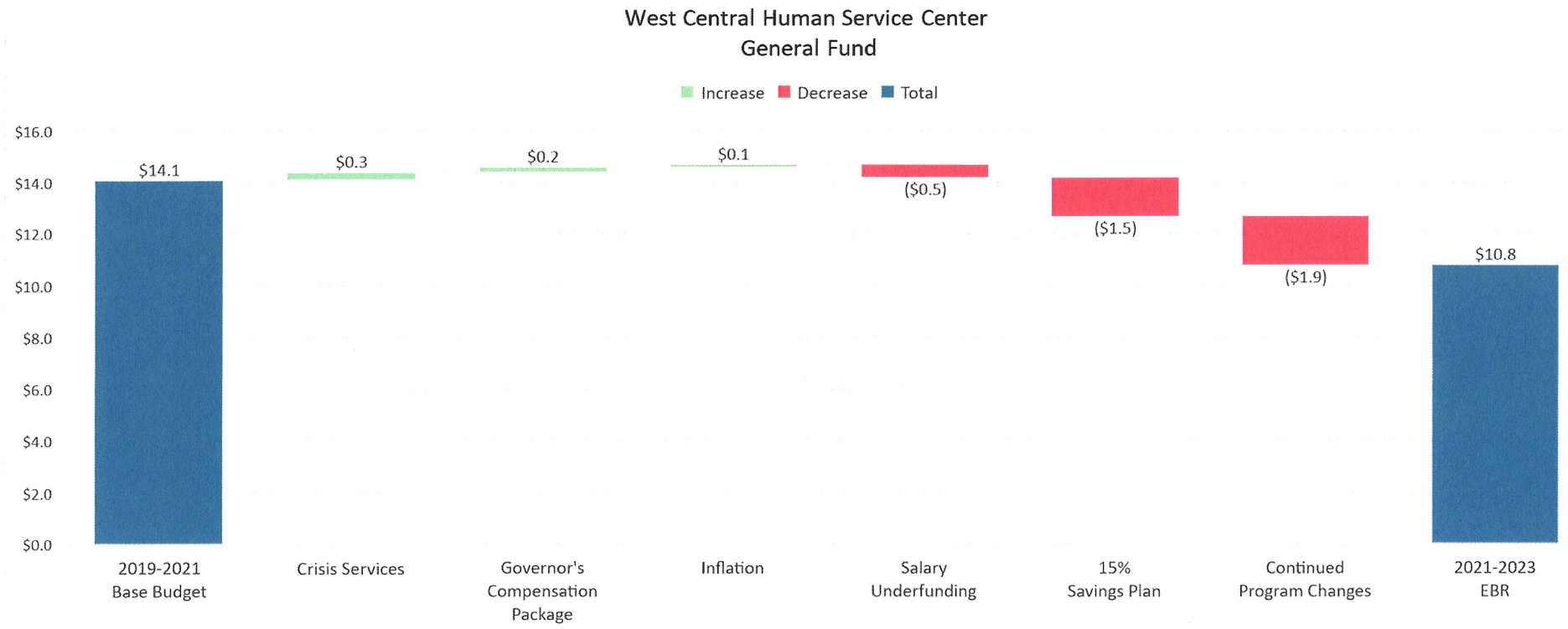
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salary and Benefits	17,905,866	926,119	18,831,985
Operating	1,887,921	(23,152)	1,864,769
Grants	5,199,758	(1,351,876)	3,847,882
Total	24,993,545	(448,908)	24,544,637
General Fund	14,087,606	(3,296,476)	10,791,130
Federal Funds	8,477,847	1,183,295	9,661,142
Other Funds	2,428,092	1,664,273	4,092,365
Total	24,993,545	(448,908)	24,544,637
Full Time Equivalent (FTE)	93.10	(0.00)	93.10

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	15,378,024	17,905,866	8,352,177	926,119	18,831,985
52x Travel	242,476	316,131	101,909	(101,881)	214,250
53x Supply	75,226	86,237	29,892	(14,321)	71,916
54x Postage & Printing	41,129	14,000	16,813	24,000	38,000
55x Equipment Under $5,000	3,526	29,000	9,872	(19,000)	10,000
58x Rent/Leases - Bldg./Equip	1,129,400	1,202,393	602,158	44,612	1,247,005
59x Repairs	9,561	8,000	2,250	-	8,000
61x Professional Development	27,296	30,441	31,994	33,220	63,661
62x Fees - Operating & Professional	75,708	110,109	51,153	(3,907)	106,202
60x IT Expenses	92,016	91,610	44,981	14,126	105,736
71x Grants, Benefits, & Claims	4,623,875	5,199,758	1,837,854	(1,351,876)	3,847,882
Total	21,698,237	24,993,545	11,081,053	(448,908)	24,544,637

Overview Of Budget Changes By Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	12,091,784	14,087,606	8,651,800	(3,296,476)	10,791,130
Federal	7,620,935	8,477,847	2,297,527	1,183,295	9,661,142
Other	1,985,518	2,428,092	131,726	1,664,273	4,092,365
Total	21,698,237	24,993,545	11,081,053	(448,908)	24,544,637



HOUSE BILL 1012

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

BADLANDS HUMAN SERVICE CENTER OVERVIEW

Jessica Odermann, Regional Director

NORTH Dakota | Human Services

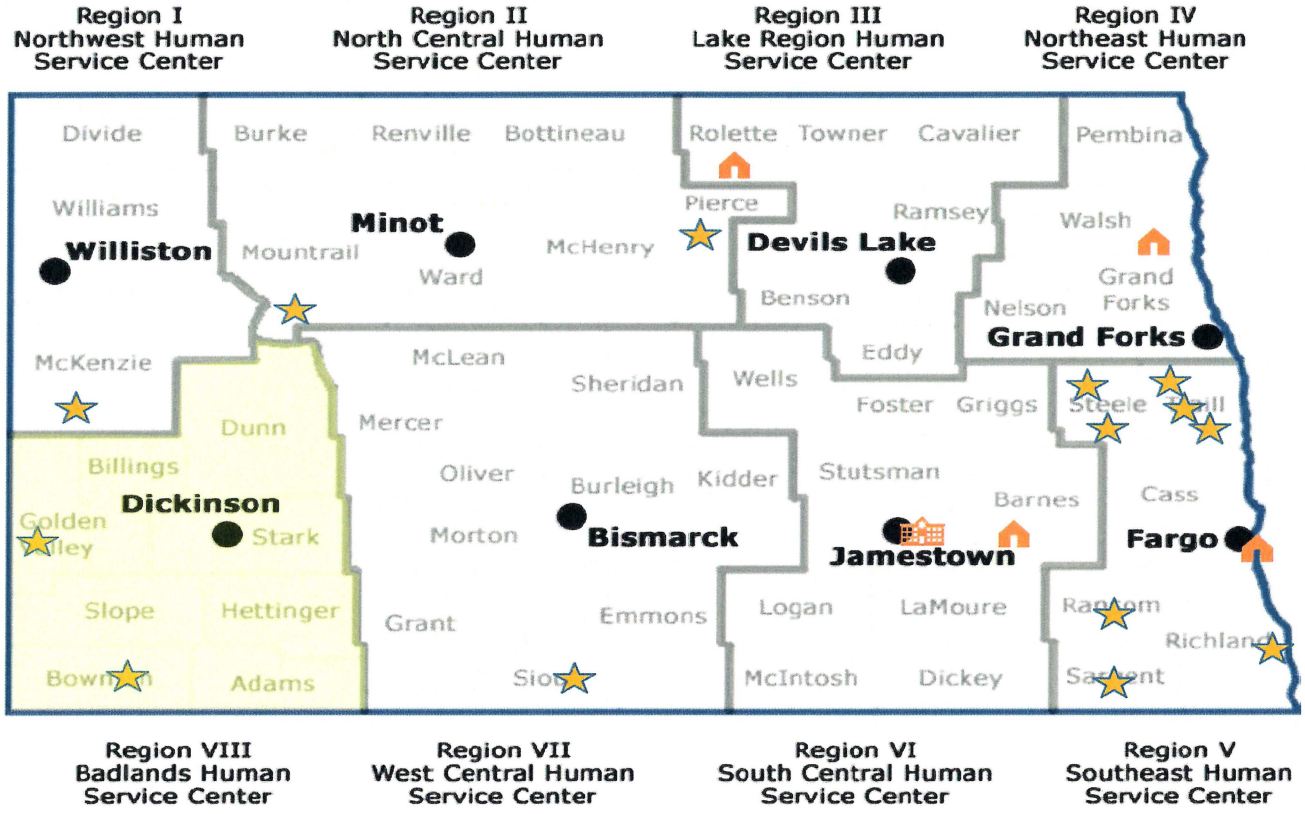
Be Legendary.™

Badlands Human Service Center
Region VIII



Public Behavioral Health System

- 8 Regional Human Service Centers
- 14 Outreach Offices
- 4 Satellite Clinics
- 1 North Dakota State Hospital



Department of Human Services

BLHSC

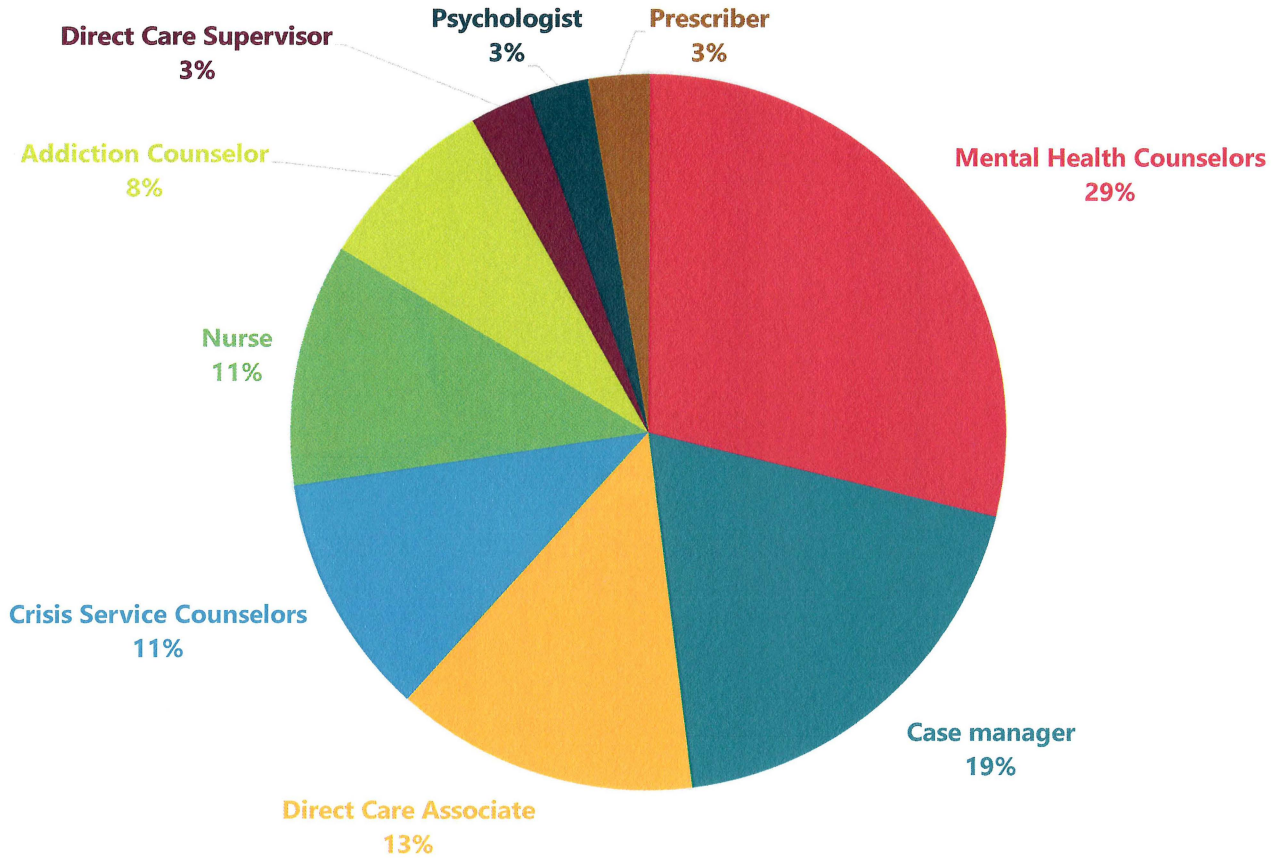
19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
				9%	Administration	5.5
80.75	60.00	60.00	7	8%	Client Facing Administration	5
				83%	Behavioral Health	49.5

COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

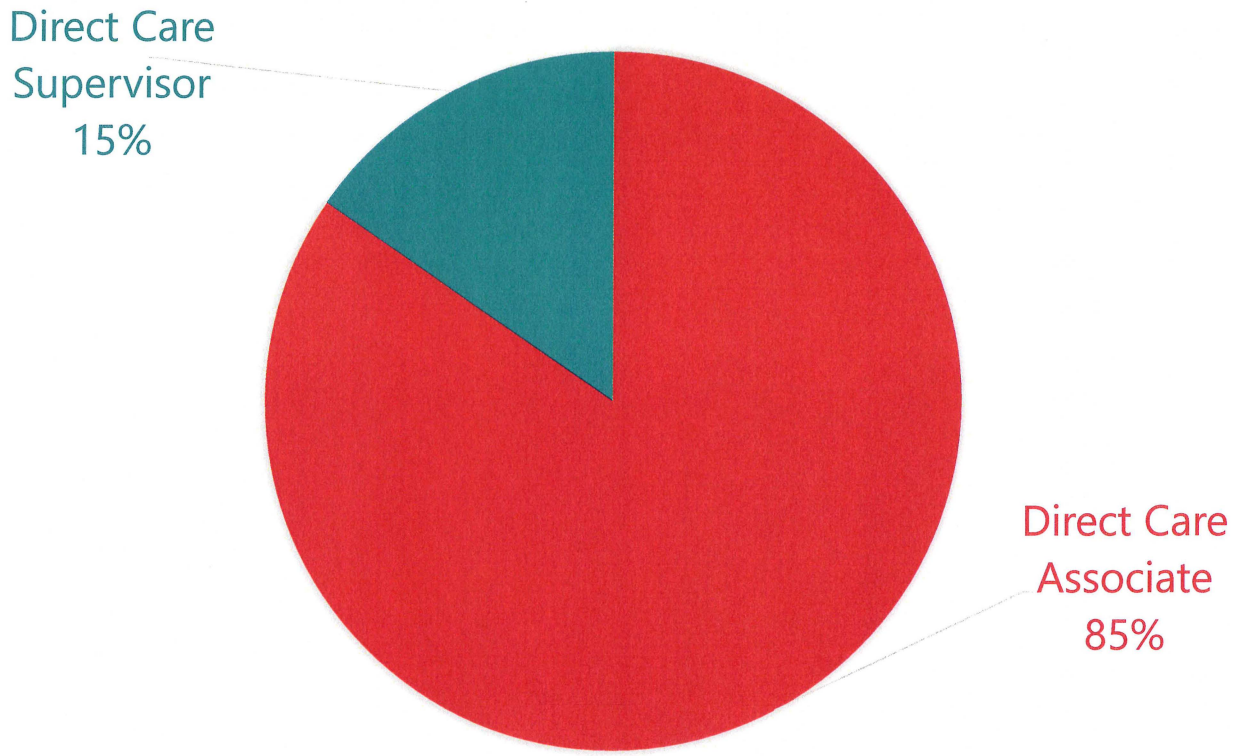
Telework Headcount	
Pre-COVID	Current
3	4.50

Badlands Human Service Center
Behavioral Health FTE Breakdown, HSC



Badlands Human Service Center

Behavioral Health FTE Breakdown, Residential Care Center



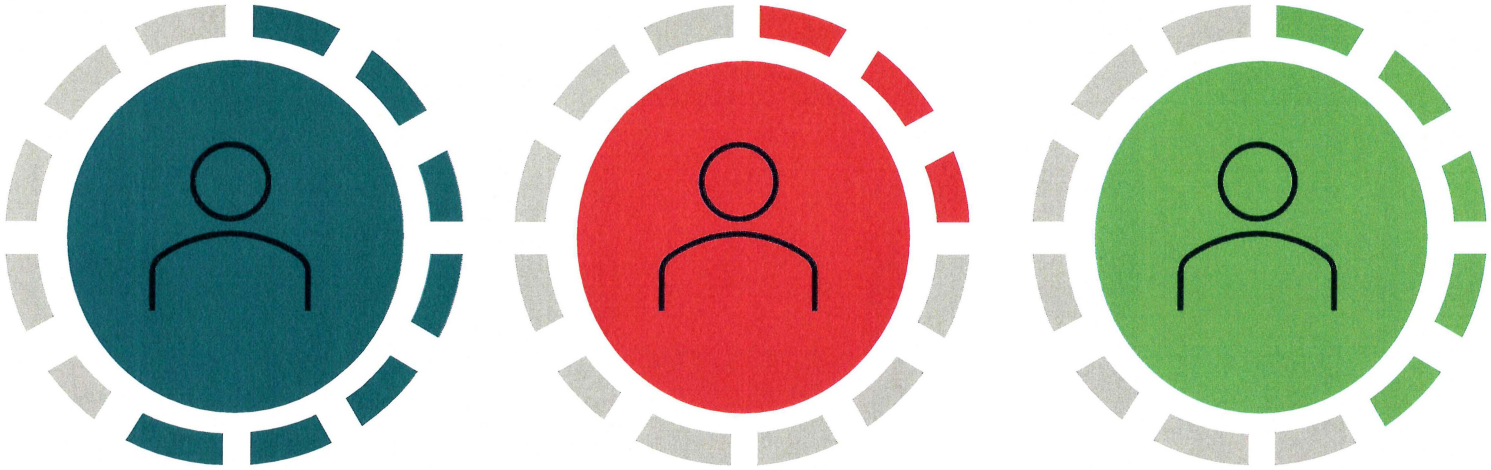
Badlands Human Service Center
Crisis Services Staffing

BLHSC	Filled	Vacant
New Crisis Staff FTE (4)	1	3
Existing Crisis Staff FTE	2	0

Badlands Human Service Center

Our Clients

The Badlands HSC provided services to 1,841 clients between March 2019 and Nov. 2020.



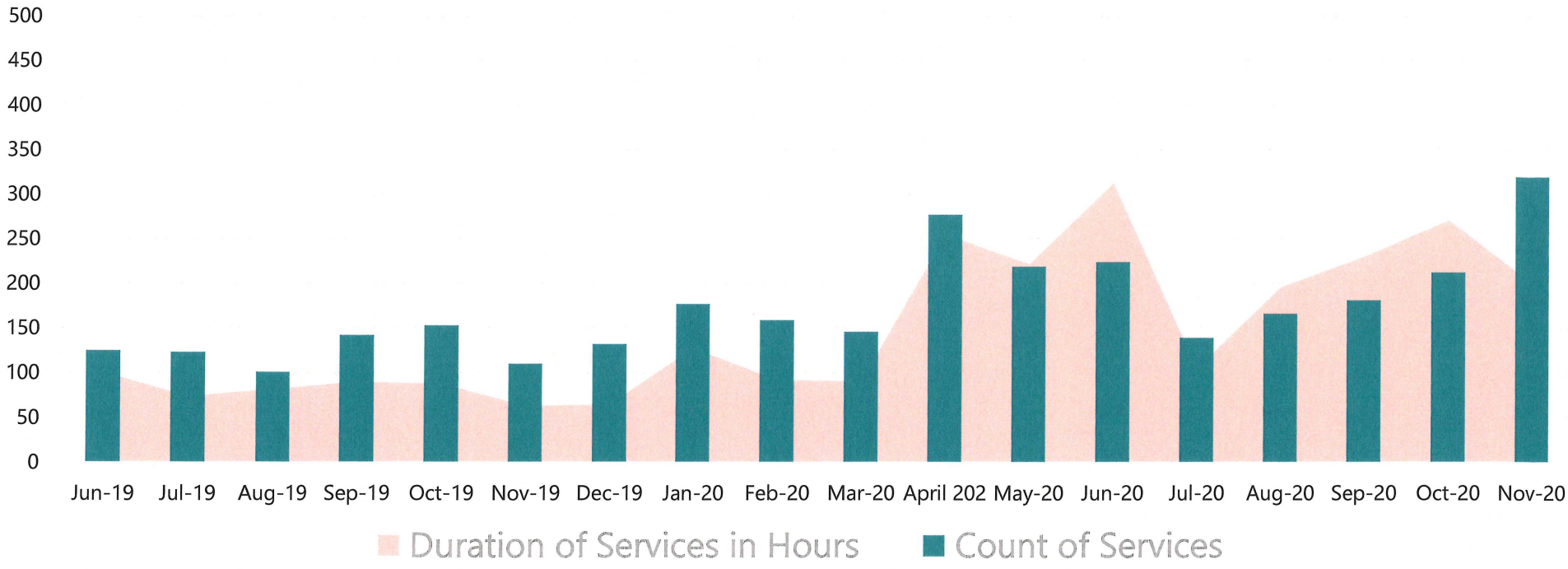
55% Serious Mental Illness (SMI) Primary Diagnosis

18% Substance Use Disorder (SUD) Primary Diagnosis

41% Co-Diagnosis of SUD and Mental Health Disorder

Badlands Human Service Center
Telehealth Services

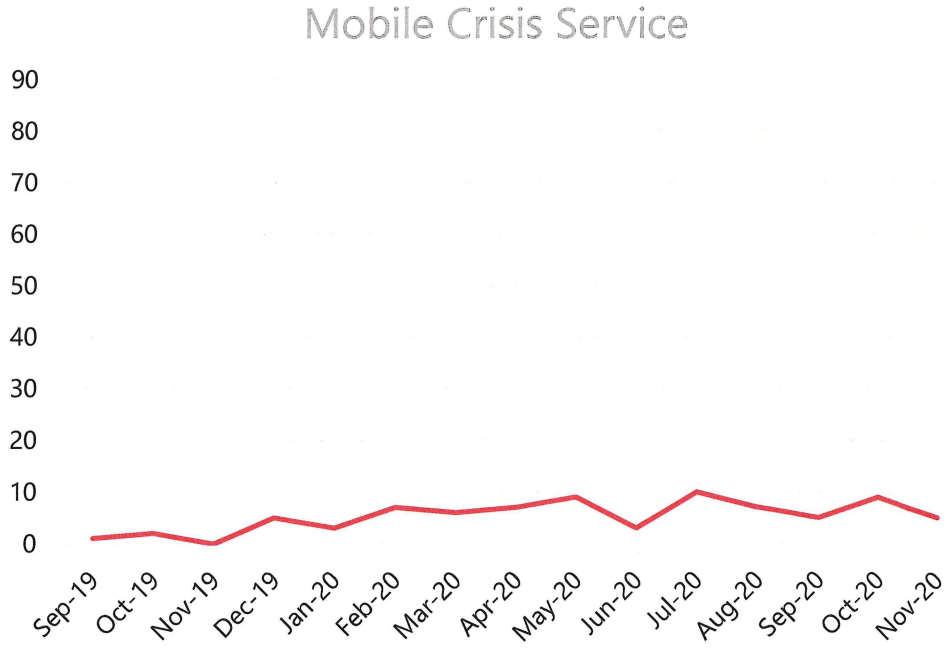
Badlands HSC transitioned quickly to provide telehealth services to clients during the COVID-19 pandemic to ensure continued necessary services while maintaining safety.



Badlands Human Service Center
Crisis Services

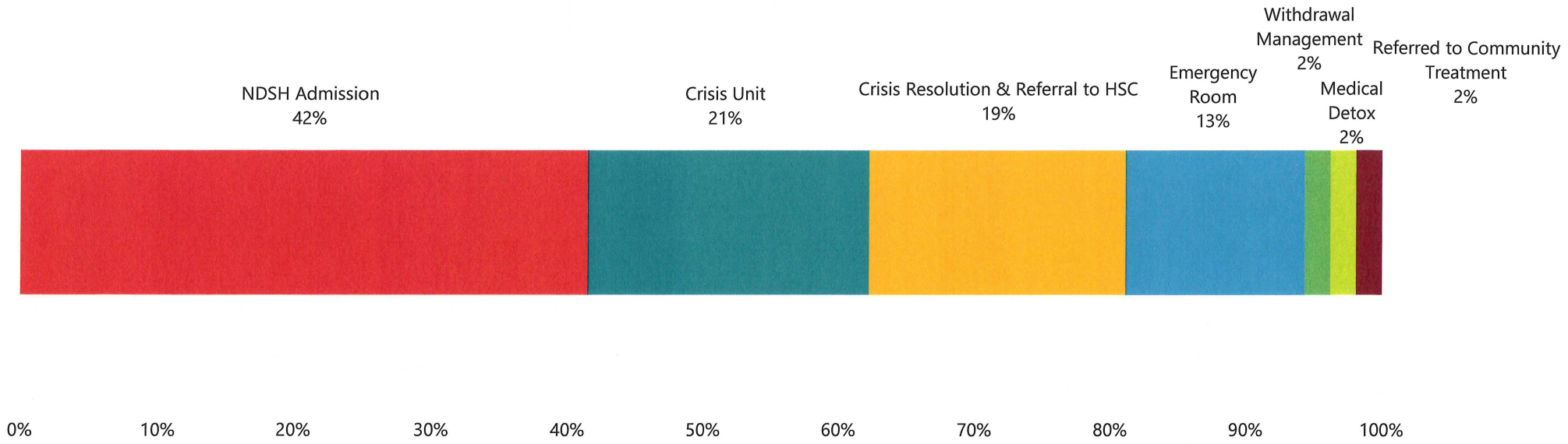
Badlands HSC provided 471 crisis services from September 2019 through November 2020.



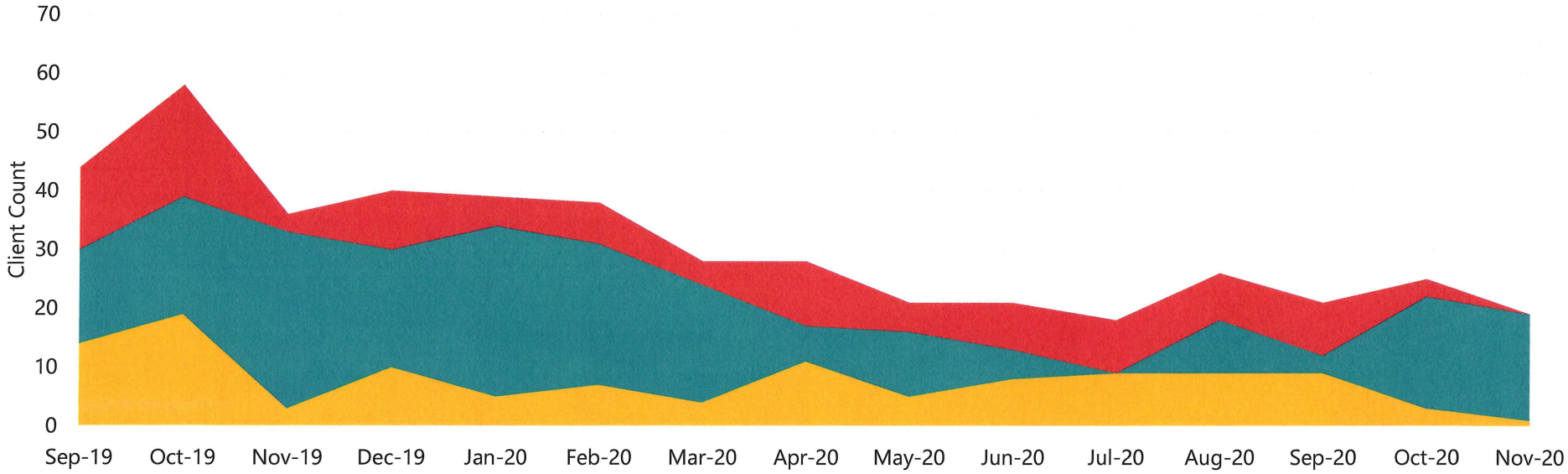


Badlands Human Service Center
Disposition following Screening and Triage of Crisis Services

Between September 2019 through November 2020, Badlands HSC triaged and screened 48 individuals for crisis services. Of those individuals, 82% were either referred to the North Dakota State Hospital, Crisis Unit, or Crisis Resolution and Referral of HSC.



Badlands Human Service Center
Open Access

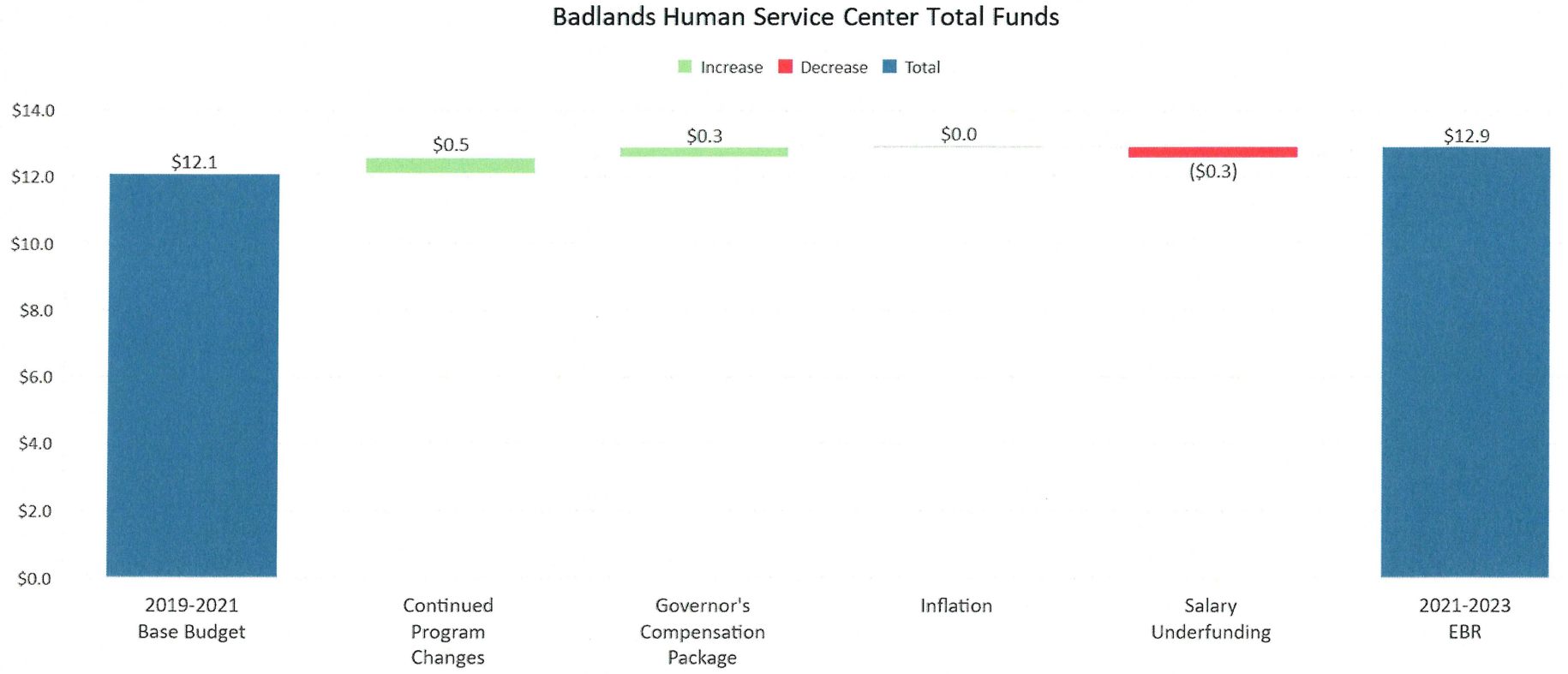


	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Assessed	44	58	36	40	39	38	28	28	21	21	18	26	21	25	19
Referred to HSC	30	39	33	30	34	31	24	17	16	13	9	18	12	22	19
Referred Out	14	19	3	10	5	7	4	11	5	8	9	9	9	3	1

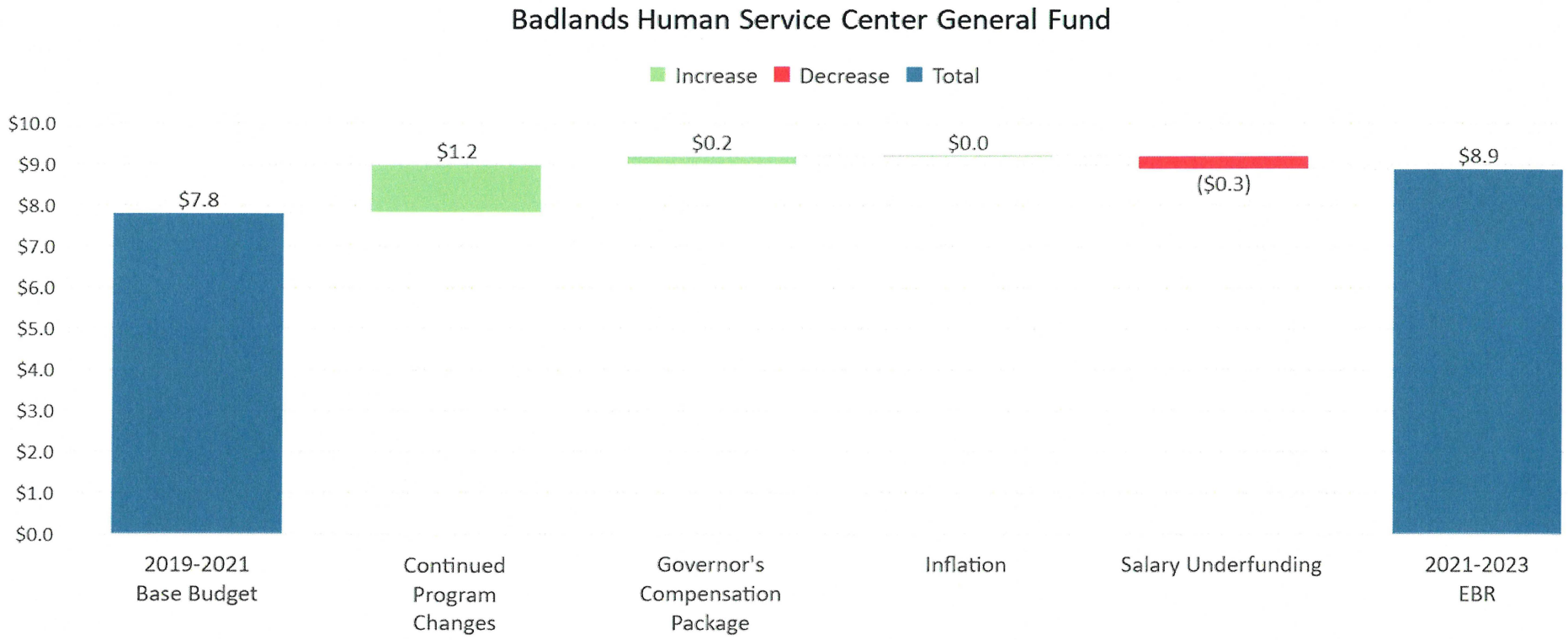
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	10,193,522	784,941	10,978,463
Operating	1,479,745	139,511	1,619,256
Grants	378,234	(88,183)	290,051
Total	12,051,501	836,268	12,887,769
General Fund	7,753,557	1,099,291	8,852,848
Federal Funds	2,671,537	(389,751)	2,281,786
Other Funds	1,626,407	126,728	1,753,135
Total	12,051,501	836,268	12,887,769
Full Time Equivalent (FTE)	60.00	(0.00)	60.00

Overview of Budget Changes (In Millions)



General Fund Changes (In Millions)



Overview Of Budget Changes By Expense Category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
51x Salary & Benefits	7,613,018	10,193,522	4,279,765	784,941	10,978,463
52x Travel	102,303	124,934	37,092	(4,934)	120,000
53x Supply	87,676	137,716	45,016	(12,629)	125,087
54x Postage & Printing	12,489	27,028	4,881	(7,878)	19,150
55x Equipment Under $5,000	8,482	7,000	4,408	(1,750)	5,250
56x Utilities	22,215	27,448	11,691	(448)	27,000
58x Rent/Leases - Bldg./Equip	746,083	989,971	372,980	(49,872)	940,099
59x Repairs	8,936	8,560	3,405	2,000	10,560
61x Professional Development	13,047	16,228	4,912	2,184	18,412
62x Fees - Operating & Professional	49,904	82,999	41,134	209,632	292,631
60x IT Expenses	57,685	57,861	27,744	3,205	61,066
71x Grants, Benefits, & Claims	278,522	378,234	109,751	(88,183)	290,051
Total	9,000,360	12,051,501	4,942,779	836,268	12,887,769

Overview Of Budget Changes By Funding Source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	4,738,342	7,753,557	4,124,958	1,099,291	8,852,848
Federal	2,895,312	2,671,537	375,994	(389,751)	2,281,786
Other	1,366,706	1,626,407	441,827	126,728	1,753,135
Total	9,000,360	12,051,501	4,942,779	836,268	12,887,769

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/19/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson called the meeting to order at 8:31 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Child Support Division
- Summary of Division Leases
- Green sheet walk through
- Budget changes
- Vocational Rehabilitation
- Aging Services
- Disability Determination Services

Jim Fleming, Division Director, DHS(8:32 am) testified about the Child Support Division #1694

Damian Schlinger, Division Director, DHS (9:12 am) testified about Vocational Rehabilitation Division #1697

Nancy Nikolas Maier, Division Director, DHS (10:06 am) testified about the Aging Services Division #1698

Sheri Seil, Director, DHS (10:58 am) testified about Disability Determination Services #1696

Julianne Horntvedt, Division Director, DHS (11:10 am) testified about the DD Council Division #1695

Chair Nelson close the meeting at 11:25 a.m.

Cole Fleck, Committee Clerk

HOUSE BILL 1012 #1694
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Child Support Division

Jim Fleming, Division Director

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Department of Human Services

Child Support

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
157.7	157.7	157.7	7.2	48%	Casework	75.9
				24%	Legal/policy	38.1
				22%	Customer Service	34.7
				6%	Admin	9

COVID INFO

We were able develop new processes for attorneys and case managers creating documents from home, including signatures, and coordinating with the office for printing and mailing. These processes will continue in the future.

Telework Headcount

Pre-COVID	Current
12	116

SUMMARY OF DIVISION LEASES

LOCATION	Street Address	City	Sq Ft	Rate/ Sq Ft	Total Cost	Term	Expires	Notes
Child Support - Bismarck	Rosser and 5th Street	Bismarck, ND 58501	7844	$ 17.25	$135,309.00	60 Months	6/30/2021	
Child Support - Devils Lake	1820 Walnut Street E,Suite 4	Devils Lake ND	4800	$ 11.50	$ 55,200.00	2 years	6/30/2021	1 of 2 renewals
Child Support - Dickinson	132 Sims Street, Suite 202	Dickinson, ND 58601	2158	$ 12.51	$ 26,996.58	5 years	6/30/2021	
Child Support - Fargo	4950 13th Avenue South	Fargo, ND	6021	$ 18.00	$108,378.00	120 Months	6/30/2023	5 year renewal option
Child Support - Grand Forks	3001 A 32nd Ave S Suite 3	Grand Forks, ND 58201	3900	$ 19.75	$ 77,025.00	77 months	11/30/2025	
Child Support - Jamestown	Lot 2 Block 1 Began's College Park	Jamestown, ND	2941	$ 10.00	$ 29,410.00	24 months	6/30/2021	
Child Support - Minot	325 28th Avenue SW, Suite C	Minot, ND 58703	4200	$ 16.10	$ 67,620.00	62 months	6/30/2020	5 year renwal option used
Child Support - Williston	206 E Broadway Suites 103 & 113	Williston, ND 58801	664	$ 7.80	$ 5,179.20	24 months	9/30/2022	
Child Support - Work Force Safety & Insurance	1600 East Century Avenue Suite 5 & 7	Bismarck, ND 58501	9251	$ 16.00	$148,016.00	2 years	6/30/2021	Unlimited renewals

These leases have been terminated or have not been budgeted in the 21-23 executive budget request

These leases do not expire at the end of the biennium

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	General Fund	Other Funds	Total
Child Support				
Continued program changes		36,397	(91,785)	(55,388)
Savings plan		(103,906)	(357,788)	(461,694)
Total Child Support	-	(67,509)	(449,573)	(517,082)

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	15,899,350	16,672,998	8,229,562	1,086,600	17,759,598
512x Salaries - Other	-	-	-	-	-
513x Salaries - Temp	41,563	78,096	47,103	3,824	81,920
514x Salaries - Over Time	22,577	-	31,359	-	-
516x Salaries - Benefits	7,802,688	9,002,375	4,213,361	160,253	9,162,628
Total Salaries & Benefits	**23,766,178**	**25,753,469**	**12,521,385**	**1,250,677**	**27,004,146**
52x Travel	103,925	86,090	30,887	(51,250)	34,840
53x Supply	113,208	99,584	55,537	(9,795)	89,789
54x Postage & Printing	310,619	335,016	148,206	(40,814)	294,202
55x Equipment Under $5,000	55,559	9,775	9,775	(775)	9,000
57x Insurance	344	975	533	25	1,000
58x Rent/Leases - Bldg./Equip	1,283,361	1,363,075	635,748	(456,401)	906,674
59x Repairs	75,595	87,018	33,214	(17,330)	69,688
61x Professional Development	43,565	20,542	5,129	(1,432)	19,110
62x Fees - Operating & Professional	1,484,956	1,951,443	517,535	117,655	2,069,098
60x IT Expenses	88,953	98,520	33,052	(56,965)	41,555
Total Operating	**3,560,085**	**4,052,038**	**1,469,616**	**(517,082)**	**3,534,956**
Total	**27,326,263**	**29,805,507**	**13,991,001**	**733,595**	**30,539,102**

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ 7,521,591	$ 8,088,500	$ 4,049,365	$ 117,317	$ 8,205,817
FEDERAL	$ 16,568,331	$ 17,605,475	$ 8,445,716	$ 704,203	$ 18,309,678
OTHER	$ 3,236,341	$ 4,111,532	$ 1,495,920	$ (87,925)	$ 4,023,607
Total	$ 27,326,263	$ 29,805,507	$ 13,991,001	$ 733,595	$ 30,539,102

HOUSE BILL 1012 #1697
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Vocational Rehabilitation Division

Damian Schlinger, Division Director

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Department of Human Services
Leases/Building Rent
For the 2019-2021 Biennium

	STATE OWNED BUILDINGS								
	LOCATION	Street Address	City	Sq Ft	Rate/ Sq Ft	Total Cost			
	Judicial Wing - Capitol (Pay federal portion only)	600 E Boulevard Ave	Bismarck ND 58501	30,041	14.38	431,989.58			
	SEHSC	2624 9th Ave S	Fargo ND 58103			-			
	State Hospital	2605 Circle Dr	Jamestown ND 58401			-			
	Life Skills & Transition Center	701 W 6th St	Grafton ND 58237			-			
	Life Skills & Transition Center - NEHSC	701 W 6th St	Grafton ND 58237	9,434					
	Telecommute					-			
	NON-STATE BUILDINGS								
	LOCATION	Street Address	City	Sq Ft	Rate/ Sq Ft	Total Cost	Term	Expires	Notes
*	DHS North - HD Partners	3451 North 14th	Bismarck, ND 58501	24,000	8.84	212,160.00	48 Months	6/30/2020	1st of 5 renewals
	Central Office - Job Service Building	1000 E Divide Avenue	Bismarck, ND 58501	10,710	15.00	160,650.00	27 months	6/30/2022	5 year renewal option
	Central Office/WCHSC - Prairie Hills Plaza	1237 W Divide Avenue	Bismarck, ND 58501	64,286	17.41	1,119,374.00	2 years	6/30/2021	On 8th of 10 renewals
*	Child Support - Bismarck	Rosser and 5th Street	Bismarck, ND 58501	7,844	17.25	135,309.00	60 Months	6/30/2021	
	Child Support - Devils Lake	1820 Walnut Street E,Suite 4	Devils Lake ND	4,800	11.50	55,200.00	2 years	6/30/2021	1 of 2 renewals
*	Child Support - Dickinson	132 Sims Street, Suite 202	Dickinson, ND 58601	2,158	12.51	26,996.58	5 years	6/30/2021	
	Child Support - Fargo	4950 13th Avenue South	Fargo, ND	6,021	18.00	108,378.00	120 Month	6/30/2023	5 year renewal option
	Child Support - Grand Forks	3001 A 32nd Ave S Suite 3	Grand Forks, ND 58201	3,900	19.75	77,025.00	77 months	11/30/2025	
*	Child Support - Jamestown	Lot 2 Block 1 Began's College Park	Jamestown, ND	2,941	10.00	29,410.00	24 months	6/30/2021	
*	Child Support - Minot	325 28th Avenue SW, Suite C	Minot, ND 58703	4,200	16.10	67,620.00	62 months	6/30/2020	5 year renwal option used
	Child Support - Williston	206 E Broaddway Suites 103 & 113	Williston, ND 58801	664	7.80	5,179.20	24 months	9/30/2022	
	Child Support - Work Force Safety & Insurance	1600 East Century Avenue Suite 5 & 7	Bismarck, ND 58501	9,251	16.00	148,016.00	2 years	6/30/2021	Unlimited renewals
*	Economic Assistance - Fritel Enterprise	208 Main Street	Rolette, ND	208	14.42	2,999.36	24 months	1/31/2022	1 of 1 renewal
*	Economic Assistance - Fritel Enterprise	302 Main Street Suite 103	Elgin ND 58533	108	60.00	6,480.00	12 months	10/31/2020	
*	Economic Assistance - Towner Health & Wellness	2 3rd Avenue SW	Towner, ND 58788	94	31.91	2,999.54	24 months	12/31/2020	1 of 2 renewals
	NWHSC - Gray Building (Outreach)	109 5th Street SW	Watford City, ND	336	17.86	6,000.96	2 years	6/30/2021	3rd of 5 renewals
	NWHSC - Metro 316	316 2nd Avenue West	Williston, ND 58801	28,579	16.48	470,981.92	2 years	6/30/2023	
	NCHSC - Ortorro (Open Arms)	18 3rd St SE, Suite 300	Minot, ND 58701	3,121	14.23	44,411.83	2 years	6/30/2021	1st of 6 renewals
	NCHSC - Mountrail	228 Eagle Drive	New Town ND 58763	215	5.58	1,200.00	2 years	6/30/2021	5 24 month renewals
	NCHSC - Rugby (Outreach)	126 2nd Aveune	Rugby, ND 58368	950	9.48	9,006.00	30 months	6/30/2021	4 of 5 renewals
	NCHSC - Minot Town & Country Investors	1050 South Broadway	Minot, ND 58701	50,911	10.82	550,857.02	2 years	6/30/2021	5 24 month renewals
	NEHSC - Grand Forks County Commission	151 South 4th Street	Grand Forks, ND 58201	40,040	14.34	574,173.60	24 months	6/30/2021	9 24 month renewals
	NEHSC - Grand Forks Housing Authority - Ruth Meier	770 S 14th St,	Grand Forks, ND 58201	9,352	11.04	103,246.08	24 months	6/30/2021	5 of 5 renewals
	NEHSC - Job Service (VR)	1501 29th Avenue South	Grand Forks, ND 58201	3,306	9.00	29,754.00	25 months	6/30/2021	0 of 4 renewal options
	SEHSC - Capital Building Four (VR)	1655 43rd St South	Fargo, ND	6,450	19.93	128,548.50	2 years	6/30/2021	2nd of 10 renewals
	SEHSC - Carlson Properties (MFP/Aging/CFS)	1401 32nd St South	Fargo, ND	1,882	13.90	26,159.80	24 months	6/30/2021	4th of 5 renewals
	SEHSC - Dakota Pioneer (contracted)	631 1st Avenue North	Fargo, ND	2,043	10.54	21,533.22	24 months	6/30/2021	1 of 5 renewals
	SEHSC - Liffrig Family Investments (Off Main)	1122 1st Avenue North	Fargo, ND	7,875	13.25	104,343.75	2 years	6/30/2021	7 of 10 renewals
*	SEHSC - Liffrig Family Investments (Off Main)	1122 1st Avenue North	Fargo, ND	1,254	12.36	15,499.44	14 Months	6/30/2021	1 of 5 renewals
	LRHSC - Hamilton Enterprise Central	200 Hwy 2 SW	Devils Lake ND	18,236	13.00	237,068.00	118 month	6/30/2023	
	LRHSC - Job Service (VR)	301 South College Drive	Devils Lake ND	950	0.57	541.50	25 Months	6/30/2021	0 of 4 renewal options
	LRHSC - Paul Munro (Outreach)	1102 Main Avenue West	Rolla, ND	5,060	13.67	69,170.20	2 years	6/30/2023	
	SCHSC - City/County Health District (Outreach)	415 2nd Avenue	Valley City, ND	1,749	9.00	15,737.67	13 months	6/30/2021	1st of 5 renewals
	SCHSC - N & F Construction	520 3rd Street NW	Jamestown, ND	27,577	10.37	285,973.49	2 years	6/30/2021	8 of 9 renewals
	BLHSC - Golden Valley/Billings County Social Services (Outreach)	67 1st SE	Beach, ND 58621	1,721	0.87	1,500.00	24 months	6/30/2021	3rd of 5 renewals
	BLHSC - KD Builders (VR)	1674 15th Street West	Dickinson, ND 58601	2,022	16.00	32,352.00	5 years	6/30/2023	1 of 1 five year renewals
	BLHSC - Community Action Partnership	990 3rd Ave W	Dickinson, ND 58601	320	13.45	4,304.00	24 months	6/30/2021	4 of 5 renewals
	BLHSC - Driscoll Services LLC	1463 I-94 Business Loop	Dickinson, ND 58601	24,000	14.83	355,920.00	6 years	6/30/2026	1 additional 6 year term and 5 - 2 year renewals

* These leases are no longer active

LEASE SUMMARY – VR SPECIFIC

Office	Total Sq Ft	Per Sq Ft Per Annum	Per Annum	Per Month	Location	Term
Williston	2,078.24	$ 18.04	$ 37,491.45	$ 3,124.29	Co-located w/HSC	6/30/2023
Minot	5,661.00	$ 11.63	$ 65,837.43	$ 5,486.45	Co-located w/HSC	6/30/2021
Devils Lake	1,397.00	$ 9.00	$ 12,573.00	$ 1,047.75	Co-located w/Job Svc	6/30/2021
Grand Forks	3,306.00	$ 11.00	$ 36,366.00	$ 3,030.50	Co-located w/Job Svc	6/30/2021
Fargo	6,450.00	$ 20.53	$ 132,418.50	$ 11,034.88	Not co-located	6/30/2021
Jamestown	2,711.62	$ 11.88	$ 32,214.05	$ 2,684.50	Co-located w/HSC	6/30/2021
Bismarck	5,336.00	$ 19.10	$ 101,917.60	$ 8,493.13	Co-located w/HSC	6/30/2021
Dickinson	2,022.00	$ 16.00	$ 32,352.00	$ 2,696.00	Not co-located	6/30/2023
State Office	3,337.24	$ 15.00	$ 50,058.60	$ 4,171.55	Co-located w/Job Svc	6/30/2022
All leases have 30 day opt-out clause if legislature alters funding, except Dickinson (federal dollars)						

1915I

Eligibility

1. Individuals of any age (VR would start with those 14 and older, at least 9th grade)
2. Medicaid or Medicaid Expansion eligible
3. Will receive services in their home or community not in an institution
4. Diagnosis of mental illness, substance use disorder, traumatic brain injury (excluding intellectual or developmental disability)
5. Functional impairment requirement/impact on daily living (WHODAS)

Services Specific to VR (of the 12 possible services)

1. Benefits Planning Services
2. Pre-Vocational Training
3. Supported Employment
4. Supported Education

STATE PLAN FOR INDEPENDENT LIVING

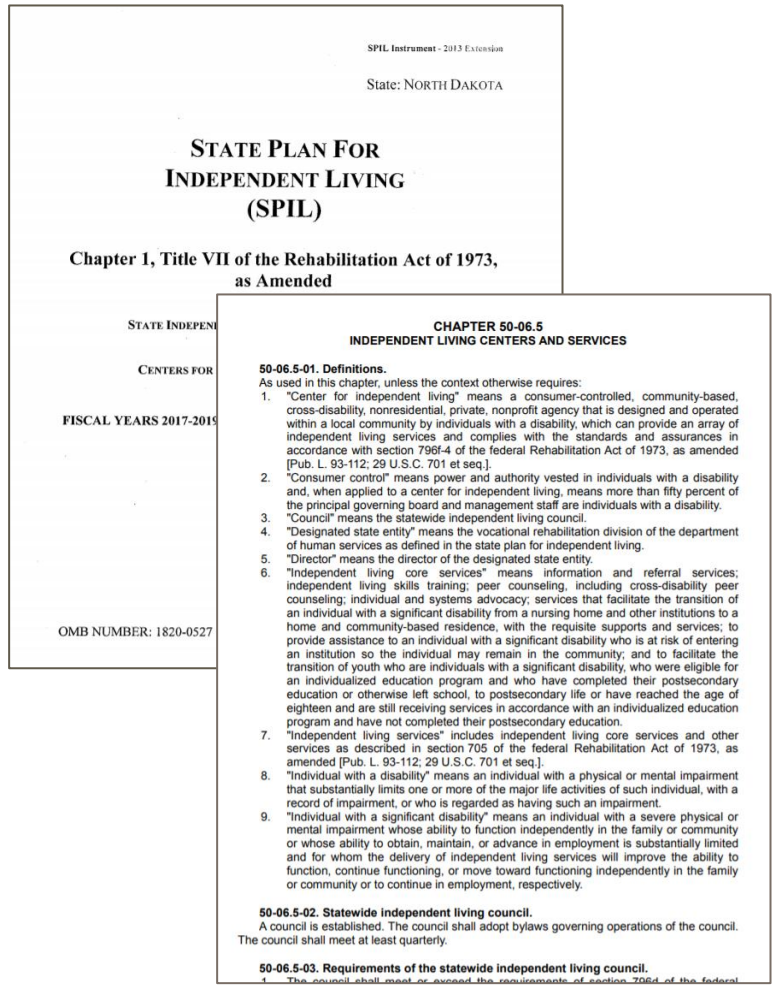
- ND receives approx. $663,808 from the federal Administration for Community Living (ACL) to support independent living services each biennium
- In the past, ND appropriated the $73,756 required match plus $1,675,406 of general funds for a total of approximately $1,749,162 each biennium
- Title VII Funds go directly to Centers for Independent Living
- Outcomes defined in SPIL (3-year renewal)

Dakota
Center for Independent Living

Freedom
Resource Center for Independent Living

Independence, Inc.
A Resource Center for Independent Living

Options
Resource Center for Independent Living



SPIL Instrument - 2013 Extension

State: NORTH DAKOTA

STATE PLAN FOR INDEPENDENT LIVING (SPIL)

Chapter 1, Title VII of the Rehabilitation Act of 1973, as Amended

STATE INDEPEN

CENTERS FOR

FISCAL YEARS 2017-2019

OMB NUMBER: 1820-0527

CHAPTER 50-06.5
INDEPENDENT LIVING CENTERS AND SERVICES

50-06.5-01. Definitions.
As used in this chapter, unless the context otherwise requires:

1. "Center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential, private, nonprofit agency that is designed and operated within a local community by individuals with a disability, which can provide an array of independent living services and complies with the standards and assurances in accordance with section 796f-4 of the federal Rehabilitation Act of 1973, as amended [Pub. L. 93-112; 29 U.S.C. 701 et seq.].
2. "Consumer control" means power and authority vested in individuals with a disability and, when applied to a center for independent living, means more than fifty percent of the principal governing board and management staff are individuals with a disability.
3. "Council" means the statewide independent living council.
4. "Designated state entity" means the vocational rehabilitation division of the department of human services as defined in the state plan for independent living.
5. "Director" means the director of the designated state entity.
6. "Independent living core services" means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; individual and systems advocacy; services that facilitate the transition of an individual with a significant disability from a nursing home and other institutions to a home and community-based residence, with the requisite supports and services; to provide assistance to an individual with a significant disability who is at risk of entering an institution so the individual may remain in the community; and to facilitate the transition of youth who are individuals with a significant disability, who were eligible for an individualized education program and who have completed their postsecondary education or otherwise left school, to postsecondary life or have reached the age of eighteen and are still receiving services in accordance with an individualized education program and have not completed their postsecondary education.
7. "Independent living services" includes independent living core services and other services as described in section 705 of the federal Rehabilitation Act of 1973, as amended [Pub. L. 93-112; 29 U.S.C. 701 et seq.].
8. "Individual with a disability" means an individual with a physical or mental impairment that substantially limits one or more of the major life activities of such individual, with a record of impairment, or who is regarded as having such an impairment.
9. "Individual with a significant disability" means an individual with a severe physical or mental impairment whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited and for whom the delivery of independent living services will improve the ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment, respectively.

50-06.5-02. Statewide independent living council.
A council is established. The council shall adopt bylaws governing operations of the council. The council shall meet at least quarterly.

50-06.5-03. Requirements of the statewide independent living council.

Department of Human Services

Vocational Rehabilitation

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
10.0	85.0	85.0	0	47%	VR Counselors	40
				21%	Client Supportive Services	18
				13%	Support Staff	11
				19%	Administration	16

COVID INFO

- **Worked quickly to identify innovations and make better use of technology (i.e. new employee training, communications, etc.)**
- **Challenges with locating students with shifting school formats (online, hybrid, etc.)**

Telework Headcount

Pre-COVID	Current
0	28

GREEN SHEET WALKTHROUGH GF/FTE

	EBR			
	FTE Positions	**General Fund**	**Other Funds**	**Total**
Vocational Rehabilitation				
Continued program changes		(416,293)	(381,081)	(797,374)
Agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Subtotal Vocational Rehabilitation	**-**	**(2,220,247)**	**(472,081)**	**(2,692,328)**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	8,419,629	9,159,399	4,310,952	652,652	9,812,051
512x Salaries - Other	-	-	-	-	-
513x Salaries - Temp	17,494	25,920	-	-	25,920
514x Salaries - Over Time	9	-	-	-	-
516x Salaries - Benefits	4,037,531	4,915,733	2,210,386	34,812	4,950,545
Total Salaries & Benefits	**12,474,663**	**14,101,052**	**6,521,338**	**687,464**	**14,788,516**
52x Travel	186,830	389,319	121,591	(23,816)	365,503
53x Supply	84,143	84,312	21,900	23,860	108,172
54x Postage & Printing	49,774	65,799	23,878	(9,500)	56,299
55x Equipment Under $5,000	235,432	9,965	9,058	-	9,965
56x Utilities	5,983	6,900	2,804	-	6,900
57x Insurance	-	-	-	-	-
58x Rent/Leases - Bldg./Equip	770,958	695,963	334,722	8,668	704,631
59x Repairs	13,810	12,592	9,791	(3,818)	8,774
61x Professional Development	135,366	354,924	105,959	48,594	403,518
62x Fees - Operating & Professional	6,190,449	5,912,761	2,902,047	(188,674)	5,724,087
67x Non Operating Expenses	-	-	-	-	-
60x IT Expenses	7,229	688	-	-	688
Total Operating	**7,679,974**	**7,533,223**	**3,531,750**	**(144,686)**	**7,388,537**
68x Land, Building, Other Capital	-	-	-	-	-
69x Equipment Over $5,000	-	-	-	-	-
Total Capital/Equipment over 5,000	-	-	-	-	-
71x Grants, Benefits, & Claims	7,732,053	10,218,764	3,965,406	(1,867,494)	8,351,270
72x Transfers	-	-	-	-	-
Total Grants	**7,732,053**	**10,218,764**	**3,965,406**	**(1,867,494)**	**8,351,270**
Total	27,886,690	31,853,039	14,018,494	(1,324,716)	30,528,323

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	14,551,077	9,308,268	8,187,666	(2,024,678)	7,283,590
Federal	13,251,493	22,370,770	5,800,293	678,961	23,049,731
Other	84,120	174,001	30,535	21,001	195,002
Total	27,886,690	31,853,039	14,018,494	(1,324,716)	30,528,323

GRANTS NOT-ON-A WALKTHROUGH

Vocational Rehabilitation - 2021-23 Biennium Budget

Budget Account Code 712000 - Grants, Benefits, and Claims

		$10,218,764	**$8,351,270**	**$1,619,305**	**$6,595,833**	**$136,132**
Vendor	**Description**	**2019-21 Biennium Amount**	**2021-23 Biennium Amount**	**General Fund**	**Federal Funds**	**Other Funds**
Various vendors	Older blind consumer purchases	161,326	161,326	100,006	61,320	
Randolph Sheppard Vendords	Pass-through to Randolph Sheppard vendors	150,000	124,000			124,000
Various vendors	Case services to consumers	6,661,031	6,661,031	1,418,800	5,242,231	
Various vendors	Supported employment services	633,333	633,333	85,120	548,213	
Independent Living centers	Independent living services	2,413,074	731,580	9,443	722,137	
Various vendors	Mobility impaired parking tickets	-	40,000	5,936	21,932	12,132
Bottineau Winter Park	Winter Park activities for individuals with disabilities	200,000	-			

HOUSE BILL 1012 #1698
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Aging Services Division

Nancy Nikolas-Maier, Division Director

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Department of Human Services

Aging Services

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
25.50	44	44	0	35%	Program & Policy (Admin, MFP)	15.5
				22%	Vulnerable Adult Protective Services	9.75
				43%	Ombudsman, RASPAs, ADRL Intake	18.75

COVID INFO

Aging Services has implemented workflow automation solutions which allows staff to work from home, both during COVID and into the future.

Telework Headcount	
Pre-COVID	Current
2	43

GREEN SHEET WALKTHROUGH GF/FTE

	EBR			
	FTE Positions	**General Fund**	**Other Funds**	**Total**
Aging Services				
Continued program changes		126,302	2,384,246	2,510,548
Agency savings plan		(248,240)	(163,425)	(411,665)
Subtotal Aging Services	**-**	**(121,938)**	**2,220,821**	**2,098,883**

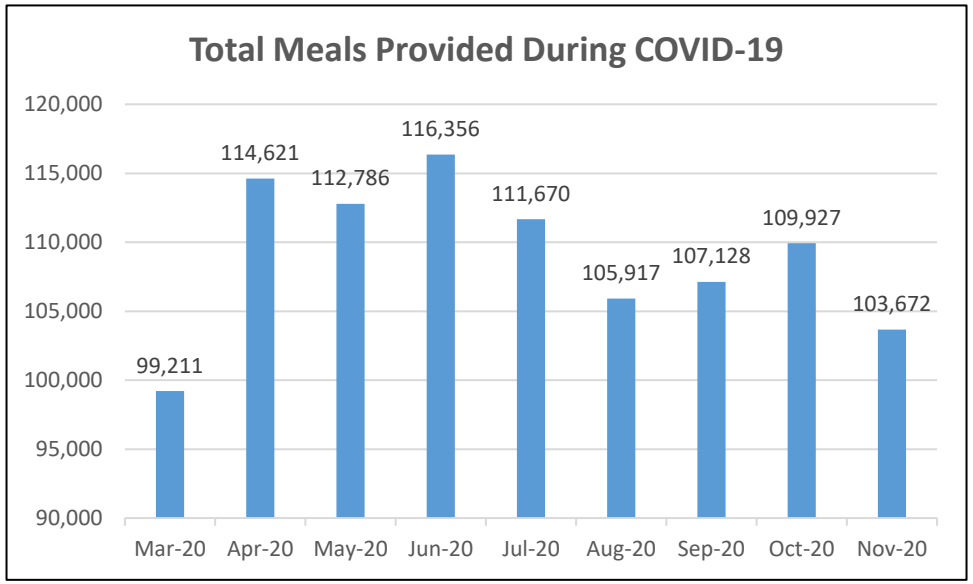
OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

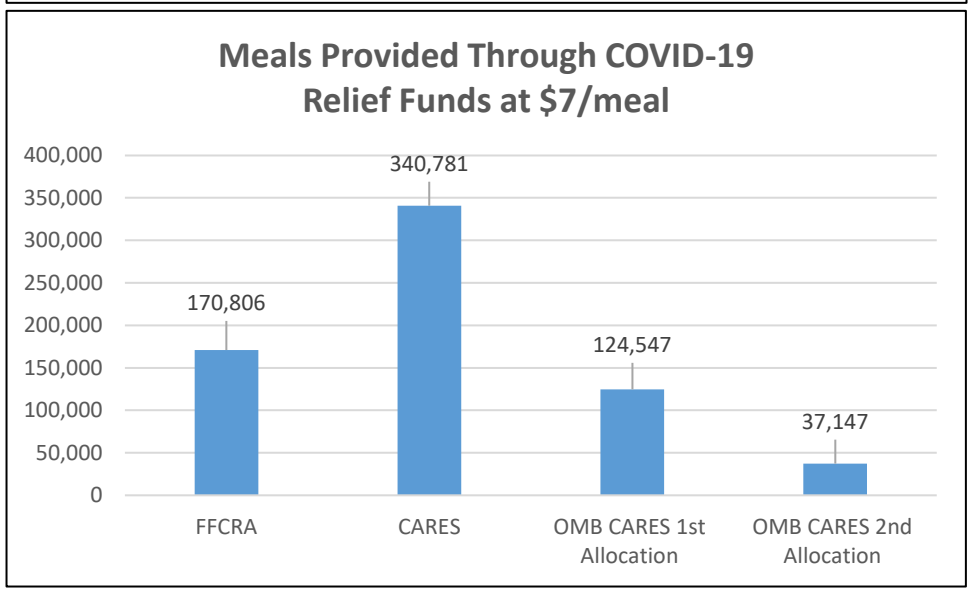
Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	4,324,999	5,028,525	2,411,252	731,115	5,759,640
512x Salaries - Other	-	-	-	-	-
513x Salaries - Temp	-	-	-	110,082	110,082
514x Salaries - Over Time	-	-	-	-	-
516x Salaries - Benefits	1,928,065	2,503,471	1,107,586	274,145	2,777,616
Total Salaries & Benefits	**6,253,064**	**7,531,996**	**3,518,838**	**1,115,342**	**8,647,338**
52x Travel	102,943	125,958	47,297	(3,337)	122,621
53x Supply	5,760	10,918	3,761	-	10,918
54x Postage & Printing	10,740	11,273	5,952	-	11,273
55x Equipment Under $5,000	356	750	749	-	750
56x Utilities	-	-	-	-	-
57x Insurance	-	3,300	-	-	3,300
58x Rent/Leases - Bldg./Equip	147,208	131,846	75,884	(70,262)	61,584
59x Repairs	-	-	-	-	-
61x Professional Development	29,666	31,088	31,088	10,450	41,538
62x Fees - Operating & Professional	18,289,631	20,189,065	8,295,081	1,241,786	21,430,851
67x Non Operating Expenses	-	-	-	-	-
60x IT Expenses	2,167	3,000	1,058	-	3,000
Total Operating	**18,588,471**	**20,507,198**	**8,460,870**	**1,178,637**	**21,685,835**
68x Land, Building, Other Capital	-	-	-	-	-
69x Equipment Over $5,000	-	-	-	-	-
Total Capital/Equipment over 5,000	-	-	-	-	-
71x Grants, Benefits, & Claims	2,962,347	2,929,106	1,876,159	944,105	3,873,211
72x Transfers	104,157	245,996	40,560	386	246,382
Total Grants	**3,066,504**	**3,175,102**	**1,916,719**	**944,491**	**4,119,593**
Total	27,908,039	31,214,296	13,896,427	3,238,470	34,452,766

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ 10,028,204	$ 12,128,232	$ 5,298,412	$ 297,546	$ 12,425,778
FEDERAL	$ 16,302,449	$ 18,109,325	$ 8,203,381	$ 3,171,725	$ 21,281,050
OTHER	$ 1,577,386	$ 976,739	$ 394,634	$ (230,801)	$ 745,938
Total	**$ 27,908,039**	**$ 31,214,296**	**$ 13,896,427**	**$ 3,238,470**	**$ 34,452,766**

COVID-19 Impact on Nutrition Services





- Since the beginning of the pandemic, seen an increase in the number of meals provided to older adults in the community.
  - At the start of pandemic, meals were split between Congregate Meals and Home-Delivered Meals.
  - After COVID-19, most meals became Home-Delivered. COVID-19 relief funding from the ACL and OMB was provided to meet demand.
- As of Nov. 2020, 981,288 meals were provided.
  - 673,281 were funded by COVID-19 relief funding at a rate of $7/meal.
    - These pandemic response funds were depleted through Nov. 2020.
  - 308,007 were provided at the regular rate of $4.60/meal.

Connection Carts

Reduce Social Isolation of LTC Residents

- Partnership ND Assistive
- Equipment provided 100 facilities
  - Nursing Home
  - Basic Care
  - Assisted Living

Funding Source	Amount
Ombudsman Cares	89,250
ADRL Grant	55,454
OMB Cares Relief	100,000
Total Contract Cost	244,704



HOUSE BILL 1012 #1696
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Disability Determination Services

Sheri Seil, Director

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Department of Human Services

Disability Determination Services

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
23	23	23	3	61%	Claims Analyst	14
				17%	Management	4
				14%	Administrative	3
				4%	CDI Management	1
				4%	Systems Admin	1

COVID INFO

- SSA requires dedicated space for network and IT equipment- DDS staff cannot use hoteling space.
- We do have some hybrid employees who must go to the office to work paper claims.
- We have administrative support staff at the office everyday handling mail.
- SSA has not allowed automation of our procedures, so we are required to still print and mail documents and communications to claimants.

Telework Headcount

Pre-COVID	Current
0	19

GRANTS NOT ON A WALKTHROUGH

Vendor	Description	2019-21 Biennium Amount	2021-23 Biennium Amount	General Fund	Federal Funds	Other Funds
Various vendors	Consultative exams & medical records for DDS claims	1,970,000	1,650,000		1,650,000	

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	2,207,649	2,651,687	1,146,559	124,300	2,775,987
513x Salaries - Temp	42,352	33,744	24,783	(33,744)	-
514x Salaries - Over Time	1,497	17,832	385	(17,832)	-
516x Salaries - Benefits	1,014,560	1,280,725	541,061	91,701	1,372,426
Total Salaries & Benefits	**3,266,058**	**3,983,988**	**1,712,788**	**164,425**	**4,148,413**
52x Travel	25,791	60,927	5,387	(32,927)	28,000
53x Supply	7,556	13,000	4,636	(1,120)	11,880
54x Postage & Printing	59,152	65,000	23,317	5,000	70,000
55x Equipment Under $5,000	2,258	17,000	13,469	-	17,000
58x Rent/Leases - Bldg./Equip	317,215	341,573	170,844	11,299	352,872
59x Repairs	814	600	211	-	600
61x Professional Development	712	900	433	-	900
62x Fees - Operating & Professional	330,146	1,229,174	246,644	(342,400)	886,774
Total Operating	**743,644**	**1,728,174**	**464,941**	**(360,148)**	**1,368,026**
69x Equipment Over $5,000	21,560	-	-	-	-
Total Capital/Equipment over 5,000	**21,560**	**-**	**-**	**-**	**-**
71x Grants, Benefits, & Claims	1,679,976	1,970,000	755,821	(320,000)	1,650,000
72x Transfers	-	-	-	-	-
Total Grants	**1,679,976**	**1,970,000**	**755,821**	**(320,000)**	**1,650,000**
Total	**5,711,238**	**7,682,162**	**2,933,550**	**(515,723)**	**7,166,439**

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ -	$ -	$ -	$ -	$ -
FEDERAL	$ 5,711,238	$ 7,682,162	$ 2,933,550	$ (515,723)	$ 7,166,439
OTHER	$ -	$ -	$ -	$ -	$ -
Total	$ 5,711,238	$ 7,682,162	$ 2,933,550	$ (515,723)	$ 7,166,439

HOUSE BILL 1012 #1695
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

DD Council Division

Julianne Horntvedt, Division Director

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COUNCIL MEMBERSHIP

- Lori Garnes, North Dakota Center for Persons with Disabilities
- Susan Karypak, Parent
- Roxane Romanick, Parent
- Sheryl Beard, Consumer
- Tammy DeSautel, Parent and Job Service Representative
- Sue Foerester, Life Skills and Transition Center
- Kim Hruby, Department of Health
- Jeff Jacobson, Provider Representative (Lake Region Corporation)
- Melissa Bristol, Parent
- Jon Fettig, Consumer
- Brittany Hanson, Parent
- Toby Lundstad, Parent
- Tom Solberg, Department of Human Services
- Gerry Teevens, Department of Public Instruction
- Sheryl Stradinger, Council Chair, and Parent
- Trevor Vannett, Counsumer
- Teresa Larsen, Protection and Advocacy
- Darrel Wahl, Consumer
- One Vacancy, Parent
- One Vacancy, Consumer
- Julie Horntvedt, Council Director

Department of Human Services

DD Council

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
1.0	1.0	1.0	0	100%	Director of Council	1

COVID INFO
No substantive impact on the one FTE in DD Council

Telework Headcount	
Pre-COVID	Current
1	1

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	General Fund	Other Funds	Total
DD Council				
Continued program changes		-	124,949	124,949

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	170,022	152,350	71,477	(5,262)	147,088
513x Salaries - Temp	13,779	83,208	-	(77,608)	5,600
516x Salaries - Benefits	61,134	72,296	31,274	(6,622)	65,674
Total Salaries & Benefits	244,935	307,854	102,751	(89,492)	218,362
52x Travel	79,360	164,938	34,905	(99,938)	65,000
53x Supply	1,486	800	155	(100)	700
54x Postage & Printing	853	760	169	140	900
58x Rent/Leases - Bldg./Equip	25,835	21,508	4,139	(16,348)	5,160
59x Repairs	1,113	1,416	468	(616)	800
61x Professional Development	12,721	14,730	13,689	4,270	19,000
62x Fees - Operating & Professional	110,713	140,884	68,032	9,500	150,384
Total Operating	232,081	345,036	121,557	(103,092)	241,944
71x Grants, Benefits, & Claims	810,695	360,131	130,039	228,041	588,172
Total Grants	810,695	360,131	130,039	228,041	588,172
Total	1,287,711	1,013,021	354,347	35,457	1,048,478

OVERVIECW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL					
FEDERAL	$ 1,287,711	$ 1,013,021	$ 354,347	$ 35,457	$ 1,048,478
OTHER					
Total	$ 1,287,711	$ 1,013,021	$ 354,347	$ 35,457	$ 1,048,478

GRANTS NOT ON A WALKTHROUGH

DD Council - 2021-23 Biennium Budget

Budget Account Code 712000 - Grants, Benefits, and Claims

$360,131	$588,172	$-	$588,172	$-

Vendor	Description	2019-21 Biennium Amount	2021-23 Biennium Amount	General Fund	Federal Funds	Other Funds	Funding Explanation	Explanation of Increase or Decrease over the 2019-21 Biennium Amount
*Various grant awards	Funds awarded to applicants for projects	360,131	588,172		588,172			A decrease in operating expenses allows more funds to be awarded.
			-					
			-					

* DD Council awards grants on an annual basis. Funds are are awarded for applicable projects by the board after evaluation of the applications.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/20/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson opened the meeting at 8:24 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Life Skills and Transition Center
- Budget Summary
- FTE's
- Developmental Disabilities
- Economic Assistance Policy

Sue Foerster, Superintendent of LSCTC (8:32 am) testified about the Life Skills and Transition Center Budget Detail #1875

Tina Bay, Division Director (9:13 am) testified about the Developmental Disabilities Division #1879

Michele Gee, Director (10:06 am) testified about the Economic Assistance Policy Division #1899

Sara Stolt, Chief Operating Officer (10:29 am) testified about Human Service Zones #1907

Michele Gee, Director of (11:26 am) testified and explained the handout #1955

Chair Nelson closed the meeting at 11:37 a.m.

Cole Fleck, Committee Clerk



House Bill 1012 #1875

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

Life Skills and Transition Center Budget Detail

Providing support and services so people can move back to homes of their choice

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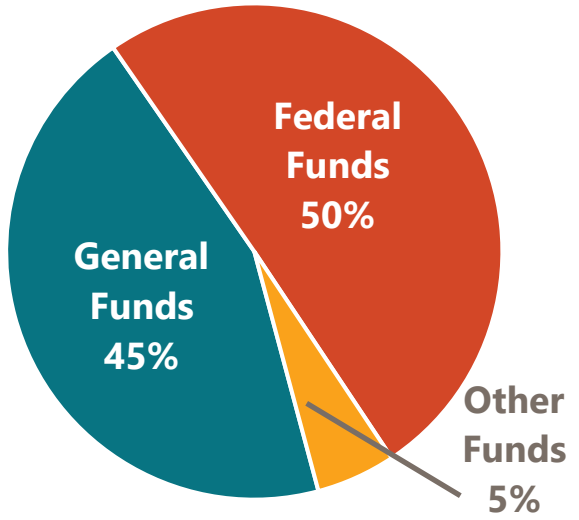
LSTC Budget Summary

19-21 Budget	**$58,794,948**
21-23 Budget (exec)	**$48,619,605**

Reduction of 14.5 FTEs; $10,175,343 budget reduction (50% in federal funds)

- Reduce census by 26 (16 youth, 10 adults) via both transitions and diversions
- Shift operations to re-orient toward crisis and stabilization service
- Reduce general fund contribution to adaptive equipment service, seeking alternate revenue sources

NOTE: Interconnection between LSTC, CFS and DD budgets as service models shift



Department of Human Services

Life Skills & Transition Center

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
322.84	322.84	308.34	63.4	83.2%	Client Facing	256.54
				7.2%	Statewide Community & Crisis Support	22.30
				7.3%	Facility Management	22.50
				2.3%	Administrative	7.00

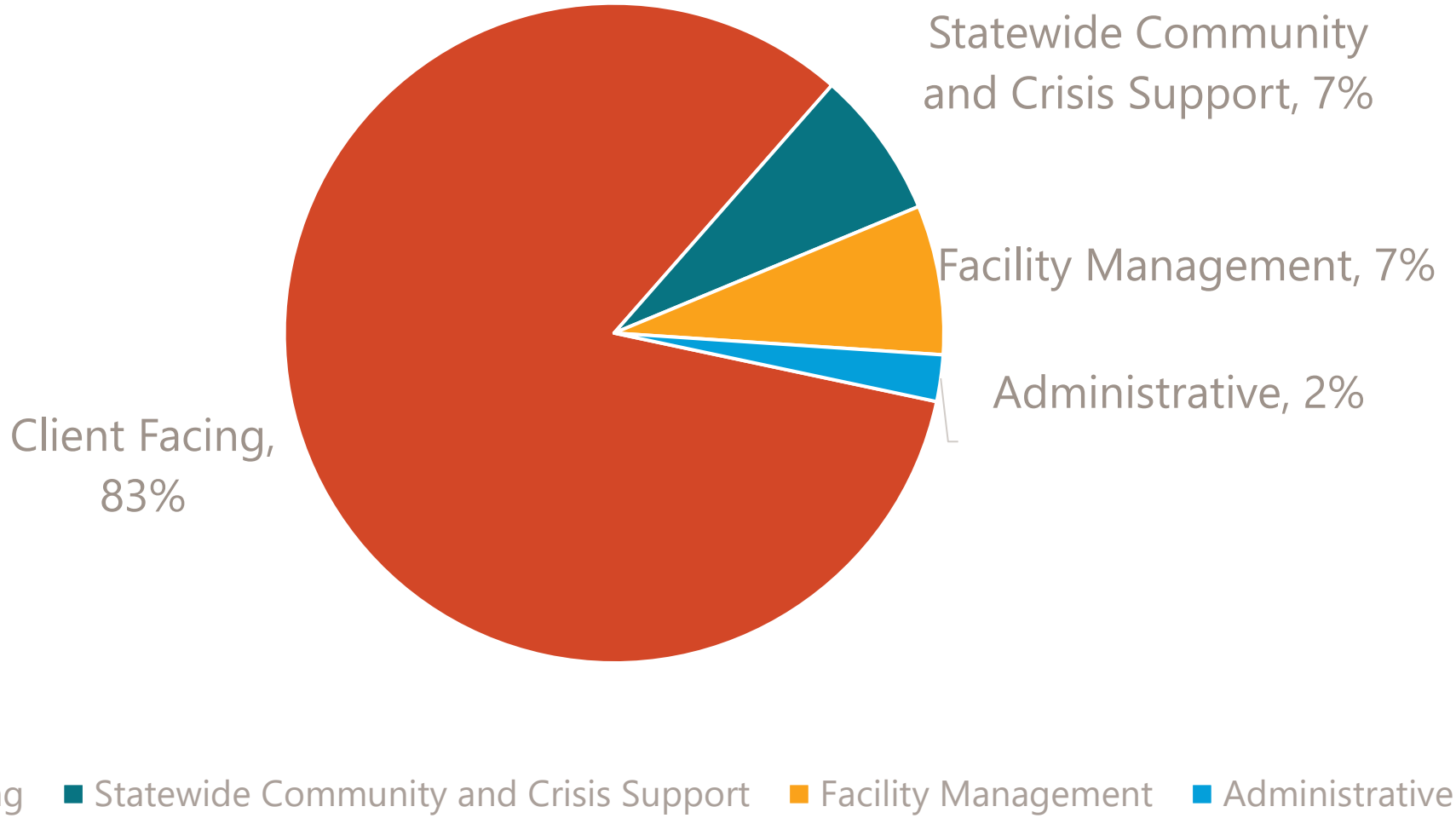
COVID INFO

With the LSTC being a 24/7 residential service provider, most employees cannot work from a location other than our facility. However, we were able to make modifications to operations which allowed for 4 additional positions to work from their home.

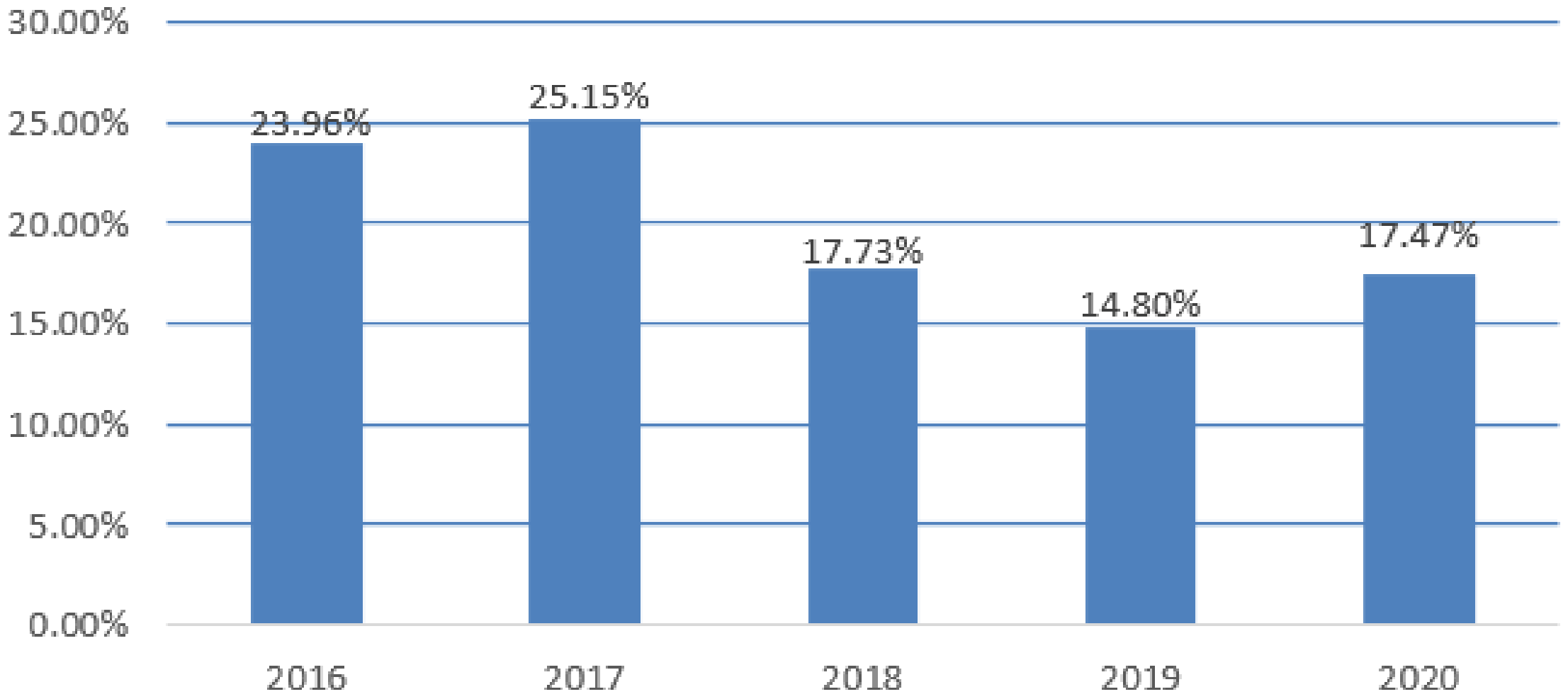
Telework Headcount

Pre-COVID	Current
7	14

Life Skills and Transition Center FTEs



Life Skills and Transition Center turnover history 2016-2020

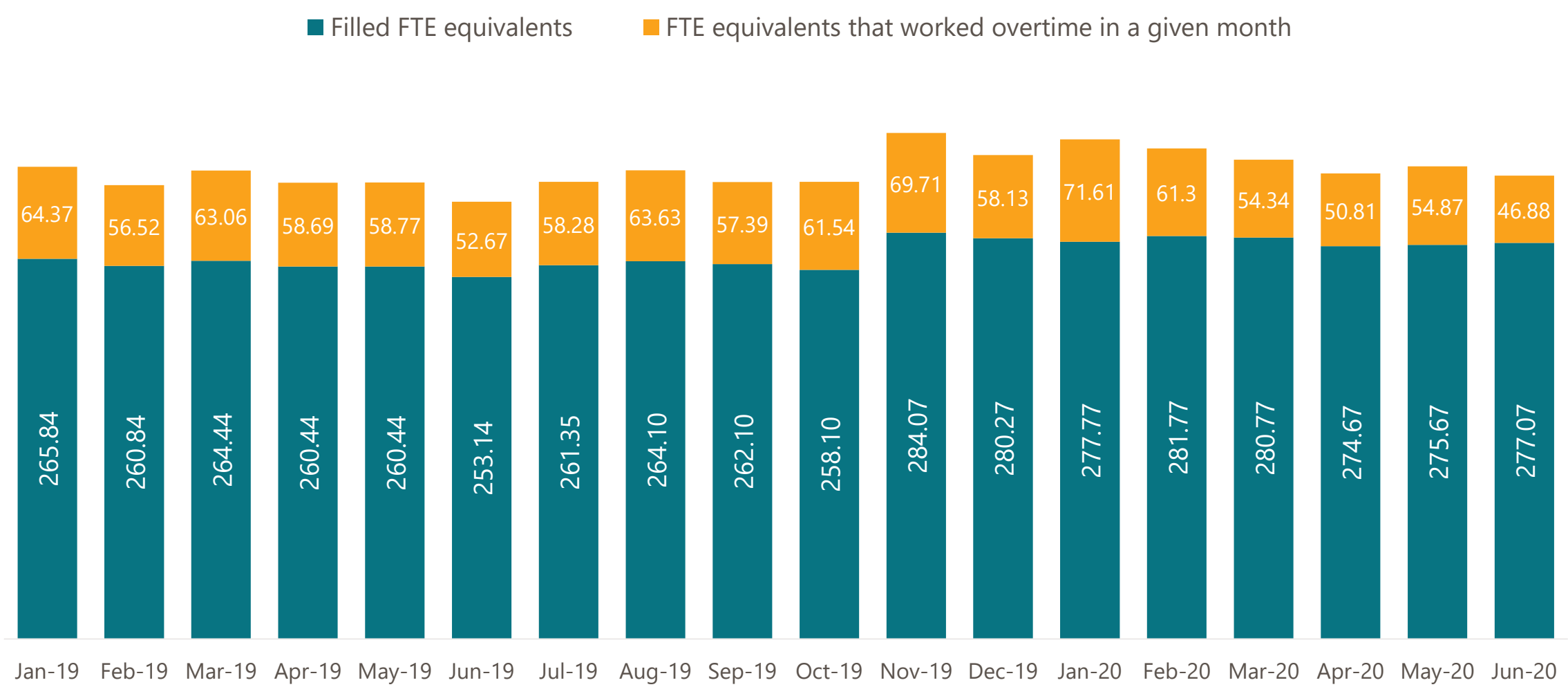


Life Skills and Transition Center vacancies

Job Classification	Vacant FTE	Job Classification	Vacant FTE
Activity Assistant II	4.5	Food Service Assistant	3.0
Applied Behavior Analyst II	1.5	Health Human Svc Program Admin III	1.0
Cook I	3.5	Heating Plant Operator II	2.0
Dental Hygienist	1.0	Institutions Custodian	0.6
Direct Care Associate I	10.0	LP Nurse II	1.0
Direct Care Associate II	15.9	Physical Therapy Aide	1.0
Direct Care Associate III	11.9	Registered Nurse III	0.5
Direct Care Supervisor	5.0	Training Officer I	1.0

Total Vacant FTE: 63.4

FTE Equivalency in Overtime Worked





Other budget impacts

Permission to convey a portion of two parcels of land commonly referred to as “the bowl” to the Grafton Park Board

Update: Payment of Special Assessments - City Postponed the project. This will not occur during the 21-23 biennium.



Additional unanticipated budget request: $183,040

- Unanticipated retirement of psychiatrist from Northeast Human Service Center
- Added to amendment that administration-fiscal will present before the committee.
- Critical need due to Behavioral Health diagnosis and acuity

Overview of budget changes by expense category

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	27,146,245	26,605,150	13,639,498	(2,908,024)	23,697,126
512x Salaries - Other	604,179	595,128	299,206	14,999	610,127
513x Salaries - Temp	1,497,766	1,009,800	667,936	-	1,009,800
514x Salaries - Over Time	4,969,261	5,070,728	2,753,139	(4,585,998)	484,730
516x Salaries - Benefits	15,048,735	15,526,736	7,758,752	(1,372,310)	14,154,426
Total Salaries & Benefits	49,266,186	48,807,542	25,118,531	(8,851,333)	39,956,209
52x Travel	448,480	512,148	197,255	(131,100)	381,048
53x Supply	1,439,058	1,389,224	676,301	(239,950)	1,149,274
54x Postage & Printing	17,455	36,108	9,946	(5,000)	31,108
55x Equipment Under $5,000	233,304	151,048	21,001	(42,075)	108,973
56x Utilities	5,418,565	1,501,293	462,916	(311,555)	1,189,738
57x Insurance	63,523	81,100	33,478	(16,979)	64,121
58x Rent/Leases - Bldg./Equip	82,144	98,405	48,235	5,650	104,055
59x Repairs	175,547	502,142	88,142	(277,577)	224,565
61x Professional Development	40,912	72,527	12,918	54,409	126,936
62x Fees - Operating & Professional	4,272,437	4,602,969	2,063,636	(345,833)	4,257,136
60x IT Expenses	193,596	194,311	87,658	(14,000)	180,311
Total Operating	12,385,021	9,141,275	3,701,486	(1,324,010)	7,817,265
68x Land, Building, Other Capital	1,682,257	833,445	2,827,688	(195,369)	638,076
69x Equipment Over $5,000	52,281	12,686	-	195,369	208,055
Total Capital/Equipment over 5,000	1,734,538	846,131	2,827,688	-	846,131
Total	63,385,745	58,794,948	31,647,705	(10,175,343)	48,619,605

Overview of budget changes by funding source

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	29,437,552	29,426,161	13,322,472	(7,777,688)	21,648,473
Federal	30,011,258	26,880,105	16,726,536	(2,430,575)	24,449,530
Other	3,936,935	2,488,682	1,598,697	32,920	2,521,602
Total	63,385,745	58,794,948	31,647,705	(10,175,343)	48,619,605

LSTC net budget savings plan requires partnership

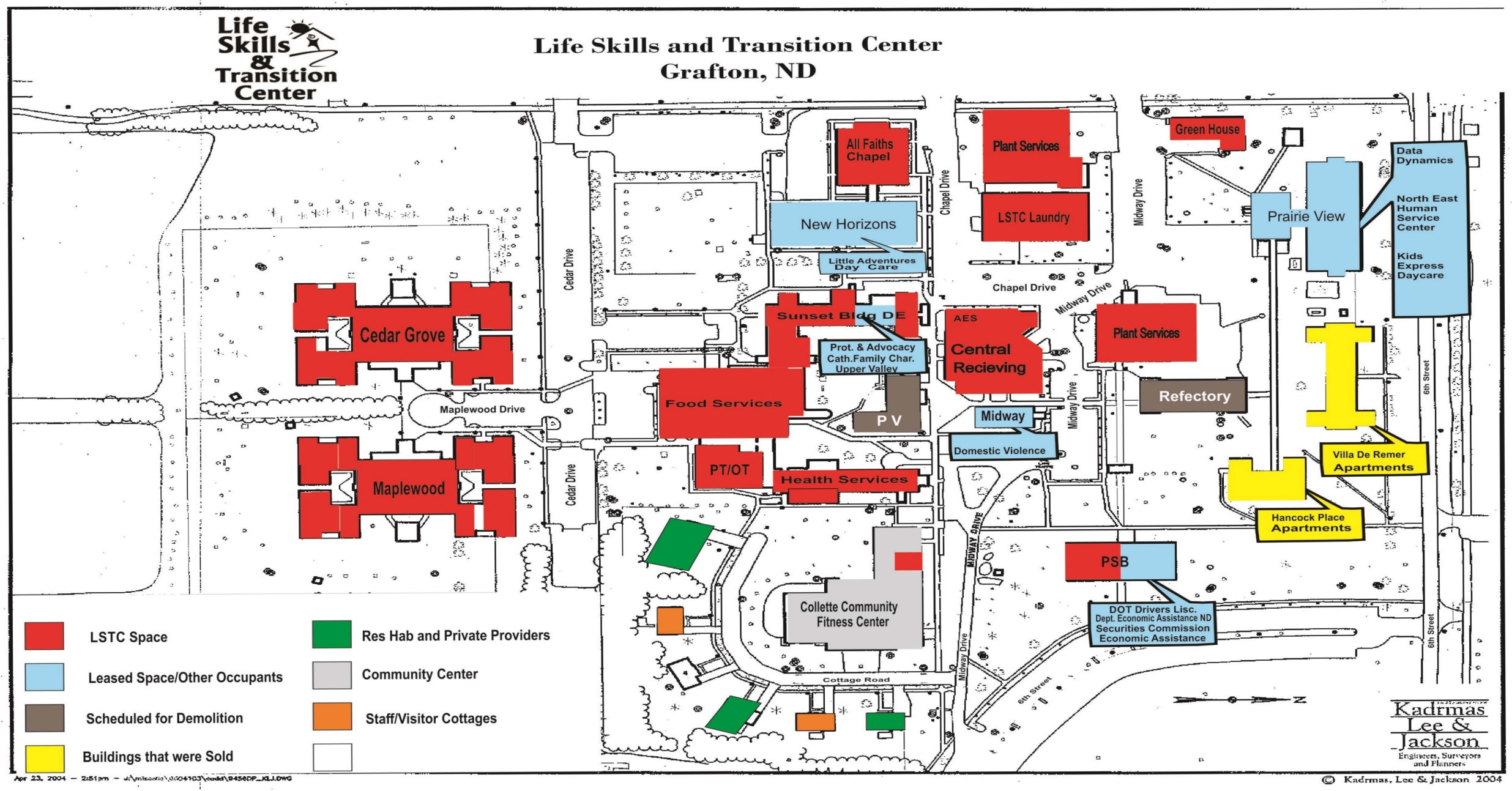
Collaboration between LSTC, DD, and Children Family Services as well as ND community providers.

Census reduction of 16 youth and 10 adults to homes in their community.

The transition of people will occur gradually throughout the biennium as appropriate settings are developed by community providers.

Each person and their family/guardian will be involved in the development of their Person-Centered Transition Plan.

The LSTC is recognized as a setting that specializes in crisis and stabilization services.


Life Skills & Transition Center
Life Skills and Transition Center
Grafton, ND
All Faiths Chapel
Plant Services
Green House
Data Dynamics
North East Human Service Center
Kids Express Daycare
Prairie View
New Horizons
LSTC Laundry
Little Adventures Day Care
Chapel Drive
Midway Drive
Cedar Drive
Cedar Grove
Sunset Bldg DE
AES
Central Recieving
Plant Services
Prot. & Advocacy Cath.Family Char. Upper Valley
Food Services
P V
Refectory
Maplewood Drive
Midway
Domestic Violence
Villa De Remer Apartments
Maplewood
PT/OT
Health Services
Hancock Place Apartments
6th Street
PSB
Collette Community Fitness Center
DOT Drivers Lisc.
Dept. Economic Assistance ND
Securities Commission
Economic Assistance
Cottage Road
LSTC Space
Leased Space/Other Occupants
Scheduled for Demolition
Buildings that were Sold
Res Hab and Private Providers
Community Center
Staff/Visitor Cottages
Kadrmas Lee & Jackson
Engineers, Surveyors and Planners
Apr 23, 2004 – 2:51pm
© Kadrmas, Lee & Jackson 2004



Contact Information

Sue Foerster, Superintendent
Life Skills Transition Center
701 W 6th Street
Grafton, ND 58237

Phone: 701-352-4302
Toll Free: 1-800-252-4911
ND Relay TTY: 7-800-366-6888
E-mail: sfoerster@nd.gov



HOUSE BILL 1012 #1879
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Developmental Disabilities Division

Tina Bay, Division Director

NORTH Dakota | Human Services
Be Legendary.™

Department of Human Services

Developmental Disabilities

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
13	125.87	125.87	0	10%	Program & Policy	13.00
				79%	DD Program Managers	98.87
				11%	Administrators & support staff	14.00

COVID INFO

Developmental Disabilities has implemented virtual flexibilities and procedural changes which allows staff to work from home, both during COVID and into the future.

Telework Headcount

Pre-COVID	Current
5	112

GREEN SHEET WALKTHROUGH

	EBR			
	FTE Positions	**General Fund**	**Other Funds**	**Total**
Developmental Disabilities				
Continued program changes		(11,821)	163,017	151,196
Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)
Grant cost and caseload changes		19,323,007	22,244,014	41,567,021
Subtotal Developmental Disabilities	**-**	**17,058,897**	**20,480,181**	**37,539,078**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	12,887,551	13,499,651	6,874,394	1,279,102	14,778,753
512x Salaries - Other	-	-	-	-	-
513x Salaries - Temp	347,871	602,520	280,108	164,728	767,248
514x Salaries - Over Time	43,609	14,496	14,496	3,503	17,999
516x Salaries - Benefits	6,154,196	6,924,887	3,454,158	699,716	7,624,603
Total Salaries & Benefits	19,433,227	21,041,554	10,623,156	2,147,049	23,188,603
52x Travel	234,118	249,752	118,954	(2,879)	246,873
53x Supply	14,137	69,504	7,885	5,000	74,504
54x Postage & Printing	30,269	8,235	4,285	-	8,235
55x Equipment Under $5,000	41,044	5,000	2,556	-	5,000
56x Utilities	-	-	-	-	-
57x Insurance	-	-	-	-	-
58x Rent/Leases - Bldg./Equip	213,204	83,838	46,897	(61,468)	22,370
59x Repairs	31,219	30,000	28,218	(2,000)	28,000
61x Professional Development	29,095	45,708	9,233	13,000	58,708
62x Fees - Operating & Professional	8,882,741	7,907,337	1,971,036	(514,487)	7,392,850
67x Non Operating Expenses	-	-	-	-	-
60x IT Expenses	4,334	2,743	784	-	2,743
Total Operating	9,480,161	8,402,117	2,189,848	(562,834)	7,839,283
68x Land, Building, Other Capital	-	-	-	-	-
69x Equipment Over $5,000	-	10,000	-	-	10,000
Total Capital/Equipment over 5,000	-	10,000	-	-	10,000
71x Grants, Benefits, & Claims	585,538,051	659,562,851	300,325,579	48,669,082	708,231,933
72x Transfers	-	-	-	-	-
Total Grants	585,538,051	659,562,851	300,325,579	48,669,082	708,231,933
Total	614,451,439	689,016,522	313,138,583	50,253,297	739,269,819

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	305,885,063	336,131,217	157,513,546	8,629,328	344,760,545
Federal	308,566,376	352,885,305	155,625,037	41,623,969	394,509,274
Other	-	-	-	-	-
Total	614,451,439	689,016,522	313,138,583	50,253,297	739,269,819

GRANTS NOT-ON-A WALKTHROUGH

Developmental Disabilities

2021-23 Biennium Budget

Budget Account Code 712000 - Grants, Benefits, and Claims	**$672,928**	**$522,928**	**$88,108**	**$434,820**	**$-**

Vendor	Description	2019-21 Biennium Amount	2021-23 Biennium Amount	General Fund	Federal Funds	Other Funds
L.I.S.T.E.N. & Red River HSF	Recreational services for clients	150,000	-	-		
Various vendors	Crisis bed units	86,400	86,400	(30,156)	116,556	
Minot State University	DD training curriculum	236,528	236,528	118,264	118,264	
ND Protection & Advocacy	Follow-up investigations	200,000	200,000	-	200,000	
			-			

DEVELOPMENTAL DISABILITIES
19-21 to 21-23 Services Overview

North Dakota Department of Human Services
Changes in Developmental Disabilities from 2019-2021 Appropriation to 2021-2023 Executive Budget

Service Description	2019-2021 Appropriation	Cost to Continue	FMAP	Rate Adj. for ICF, Res Hab & Day Hab *	ICF Transitions from LSTC ^	Total Changes	2021-2023 Budget To OMB	Inflation 1% / 1%	2021-2023 Budget To House
Intermediate Care Fac. for Intellectually Disabled	195,829,588	10,921,101	47	(4,516,667)	7,879,858	14,284,339	210,113,927	3,082,105	213,196,032
DD Home & Community Based Services	470,060,334	24,091,758	(47)	(6,633,333)		17,458,378	487,518,712	7,440,098	494,958,810
Residential Services - Daily Rates	248,973,777	18,201,674	(6)	(9,033,333)		9,168,335	258,142,112	4,043,131	262,185,243
Day Habilitation	121,540,853	(37,840,303)	(6)	2,400,000		(35,440,309)	86,100,544	1,241,722	87,342,266
Family Support Services - In Home Support	44,653,768	2,054,511	(3)			2,054,508	46,708,276	705,163	47,413,439
Infant Development	30,483,702	4,017,189	(3)			4,017,186	34,500,888	506,195	35,007,083
Remaining Services	24,408,234	37,658,687	(29)			37,658,658	62,066,892	943,887	63,010,779
Cost Settlement & Underfunding	(7,000,000)	6,554,163				6,554,163	(445,837)		(445,837)
Total	658,889,922	41,567,022		(11,150,000)	7,879,858	38,296,880	697,186,802	10,522,203	707,709,005
General Fund	319,198,437	19,323,007	(14,656,562)	(5,240,000)	3,706,523	3,132,968	322,331,405	4,859,222	327,190,627

Notes:

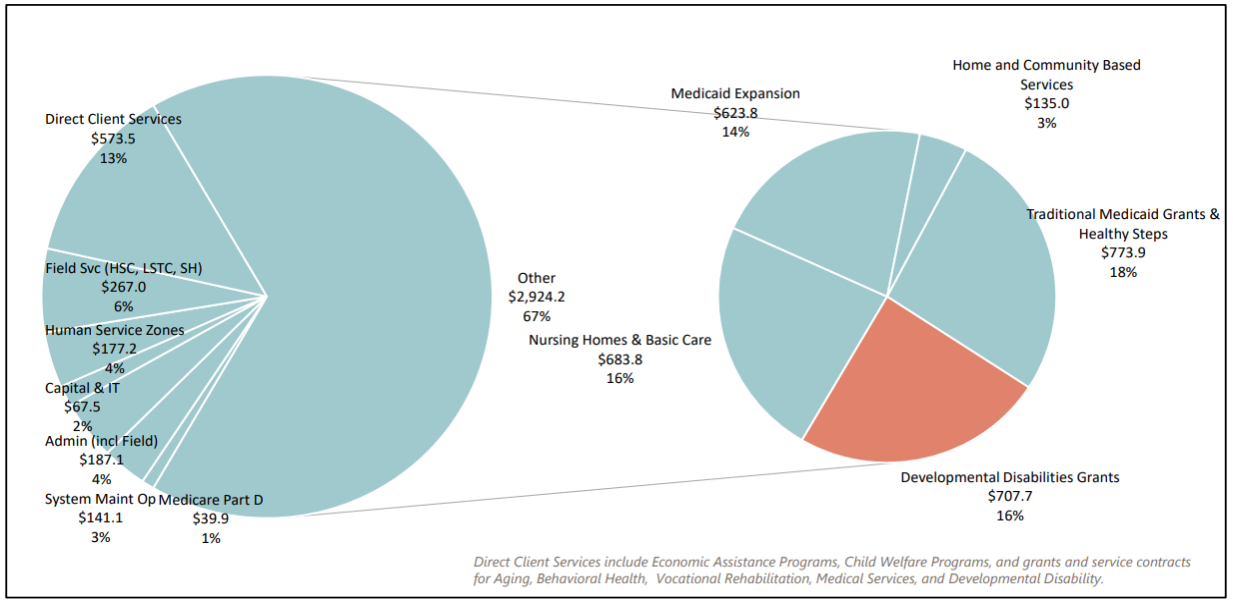
* Recommended Rate Adjustments for ICF, Residential Habilitation and Day Habilitation per Optumus analysis.

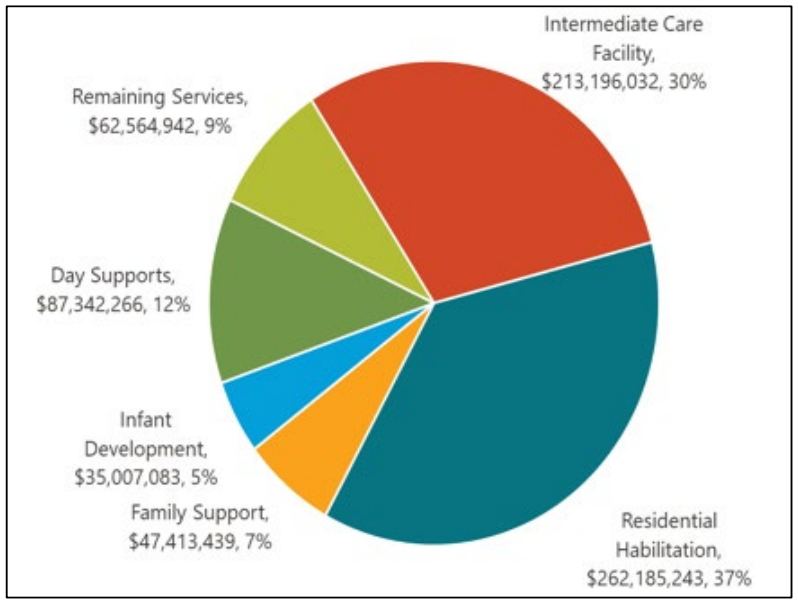
^ Budget Adjustment for ICF Transitions from LSTC (16 children and 10 adults)

DEVELOPMENTAL DISABILITIES UNIT AND COST COMPARISON

First 8 Months of 2019 - 2021 Biennium to Executive Budget Request (EBR) 2021 - 2023 Biennium
Developmental Disabilities

Division/Program	Monthly average units for first 8 months of 19 - 21	Monthly average units for EBR of 21 - 23	Change from EBR to 8 mo Avg units	Monthly average unit cost for first 8 months of 19 - 21	Monthly average unit cost for EBR of 21 - 23 includes Rate Adjustments & 1/1 inflation	Change from EBR to 8 mo Avg unit cost	Monthly average units for first 14 months of 19 - 21	Monthly average unit cost for first 14 months of 19 - 21
DD								
Residential Services - Daily Rates	1,152	1,192	40	$ 298.64	$ 298.01	-$0.63	1,150	$ 297.84
Community ICF/IID	426	438	12	$ 644.35	$ 641.50	-$2.85	418	$ 620.05
Day Habilitation	1,138	1,238	100	$ 5.95	$ 6.36	$0.41	1,051	$ 6.07
Family Support Services - In Home Support	825	938	113	$ 34.89	$ 36.95	$2.06	744	$ 35.20
Infant Development	1,350	1,607	257	$ 208.73	$ 221.95	$13.22	1,329	$ 208.70





#1899

HOUSE BILL 1012
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Economic Assistance Policy Division

Michele Gee, Director

NORTH Dakota | Human Services

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Department of Human Services

Economic Assistance

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)
39.80	39.80	39.80	4

Assignment of Requested FTE

% of FTE	Descriptor	# of FTE
33%	Program and System Support	13
28%	Quality Assurance	11
25%	Program Administration	9.8
7%	Support Staff	3
7%	Administration	3

COVID INFO

Economic Assistance transitioned to electronic files which allows staff access to necessary information while working remote

Telework Headcount

Pre-COVID	Current
2	35

GREEN SHEET WALKTHROUGH

Executive Budget Request						
Economic Assistance	**FTE Positions**		**General Fund**		**Other Funds**	**Total**
Continued Program Changes			(210,585)		3,276,939	3,066,354
Grant Cost and Caseload Changes			2,952,453		8,382,789	11,335,242
Subtotal Economic Assistance			**2,741,868**		**11,659,728**	**14,401,596**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	4,113,236	4,351,589	2,136,444	749,000	5,100,589
513x Salaries - Temp	192,686	214,248	107,551	(108,168)	106,080
514x Salaries - Over Time	19,540	59,106	19,131	(59,106)	-
516x Salaries - Benefits	1,825,453	2,152,885	1,044,136	168,498	2,321,383
Total Salaries & Benefits	6,150,915	6,777,828	3,307,262	750,224	7,528,052
52x Travel	36,418	149,662	147,251	(62,853)	86,809
53x Supply	15,069	10,000	7,803	360	10,360
54x Postage & Printing	103,582	149,621	99,097	25,994	175,615
55x Equipment Under $5,000	3,722	2,100	956	2,900	5,000
56x Utilities	604	650	289	(70)	580
58x Rent/Leases - Bldg./Equip	46,017	67,636	28,116	103,364	171,000
59x Repairs	848	825	360	(117)	708
61x Professional Development	23,438	36,325	20,317	(4,679)	31,646
62x Fees - Operating & Professional	9,223,234	9,762,433	3,707,277	(195,118)	9,567,315
60x IT Expenses	5,827	4,110	2,795	279	4,389
Total Operating	9,458,759	10,183,362	4,014,261	(129,940)	10,053,422
71x Grants, Benefits, & Claims	223,011,318	242,885,074	103,317,147	14,531,536	257,416,610
Total Grants	223,011,318	242,885,074	103,317,147	14,531,536	257,416,610
Total	238,620,992	259,846,264	110,638,670	15,151,820	274,998,084

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

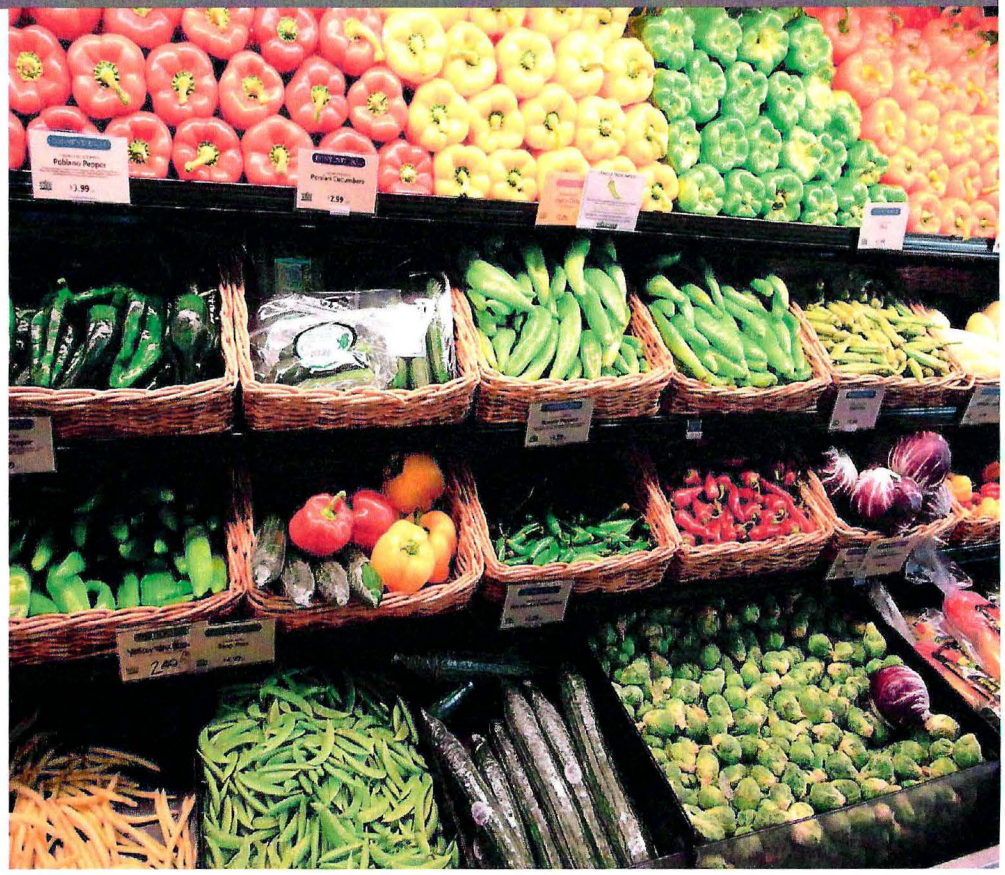
Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ 7,896,865	$ 8,605,617	$ 1,881,801	$ 3,256,938	$ 11,862,555
FEDERAL	$ 212,706,093	$ 231,997,094	$ 101,909,700	$ 11,701,119	$ 243,698,213
OTHER	$ 18,018,034	$ 19,243,553	$ 6,847,169	$ 193,763	$ 19,437,316
Total	**$ 238,620,992**	**$ 259,846,264**	**$ 110,638,670**	**$ 15,151,820**	**$ 274,998,084**

ECONOMIC ASSISTANCE
COVID 19 - SNAP Enhancement Grants

Grant program to help ND grocers update their point-of-sale systems and websites to enable online and by-phone ordering and delivery, improving access to food for both SNAP beneficiaries and community residents

Through Dec 2020 assisted grocery stores with system upgrades in:

- Minot – **Karma Convenience Store**
- Ruthville – **Karma Convenience Store**
- Mohall – **Jason's Super Foods**
- Newtown – **Jason's Super Foods**
- Michigan – **Michigan Hometown Foods**
- Scranton – **SuperValu**



ECONOMIC ASSISTANCE
Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP helps households with **home heating costs** by paying a portion of their heating bills, **and** with **improving** their home's overall **energy efficiency**.



FY 2020 funds obligated for energy efficiencies services.

- $1.1 Million – Weatherization
- $1.9 Million – Furnace Repair & Replacement



House Bill 1012 #1907

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

NORTH Dakota | Human Services

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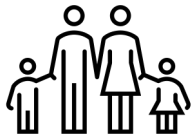
Human Service Zones

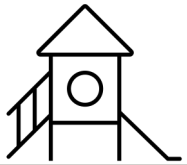
Local + State Partnerships For Effective and Efficient Service Delivery

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



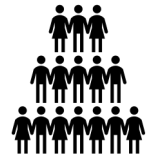
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

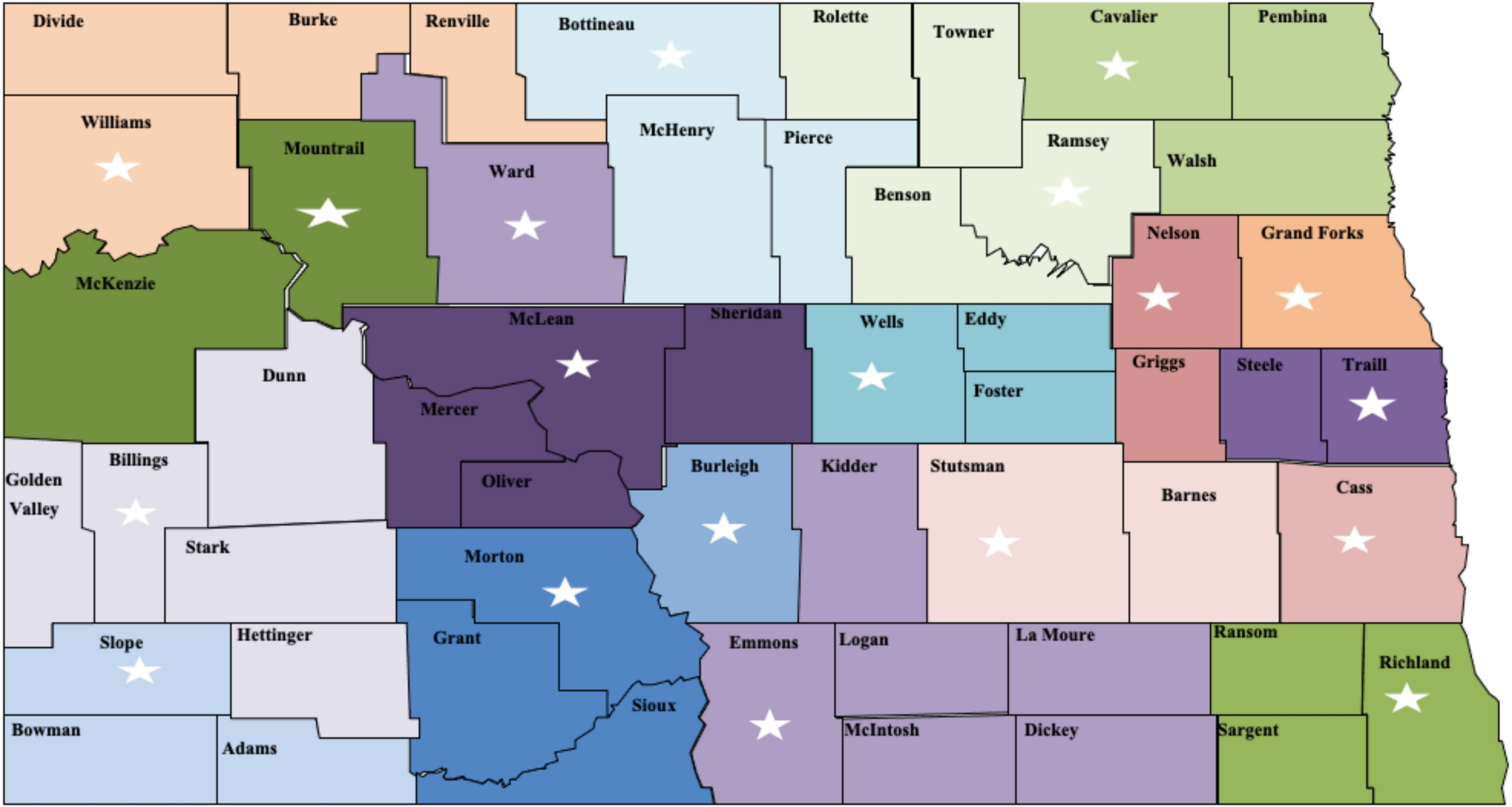
   Serving people in **lowest level of care necessary** will return **better outcomes**.

   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.


Divide
Burke
Renville
Bottineau
Rolette
Towner
Cavalier
Pembina
Williams
Mountrail
Ward
McHenry
Pierce
Ramsey
Walsh
Benson
Nelson
Grand Forks
McKenzie
McLean
Sheridan
Wells
Eddy
Griggs
Steele
Traill
Dunn
Mercer
Foster
Billings
Golden Valley
Oliver
Burleigh
Kidder
Stutsman
Barnes
Cass
Stark
Morton
Slope
Hettinger
Grant
Emmons
Logan
La Moure
Ransom
Richland
Sioux
Bowman
Adams
McIntosh
Dickey
Sargent

Q1: LOCAL HCBS/QSP PROGRAMS

Human Service Zone	QSP Provided	Zone Administered	Zone Direct Care Team Members	Number of clients
Agassiz Valley	Yes	Yes	Yes	35-40
Buffalo Bridges	Yes	Yes	Yes	11
Cass	Yes	Yes	Yes/No	58
Central Prairie	Yes	Yes	Yes	15
Dakota Central	Yes	Yes	Yes	7
Grand Forks	No	Yes	No	11
Mountrail McKenzie	Yes	Yes	Yes	4
Northern Prairie	Yes	Yes	Yes	1 county funded 1 private pay
Northern Valley	Yes	Yes	Yes	3
North Star	Yes	Yes	Yes	4
RSR	Yes	Yes	Yes	28
Roughrider North	Yes	Yes	Yes	7
South Country	Yes	Yes	Yes	10 zone admin 9 private pay
Southwest Dakota	Yes	Yes	Yes	8 zone admin 9 private pay
Three Rivers	Yes	Yes	Yes	3
				229 total

Q2: LEGISLATORS ON HSZ BOARDS

Zone	#	Zone	#
Ward	1	Southwest	1
Roughrider North	1	Mountain Lakes	1
Grand Forks	2	Northern Valley	1
Northern Prairie	1	Burleigh	1
Dakota Central	1		

Q3: ELIGIBILITY ERROR TRACKING

1. Errors are found through case file reviews
2. Reviews are completed by the Economic Assistance QA/QC Unit
3. See handout

Q4: WHICH ZONES COVER HOUSING IN GA

- 10 out of 19 zones covering some form of housing assistance in their General Assistance funds

Q5: COLLABORATION OPPORTUNITIES

56

Collaborative Services Across All Zones

Q6: ZONE FUND BALANCES

- Fund balances are reported in January of each year.
- Anything above the fund balance limitation is reduced in the June payment of the following year. Note there were no fund balance reduction in CY 2020.
- If the payment provided to the HSZ to defray costs to provide Human Services, the HSZ would then utilize fund balances.
- HSZ must utilized the full balance of their human service zone human services fund before requesting additional dollars from the Department.
- It is anticipated fund balances will be exhausted in 21-23.

Estimated Fund Balances	In Millions
CY 2020 Beginning Balances Report by HSZ	$10.30
Estimated Beginning Fund Balances Ending CY 2020	$15.02
Less: Estimated Fund Balance Reduction CY 21	$8.85
Remaining Fund Balance CY 21	$6.18

	19-21	21-23
Expenditures > $2,000,000	$500,000	$500,000
Expenditures < $2,000,000	$100,000	$250,000

Q7: TOTAL COST OF HEALTH INSURANCE IF ZONE EMPLOYEES HAD STATE PLAN

21-23 Health Insurance	$29,448,645
21-23 Health Insurance to Transition to State Employment	
Monthly Health Insurance Premium	$1,429
FTE per Budget	867
Number of Months	24
21-23 Health Insurance Move to State	$29,736,018
Less Transitioned Foster Care/Sub Adopt Benefits	$(548,648)
(Savings)/Increase	$(261,275)

Q6: TOTAL COST OF STATE EMPLOYMENT

21-23 Zones Budget	23-25 Optional State Employment	Difference
$158,406,443	$158,260,396	$(146,047)

Department of Human Services

Human Service Zones

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
140	140	143	22	**47%**	Home and Community Based	67
				19%	Early Childhood Services	27
				11%	Long Term Care Eligibility	16
				11%	Foster Care/Sub-Adopt	16
				7%	QA/QC	10
				5%	Administration	7

GREEN SHEET WALKTHROUGH GF/FTE

Executive Budget Request

	FTE Positions	General Fund	Other Funds	Total
County Social Service Funding				
2021-23 Biennium Base Level	140.00	$0	$173,700,000	$173,700,000
2021-23 Ongoing Funding Changes				
Base payroll changes			$1,653,466	$1,653,466
Salary increase		$351,365	$292,562	$643,927
Health insurance increase		$3,287	$2,737	$6,024
Retirement contribution increase		$72,382	$60,269	$132,651
Continued program changes		$896,189	($372,192)	$523,997
Home- and community-based services staff	3.00		$498,673	$498,673
Subtotal Ongoing Funding Changes	**3.00**	**1,323,223**	**2,135,515**	**3,458,738**
One Time Funding				
No one-time funding items		$0	$0	$0
Total one-time funding changes	**-**	**-**	**-**	**-**
Total Changes to Base Level Funding	**3.00**	**1,323,223**	**2,135,515**	**3,458,738**
2021-23 Total Funding	**143.00**	**$1,323,223**	**$175,835,515**	**$177,158,738**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	-	17,001,607	2,040,254	2,043,496	19,045,103
512x Salaries - Other	-	62,314	10,339	(62,314)	-
514x Salaries - Over Time	-	114,339	34,369	(114,339)	-
516x Salaries - Benefits	-	7,008,001	1,047,899	1,067,898	8,075,899
Total Salaries & Benefits	-	24,186,261	3,132,861	2,934,741	27,121,002
52x Travel	-	379,615	48,984	(52,631)	326,984
53x Supply	-	4,205	451	-	4,205
54x Postage & Printing	-	685	141	60	745
58x Rent/Leases - Bldg./Equip	-	3,242	541	-	3,242
61x Professional Development	-	37,380	5,547	(11,780)	25,600
62x Fees - Operating & Professional	-	4,179,047	449,763	(368,063)	3,810,984
60x IT Expenses	-	17,129	1,923	-	17,129
Total Operating	-	4,621,303	507,350	(432,414)	4,188,889
71x Grants, Benefits, & Claims	154,012,317	144,892,436	53,258,658	956,411	145,848,847
Total Grants	154,012,317	144,892,436	53,258,658	956,411	145,848,847
Executive Budget Request Total	154,012,317	173,700,000	56,898,869	3,458,738	177,158,738
71x Grants Additional Need	-	-	-	12,557,596	12,557,596
Total Request	154,012,317	173,700,000	56,898,869	16,016,334	189,716,334

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	19,312,317	-	-	1,323,223	1,323,223
Federal	-	-	-	1,176,874	1,176,874
Other	134,700,000	173,700,000	56,898,869	958,641	174,658,641
Total	154,012,317	173,700,000	56,898,869	3,458,738	177,158,738
General Additional Need	-	-	-	-	-
Federal Additional Need	-	-	-	-	-
Other Additional Need	-	-	-	12,557,596	12,557,596
Total Request	154,012,317	173,700,000	56,898,869	16,016,334	189,716,334

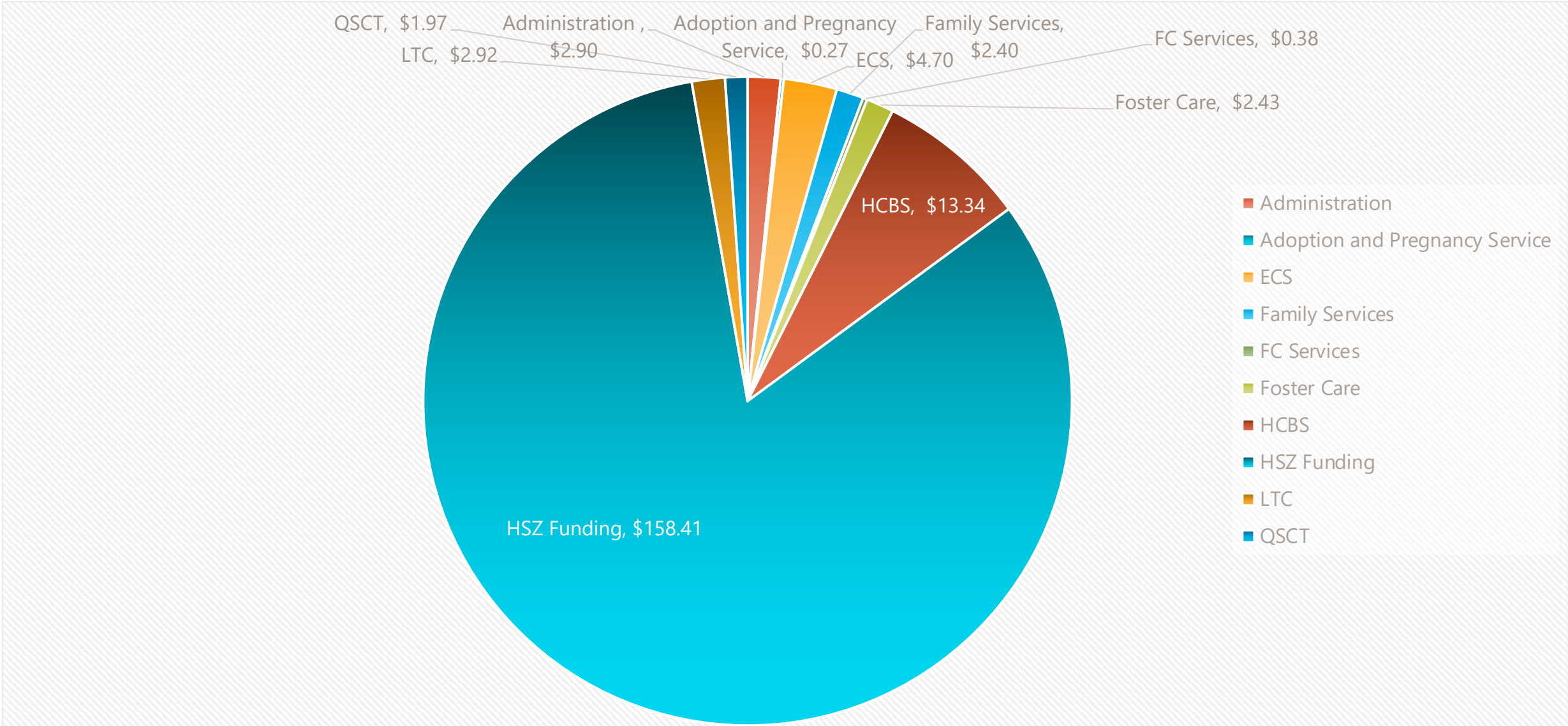
Q7: WHAT IS THE BREAKDOWN OF THE $9.1M

Proposed Legislative Increase of 2/2	3,468,215
21-23 Zones Uncovered Need	9,089,381
Total Increase Requested	**12,557,596**

Equivalent to approximately 59 FTE

Expenditure Type	Amount	Percentage
Salaries	5,568,518	61%
Benefits	3,003,867	33%
Operating	516,996	6%
Total	9,089,381	

HUMAN SERVICE ZONE FUNDING (IN MILLIONS)





Contact Information

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3rd Floor, Judicial Wing
Bismarck, ND 58505

Phone: 701-328-1891
E-mail: sarastolt@nd.gov



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#1955

TANF

Federal Fiscal Year	Number of cases pulled per month	Total Number of cases reviewed	Error rate
FFY 19	16	190	Q1 – Q2 – Q3 – Q4 - Overall - 3%
FFY 20	16	193	Q1 – Q2 – Q3 – Q4 - Overall - 3%

LIHEAP

Federal Fiscal Year	Number of cases pulled per month	Total Number of cases reviewed	Error rate
FFY 19	15	178	Q1 – Q2 – Q3 – Q4 - Overall - 5%
FFY 20	15	180	Q1 – Q2 – Q3 – Q4 - Overall - 4%

CCAP

Federal Fiscal Year	Number of cases pulled per month	Total Number of cases reviewed	Error rate
FFY 19	23	276	Overall - 13% (federal reporting year, unable to break out by quarters)
FFY 20	30	180	Q1 – 13% Q2 – 10% Q3 – not complete Q4 – not complete Overall - 4%

Medicaid

Federal Fiscal Year	Number of cases pulled per month	Total Number of cases reviewed	Error rate
January 1, 2019 – December 31, 2019	33 Medicaid Active	400	Overall - 11% (federal reporting year, unable to break out by quarter)
January 1, 2019 – December 31, 2019	33 Medicaid Negative	400	Overall - 16% (federal reporting year, unable to break out by quarter)

SNAP			
Federal Fiscal Year	Number of cases pulled per Quarter	Total Number of cases reviewed	Error rate
FFY 19 SNAP Active	Q1 – 116 Q2 – 91 Q3 – 136 Q4 - 143	486	Q1 – 3.91% Q2 – 2.81% Q3 – 4.28% Q4 – 7.54% Overall – 4.81%
FFY 19 SNAP Negative	Q1 – 106 Q2 – 84 Q3 – 73 Q4 - 75	338	Q1 – 22.64% Q2 – 20.24% Q3 – 23.29% Q4 – 25.33% Overall – 22.78%
FFY 20 SNAP Active	Q1 – 116 Q2 – 74 Q3 – 35 Q4 – 113	338	Q1 – 7.09% Q2 – 2.64% Q3 – 4.02% Q4 – 8.05% Overall – 6.09%
FFY 20 SNAP Negative	Q1 – 63 Q2 – 40 Q3 – 27 Q4 – 66	196	Q1 – 24.40% Q2 – 32.50% Q3 – 33.33% Q4 – 31.82% Overall – 30.10%

***NOTE: FFY20 SNAP cases were suspended for March, April, & May 2020 due to Covid, therefore a reduction in reviews completed during Quarters 2 & 3

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/21/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson called the meeting to order at 8:30 a.m.

Discussion Topics:

- Behavioral Health Division
- FTE overview
- Budget Changes
- Administrative support budget overview

Pamela Sagness, Director (8:33 am) testified about the Behavioral Health Division #2084

Jamie Wilke, Assistant CFO, DHS(9:26 am) testified about the Program and Policy of the Human Resources Division #2055

Joe Morisette, OMB (10:46 am) testified about the budget changes #2164

Arnie Strebe, CEO CFO, DHS(11:09 am) testified about the Department of Human Services FMAP #2165

Chair Nelson closed the meeting at 11:28 a.m.

Cole Fleck, Committee Clerk

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House Bill 1012 #2084
House Appropriations
Representative Nelson, Chairman

Behavioral Health Division
Pamela Sagness, Director

FTE Overview

Behavioral Health Division

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)
36.0	36.0	36.0	6.0

Assignment of Requested FTE

% of FTE	Descriptor	# of FTE
33%	Community Behavioral Health (FTR and Community Connect)	12
5.5%	Children's Behavioral Health	2
8%	Adult Mental Health	3
17%	Addiction (Treatment and Recovery)	6
14%	Prevention	5
17%	Quality management, communications and administration	6
5.5%	Support staff	2

COVID INFO

Although much of the Division's work can be done through telework, there is still a need in all regions for office space to meet with providers and participants.

Telework Headcount

Pre-COVID	Current
0	34

Green Sheet Walkthrough

Behavioral Health Division

	FTE Positions	General Fund	Other Funds	Total
Continued program changes		156,645	(1,957,536)	(1,800,891)
Cost to continue		5,427,067	-	5,427,067
Savings plan		(832,173)	-	(832,173)
Expanded Substance Use Disorder Voucher		9,000,000	-	9,000,000
Subtotal Behavioral Health Division	**-**	**13,751,539**	**(1,957,536)**	**11,974,003**

Overview of Budget Changes by **Funding Source**

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	13,238,121	21,655,789	9,724,399	15,075,517	36,731,306
Federal	21,788,497	42,723,467	11,823,269	(2,236,632)	40,486,835
Other	7,025,782	7,690,514	5,748,836	94,650	7,785,164
Total	42,052,400	72,069,770	27,296,504	12,933,535	85,003,305

Overview of Budget Changes by **Expense Category**

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	2,473,120	4,190,447	1,632,935	552,488	4,742,935
513x Salaries - Temp	14,350	65,000	21,549	3,640	68,640
516x Salaries - Benefits	1,101,869	2,061,645	793,090	189,415	2,251,060
Total Salaries & Benefits	**3,589,339**	**6,317,092**	**2,447,574**	**745,543**	**7,062,635**
52x Travel	92,792	42,752	33,063	(17,752)	25,000
53x Supply	7,198	6,000	2,188	-	6,000
54x Postage & Printing	61,686	2,500	1,313	-	2,500
58x Rent/Leases - Bldg./Equip	231,284	253,195	139,488	(253,195)	-
61x Professional Development	149,797	68,000	63,739	(3,542)	64,458
62x Fees - Operating & Professional	27,432,793	47,941,697	16,242,460	1,797,938	49,739,635
Total Operating	**27,975,550**	**48,314,144**	**16,482,251**	**1,523,449**	**49,837,593**
71x Grants, Benefits, & Claims	10,487,511	17,438,534	8,366,679	10,664,543	28,103,077
Total Grants	**10,487,511**	**17,438,534**	**8,366,679**	**10,664,543**	**28,103,077**
Total	**42,052,400**	**72,069,770**	**27,296,504**	**12,933,535**	**85,003,305**

Grants not on Walkthrough

Behavioral Health Division - 2021-23 Biennium Budget						
Budget Account Code 712000 - Grants, Benefits, and Claims		**$ 17,438,534**	**$ 28,103,077**	**$ 21,470,277**	**$ 6,000,000**	**$ 632,800**
Vendor	**Description**	**2019-21 Biennium Amount**	**2021-23 Biennium Amount**	**General Fund**	**Federal Funds**	**Other Funds**
	Voluntary Treatment Program	533,440	453,424	453,424		
	Parent to Parent	75,000	63,750	63,750		
	Recovery Home Grants	200,000	200,000	200,000		
	Treatment Collaborative for Traumatized Youth	200,000	200,000	200,000		
	Behavioral Health School Grants	1,500,000	3,000,000	3,000,000		
	School Pilot 2017 HB 1040	300,000	300,000	300,000		
	SUD Voucher	7,997,294	17,253,103	17,253,103		
	System of Care	6,000,000	6,000,000		6,000,000	
Lutheran Social Services	Gambling	632,800	632,800			632,800

NORTH Dakota | Behavioral Health

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HOUSE BILL 1012 #2055

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

ADMINISTRATIVE SUPPORT BUDGET OVERVIEW

Jamie Wilke, Assistant CFO – Program and Policy

NORTH Dakota | Human Services

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Department of Human Services

Administration

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
90.45	89.85	97.85	8.5	11%	Executive Office	11
				55%	Fiscal Administration	54.3
				22%	Human Resources	21.8
				11%	Legal Advisory	10.75

COVID INFO

- Several processes were automated to allow for employees to work remotely
- Limited number of staff coming to office periodically for those items that cannot be completed remotely

Telework Headcount	
Pre-COVID	Current
2	82

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	General Fund	Other Funds	Total
Administration				
2021-23 Biennium Base Level - Administration	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362
2021-23 Ongoing Funding Changes				
Transfers and adjustments	(18.10)	$ (838,781)	$ (3,553,654)	$ (4,392,435)
Base payroll changes		$ (508,525)	$ 732,079	$ 223,554
Salary increase		$ 385,855	$ 82,012	$ 467,867
Retirement contribution increase		$ 79,629	$ 16,925	$ 96,554
Health insurance increase		$ 3,903	$ 830	$ 4,733
Subtotal Ongoing Funding Changes	(18.10)	$ (877,919)	$ (2,721,808)	$ (3,599,727)
Administration				
Continued program changes		$ 341,831	$ 841,290	$ 1,183,121
Savings plan	8.00	$ 431,068	$ 440,358	$ 871,426
Capital complex rent model change		$ 474,286	$ -	$ 474,286
Subtotal Administration	8.00	$ 1,247,185	$ 1,281,648	$ 2,528,833

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY - ADMINISTRATION

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	11,989,032	10,453,226	5,335,704	2,900,138	13,353,364
514x Salaries - Over Time	204,873	856,630	97,432	(856,630)	-
516x Salaries - Benefits	5,227,131	5,629,320	2,558,611	465,802	6,095,122
Total Salaries & Benefits	**17,421,036**	**16,939,176**	**7,991,747**	**2,509,310**	**19,448,486**
52x Travel	780,026	944,790	378,020	(115,853)	828,937
53x Supply	77,447	67,093	45,848	42,371	109,464
54x Postage & Printing	1,963,785	2,115,588	766,946	(5,972)	2,109,616
57x Insurance	359,331	177,413	112,170	27,531	204,944
58x Rent/Leases - Bldg./Equip	529,386	536,422	318,939	427,323	963,745
59x Repairs	45,362	46,570	14,963	(21,265)	25,305
61x Professional Development	82,293	89,522	37,073	(20,472)	69,050
62x Fees - Operating & Professional	4,518,954	2,903,673	1,167,959	468,416	3,372,089
60x IT Expenses	996,121	1,044,232	438,751	10,152	1,054,384
Total Operating	**9,352,705**	**7,925,303**	**3,280,669**	**812,231**	**8,737,534**
Total	26,773,741	24,864,479	11,272,416	3,321,541	28,186,020

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE – ADMINISTRATION

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ 17,103,105	$ 16,861,917	$ 7,495,737	$ 1,208,047	$ 18,069,964
FEDERAL	$ 9,298,933	$ 6,581,522	$ 3,751,770	$ 3,322,295	$ 9,903,817
OTHER	$ 371,703	$ 1,421,040	$ 24,909	$ (1,208,801)	$ 212,239
Total	**$ 26,773,741**	**$ 24,864,479**	**$ 11,272,416**	**$ 3,321,541**	**$ 28,186,020**

IT SERVICES

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	General Fund	Other Funds	Total
Information Technology Services				
Data processing costs and other program changes		$ 14,822,924	$ 4,401,791	$ 19,224,715
Savings plan		$ (4,396,355)	$ (3,012,157)	$ (7,408,512)
Technology contractual services and repairs		$ 4,010,886		$ 4,010,886
Early childhood data system		$ 500,000		$ 500,000
Microsoft Office 365		$ 200,315	$ 50,079	$ 250,394
Other funds reprioritizing			$ 2,324,362	$ 2,324,362
Subtotal ongoing funding changes	0.00	$ 15,137,770	$ 3,764,075	$ 18,901,845
One-time funding items				
Upgrade MMIS system		$ 4,326,686	$ 30,673,314	$ 35,000,000
Child welfare technology project		$ 15,000,000	$ 15,000,000	$ 30,000,000
Total one-time funding changes	0.00	$ 19,326,686	$ 45,673,314	$ 65,000,000

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY – INFORMATION TECHNOLOGY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	5,617,096	-	-	-	-
513x Salaries - Temp	420,640	-	-	-	-
514x Salaries - Over Time	32,320	-	-	-	-
516x Salaries - Benefits	2,462,881	-	-	-	-
Total Salaries & Benefits	8,532,937	-	-	-	-
52x Travel	125,854	-	-	-	-
53x Supply	124,388	-	-	-	-
54x Postage & Printing	316,675	316,860	141,510	(2,201)	314,659
55x Equipment Under $5,000	1,500,782	-	-	-	-
56x Utilities	1,897	-	-	-	-
58x Rent/Leases - Bldg./Equip	422,181	396,720	174,743	(396,720)	-
59x Repairs	17,993	-	-	-	-
61x Professional Development	46,625	-	-	-	-
62x Fees - Operating & Professional	187,349	-	-	-	-
60x IT Expenses	176,899,537	124,690,868	83,342,987	84,275,766	208,966,634
Total Operating	179,643,281	125,404,448	83,659,240	83,876,845	209,281,293
69x Equipment Over $5,000	77,237	50,000	-	25,000	75,000
Total Capital/Equipment over 5,000	77,237	50,000	-	25,000	75,000
Total	188,253,455	125,454,448	83,659,240	83,901,845	209,356,293

OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE – INFORMATION TECHNOLOGY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
GENERAL	$ 61,784,358	$ 46,989,576	$ 28,528,050	$ 34,464,456	$ 81,454,032
FEDERAL	$ 115,702,315	$ 74,426,552	$ 54,202,506	$ 51,056,184	$ 125,482,736
OTHER	$ 10,766,782	$ 4,038,320	$ 928,684	$ (1,618,795)	$ 2,419,525
Total	**$ 188,253,455**	**$ 125,454,448**	**$ 83,659,240**	**$ 83,901,845**	**$ 209,356,293**

IT DIFFERENCES (IN MILLIONS)

- **Medicare Management Information System (MMIS) Modernization Project - $35.0**
  - Collaborated with other states that have a mature modularization model for the estimated budget.
  - Budget includes estimates for systems integrator, solution vendors, project management and CMS IV&V.



- **Comprehensive Child Welfare Information System (CCWIS) Project - $30.0**
  - Collaborated with other states that recently implemented for the estimated budget.
  - Budget includes estimates for solution vendor and project management.

- **Continued Program Changes - $23.3**
  - $17.3 for SPACES M&O
  - $3.4 for Field Services M&O
  - $2.2 for NDHIN
  - $1.5 for MMIS M&O
  - $1.0 for Child Support M&O
  - $1.0 for Aging M&O
  - ($1.9) for CFS M&O
  - ($1.2) for other

M&O Maintenance of Operations



Contact Information

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BUDGET CHANGES

RENT MODEL CHANGE

- Current model
  - Only non-general fund agencies pay rent
- Proposed model
  - All agencies pay a consistent rental rate per square foot
  - Funding added in executive budget for all general fund agencies to pay rent based on current occupied space
    - Offsetting general fund savings in FM salary budget, which would now be funded from special funds
- Outcome
  - Agencies will be incentivized to efficiently manage space utilization and benefit from future rent savings if space is reduced
  - Better utilization of existing space has positive return by minimizing use of offsite space and makes best use of state resources

BUDGET CHANGES

FACILITY MANAGEMENT FUNDING SOURCE CHANGE

- Rent model change results in additional rent collection
- Provides opportunity to fund Facility Management from facility rent payments and move toward self-funded facility services model

- Net amount deposited in general fund remains nearly unchanged:
  - 2019-21 biennium rent deposited in general fund $2,545,000
  - 2021-23 biennium:
    - Total rent collected $7,762,000
    - Less amount used to fund FM salaries $5,245,000
    - Net amount deposited in general fund $2,517,000

NORTH Dakota Be Legendary. | Management and Budget

Capitol Complex Rent Model Change Proposal

Agency	Building	Office SF	Rate Per SF (office)	Storage SF	Rate Per SF (storage)	Total Office Rent Annual	Total Office Rent Biennial	Current Billable Rent	Additional Rent Amount	Amounts to use for Budget Adjustments
Governor's Office	Capitol/Jwing	5,142.00	$14.38	252	$1.10	$74,219.16	$148,438.32		$148,438.32	$148,438.00
Secretary of State	Capitol/Jwing	6,851.00	$14.38	943	$1.10	$99,554.68	$199,109.36	$6,248.66	$192,860.70	$192,861.00
Office of Management & Budget	Capitol/Jwing	6,419.00	$14.38	1,931	$1.10	$94,429.32	$188,858.64	$103,151.20	$85,707.44	$85,707.00
Facility Management	Capitol/Jwing	4,185.00	$14.38	3,171	$1.10	$63,907.76	$127,815.52		$127,815.52	$127,816.00
Facility Management	State Office Building			128	$1.87		$0.00		$0.00	$0.00
Human Resource Management Services	Capitol/Jwing	2,478.00	$14.38			$35,633.64	$71,267.28		$71,267.28	$71,267.00
Central Services Division	Capitol/Jwing	6,934.00	$14.38	1,747	$1.10	$101,632.62	$203,265.24		$203,265.24	$203,265.00
Information Technology	Capitol/Jwing	6,211.00	$14.38			$89,314.18	$178,628.36	$178,628.36	$0.00	$0.00
Auditor's Office	Capitol/Jwing	5,753.00	$14.38			$82,728.14	$165,456.28		$165,456.28	$165,456.00
Treasurer's Office	Capitol/Jwing	2,665.00	$14.38	170	$1.10	$38,509.70	$77,019.40		$77,019.40	$77,019.00
Attorney General	Capitol/Jwing	11,563.00	$14.38	370	$1.10	$166,682.94	$333,365.88	$43,864.86	$289,501.02	$289,501.00
Tax Department	Capitol/Jwing Liberty Memorial	19510.00 2,157.00	$14.38 $15.58	4,652	$1.10	$319,277.06	$638,554.12		$638,554.12	$638,554.00
Legislative Council	Capitol/Jwing	11,517.00	$14.38			$165,614.46	$331,228.92		$331,228.92	$331,229.00
Supreme Court	Capitol/Jwing	26,216.00	$14.38	890	$1.10	$377,965.08	$755,930.16		$755,930.16	$755,930.00
Public Instruction	Capitol/Jwing	15,960.00	$14.38	1,004	$1.10	$230,609.20	$461,218.40	$323,768.16	$137,450.24	$137,450.00
North Dakota University Systems	Capitol/Jwing	4,623.00	$14.38	184	$1.10	$66,681.14	$133,362.28		$133,362.28	$133,362.00
State Library	Liberty Memorial	12,660.00	$11.18	12,741	$1.12	$155,808.72	$311,617.44	$30,924.18	$280,693.26	$280,693.00
Career & Technical Education	Capitol/Jwing	6,730.00	$14.38	257	$1.10	$97,060.10	$194,120.20	$24,807.52	$169,312.68	$169,313.00
Health Department	Capitol/Jwing	28,943.00	$14.38	798	$1.10	$417,078.14	$834,156.28	$497,757.32	$336,398.96	$336,399.00
Indian Affairs	Capitol/Jwing	1,050.00	$14.38	29	$1.10	$15,130.90	$30,261.80		$30,261.80	$30,262.00
Human Services	Capitol/Jwing	30,041.00	$14.38	3,434	$1.10	$435,766.98	$871,533.96	$397,248.24	$474,285.72	$474,286.00
Insurance Department	Capitol/Jwing	5,236.00	$14.38	308	$1.10	$75,632.48	$151,264.96	$151,437.44	($172.48)	$0.00
Industrial Commission	Capitol/Jwing	635.00	$14.38	184	$1.10	$9,333.70	$18,667.40	$18,770.44	($103.04)	$0.00
ND Department of Labor & Human Rights	Capitol/Jwing	3,720.00	$14.38			$53,493.60	$106,987.20	$11,458.32	$95,528.88	$95,529.00
Public Service Commission	Capitol/Jwing	10,373.00	$14.38	473	$1.10	$149,684.04	$299,368.08	$89,080.88	$210,287.20	$210,287.00
Securities Commission	Capitol/Jwing	1,504.00	$14.38	644	$1.10	$22,335.92	$44,671.84	$45,032.48	($360.64)	$0.00
Highway Patrol	Capitol/Jwing	4,008.00	$14.38	425	$1.10	$58,102.54	$116,205.08	$19,411.06	$96,794.02	$96,794.00
Agriculture	Capitol/Jwing	7,357.00	$14.38	466	$1.10	$106,306.26	$212,612.52	$46,172.24	$166,440.28	$166,440.00
Historical Society	Heritage Center	13,732.00				$0.00	$0.00		$0.00	$0.00
Water Commission	State Office Building	21,435.00	$12.98	210	$1.87	$278,619.00	$557,238.00	$557,351.40	($113.40)	$0.00
Total for Current Capitol Occupants						**$3,881,111.46**	**$7,762,222.92**	**$2,545,112.76**	**$5,217,110.16**	**$5,217,858.00**

THE FMAP

The Federal Medical Assistance Percentage #2165

WHAT IS THE FMAP?

The Federal Medical Assistance Percentage (FMAP) rates are used in determining the amount of federal matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures.

AT DHS, THESE RATES APPLY TO:

- Traditional Medicaid Services
- Long-Term Care Services*
- Medicaid Wavier Services**
- Child Welfare/ IV-E Foster Care & Subsidized Adoption

**Excluding state programs SPED (Service Payments to Elderly and Disabled) and expanded SPED.*

***Including Home and Community Based Services, Developmental Disabilities Services and 1915(i) Services.*

BY THE NUMBERS

Federal Matching Assistance Percentage (N.D.)

FMAP follows the federal fiscal year from Oct-Sept	Rate
Oct. 1, 2015 - Sept. 30, 2019	50%
Oct. 1, 2019 - Sept. 30, 2020	50.05%
Oct. 1, 2020 - Sept. 30, 2021	52.4%
Oct. 1, 2021 - Sept. 30, 2022	53.59%

COVID FMAP Increase of 6.2% to FMAP	Rate
Jan. 1, 2020 - Sept. 30, 2020	56.25%
Oct. 1, 2020 - June 30, 2021***	58.60%

****This date may change pending extension of public health emergency.*

FEDERAL FISCAL YEAR EFFECTIVE DATES:

OCT. 1 — SEPT. 30

2020 → 2021

The FMAP is calculated each federal fiscal year and is effective Oct. 1 through Sept. 30 each year.

HOW FMAP WORKS...

The FMAP formula compares a state's three year average per capita income relative to the U.S. three year average per capita income.



Lower FMAP Reimbursement (Federal match minimum of 50%)

If the State and the U.S. per capita income are equal, then the FMAP is 55%

Higher FMAP Reimbursement (Federal match maximum of 83%)

Jan. 21, 2021

NORTH Dakota | Human Services
Be Legendary.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/21/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson called the meeting to order at 2:17 p.m.

Discussion Topics:

- Legislative Management Healthcare study
- Insurance Department
- Hospital Data
- Insurers
- Current Market Status
- Policy Alternatives

Jon Godfread, Insurance Commissioner (2:18 pm) introduced Jenn Hammer and introduced the health care study, oral testimony

Jenn Hammer, (2:24 pm) testified about the health care study #2220 #2219

Tim Blasl, President of the NDHA (3:53 pm) testified and provided comments about the Health care cost study #2214 #2215

Dave Molmon, CEO of Altru Health (4:21 pm) testified in favor of HB 1012, oral testimony

Chair Nelson Closed the meeting at 4:50 p.m.

Cole Fleck, Committee Clerk



North Dakota #2220
Legislative Management
Interim Healthcare Study

Updated with 2019 Data

North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

North Dakota
Insurance Department
Jon Godfread, Commissioner

Jan. 8, 2021

Legislative Leaders, Stakeholders and North Dakotans:

During the 66th Legislative Session the North Dakota Insurance Department was tasked with assisting Legislative Management in conducting an interim study of health insurance premium trends. The study is unique because the legislature foresaw the need to look beyond insurance carriers and authorized the collection of data from the state's hospitals.

To conduct this study the Insurance Department contracted JWHammer, LLC for project management services, and Horizon Government Affairs for actuarial services. JWHammer and Horizon both have experience in the insurance and healthcare fields.

The following study was done in cooperation with a great number of stakeholders, including both hospitals and insurers. I want to personally thank them for their willingness to be open and transparent throughout the process. As with any study, different conclusions may be drawn from the data presented. However, those conclusions are best left to the policy making branch of our government, this study should serve as an opportunity to guide a discussion on health care delivery and health care insurance coverage in our great state.

The report is an account of driving factors in the expense of healthcare and how that may impact the premiums consumers pay. The data, analysis, and recommendations will be vital as the state policy makers consider policies aimed at ensuring that North Dakotans are receiving quality healthcare at a fair and reasonable price.

I am proud of the work that was completed, the accuracy of the data, and the in-depth policy options provided. This is just the beginning of the discussion and I look forward to continuing to work together with the stakeholders of this report as well as legislative leaders to benefit all North Dakotans.

Sincerely,

Jon Godfread
Insurance Commissioner

JWHammer LLC
Access, Analysis, Results

North Dakota Insurance Department
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

HORIZON
GOVERNMENT AFFAIRS

Final Report January 2021
ND Legislative Management Interim Healthcare Study
January 8, 2021

Healthcare Cost Study Program Manager: Jennifer Hammer, JWHammer, LLC (jennifer@jwhammerllc.com)
Policy Manager: J.P Wieske, Horizon Government Affairs (HGA), VP State Policy (jpweiske@horizondc.com)
Data and Analysis: Jeff Lemieux, HGA Chief Economist (jlemieux@horizondc.com)
Research Assistant: Rundell Douglas, HGA

Background

In October 2019, the North Dakota Insurance Department (NDID) engaged JWHammer, LLC and consultant Horizon Government Affairs (HGA) to develop a multi-pronged study of North Dakota's health costs, including data gathering and analysis, baseline current-policy projections for the next several years, development of policy alternatives, and cost estimates of alternative policies relative to baseline.

This final report updates our September 2020 interim final report.[1] The main updates are new data for 2019 on North Dakota and 50-state insurance markets from the National Association of Insurance Commissioners (NAIC), and some new data on North Dakota hospitals in 2019 from the Medicare Cost Report system.

Covid-19 has had an extreme impact on the U.S. health care system and in North Dakota. As we reported in September, North Dakota's health costs dipped in April 2020, but rebounded by June, as more normal care patterns re-emerged and deferred care was delivered. By September, we estimate that monthly claims costs rose to considerably above their prior-year levels as Covid cases surged in North Dakota. As of mid-December 2020, North Dakota had recorded over 1,000 deaths directly attributed to Covid-19,[2] and the CDC estimated that all-cause deaths in North Dakota during the pandemic were 10 percent higher than expected.[3] Due to the pandemic, we did not attempt to formally gather additional data from hospitals and in-state insurers in late 2020.

In this report, we use the terms "discharges" and "admissions" synonymously. Likewise, "Covid-19" and "Covid." Years may be marked as calendar years or hospital cost report years. Calendar years are used for most hospital-to-hospital comparisons; Medicare Cost Report years are used for most of the broader state-to-state comparisons. Insurance comparisons are in calendar years.

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[1] https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/20200910%20North%20Dakota%20Legislative%20Management%20Interim%20Health%20Care%20Study.pdf

[2] https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases (accessed December 18, 2020).

[3] https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm (accessed December 18, 2020).

We view this report as a living document. Ongoing comments and feedback from state officials and stakeholders, particularly for the data comparisons, policy alternatives, and preliminary cost estimates are appreciated.

Outline

Executive Summary	Page 3
I. Hospital Data – Historical Data 2010-2019	Page 19
II. Hospitals – 50 State Comparisons	Page 28
III. North Dakota Insurers – Historical Data	Page 73
IV. Insurers – 50 State Data	Page 78
V. Current Market Status, Covid-19 Update, Baseline Projections to 2024	Page 92
VI. Policy Alternatives and Options	Page 105
VII. Cost and Impact Discussion	Page 123

Appendix A – Hospital Data Request
Appendix B – Information from IRS Form 990s and Financial Statements
Appendix C – Financial Assistance Detailed Data for All North Dakota Hospitals
Appendix D – Insurer Data Request
Appendix E – Aon Private Reinsurance Proposal

Executive Summary

Health Costs in North Dakota

In October 2019, the North Dakota Insurance Department (NDID) engaged JWHammer, LLC and consultant Horizon Government Affairs (HGA) to develop a multi-pronged study of North Dakota's health costs, including comparisons with all 50 states, development of policy alternatives, and cost estimates of alternative policies. We have focused mainly on hospital and insurance costs – those most closely monitored by North Dakota state agencies – and on policy alternatives the state could implement using in-state revenues. This final report updates our interim report from September 2020. Major changes include updated NAIC data for insurers' costs in all 50 states and updated 2019 data from the Medicare cost reports for North Dakota hospitals.

Hospital Costs. We gathered data on hospitals' overall costs and revenues in all the states from the Medicare cost reports. The data in these cost reports is not audited, so we compared it with data provided directly to us from the largest nine hospitals in North Dakota. In general, we found that the data for 2010-2018[4] matched well, giving us confidence that the Medicare cost report data was a good source for 50-state comparisons.

On a per-capita basis, hospital expenses in North Dakota were highest in the nation in 2018, and their growth rate of about 8% per year since 2010 was among the fastest in the U.S. (see Summary Figure 1 and Summary Table 2). That 8% growth was comprised of a 1.5% growth in utilization (inpatient days, outpatient visits etc.) and about 6.5% growth in unit costs between 2010 and 2019 (see Summary Table 1). The hospitals' largest expense is wages and benefits. We estimate that among the 9 largest hospitals in North Dakota, aggregate wages and benefits grew by about 7% annually between 2010 and 2019. This growth, in turn, was comprised of employment growth of about 3% annually, and wage and benefit growth per employee of about 4%. North Dakota's average wage per full-time equivalent employee (FTE) was about $88,000 in 2019, and wages grew rapidly between 2010 and 2019 (see Summary Figure 2).

As Summary Table 1 shows, hospital expense growth was not uniform across North Dakota's hospitals. In particular, expense growth was higher-than-average at Sanford Health's Bismarck and Fargo hospitals. At the committee hearing that discussed the interim version of this report[5], Sanford noted that their Fargo hospital had been certified as the state's first Level 1 trauma center during this period of rapid expenditure growth. However, the contrast between North Dakota's hospital costs and those of other states cannot be fully explained by service upgrades. For example, Minnesota's per-capita hospital costs were one-third less than North Dakota's in 2018, yet the state has 5 Level 1 trauma facilities.[6]

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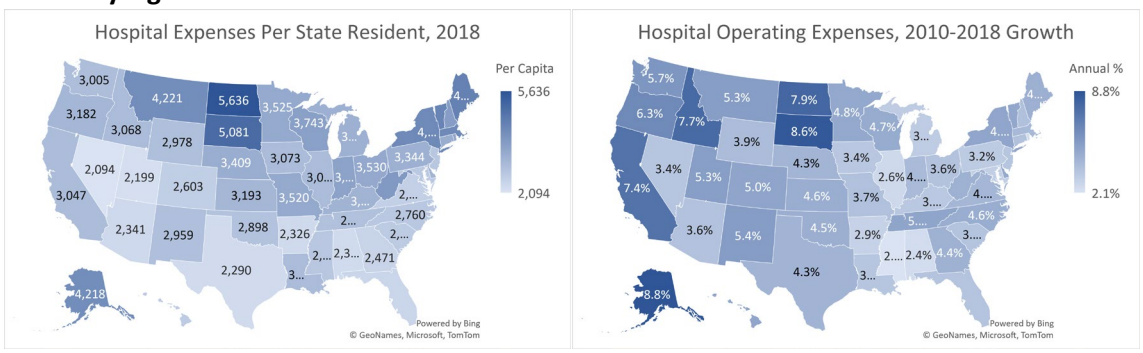
[4] For reasons of completeness of data, comparisons in this report start in 2010 or 2011, and end in 2018 or 2019.

[5] http://video.legis.nd.gov/en/PowerBrowser/PowerBrowserV2/20200910/-1/18285.

[6] https://www.health.state.mn.us/facilities/traumasystem/designatedhospitals.html. In the 2010-2019 period, North Dakota and Minnesota had similar results for Medicare's Case Mix Index – an indication of the complexity of cases among Medicare patients – with each state's results ranging from about 1.5 to 1.8 during the period. A fuller state-by-state and hospital-to-hospital comparison of indicators of patient outcomes, mortality and adverse event rates, readmissions, and other quality measures, for all patients (not just Medicare enrollees), is beyond the scope of this report.

Summary Figure 1.



Source: Horizon Government Affairs based on data from CMS.

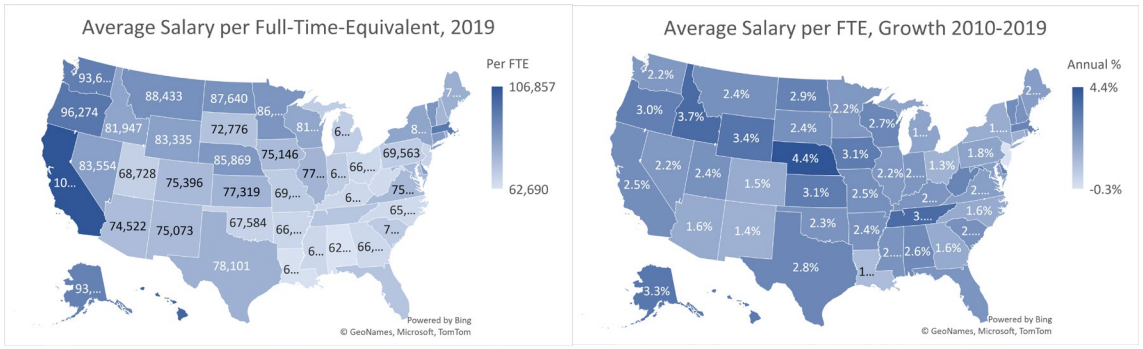
Summary Table 1.

Participating North Dakota Hospitals
Average Annual Growth in Expenses Per Unit of Use, 2010-2019

Six Large Acute Care Hospitals	Expense Growth	Utilization Growth	Unit Costs Expenses/Use
St Alexius	4.0%	-1.0%	5.0%
Sanford Bismarck	8.9%	4.4%	4.3%
Essentia	5.1%	0.8%	4.3%
Sanford Fargo	14.0%	2.4%	11.3%
Altru	6.0%	1.4%	4.5%
Trinity	3.1%	-1.0%	4.1%
Large Hospitals Weighted Average	**8.0%**	**1.5%**	**6.5%**
Three Critical Access Hospitals	7.4%	0.2%	7.2%
All 9 Hospitals Weighted Average	**8.0%**	**1.4%**	**6.5%**

Source: Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.

Summary Figure 2.



Source: Horizon Government Affairs based on data from CMS.

Summary Table 2.

North Dakota Hospital Rankings vs. Other States, 2010-2019*	Rank (highest to lowest)	
	Level	Growth
Inpatient Discharges		19
Inpatient Days		5
Inpatient Days per 1,000 People	4	18
Average Length of Stay	3	5
Occupancy Rate	37	24
Beds Per Person	5	16
Operating Expenses		3
Operating Expenses per Person	1	4
Operating Revenues		4
Operating Revenues per Person	2	4
Average Salaries per FTE	8	9
Inpatient Revenue per Discharge	6	2
Commercial to Medicare Rate Ratio	7	5
Medicare Case Mix Index	35	32
Medicare Revenues per Enrollee	2	2
Medicare Inpatient Revenues		6
Medicare Inpatient Revenue per Discharge +	33	6
Medicare Outpatient Revenues		4
Medicare Outpatient Revenues per Enrollee	1	3
Medicaid Revenues		3
Medicaid Inpatient Discharges		7
Medicaid Inpatient Days		7
Medicaid Revenues per Enrollee	1	1
Private Patient Revenues per Private Insurance Enrollee	3	10
Patient Financial Assistance	35	3

Source. HGA based on data from the Medicare Hospital Cost Reports.
Level Rankings are based on 2018 or 2019, and Growth Rankings are based on 2010 or 2011 to 2018 or 2019, depending on data availability.

Insurance Costs. Individual market premiums jumped by about 15 percent in 2018, and HGA estimates they rose by another 10 percent in 2019. However, premiums fell in 2020 by about 9 percent due to the establishment of North Dakota's reinsurance program. Premiums in the small group and large group markets have been a bit more stable, growing by roughly 4-6 percent per year on average in recent years (see Summary Table 3).

Despite higher-than-average hospital costs, North Dakota's premium levels compare favorably with those of other states. For example, Summary Figure 3 shows premiums for the individual market on a per-member-per-month basis and as an average annual growth rate from 2014 through 2019, the period in which the ACA benefit mandates were in force. Summary Table 4 shows North Dakota's rank among the 50 states on measures of premiums, benefit costs, and administrative costs for the individual, small group, and large group markets.

There are several possible explanations for North Dakota's lower-than-average premium costs. First, North Dakota's prescription drug claims have been moderate (see Summary Figure 4). Second, the state's insurers have had lower-than-average administrative costs (see Summary Figure 5), although those costs in North Dakota rose rapidly in the 2014-2019 period.[7] Third, North Dakota's individual market demographics are more favorable than most other states. A CMS study of enrollment in 2017 pegged North Dakota's enrollment of children under age 18 (who collectively tend to have lower claims costs than older enrollees) at 60% higher than the national average, while enrollment of people aged 35-64 (usually higher cost) was 12 percent less than the average nationally.[8] Finally, we suspect that North Dakota's health plans have relatively high average deductibles compared with other states. In the individual market, we estimate that deductibles currently average more than $4,000.

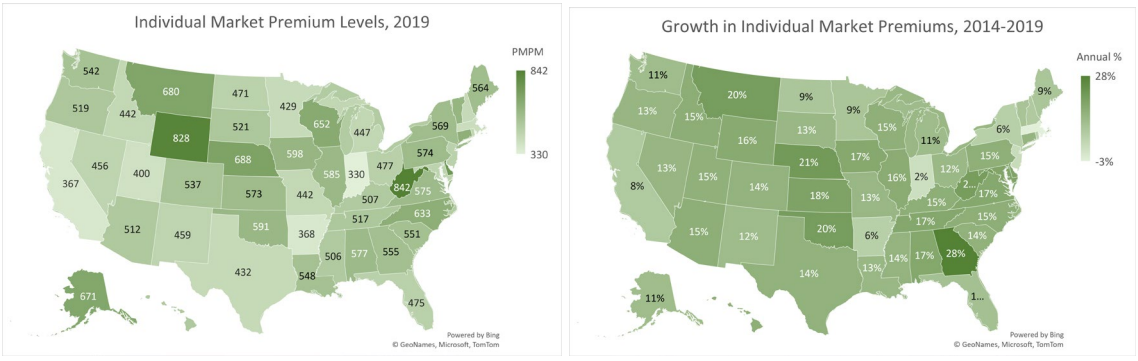
Summary Table 3.

North Dakota Insurance Coverage and Premiums

	2014	2015	2016	2017	2018	2019e	2020e
			Individual Market				
Covered Lives	48,356	53,234	51,183	48,968	45,294	43,747	41,547
Premiums (per member per month)	326	369	404	407	467	512	468
Growth		13%	9%	1%	15%	10%	-9%
			Small Group Market				
Covered Lives	64,497	64,424	62,179	60,381	60,028	61,351	59,314
Premiums (per member per month)	369	401	397	422	447	467	498
Growth		8%	-1%	6%	6%	4%	7%
			Large Group Market				
Covered Lives	160,820	149,872	151,322	149,111	154,872	156,685	152,178
Premiums (per member per month)	367	388	402	419	440	451	487
Growth		6%	3%	4%	5%	3%	8%

Sources: Large and Small Group market from NAIC. Individual market by HGA based on data from the NAIC, NDID/Novarest, and CMS. Estimates for 2019 and 2020 by HGA.
Note: Large group market does not include coverage by self-funded firms.

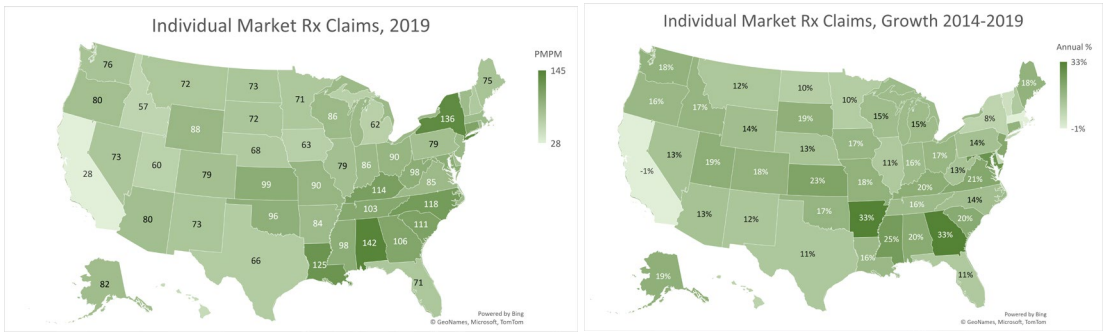
Summary Figure 3.



Source: HGA based on data from the NAIC.

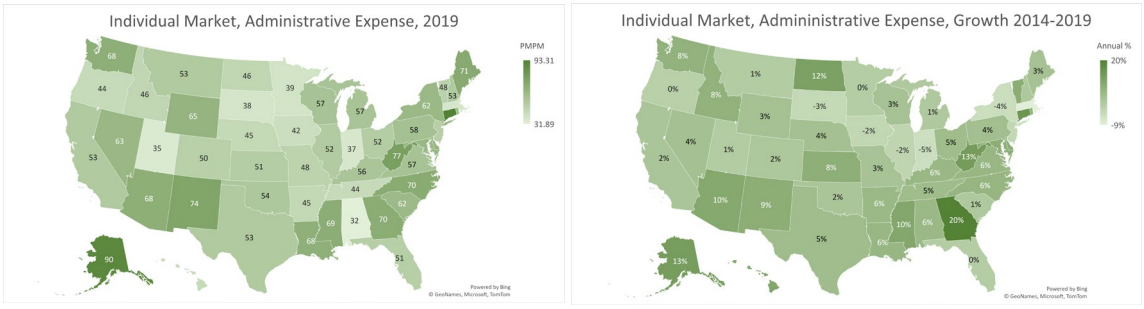
[7] At the legislative committee hearing, BCBSND noted a substantial IT upgrade during this period.
[8] CMS 2017 Marketplace Open Enrollment Period Public Use File.

Summary Figure 4.



Source: HGA based on data from the NAIC.

Summary Figure 5.



Source: HGA based on data from the NAIC.

Summary Table 4.

Insurance Measures Compared	**North Dakota Rank (highest to lowest)**	
	Level	Growth
Individual Market Premiums (PMPM)	35	43
Individual Market Claims	26	38
Individual Market Admin. Costs	38	5
Small Group Market Premiums	30	22
Small Group Market Claims	27	25
Small Group Market Admin. Costs	24	1
Large Group Market Premiums	18	12
Large Group Market Claims	16	13
Large Group Market Admin. Costs	41	3

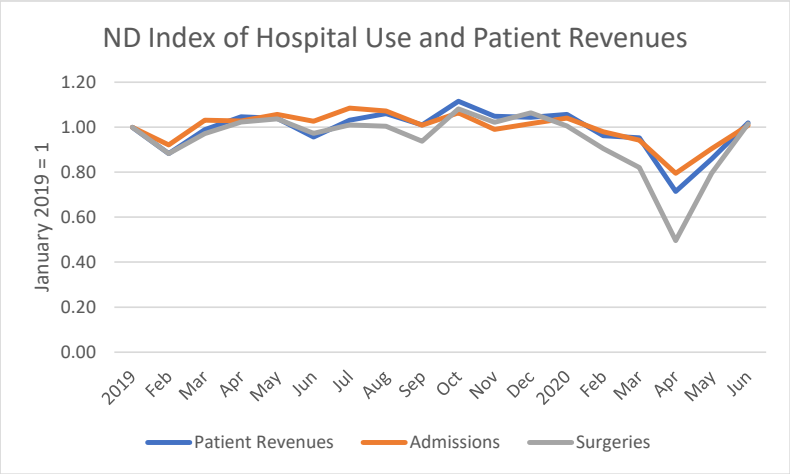
Source. HGA based on data from the Medicare Hospital Cost Reports.
Note: Level Rankings are based 2019, and Growth Rankings are based on 2014 to 2019.

Covid-19 and Baseline Projections

The impact of Covid-19 on the medical community and insurance costs have defied predictions. For some medical providers, it initially led to an unprecedented drop in demand for medical services, despite the pandemic. For insurers in some states, this drop in demand has led to a significant drop in claims.[9] Early reports indicated that treatment of heart attacks and strokes fell considerably at the onset of the pandemic – likely a reflection of individuals forgoing needed care.[10] By late 2020, however, both providers and insurers were facing sizable pent-up demand, as well as a surging pandemic, which led to increasing utilization and costs.

Our initial post-Covid surveys of North Dakota hospitals and insurance companies showed that while health care claims and utilization fell in April 2020, they had resumed their prior levels by June (see Summary Figure 6). The dip and recovery pattern was also evident in our surveys of North Dakota insurers, with cumulative claims per-member per-month in 2020 only slightly above levels for the same months by Summer of 2019.

Summary Figure 6.

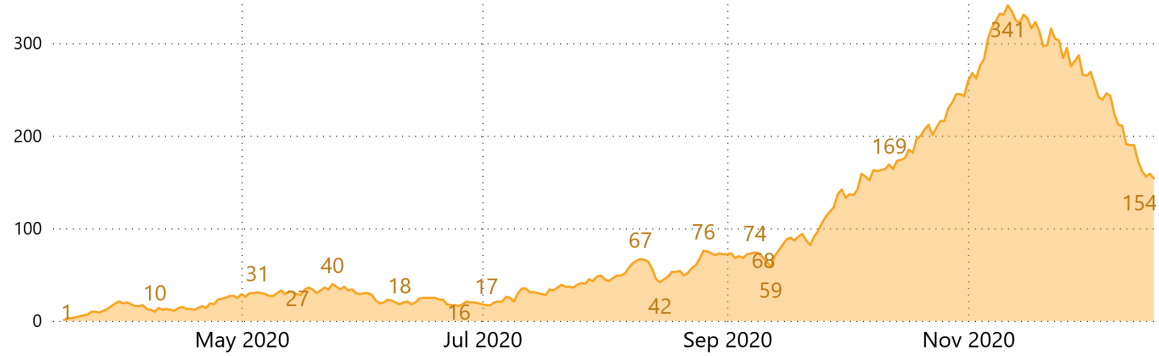


Sources: US: Bureau of Economic Analysis; ND: Horizon Government Affairs.
Note: ND index of patient revenues does not include federal emergency funding or other non-patient revenues.

However, by August and September 2020, North Dakota's Covid-19 case counts started increasing rapidly and by October and November, hospitalization rates jumped to among the highest in the nation (see Summary Figure 7). Hospitalization rates were declining as of late December, but we believe that by September through November, insurers' claims costs were running nearly 10 percent above costs for those months in 2019.

[9] https://www.houstonchronicle.com/business/article/Insurer-Anthem-s-2Q-profit-swells-helped-by-drop-15442284.php
[10] https://medicalxpress.com/news/2020-07-decline-emergent-hospitalizations-early-phase.html

Summary Figure 7.
Hospitalizations for Covid-19 in North Dakota



Source: North Dakota Covid Dashboard (accessed December 19, 2020) https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases .

During the initial Covid recession in the 2nd quarter of 2020, North Dakota lost about 8 percent of its payroll jobs (non-farm). The state's unemployment rate peaked at 9 percent in May, before falling to 6 percent by June and further to 4.5 percent in November.[11] Our surveys noted a corresponding decline in private insurance coverage mid-2020, which we reflected in our baseline projections.

Anecdotal indications from insurers show continuing reductions in private insurance coverage through November. The combination of accelerating numbers of Covid cases and the withdrawal of some federal economic relief in August led to a 5 percent decline in personal income in the state in the third quarter of 2020, which likely put further pressure on employers and individuals trying to maintain coverage.[12] Our baseline projections reflect the assumption that the state's economic outlook will remain weak heading into early 2021.

Preliminary Baseline Projections. Cost estimates of policy alternatives begin with a "baseline" projection of costs absent any policy change. Importantly, baseline projections aren't necessarily intended to be predictions of the future. Instead, they are used as a neutral benchmark against which the impact of policy alternatives can be assessed. In general, we project that rates of growth in both North Dakota's economy and its health sector will be quite subdued for an extended period.

Summary Table 5 shows our projections of enrollment by primary insurance type. Comparing post-Covid 2020 and beyond with pre-Covid 2019, we are assuming a small decline in individual coverage, some continued erosion of group coverage, particularly in the small group and large group non-ERISA markets, expansions of Medicare and Medicaid coverage, and an uptick in the number of uninsured.

[11] Bureau of Labor Statistics (https://www.bls.gov/web/laus/laumstrk.htm, accessed December 19, 2020).
[12] Bureau of Economic Analysis https://www.bea.gov/data/income-saving/personal-income-by-state (accessed December 18, 2020). The 5 percent decline is based on a reported 20.6 percent decline in the third quarter expressed as an annual rate (approximately 4 times the on-the-ground quarterly decline).

Relative to the interim final report, the adjustments to the coverage model in this final report are relatively minor. We updated large and small group coverage levels from the 2019 NAIC Supplemental Health Care Exhibit, which became available in November. We also updated some data for Medicaid and Medicare coverage for 2019 based on new compilations from the Kaiser Family Foundation, which are, in turn, based on new data from the U.S. Census Annual Community Survey (annual data).

Summary Table 5.

Baseline Enrollment Model

Primary Coverage for Acute Care	2019	2020	2021	2022	2023	2024	Change 2019-2024
			Number of Covered Lives				
Individual Market	43,747	41,547	41,538	41,581	41,673	41,810	-1,937
Small Group Employer	61,351	59,314	58,531	57,173	55,846	54,550	-6,801
Large Group Employer	156,685	152,178	152,365	152,553	153,504	154,461	-2,224
Large Group ERISA	201,187	197,551	195,957	196,335	196,713	197,093	-4,094
Medicaid	73,767	75,170	76,599	78,056	79,540	81,053	7,286
Medicare	114,549	116,803	119,102	121,447	123,837	126,274	11,726
Military and Other	29,745	28,932	28,164	27,439	26,754	26,106	-3,639
Uninsured	49,969	60,915	61,565	60,654	58,788	56,728	6,759
Total Population	731,000	732,410	733,822	735,237	736,655	738,076	7,076

Source: Horizon Government Affairs.

Summary Table 6 illustrates the basic contours of HGA's baseline assumptions about growth in the state's health costs. We assume hospital utilization continues to grow very slowly in the 2020-2024 period, while unit costs (costs per unit of utilization) rise by about 5 percent annually. We estimate that prescription drug costs (net of manufacturer rebates) will also continue growing relatively slowly, at about 4 percent per year on average. Compared with the interim report, we have made only one small modification to projections of claims and premium costs on a per-member per-month (PMPM) basis for this final report: a small reduction in the growth of costs in the small group market in 2021, which is based on the recent announcement by NDID of approved rates in that market.[13]

Summary Table 6.

Baseline Insurance Projections

	2019	2020	2021	2022	2023	2024
			Premiums PMPM			
Individual Market	512	468	481	511	543	577
Small Group Employer	467	498	506	529	559	591
Large Group Employer	451	487	511	538	565	594
			Annual Growth			
Individual Market		-8.7%	2.8%	6.3%	6.2%	6.2%
Small Group Employer		6.6%	1.6%	4.6%	5.6%	5.6%
Large Group Employer		7.9%	5.1%	5.1%	5.1%	5.1%
Memorandum:						
Growth of Hospital Unit Costs \1	4.0%	4.1%	4.5%	5.0%	5.0%	5.0%
Growth of Rx Claims (net of rebates)	3.9%	4.0%	4.2%	4.8%	5.4%	5.4%
Average Deductible (Individual Market)	$4,000	$4,500	$4,800	$5,100	$5,400	$5,700

Source: Horizon Government Affairs.

Notes: PMPM = per member per month; large group employer does not include self-funded (ERISA) plans.

\1 Overall hospital expenses per HGA composite index of utilization (admissions, outpatient visits etc.)

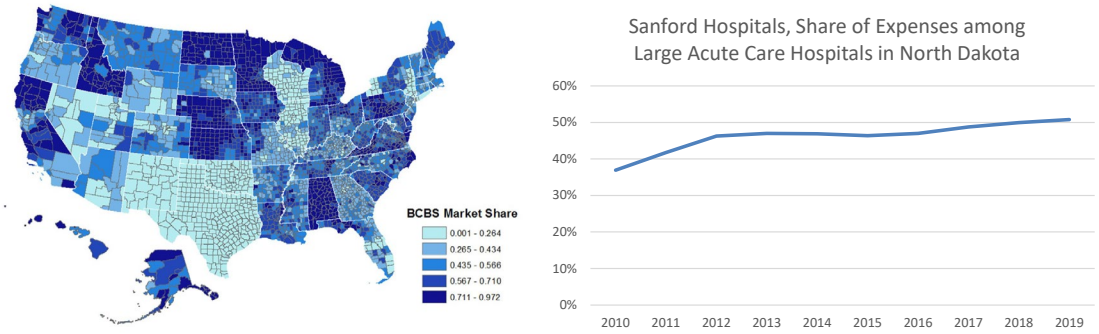
[13] https://www.insurance.nd.gov/news/godfread-announces-approved-2021-health-insurance-rates.

Competition and Markets. Although several insurers serve the North Dakota market, the dominant presence is Blue Cross Blue Shield of North Dakota, particularly in the individual market. Two metro areas (Bismarck and Fargo) host two hospitals; other cities and towns in North Dakota have at most one. Sanford Health Group owns the state's two fastest-growing hospitals, accounting for more than 50 percent share of the state's hospital expenses among large acute care facilities (see Summary Figure 8).

From an outsider's perspective at least, there are some areas of concern in North Dakota's health markets. Sanford hospital group is operating under a Corporate Integrity Agreement with the federal Department of Health and Human Services Office of Inspector General, resulting from whistleblower claims of unnecessary surgeries and self-dealing.[14] BCBS was recently fined following a market conduct exam, based on findings of improper payments for telehealth, mental health, and other services.[15]

North Dakota has few managed care plans and limited use of value-based payment methods, population health efforts or care coordination programs. Based on our pre-Covid interviews, the state's health system was characterized as a fee-for-service reimbursement regime, with providers competing to offer lucrative elective surgeries and insurers concentrating on holding down reimbursement rates across the board, with little regard for value of specific providers or patient outcomes from various care patterns.

Summary Figure 8.
Estimated Blue Cross Blue Shield and Sanford Group Market Share



Sources Horizon Government Affairs. BCBS data from Cooper et al. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" The Quarterly Journal of Economics (2019), 51–107. doi:10.1093/qje/qjy020 (Oxford University Press), Supplemental Appendices, page 81. Data from HealthLeaders Interstudy and U.S. Census.

[14] See https://www.justice.gov/opa/pr/sanford-health-entities-pay-2025-million-settle-false-claims-act-allegations-regarding and https://oig.hhs.gov/fraud/cia/agreements/Sanford_Health_Sanford_Clinic_and_Sanford_Medical_Center_10252019.pdf (PDF).

[15] See https://www.insurance.nd.gov/news/insurance-commissioner-fines-blue-cross-blue-shield-north-dakota-125000-result-market-conduct and https://www.nd.gov/ndins/sites/www/files/documents/Enforcement/Market%20Conduct%20Exams/2018-19%20BCBSND%20Exam%20Report%20-%20Signed%20-%20FINAL.pdf.

Certainly, North Dakota is not unique in this regard. On a nationwide basis, the pandemic has exposed problems with existing markets for health care delivery and financing. In general, we assume that competitive markets produce efficient and desirable outcomes. In theory, and in practice in most industries, competitive market outcomes provide choices and value. However, it's not clear that North Dakota has benefited to the fullest extent from competitive efficiencies and innovations.

A key question for North Dakota is: Are competitive markets in health care possible? If so, can we strengthen them? If not, can the state work with health care providers and insurers to approximate competitive-style outcomes under a more collaborative system? What degree of public transparency and/or cooperation could lead to more dynamic outcomes without falling into the trap of over-regulation?

Early on in this project, we interviewed representatives from a coalition of hospitals attempting to develop a plan to convert North Dakota's health system from an old-fashioned fee-for-service and hospital dominated approach to better population health and care management.

We believe that the Covid-19 emergency has the potential to spark a more serious discussion of how North Dakota could re-wire its existing health system, while also maintaining and encouraging new competition. Hospitals accustomed to competing for lucrative patients or physicians may need to refocus their efforts on population health and monitoring, using common data. The state's dominant insurer may need to develop population-health and outcomes-based global reimbursement systems rather than simply paying under the same fee-for-service regime year after year. The idea of getting more competitive results, either through additional competition, better directed competition, or public-private cooperation and transparency runs through the policy alternatives discussed below.

Policy Alternatives

As part of our charge, we propose a variety of policy alternatives. Ultimately these policy alternatives reflect value judgements that must be made by North Dakotans and not by outside consultants. Not all of these policy alternatives will work for North Dakota. Some may even contradict one another. We have provided, what we hope, is sufficient information for the North Dakota Legislature, Insurance Commissioner, and Governor to make informed decisions on a path forward to lowering health insurance premiums, lowering health care costs, and providing better population health for North Dakotans.

Important disclosures – Horizon Government Affairs represents clients and coalition members who provide real-time benefit and pricing information for prescription drugs and who provide telehealth services; expansion of both services is recommended below. JWHammer LLC has clients that could potentially offer services to North Dakota under these recommendations. Additional disclosures are listed in the footnote.[16]

[16] Horizon Government Affairs (HGA) is a Washington, D.C.-based government affairs consulting firm that serves a number of clients in the health care industry and operates a number of coalitions that are similarly focused on health care issues. Horizon is not aware of, nor do we have reason to believe, that any of the recommendations included in this report would substantially benefit any of our clients or coalition members. None of the recommendations

Utilization & Care Management. Medication nonadherence and the related hospital admissions and emergency department visits are a significant driver of health care costs. Aligning the interests of the insurer, consumer and medical provider are key to driving down costs and moving consumers to better health.

1. **Benchmark Plan Revisions - Optimized Medication Plans:** The estimated annual cost of prescription drug-related morbidity and mortality resulting from nonoptimized medication therapy was $528.4 billion in 2016 US dollars.[17] Creating a medication optimization plan can have great health benefit for patients and save money.
2. **Private Insurance (Group) Mandate - Optimized Medication Plans:** Similar to the Benchmark Plan revisions, huge strides could be made in the group market. Small and large group plans could be required to offer an optimization program.
3. **Integrated Health Homes:** Our health system has become increasingly byzantine in its complexity and a consumer's ability to manage their own health care. The chronically ill face many issues usually including the management of multiple medical issues. Creating an integrated health home can help patients better manage their health conditions.
4. **Medicaid Strict Managed Care/Value-based Benefit Design** The state should encourage the use of value-based design in the state employee health plan and consider providing incentives for adherence. An outside vendor – not a PBM –may be able to assist state workers in managing their prescriptions and helping with adherence.[18]
5. **Other Options:**

   Limit Medicaid expansion to 100% of poverty. Currently North Dakota has expanded eligibility for Medicaid to 138% of poverty. However, the Affordable Care Act provides subsidies for private insurance to all individuals over 100% of poverty. This option would place people in the 100-138% of poverty range back into ACA subsidized private coverage. Note, the state savings may be limited due to federal matching of 90 percent for Medicaid expansion enrollees in the 100-138% of poverty range.

   Re-form Medicaid expansion as an exclusively managed care model. The importance of a medical home is highlighted above, but a number of states have begun using a similar managed care model in Medicaid. The idea is to eliminate

included herein have been generated for the purpose of directly or indirectly benefitting HGA's direct clients or coalition members. Additional information on HGA is available at www.horizondc.com. Information on our coalitions, including member organizations are available at the following websites: Council for Affordable Health Coverage (www.cahc.net), Health Innovation Alliance (www.health-innovation.org), Health Benefits Institute (www.thehealthbenefitsinstitute.org). J W Hammer, LLC is a Springfield, IL based law and consulting firm that serves clients in multiple industries and states, including clients that may or may not respond to the state's future requests for proposals that may be the result of this report, including but not limited to Aon and Affinity. It is unclear whether Hammer's clients may or may not substantially benefit from recommendations included herein. None of the recommendations included herein have been generated solely for the purpose of directly or indirectly benefitting Hammer's direct clients. Additional information regarding J W Hammer, LLC is available at www.jwhammerllc.com.

[17] Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. *Ann Pharmacother.* 2018;1060028018765159. doi: 10.1177/1060028018765159.

[18] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.

a fee-for-service program in its entirety and require insurers to manage the health of Medicaid recipients. This could streamline state efforts if the state managed a single risk pool rather than two separate pools paying different rates and managed differently.

Prices, Coverage, and Insurance Initiatives. Pricing reforms have the potential to restrain the ever-upward push of commercial rates, improve coverage for telehealth services, and consider an alternative method of providing reinsurance coverage. The rate cap policy is explained in more detail by researchers from RAND, who offer it as a less disruptive alternative to broader rate setting or public option proposals.

6. **Cap on Out-of-Network Payment Rates:** Medicare's payment rates are commonly used as a benchmark for insurers, and rates relative to Medicare have been rising in North Dakota. By limiting rates to a percentage of Medicare in the out-of-network market, North Dakota would effectively stem the ever-upward drift of commercial payment rates.
7. **Private Reinsurance:** To supplement the cost-saving efforts of the 1332 waiver program, the State should evaluate purchasing private reinsurance to further reduce costs for individual taxpayers participating in the State's healthcare marketplace. Private reinsurance can assist in driving down/stabilizing rates and preventing spikes, providing consistency for taxpayers/users.
8. **Telehealth:** If structured properly, telehealth services may increase access to needed care while also controlling costs. For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000% increase in telehealth visits in the Midwest between April 2019 and April 2020.[19] Consumers are increasingly becoming accustomed to telehealth, and states should consider whether existing regulatory barriers are necessary.

Transparency. Price transparency is seen as a panacea to our health system and blame for opaque pricing is assigned to hospitals, insurance companies, government policy, consumer disinterest, and an overly complicated health care system. The truth is, there is more than enough blame to go around. The most important issue to understand about price transparency is that it is a means to an end. Transparency is necessary to encourage competition. Competition stimulates innovation – lower prices and better quality.

9. **Direct to Consumer Pricing: Disclosure of Consumer Prices.** We used a secret shopper to compare prices at several hospitals in North Dakota for three common procedures: colonoscopy, normal vaginal delivery, and caesarian section (see Summary Table 7). What we found was drastically different price estimates. For consumers, these price differences are confusing. We suggest using Medicare rates as a reference and requiring hospitals to disclose their prices as a percentage of Medicare.
10. **Right to Shop:** As highlighted above, there is significant cost variation for common procedures across North Dakota providers. Consumers often are referred by the

[19] https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2020-midwest-telehealth.pdf

medical provider to the most convenient care delivery center. However, there may be cheaper alternatives with equal or even better-quality outcomes. Right to Shop legislation would allow insurers to make a cash payment back to a consumer when the consumer has shopped for and chosen a less expensive option.

Summary Table 7.

Hospital-Reported Prices for Selected Common Procedures

	Colonoscopy	Normal Vaginal Delivery	Caesarian Section
Trinity Hospital - St.Josephs (Minot)	2,980	4,343	5,058
St.Alexius Medical Center (Bismarck)	1,775	4,895	9,675
Sanford Medical Center (Fargo)	3,843	15,056	22,376
Sanford Medical Center (Bismarck)	5,509	13,603	20,386
Altru Health System (Grand Forks)	2,064	12,239	19,269
Jamestown Regional Medical Center	2,100	13,000	25,000
Innovis Health (Fargo)	4,700	11,000	31,000
Ratio of Highest to Lowest (Percent)	**310%**	**347%**	**613%**

Source: JWHammer LLC.

Program Integrity. Program Integrity focuses on maximizing taxpayer resources by ensuring that North Dakotans receiving health benefits are covered by the correct payer. For example, a Medicaid recipient shouldn't be covered by Medicaid if they are eligible for a group health plan. Whether it is mission creep, shifting priorities or just loss of focus, states stray away from dedicating time and resources to program integrity. Program integrity can provide quick and consistent wins.

11. **Medicaid Integrity Audit:** When a consumer receives financial assistance, North Dakota law allows for full assignment of benefits with no time limit. It is important for the state to periodically audit Medicaid benefits for other responsible payers. In some cases, children may be eligible for coverage under a non-custodial parent. Some recipients have opted out of their employer coverage. In other cases, the care received was reimbursed as part of a lawsuit. Contingency fee contracts provide vendors the opportunity to find savings for the state. The state also has an opportunity to build program integrity requirements into the RFP for the Medicaid expansion.
12. **State Group Health Integrity Audit:** This effort is similar to the Medicaid audit but would be applied to the state employee health plan.
13. **State Group Health Waiver**: The state currently provides no-cost health insurance to state employees and their families but the offer of "free" health insurance can lead to double coverage regardless of whether or not their spouse works for the state. Offering a small bonus to state employees who choose to opt entirely out of coverage may lower overall benefits expenses.
14. **Coordination of Benefits:** Coordination of Benefits rules in health insurance clarify which insurer is responsible for paying for certain benefits. The rules work entirely automatically and are a great example of program integrity. The North Dakota Department of Insurance could consider the benefits of adopting the newer National Association of Insurance Commissioner's model.

Employer Coverage. The vast majority of consumers receive coverage through their employer. As employer coverage continues to erode due to rising costs, states need to find new solutions to help employers.

15. **Study Combined Individual and Small Group Market :** Most states have an unstable individual market but North Dakota appears to be in good shape. A number of states have combined their individual and small group markets to make it easier for small employers to offer coverage. For example, employers offering coverage in the District of Columbia Exchange set their subsidy level (an amount or plan level) and the employee chooses coverage. It provides administrative simplicity for the small employer and choice of benefits for the employee.

Crisis & Pandemic Planning. It seems clear that some hospitals and insurers nationally were caught flat-footed by the pandemic. However, the Covid-19 crisis shouldn't have been a complete surprise, based on experience with numerous prior pandemics. Based on our preliminary analysis, the effects on North Dakota hospitals haven't been as dramatic as in harder-hit states. But this pandemic is not yet over.

16. **Risk Assessments:**
    Hospital and Insurer Own Risk Solvency Assessment. Domestic insurers are required to file a highly confidential report that details the risks to their business called the Own Risk Solvency Assessment or ORSA. This board level report is expected to detail all of the potential risks facing an insurer. North Dakota could consider adding a pandemic requirement for insurers and requiring hospitals to address potential public health risks with a required confidential report reviewed by the hospital's Board of Directors.

Cost and Impact Estimates

For some of the policy alternatives noted above we have prepared preliminary cost estimates and discussion. It may seem odd to discuss cost containment during a pandemic, when many health care providers are pushed to heroic limits. However, the pandemic won't last forever, and nuts and bolts discussions of the growth of health costs vs. affordability for government, employer, and consumer budgets will inevitably return to the spotlight.

Option: Cap Patients' and Insurers' Responsibility for Out-of-Network Charges. In March 2020, researchers at the RAND Corporation published a report demonstrating the savings and impact of capping hospitals rates for out-of-network services.[20] This policy would effectively stem the ever-upward drift of commercial payment rates relative to those paid by Medicare by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates.

[20] Erin Lindsey Duffy, Christopher Whaley, Chapin White, *The Price and Spending Impacts of Limits on Payments to Hospitals for Out-of-Network Care*, RAND (March 20,2020)
https://www.rand.org/pubs/research_reports/RR4378.html

While this policy would not directly affect rates for in-network providers, it would indirectly put downward pressure on in-network rates over time. If insurers would otherwise face in-network rates higher than the cap, they could switch the provider to out-of-network status and pay a lower amount. We would view an out-of-network cap as potentially the least disruptive approach to limiting rates, compared with other policy alternatives such as public rate setting regime or public option alternative.

Summary Table 8 below shows the potential impact for a flat cap that remained at 220 percent from 2021 through 2024. Claims would be reduced by $7 million in the individual market and $29 million in the large group (insured) market by 2024, and premiums would be lowered by 2-3%, by that year. In dollars, premiums would be lowered by $166-187 per year or about $15 per member per month (PMPM) by 2024. Under an option where the cap was gradually lowered from 220 percent in 2021 to 190 percent in 2024, claims costs and premium reductions would be larger, with premiums falling by approximately $500 per year or about $40 PMPM by 2024.

Option: Re-Pricing Payment Rates for the Medicaid Expansion Population. For Medicaid expansion enrollees, North Dakota pays healthcare providers at rates more typical for commercial payers than those usually used for Medicaid enrollees not part of the expansion program. This option illustrates the magnitude of possible savings from bringing those rates down to those used in the rest of North Dakota's Medicaid program.

However, since the state's share of costs for the Medicaid expansion population is small, the savings from this proposal would mostly accrue to the federal government. We estimate that possible state savings from this policy could range from $5 to $8 million in 2021, growing to $6 to $9 million in 2024.

Option: Require Stricter Managed Care and Full Risk Health Plans in Medicaid. The Congressional Budget Office has issued two recent reports on potential savings from managed care in Medicare[21] and Medicaid.[22] To be fair, neither report directly specifies CBO's estimate of savings from tighter management of care by Medicaid or Medicare managed care organizations (MCOs). Nevertheless, we infer that the reports imply a potential savings of about 10 percent over time from the conversion of fee-for-service coverage to a strict managed care approach, and perhaps half of that potential savings from the conversion of loosely managed care to a stricter model.

We applied those potential savings amounts to North Dakota's Medicaid program, assuming the greater savings potential from the conversion of the non-expansion enrollee populations to strictly managed care, and the lesser savings from converting the current Medicaid expansion MCO to a stricter model. We estimate that the net savings for North Dakota would be low at first, but would grow to about $25 million by the year 2024 (see Summary Table 8).

[21] Congressional Budget Office, A Premium Support System for Medicare: Updated Analysis of Illustrative Options (October 5, 2017) https://www.cbo.gov/publication/53077

[22] Congressional Budget Office, Exploring the Growth of Medicaid Managed Care (August 7, 2018) https://www.cbo.gov/publication/54235

Summary Table 8.

Potential Cost Savings From Various Policy Options	DRAFT			
Savings in millions of dollars	2021	2022	2023	2024
Cap Out-of-Network Rates at 220% of Medicare Rates				
Reduction in Premiums, Individual Market PMPM	-1	-5	-9	-14
Reduction in Premiums, Small Group Market PMPM	-1	-5	-10	-15
Federal Savings (millions)	-1	-5	-9	-14
Cap Out-of-Network Rates at 220% in 2021, Declining to 190% by 2024				
Reduction in Premiums, Individual Market PMPM	-1	-13	-25	-39
Reduction in Premiums, Small Group Market PMPM	-1	-14	-28	-43
Federal Savings (millions)	-1	-13	-25	-38
Re-Price Medicaid Expansion at Regular Medicaid Rates				
Federal Savings (millions) -- Higher End Estimate	-81	-85	-89	-93
State Savings	-8	-8	-9	-9
Federal Savings (millions) -- Lower End Estimate	-53	-57	-61	-65
State Savings	-5	-6	-6	-6
Tighter Managed Care and Population Health Requirements in Medicaid				
Total Original Medicaid FFS (non-institutionalized enrollees) Federal + State	-2	-15	-29	-45
State Share	-2	-9	-16	-23
Expansion MCO	1	-3	-7	-12
State Share	0	0	-1	-1
Net State Cost (+) or Savings (-)	-2	-9	-17	-25

Source: Horizon Government Affairs.

Notes: PMPM = per member per month. FFS = fee for service. MCO = Managed Care Organization.
Components may not sum exactly to totals due to rounding.

Section I. Hospital Data – Historical 2010-2019

Contents: Key Findings

1. Patient Utilization Measures Grew by About 1-2% Per Year
2. Hospital Revenues and Expenses Have Risen by about 7.5-8.0% Per Year
3. Growth in Costs Per Unit of Use Averaged 6.5% Per Year
4. Average Salaries Rose 4% and Employment Grew 3% Per Year
5. Case Mix Index Growth in Medicare was 1% Per Year
6. Commercial Payment Rates Grew From about 170% to Over 200% of Medicare's Rates
7. Patient Financial Assistance is About 1 Percent of Patient Revenues
8. Hospital Compensation for Top Executives and Physicians Ranged Widely

HGA's data gathering started with the purchase of multiyear Medicare Cost Report Information System (HCRIS) data, processed by RAND (https://www.hospitaldatasets.org/) for all hospitals in the U.S, organized by Medicare Provider Number. From this data, we determined that nine hospitals in North Dakota met the criteria for in-depth study: acute care, nonfederal hospitals in communities with more than 10,000 residents.

In-Depth Study of Nine North Dakota Hospitals. HGA issued a data request to these nine hospitals based on the American Hospital Association's (AHA's) annual survey, after discussion with the state's hospitals and the North Dakota Hospital Association (NDHA). NDHA arranged to have the historical data submissions for the survey sent back from the AHA to each hospital, to make the data response less burdensome. The data request is shown in Appendix A.

One key purpose of the data request was to supplement and verify the publicly available data from HCRIS, which we use for state-by-state comparisons. We used concepts and definitions from the American Hospital Association's (AHA's) annual survey, so that responding hospitals could use familiar concepts.

Our preliminary finding is that the HCRIS 2010-2018 data provides a good summary of the state's utilization, expenses, and revenues, although there were several cases where we had to make corrections to the HCRIS data for individual North Dakota hospitals based on the hospital's AHA data response and in subsequent discussion with hospitals. There are other instances where the definitions used in each dataset are different, but generally similar. We further spot-checked the results against some data reported by non-profit hospitals on their IRS form 990 disclosures. The IRS data also contain additional data on compensation of top officers, executives, and physicians, which is shown in Appendix B. The one concept where the HCRIS and AHA did differ noticeably was on the hospitals' allocations of their revenues from payers: commercial vs. Medicare and Medicaid. In general, we have defaulted to using the AHA data as a guide for our projections.

The hospital-by-hospital HCRIS data we use for in-state North Dakota hospital comparisons was updated in November 2020. However, some data points and hospitals had missing data, and we have not attempted to contact hospitals during this fall's Covid surge to ask about issues with this latest data set. The preliminary 2019 hospital-by-hospital HCRIS results included in this

report are therefore subject to considerable uncertainty. Likewise, due to the missing data, we are unable to report aggregated hospital data from HCRIS for 2019.

For Tables 1-9, regarding the 9 hospitals with in-depth data, both the HRCIS and AHA data are converted to calendar years by HGA.

Patient Utilization Measures Grew by About 1-2% Per Year. Among the 9 reporting North Dakota hospitals, inpatient admissions have been roughly flat since 2010 (0.3% average annual growth AHA data; 0.1% HCRIS data; see Table 1). Meanwhile overnight inpatient "days" have grown slowly (1.3% per year AHA data; 1.6% HCRIS), such that the average length of stay increased from about 4.1-4.2 days in 2010 to 4.6 days in 2019. Outpatient and Emergency Department (ED) visits grew more rapidly, rising at average annual growth rates of 1.2 percent and 2.0 percent, respectively, and outpatient surgeries grew rapidly (5.4% per year). HGA's overall composite utilization index, which includes admissions, days, ED and outpatient visits, outpatient surgeries, and so on, increased by 1.4% per year between 2010 and 2019, with most of that growth occurring between 2010 and 2013.

Table 1.

Aggregate Utilization Measures (AHA Data vs. HCRIS)

Nine Responding Plans (by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
					DRAFT						
Admissions				**AHA Historical Data**							
Medicare	33,327	33,734	33,991	32,447	32,033	32,892	33,266	34,081	34,850	35,016	0.6%
Medicaid	11,395	12,010	11,550	10,543	11,624	13,287	15,540	15,659	16,227	16,447	4.2%
Private/Other	35,648	36,899	39,871	39,410	37,116	34,288	29,914	30,295	30,009	31,147	-1.5%
Total	80,370	82,643	85,411	82,399	80,773	80,467	78,719	80,034	81,085	82,610	0.3%
Days											
Medicare	165,591	172,163	178,394	177,299	171,340	179,089	175,646	172,764	175,152	173,370	0.5%
Medicaid	47,813	50,064	51,015	51,457	63,848	73,616	83,832	84,841	86,288	86,551	6.8%
Private/Other	124,500	128,035	139,158	137,875	130,317	125,119	119,596	113,605	114,437	120,147	-0.4%
Total	337,903	350,262	368,567	366,630	366,805	379,124	379,073	371,210	375,877	380,068	1.3%
Inpatient Surgeries	25,872	25,684	26,030	25,702	24,987	24,696	24,635	24,718	24,202	24,156	-0.8%
ED Visits	206,738	224,232	244,550	244,103	252,343	256,880	253,005	246,322	244,994	247,200	2.0%
Outpatient Visits	1,809,797	1,838,424	1,958,487	2,083,629	2,148,674	2,156,467	2,171,771	2,109,200	2,061,083	2,013,684	1.2%
Outpatient Surgeries	43,231	53,934	61,136	63,953	66,806	68,218	68,734	69,183	69,905	69,564	5.4%
Beds	1,554	1,593	1,588	1,603	1,634	1,638	1,631	1,668	1,700	1,675	0.8%
Occupancy Rate	59.6%	60.3%	63.6%	62.7%	61.5%	63.4%	63.7%	61.0%	60.6%	62.2%	0.5%
Average Length of Stay (days per admission)											
Medicare	5.0	5.1	5.2	5.5	5.3	5.4	5.3	5.1	5.0	5.0	0.0%
Medicaid	4.2	4.2	4.4	4.9	5.5	5.5	5.4	5.4	5.3	5.3	2.5%
Private/Other	3.5	3.5	3.5	3.5	3.5	3.6	4.0	3.8	3.8	3.9	1.1%
Weighted Average	4.2	4.2	4.3	4.4	4.5	4.7	4.8	4.6	4.6	4.6	1.0%
Overall Utilization Index, 2010=1 \a	1.00	1.04	1.11	1.12	1.13	1.15	1.14	1.13	1.13	1.13	1.4%
Admissions				**HCRIS Data**							
Medicare	26,680	26,921	27,699	27,191	27,753	28,782	29,288	30,106	30,354		1.6%
Medicaid	10,095	10,334	9,921	8,798	9,210	10,145	11,133	10,850	11,555		1.7%
Private/Other	39,380	40,528	39,610	39,613	36,258	35,500	35,670	36,442	35,008		-1.5%
Total	76,155	77,783	77,230	75,602	73,221	74,428	76,092	77,398	76,917		0.1%
Days											
Medicare	122,885	129,796	135,946	136,284	137,920	147,385	149,090	148,579	148,875		2.4%
Medicaid	49,019	49,788	53,843	55,584	65,111	70,929	73,126	71,768	69,828		4.5%
Private/Other	136,558	142,672	145,570	141,440	134,108	130,901	130,184	130,771	132,611		-0.4%
Total	308,463	322,257	335,359	333,308	337,139	349,215	352,400	351,118	351,315		1.6%
Beds	1,308	1,312	1,337	1,442	1,388	1,436	1,452	1,475	1,475		1.5%
Occupancy Rate	64.6%	67.3%	68.7%	63.3%	66.5%	66.6%	66.5%	65.2%	65.2%		
Average Length of Stay (days per admission)											
Medicare	4.6	4.8	4.9	5.0	5.0	5.1	5.1	4.9	4.9		0.8%
Medicaid	4.9	4.8	5.4	6.3	7.1	7.0	6.6	6.6	6.0		2.8%
Private/Other	3.5	3.5	3.7	3.6	3.7	3.7	3.6	3.6	3.8		1.1%
Weighted Average	4.1	4.1	4.3	4.4	4.6	4.7	4.6	4.5	4.6		1.5%

Source: Horizon Government Affairs. HCRIS data via RAND, vintage 11-4-19.

Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.

\a Overall utilization composite index is calculated by HGA using data from the AHA survey responses. It is not an AHA calculation.

1. ***Hospital Revenues and Expenses Have Risen by about 7.5-8.0% Per Year***. Total expenses and revenues of the nine reporting hospitals grew by about 7.5-8.0% per year in the 2010-2019 period, with only slight differences in the AHA and HCRIS estimates (see Table 2).

Table 2.

Aggregate Revenues and Expenses (AHA Data vs. HCRIS), All Nine Reporting Hospitals **DRAFT**

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
		AHA-Style Data									
AHA Data											
Payroll	947	1,062	1,187	1,226	1,261	1,360	1,467	1,561	1,631	1,681	6.6%
Benefits	169	188	210	214	220	242	271	288	298	309	6.9%
Total, Wages and Benefits	1,116	1,250	1,397	1,440	1,481	1,602	1,739	1,850	1,929	1,990	6.6%
Interest Expense	30	32	34	36	39	42	43	46	49	47	5.4%
Other Expenses	754	886	1,126	1,223	1,315	1,395	1,459	1,532	1,649	1,747	9.8%
Total, Expenses	1,899	2,169	2,556	2,699	2,835	3,038	3,240	3,428	3,627	3,784	8.0%
Patient Revenues	1,934	2,195	2,521	2,618	2,824	3,072	3,221	3,360	3,495	3,598	7.1%
Non-Patient, Non-Oper. Revenue	102	105	130	183	199	170	183	203	256	327	13.8%
Total, Revenues	2,036	2,300	2,651	2,801	3,023	3,241	3,404	3,563	3,751	3,925	7.6%
Margin	136	131	94	103	188	203	164	135	124	140	
Margin %	7%	6%	4%	4%	6%	6%	5%	4%	3%	4%	
Medicare Cost Reports		**HCRIS Data**									
Total Wages and Benefits	1,008	1,171	1,370	1,437	1,489	1,572	1,650	1,711	1,744		7.1%
Interest Expense	32	35	36	38	40	42	43	48	52		6.5%
Other Expenses	930	1,089	1,260	1,335	1,429	1,537	1,667	1,766	1,851		9.0%
Operating Expenses	1,970	2,295	2,666	2,810	2,958	3,152	3,361	3,526	3,647		8.0%
Patient Revenues	2,012	2,336	2,622	2,729	2,944	3,190	3,323	3,419	3,532		7.3%
Non-Patient, Non-Oper. Revenue	102	94	108	164	181	155	192	230	239		11.2%
Total, Revenues	2,114	2,430	2,730	2,893	3,125	3,344	3,514	3,649	3,771		7.5%
Margin	102	94	108	164	181	155	192	230	239		
Margin %	5%	4%	4%	6%	6%	5%	5%	6%	6%		

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019.
Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.

2. ***Growth in Costs Per Unit of Use Averaged 6.5% Per Year***. We compared average annual growth in expenses with growth in HGA's composite index of growth in utilization (see Tables 3 and 4). By this measure, the weighted average annual growth in expenses per unit of use was about 6.5 percent between 2010 and 2019. On a per-hospital basis, the range of annualized growth in expenses per unit of use ranged from a low of 4 percent to more than 11 percent. The hospital with the fastest-growing costs, Sanford Fargo, had annual utilization growth of 2.4 percent per year, with expense growth per unit of utilization growth of about 11 percent per year.

Table 3.

Composite Utilization and Expenses — DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
6 Large Acute Care Hospitals	**HGA Composite Utilization Index (2010 = 1)**										
St Alexius	1.00	1.04	1.09	1.08	1.07	1.03	0.92	0.87	0.88	0.92	-1.0%
Sanford Bismarck	1.00	1.07	1.18	1.20	1.25	1.29	1.31	1.37	1.40	1.48	4.4%
Essentia	1.00	0.97	0.96	1.03	1.07	1.13	1.19	1.15	1.08	1.07	0.8%
Sanford Fargo	1.00	1.08	1.15	1.15	1.15	1.17	1.17	1.17	1.21	1.24	2.4%
Altru	1.00	1.06	1.16	1.16	1.16	1.20	1.26	1.23	1.21	1.14	1.4%
Trinity	1.00	1.02	1.04	1.04	1.04	1.03	0.98	0.94	0.92	0.91	-1.0%
Weighted Average	1.00	1.05	1.12	1.12	1.13	1.15	1.15	1.13	1.14	1.14	1.5%
3 Critical Access Hospitals	1.00	0.99	0.94	1.02	1.05	1.18	1.05	1.06	1.04	1.02	0.2%
All 9 Hospitals Weighted Average	1.00	1.04	1.11	1.12	1.13	1.15	1.14	1.13	1.13	1.13	1.4%
6 Large Acute Care Hospitals	**Aggregate Expenses (HCRIS, millions)**										
St Alexius	223	238	257	267	286	314	322	313	305	308	4.0%
Sanford Bismarck	265	308	361	405	431	452	497	509	526	586	8.9%
Essentia	254	263	285	313	328	351	375	379	378	378	5.1%
Sanford Fargo	420	597	806	842	877	926	994	1,113	1,195	1,243	14.0%
Altru	363	386	429	449	461	493	533	556	578	610	6.0%
Trinity	330	374	383	377	406	437	450	457	463	476	3.1%
Total	1,856	2,166	2,522	2,653	2,789	2,973	3,170	3,327	3,446	3,602	8.0%
3 Critical Access Hospitals	114	128	144	157	169	178	190	199	202	204	7.4%
All 9 Hospitals Total	1,970	2,295	2,666	2,810	2,958	3,152	3,361	3,526	3,647	3,806	8.0%

Source: Horizon Government Affairs. HCRIS via RAND vintage 11-4-2019. 2019 HCRIS expenses projected by HGA.
Note: Weighting for the composite index of inpatient and outpatient utilization measures by HGA. HCRIS 2019 expenses projected by HGA.

Table 4.

Average Annual Growth in Expenses Per Unit of Use, 2010-2019 — DRAFT

Six Large Acute Care Hospitals	Expense Growth	Utilization Growth	Unit Costs Expenses/Use
St Alexius	4.0%	-1.0%	5.0%
Sanford Bismarck	8.9%	4.4%	4.3%
Essentia	5.1%	0.8%	4.3%
Sanford Fargo	14.0%	2.4%	11.3%
Altru	6.0%	1.4%	4.5%
Trinity	3.1%	-1.0%	4.1%
Large Hospitals Weighted Average	**8.0%**	**1.5%**	**6.5%**
Three Critical Access Hospitals	7.4%	0.2%	7.2%
All 9 Hospitals Weighted Average	**8.0%**	**1.4%**	**6.5%**

Source: Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.

3. ***Average Salaries Rose 4% and Employment Grew 3% Per Year.*** Overall wages and employee benefits grew by more than 7 percent per year, comprised of 4 percent annual wage growth and 3 percent growth in the number of full time equivalent (FTE) employees. Average salaries per FTE grew to $103,000 in 2018 (see Tables 5, 6 and 7).

Table 5.

Aggregate Wages and Benefits (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
				HCRIS Wages and Benefits							
6 Large Acute Care Hospitals											
St Alexius	122	132	138	152	156	165	163	154	136	138	1.4%
Sanford Bismarck	142	159	201	208	216	235	252	251	254	276	7.6%
Essentia \a	117	121	130	136	140	143	145	149	153	156	3.4%
Sanford Fargo	183	282	381	398	415	439	470	514	544	564	14.6%
Altru	237	250	274	287	298	309	325	340	350	358	5.0%
Trinity	149	162	177	185	191	206	216	220	222	226	4.6%
Total	949	1,107	1,301	1,366	1,416	1,497	1,571	1,628	1,659	1,719	7.2%
3 Critical Access Hospitals											
Total	59	64	69	72	73	75	80	84	85	85	4.7%
All Reporting Hospitals	1,008	1,171	1,370	1,437	1,489	1,572	1,650	1,711	1,744	1,804	7.1%

Source: HCRIS/RAND Vintage 11-4-19. Calculations and Tabulation by Horizon Government Affairs.
Note: HCRIS 2019 figures are projected by HGA.
\a 2019 is based on 2017-2018 trend.

Table 6.

FTEs (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
				HCRIS Number of Full-Time Equivalent Employees (FTEs)							
6 Large Acute Care Hospitals											
St Alexius	1,828	1,813	1,866	1,945	1,956	1,992	1,850	1,512	1,276	1,212	-4.5%
Sanford Bismarck	1,993	1,994	2,285	2,289	2,383	2,526	2,487	2,614	2,383	\a	2.6%
Essentia	1,632	1,623	1,694	1,694	1,694	1,694	1,694	1,580	1,628	1,581	-0.4%
Sanford Fargo	2,297	3,039	3,859	4,164	4,355	4,553	4,681	4,990	5,299	5,714	10.7%
Altru	2,876	2,999	3,015	3,107	3,086	3,111	3,196	3,153	3,119	\a	1.0%
Trinity	\b	2,061	2,237	2,275	2,391	2,176	2,449	2,499	2,222	2,158	0.6%
Total	12,626	13,529	14,957	15,475	15,866	16,053	16,357	16,347	15,927	\a	2.9%
3 Critical Access Hospitals	798	809	909	933	900	860	861	916	933	913	1.5%
All Reporting Hospitals	13,424	14,338	15,867	16,408	16,765	16,913	17,217	17,263	16,860	\a	2.9%

Source: HCRIS via RAND vintage 11-4-2019. Additional Calculations and Tabulation by Horizon Government Affairs.
Note: 2019 approximated by HGA based on data from HCRIS via RAND vintage 11-1-2020.
\a No 2019 data available. Average annual growth in calculated 2010-2018.
\b No 2010 data available; Average annual growth is calculated 2011-2019.

Table 7.

Average Salaries (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average Annual Growth
				HCRIS Wages and Salaries per FTE						
6 Large Acute Care Hospitals										
St Alexius	66,688	72,970	73,775	78,038	79,763	82,923	88,278	101,845	106,813	6.1%
Sanford Bismarck	70,999	79,883	87,866	88,893	89,920	86,573	100,681	97,246	103,652	4.8%
Essentia	72,667	71,527	74,581	78,618	81,676	83,275	85,040	92,315	93,902	3.3%
Sanford Fargo	79,517	90,554	98,717	95,554	95,203	96,490	100,311	103,115	102,572	3.2%
Altru	82,330	83,528	90,990	92,367	96,429	99,393	101,598	107,803	112,262	4.0%
Trinity \a	75,000	75,027	75,897	81,238	77,714	90,581	87,712	86,785	100,138	4.2%
Weighted Average	76,175	81,754	87,583	88,527	89,487	92,278	96,403	100,402	104,313	4.0%
3 Critical Access Hospitals										
Jamestown	71,088	72,469	75,005	74,807	76,079	81,821	89,217	81,652	87,322	2.6%
Dickinson	63,473	79,882	79,882	85,063	90,865	95,036	101,822	97,886	94,557	5.1%
Williston	71,560	84,470	79,205	67,530	74,404	74,404	89,186	95,240	90,427	3.0%
Weighted Average	68,565	79,824	78,296	75,573	80,402	83,195	93,680	92,507	91,113	3.6%
All Reporting Hospitals	75,682	81,638	87,047	87,747	88,905	91,704	96,239	99,924	103,532	4.0%

Source: HCRIS via RAND vintage 11-4-2019. Additional Calculation and Estimates by Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.
\a 2010 figure is a rough approximation; Average annual growth is calculated 2011-2018.

4. ***Case Mix Index Growth in Medicare was 1% Per Year.*** Although we do not have a direct estimate of the overall intensity of all patient stays, Medicare's case mix index – a proxy for the complexity or difficulty of cases – among Medicare patients rose by about 1 percent per year in the 2010-2018 period, with most of the growth between 2010 and 2014 (see Table 8).

Table 8.

Medicare Casemix Index (HCRIS Data, Approximated by RAND)

DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth /a
6 Large Acute Care Hospitals				**HCRIS/RAND Calculations ("impact_cmi")**							
St Alexius	2.03	2.10	2.08	2.08	2.08	2.01	2.02	1.99	2.04	1.92	-0.6%
Sanford Bismarck	1.75	1.85	1.83	1.78	1.87	1.89	1.90	1.92	1.89	1.89	0.8%
Essentia	1.77	1.78	1.77	1.84	1.97	1.80	1.82	1.87	1.80	1.87	0.6%
Sanford Fargo	1.89	1.86	1.89	1.96	2.07	2.04	2.13	2.13	2.13	2.14	1.4%
Altru	1.72	1.68	1.70	1.86	1.84	1.82	1.81	1.79	1.84	/a	0.9%
Trinity	1.64	1.69	1.68	1.67	1.65	1.65	1.80	1.90	1.87	1.87	1.5%
Weighted Average	1.81	1.82	1.83	1.88	1.94	1.90	1.94	1.96	1.96	/a	1.0%
				Year-to Year Growth Rate							
St Alexius		3.5%	-0.7%	-0.4%	0.3%	-3.4%	0.2%	-1.2%	2.4%	-5.9%	
Sanford Bismarck		5.4%	-1.1%	-2.7%	5.4%	1.2%	0.3%	0.8%	-1.1%	-0.2%	
Essentia		0.7%	-0.5%	4.1%	6.6%	-8.6%	1.2%	3.0%	-4.1%	4.0%	
Sanford Fargo		-1.7%	1.4%	3.8%	5.7%	-1.4%	4.5%	-0.2%	0.2%	0.4%	
Altru		-2.4%	1.6%	9.2%	-1.1%	-1.2%	-0.4%	-1.0%	2.9%	/a	
Trinity		3.1%	-0.4%	-0.2%	-1.3%	-0.3%	9.3%	5.6%	-1.7%	0.0%	
Weighted Average		0.5%	0.5%	3.1%	2.7%	-1.9%	2.4%	0.6%	0.4%	/a	

Source: HCRIS data RAND vintage 11-4-2019 and vintage 11-1-2020. Additional Calculations and Tabulation by Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.
/a Data may be missing for 2019. Average annual growth from 2010 to last year shown, 2018 or 2019, depending on data availability.

5. ***Commercial Payment Rates Grew From about 170% to Over 200% of Medicare's Rates.*** An indirect method of computing payment rates, using charge to revenue ratios, suggests that average commercial payment rates rose from about 170 percent of Medicare rates in 2011 to more than 200 percent in 2018, with most of the growth occurring in the 2014-2018 period (see Table 9). Note that the individual hospitals had widely varying ratios from year to year by this measure, so we view the individual hospital data as particularly uncertain.

Table 9.

Approximate Private to Medicare Payment Rates (HCRIS Data, Approximated by RAND) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
6 Large Acute Care Hospitals		**HCRIS/RAND Calculations ("commercial_to_mdcr_est")**								
St Alexius		1.95	1.94	1.88	1.90	2.27	2.23	1.99	2.01	1.53
Sanford Bismarck		1.93	1.51	1.92	1.82	2.08	2.17	2.03	1.95	2.19
Essentia		2.07	1.87	2.05	2.54	2.42	2.47	2.06	3.01	3.22
Sanford Fargo		1.45	1.99	1.93	1.97	1.94	2.18	2.07	2.11	2.03
Altru		1.36	1.39	1.37	1.37	1.45	1.50	1.51	1.67	/a
Trinity		2.17	2.18	1.18	1.92	2.53	2.73	2.66	2.53	2.48
Weighted Average		1.70	1.80	1.72	1.85	2.00	2.11	1.99	2.11	/a
3 Critical Access Hospitals										
Jamestown		1.48	1.25	1.34	1.21	1.17	1.32	1.35	1.46	1.45
Dickinson		1.76	1.48	1.41	1.18	1.06	1.13	1.10	1.21	1.24
Williston		2.05	1.67	1.60	1.15	1.07	1.36	1.43	1.77	1.93
Weighted Average		1.70	1.48	1.47	1.17	1.13	1.15	1.29	1.49	/a
All Reporting Hospitals		1.70	1.78	1.70	1.81	1.94	2.05	1.94	2.07	/a

Source: HCRIS data via RAND vintage 11-1-2020. Additional Calculations and Tabulation by Horizon Government Affairs.

Note: Calculated as ratio of commercial charge-to-revenue ratio to Medicare charge-to-revenue ratio. Weighting is a custom blend of inpatient and outpatient utilization by HGA.

6. ***Financial Assistance is About 1 Percent of Patient Revenues***. Table 10 shows our tabulations of total financial assistance provided to patients (both insured and uninsured) qualifying for hospitals' financial assistance programs. These amounts are HCRIS tabulations of the approximate cost of care for patients in financial assistance programs less partial patient payments.

   In general, financial assistance levels were about 1 percent of net patient revenues for all North Dakota hospitals. However, reported financial assistance grew rapidly during the 2011-2018 period, with average growth of nearly 10 percent per year. Appendix C shows the HCRIS tabulations in greater detail for all North Dakota Hospitals.

Table 10.

Financial Assistance (Uninsured and Insured Patients) DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
Raw HCRIS Data (by cost report year, millions of dollars)											
6 Large Acute Care Hospitals											
St Alexius		1	1	1	0	3	4	3	2	2	18.4%
Sanford Bismarck		5	13	7	6	8	5	5	6	4	-1.0%
Essentia		2	1	2	1	3	2	4	4	5	10.1%
Sanford Fargo		4	5	9	17	17	12	13	16	18	22.4%
Altru		2	1	2	2	1	1	1	4	/a	12.7%
Trinity \a		0	0	0	3	1	5	6	11	2	-10.2%
Total		13	22	21	30	33	30	32	43	/a	9.6%
3 Critical Access Hospitals		3	2	2	2	1	1	2	3	4	1.3%
Other Critical Access Hospitals		2	2	3	2	1	1	3	3	/a	12.4%
All North Dakota Hospials		19	27	25	34	36	32	36	49	/a	9.8%
As a Percentage of Net Patient Revenues											
6 Large Acute Care Hospitals											
St Alexius		0.3%	0.5%	0.5%	0.2%	1.0%	1.3%	1.1%	0.7%		
Sanford Bismarck		1.5%	4.1%	3.9%	1.7%	1.9%	1.0%	0.9%	1.2%		
Essentia		0.9%	0.3%	0.6%	0.3%	0.9%	0.6%	1.1%	1.0%		
Sanford Fargo		0.7%	0.7%	1.1%	1.9%	1.8%	1.2%	1.2%	1.4%		
Altru		0.4%	0.3%	0.4%	0.4%	0.3%	0.3%	0.2%	0.7%		
Trinity		0.0%	0.0%	0.0%	0.8%	0.2%	1.1%	1.3%	2.4%		
Total		0.6%	0.9%	0.9%	1.1%	1.1%	1.0%	1.0%	1.3%		
3 Critical Access Hospitals		2.9%	1.8%	1.2%	1.3%	0.4%	0.7%	1.0%	1.4%		
Other Critical Access Hospitals		0.9%	0.7%	0.8%	0.6%	0.5%	0.3%	0.8%	0.9%		
All North Dakota Hospitals		0.8%	0.9%	0.9%	1.1%	1.0%	0.9%	1.0%	1.3%		

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019; 2019 figures from vintage 11-1-2020.
Note: Average annual growth rate calculations are from 2011-2019 except as noted.
\a Data for some hospitals is missing for 2019. Average annual growth is computed from 2011-2018. Trinity reported zero financial assistance in 2011-2013; growth is calculated as 2014-2019.

7. ***Executive and Top Physician Compensation Ranged Widely***. HGA looked at the IRS form 990s to collect data on compensation of top executives and physicians at the non-profit hospitals studied. Importantly, some of the non-profit hospitals report as part of a larger group, so the top executive and physician compensation reported may not be in North Dakota. For example, many of the top executives and physicians reporting on the Sanford Group's form 990 may be based in South Dakota (see Table 11 and Appendix B).

Table 11.

Top Executive and Physician Compensation Reported on IRS Form 990 **DRAFT**

Millions of Dollars	2010	2011	2012	2013	2014	2015	2016	2017	Average Annual Growth
Top Executives				**St Alexius**					
Highest	0.61	0.50	0.70	0.56	0.80	0.76	0.61	0.62	0%
2nd	0.48	0.50	0.55	0.43	0.67	0.65	0.57	0.56	2%
3rd	0.25	0.28	0.30	0.23	0.38	0.53	0.29	0.40	7%
Top Physicians									
Highest	1.50	1.67	1.98	1.96	2.30	2.00	2.09	1.70	2%
2nd	1.40	1.65	1.60	1.56	2.10	1.98	1.30	1.46	1%
3rd	0.91	0.80	1.00	0.76	1.00	1.20	0.99	1.04	2%
Top Executives				**Sanford (group, includes other states)**					
Highest	1.85	2.07	2.15	4.80	2.50	4.60	4.17	3.16	8%
2nd	1.08	1.20	1.11	3.78	1.36	1.18	3.03	1.48	5%
3rd	1.00	0.99	0.87	1.95	1.02	1.15	1.17	1.10	1%
Top Physicians									
Highest	2.30	2.10	2.12	2.63	3.40	2.92	2.93	2.92	3%
2nd	2.30	2.08	2.10	2.43	2.49	2.68	2.68	2.69	2%
3rd	1.80	2.06	2.09	2.29	2.30	2.49	2.58	2.68	6%
Top Executives				**Altru**					
Highest	0.42	0.50	0.54	0.57	0.69	1.08	1.09	0.85	11%
2nd	0.35	0.33	0.39	0.47	0.43	0.66	0.76	0.75	12%
3rd	0.32	0.30	0.35	0.31	0.42	0.65	0.68	0.56	8%
Top Physicians									
Highest	1.60	1.77	1.85	1.86	1.19	1.20	1.36	1.40	-2%
2nd	1.10	1.08	1.07	1.10	1.03	0.99	1.00	1.18	1%
3rd	1.05	1.08	1.04	0.99	1.03	0.91	0.97	1.01	-1%
Top Executives				**Trinity**					
Highest	0.41	0.44	0.49	0.56	0.68	0.83	0.76	0.84	11%
2nd	0.29	0.26	0.26	0.25	0.30	0.35	0.37	0.38	4%
3rd	0.22	0.24	0.22	0.21	0.25	0.28	0.28	0.29	4%
Top Physicians									
Highest	0.99	1.01	0.82	1.08	0.62	0.55	0.85	0.78	-3%
2nd	0.71	0.84	0.55	0.75	0.13	0.20	0.58	0.60	-2%

Source: Tabulations and calculations by Horizon Government Affairs.

Note: Average annual growth rate calculations are from 2010-2017.

II. Hospitals – 50 State Comparisons

Contents: Measures Compared Across All States	ND Rank (highest to lowest)		
	Level		
	BEGIN*	END*	Growth
9. Inpatient Discharges			19
10. Inpatient Days			5
Inpatient Days per 1,000 People	7	4	18
11. Average Length of Stay	11	3	5
12. Occupancy Rate	42	37	24
13. Beds Per Person	5	5	16
14. Operating Expenses			3
Operating Expenses per Person	2	1	4
15. Operating Revenues			4
Operating Revenues per Person	2	2	4
16. Average Salaries per FTE	15	8	9
17. Inpatient Revenue per Discharge	21	6	2
18. Commercial to Medicare Rate Ratio	30	7	5
19. Medicare Case Mix Index	24	35	32
20. Medicare Revenues per Enrollee	3	2	2
21. Medicare Inpatient Revenues			6
22. Medicare Inpatient Revenue per Discharge [+]	42	33	6
23. Medicare Outpatient Revenues			4
24. Medicare Outpatient Revenues per Enrollee	1	1	3
25. Medicaid Revenues			3
26. Medicaid Inpatient Discharges			7
Medicaid Inpatient Days			7
27. Medicaid Revenues per Enrollee	3	1	1
28. Private Patient Revenues per Private Insurance Enrollee	4	3	10
29. Patient Financial Assistance	50	35	3

Source. HGA based on data from the Medicare Hospital Cost Reports.
*Beginning points are 2010 or 2011 and endpoints are 2018 or 2019, depending on data completeness. Growth is based on 2010 or 2011 to 2018 or 2019.

HGA used HCRIS data to make several types of comparisons of North Dakota's hospital costs and utilization with measures from the other states and the nation as a whole. Importantly, these tabulations include data from all hospitals in North Dakota and other states, including federal hospitals, specialty hospitals in the HRCIS data, and additional critical access North Dakota hospitals that did not participate in the data request for this project and whose data were not included in the tables in the prior section. The 50-state comparisons below are based on HCRIS data processed by RAND vintage 8-1-2020.

The 50-state data are shown in cost reporting years, and some data for 2019 may be incomplete. Note that the national totals include Puerto Rico, but data from U.S. territories is not otherwise shown in the tables or rankings. Because some 2019 data may be incomplete – for several measures that are not ratios or averages, we show average annual growth rates for 2010-2018. Other tabulations are based on data that were first reported in 2011. Growth rates for these items may be 2011-2018 or 2011-2019.

8. ***Inpatient Discharges.*** The growth of inpatient discharges (admissions) in North Dakota has been roughly flat in the 2010-2018 period (-0.1% annual growth), while the nationwide trend was for a slight decline during that period (-0.6% per year). Much of the growth in North Dakota admissions was during the 2010-2012 period; the number of admissions in the state has leveled off or declined slowly since 2012 (see Table 12 and Figure 1).

Figure 1.

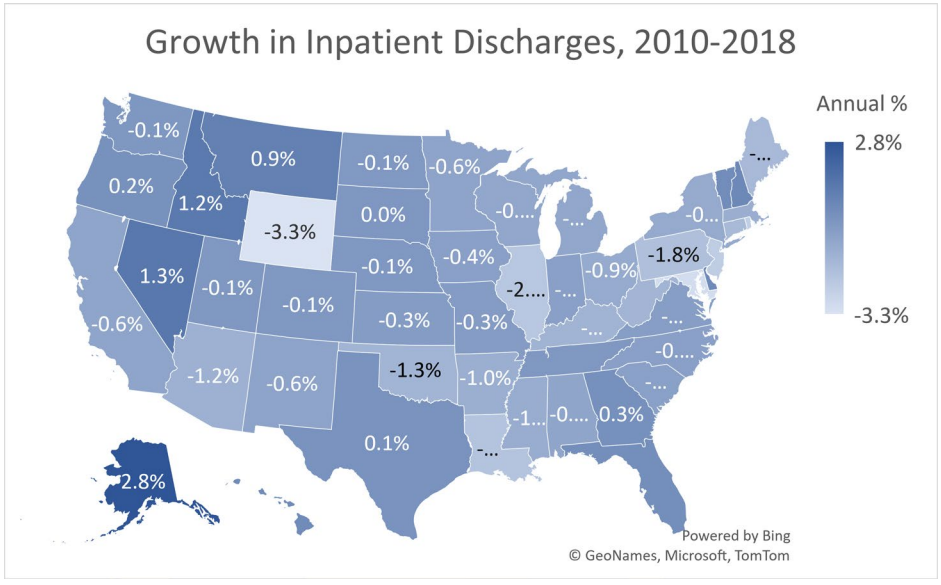


Table 12.

Inpatient Discharges, Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**33,037,591**	**32,258,915**	**32,719,872**	**31,503,146**	**30,776,651**	**30,687,975**	**32,034,872**	**31,662,942**	**31,559,922**	**19,551,291**	**-4%**	**-0.6%**	
AK	40,692	41,482	42,289	49,545	48,288	48,260	50,100	50,237	50,927	8,830	25%	**2.8%**	1
NV	267,527	261,706	249,316	261,473	255,033	259,236	270,488	285,072	297,338	96,852	11%	**1.3%**	2
ID	118,519	115,691	124,040	122,410	121,066	124,914	129,032	132,179	130,863	100,023	10%	**1.2%**	3
MT	92,334	83,364	99,207	90,570	89,092	84,282	100,345	97,470	99,508	35,456	8%	**0.9%**	4
NH	111,194	111,788	103,205	106,978	107,199	110,559	114,779	116,987	116,410	99,392	5%	**0.6%**	5
DE	89,337	89,181	88,620	94,729	95,113	89,683	88,651	91,988	92,991	93,905	4%	**0.5%**	6
HI	91,739	93,825	91,791	94,323	90,513	94,364	93,523	93,100	95,307	61,426	4%	**0.5%**	7
VT	46,297	47,886	47,349	47,339	44,910	44,622	46,752	46,864	47,835	46,247	3%	**0.4%**	8
FL	2,363,259	2,341,619	2,375,930	2,352,639	2,360,140	2,416,881	2,467,503	2,472,978	2,427,187	1,622,253	3%	**0.3%**	9
GA	916,968	884,869	899,501	879,943	883,735	871,283	907,059	931,909	936,231	781,810	2%	**0.3%**	10
OR	336,758	288,249	369,530	321,063	323,385	293,452	375,318	345,530	342,292	164,771	2%	**0.2%**	11
TX	2,461,360	2,411,139	2,481,632	2,401,209	2,337,733	2,393,099	2,487,318	2,466,108	2,491,042	1,761,962	1%	**0.1%**	12
SD	103,577	99,342	99,770	100,575	97,718	97,970	97,877	102,227	103,348	108,636	0%	**0.0%**	13
WA	571,455	554,365	582,838	580,512	551,181	559,676	589,621	554,478	569,009	282,777	0%	**-0.1%**	14
UT	206,061	201,654	212,108	203,658	200,155	198,953	214,122	207,050	205,042	195,637	0%	**-0.1%**	15
CO	410,949	387,526	381,995	373,552	379,145	389,878	395,032	421,390	408,914	210,071	0%	**-0.1%**	16
TN	785,805	743,901	794,957	753,693	746,869	742,592	783,682	802,705	781,692	615,133	-1%	**-0.1%**	17
NE	189,795	191,521	193,495	198,700	183,925	176,314	186,660	190,506	188,573	114,483	-1%	**-0.1%**	18
ND	82,990	87,166	86,149	79,069	80,761	81,276	82,040	83,878	82,269	62,460	-1%	**-0.1%**	19
MO	732,462	691,669	745,962	695,055	689,384	677,482	730,363	691,287	717,693	336,609	-2%	**-0.3%**	20
KS	292,683	284,120	280,314	280,476	277,957	272,034	297,418	291,326	286,707	178,537	-2%	**-0.3%**	21
VA	744,925	733,653	774,700	728,623	694,182	676,563	731,579	722,805	725,153	381,851	-3%	**-0.3%**	22
IN	713,687	721,925	721,932	702,492	673,891	688,125	692,112	685,090	690,096	259,309	-3%	**-0.4%**	23
NC	1,009,792	1,009,166	997,541	983,960	958,917	962,361	958,341	966,085	975,842	703,440	-3%	**-0.4%**	24
IA	309,814	312,337	309,771	302,547	294,715	310,145	305,099	301,643	299,331	237,092	-3%	**-0.4%**	25
SC	491,913	465,421	501,943	476,718	464,124	442,391	487,072	473,829	474,519	389,888	-4%	**-0.4%**	26
NM	176,967	168,374	176,950	175,056	174,025	162,435	177,610	171,178	168,878	96,883	-5%	**-0.6%**	27
MN	533,341	527,131	523,774	514,292	476,431	479,894	482,795	503,350	508,303	147,326	-5%	**-0.6%**	28
CA	3,230,631	3,154,326	3,209,418	3,065,715	3,003,841	3,070,356	3,078,808	3,088,245	3,077,032	1,788,987	-5%	**-0.6%**	29
AL	597,085	547,275	626,000	566,274	548,897	492,071	626,256	570,868	566,382	477,873	-5%	**-0.7%**	30
WI	539,141	527,930	539,659	516,295	507,205	503,236	502,927	504,864	509,112	296,400	-6%	**-0.7%**	31
MI	1,135,201	1,104,030	1,125,269	1,077,565	1,064,629	1,076,685	1,096,118	1,073,652	1,070,885	874,871	-6%	**-0.7%**	32
NY	2,221,877	2,275,337	2,219,632	2,093,975	2,062,251	2,013,226	2,061,254	2,061,174	2,072,839	438,858	-7%	**-0.9%**	33
OH	1,347,787	1,350,913	1,336,688	1,310,339	1,263,643	1,248,253	1,249,710	1,256,955	1,256,532	413,371	-7%	**-0.9%**	34
MS	364,386	344,505	377,666	352,430	332,670	332,069	342,804	333,548	337,207	271,635	-7%	**-1.0%**	35
MA	785,358	753,916	736,848	723,530	692,853	712,309	706,249	717,291	722,789	630,193	-8%	**-1.0%**	36
AR	349,177	326,810	335,577	324,306	312,872	314,803	331,147	322,906	321,186	211,089	-8%	**-1.0%**	37
AZ	678,162	651,399	676,185	629,611	638,468	629,402	636,368	606,802	617,754	276,444	-9%	**-1.2%**	38
KY	583,222	551,789	567,364	538,996	515,465	522,580	559,468	534,777	526,848	351,228	-10%	**-1.3%**	39
OK	444,286	432,975	427,673	421,976	406,501	395,526	402,277	399,046	399,621	313,107	-10%	**-1.3%**	40
WV	245,246	248,142	253,189	236,906	221,918	222,731	217,829	221,933	220,430	141,671	-10%	**-1.3%**	41
ME	141,510	137,366	136,350	131,826	126,161	131,765	127,130	127,949	125,396	109,281	-11%	**-1.5%**	42
CT	386,211	376,133	373,104	366,212	350,809	350,288	354,290	347,916	341,196	324,788	-12%	**-1.5%**	43
DC	114,221	107,552	111,409	91,258	107,206	108,008	106,666	103,900	99,492	72,374	-13%	**-1.7%**	44
PA	1,628,719	1,604,566	1,550,042	1,476,463	1,463,650	1,461,563	1,453,960	1,465,430	1,407,853	1,366,297	-14%	**-1.8%**	45
LA	576,720	550,827	557,297	521,281	494,754	472,563	507,349	492,256	492,084	274,274	-15%	**-2.0%**	46
IL	1,431,844	1,376,797	1,386,853	1,347,141	1,279,093	1,247,594	1,305,143	1,233,313	1,209,676	846,495	-16%	**-2.1%**	47
NJ	1,041,444	1,021,535	972,289	944,768	907,687	907,874	938,255	886,615	861,765	119,912	-17%	**-2.3%**	48
RI	127,860	114,518	111,130	107,116	110,333	109,127	107,068	109,866	104,831	92,764	-18%	**-2.5%**	49
MD	728,299	707,619	692,254	646,818	626,322	577,057	585,125	572,312	568,628	517,448	-22%	**-3.0%**	50
WY	47,004	42,586	41,372	41,146	39,836	40,166	38,970	37,932	35,892	33,673	-24%	**-3.3%**	51

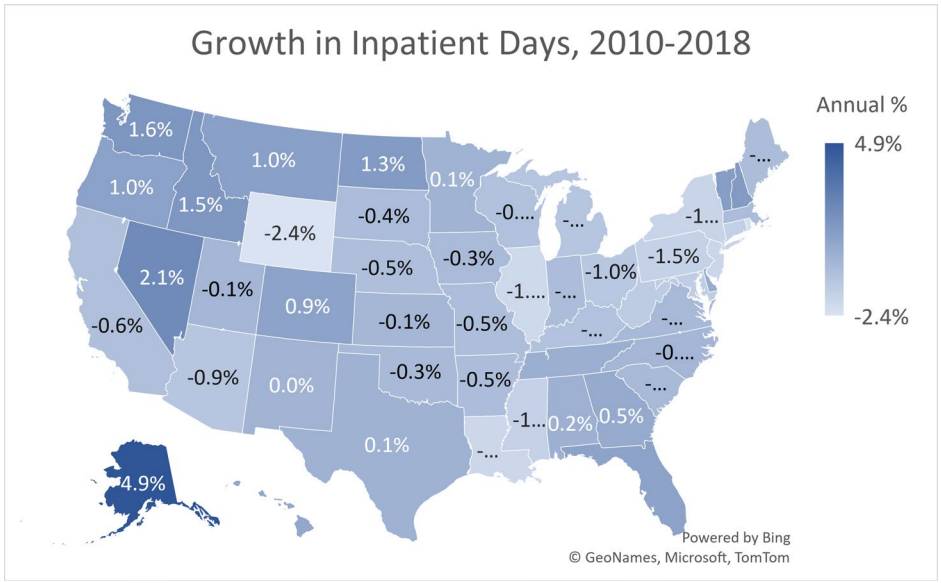
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

9. ***Inpatient Days.*** The number of inpatient days in North Dakota hospitals grew by about 1.3 percent per year from 2010 to 2018, considerably higher than the national trend of negative 0.3 percent per year. North Dakota ranked 4th nationally in the number of hospital inpatient days per person, behind DC, Kentucky, and West Virginia (see Tables 13-14 and Figure 2). In 2010, North Dakota ranked 7th on this measure.

Figure 2.



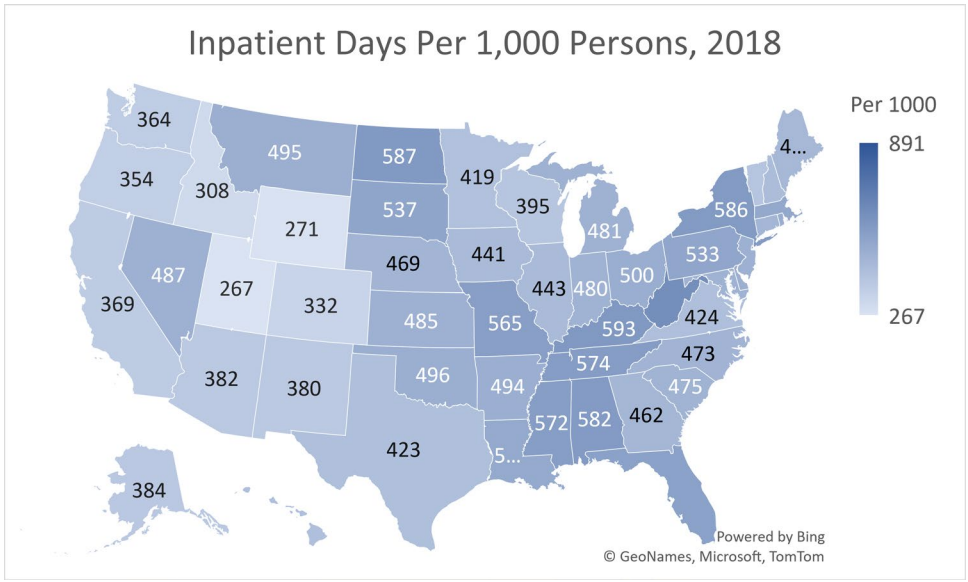


Table 13.

Inpatient Days, Ranked by 2010-2018 Growth					DRAFT						Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**153,709,358**	**150,570,693**	**151,544,617**	**147,803,091**	**146,181,249**	**146,160,757**	**152,503,841**	**150,461,141**	**150,223,687**	**94,227,228**	**-2%**	**-0.3%**	
AK	190,663	196,536	195,642	245,295	240,087	247,681	264,318	267,155	272,532	38,771	43%	**4.9%**	1
NV	1,222,824	1,214,909	1,177,236	1,228,866	1,232,810	1,256,791	1,323,595	1,418,470	1,454,295	489,828	19%	**2.1%**	2
WA	2,349,729	2,278,286	2,376,738	2,402,490	2,434,733	2,462,416	2,620,805	2,621,780	2,683,497	1,344,038	14%	**1.6%**	3
ID	473,202	455,846	470,769	482,313	484,002	505,666	517,808	525,502	529,459	411,097	12%	**1.5%**	4
ND	399,847	397,282	426,239	397,195	421,771	429,461	448,663	438,657	428,937	346,839	7%	**1.3%**	5
NH	510,709	528,124	488,068	518,035	518,953	539,367	536,246	559,662	568,968	495,852	11%	**1.3%**	6
VT	216,454	223,721	219,831	222,921	218,946	229,578	228,457	234,270	238,734	234,472	10%	**1.1%**	7
MT	473,396	439,615	500,366	481,998	480,263	459,952	527,581	509,262	511,638	245,461	8%	**1.0%**	8
OR	1,389,232	1,190,349	1,515,140	1,342,753	1,382,478	1,240,508	1,646,384	1,486,407	1,457,231	800,267	5%	**1.0%**	9
FL	11,088,086	11,103,036	11,115,773	11,058,176	11,160,129	11,608,367	11,769,094	11,804,165	11,543,506	7,700,295	4%	**0.9%**	10
CO	1,759,573	1,722,659	1,666,509	1,692,146	1,719,615	1,748,526	1,786,734	1,869,663	1,842,222	1,004,663	5%	**0.9%**	11
HI	526,037	533,130	524,279	534,894	524,772	548,447	550,242	550,232	568,381	375,431	8%	**0.6%**	12
GA	4,443,023	4,329,961	4,358,978	4,372,041	4,393,146	4,402,283	4,498,989	4,605,105	4,713,550	3,966,220	6%	**0.5%**	13
DE	440,564	429,432	421,116	420,959	441,072	448,707	438,436	452,946	460,579	470,640	5%	**0.4%**	14
TN	3,793,987	3,639,546	3,876,252	3,693,227	3,644,059	3,649,854	3,852,256	3,866,000	3,781,638	3,061,624	0%	**0.3%**	15
AL	2,778,408	2,615,225	2,935,803	2,742,294	2,703,597	2,442,597	3,104,962	2,810,658	2,766,184	2,309,037	0%	**0.2%**	16
TX	11,627,651	11,365,911	11,541,087	11,416,539	11,332,185	11,600,263	12,095,231	11,730,300	11,853,026	8,259,134	2%	**0.1%**	17
MN	2,211,145	2,211,580	2,201,939	2,158,545	2,148,066	2,169,159	2,204,353	2,223,098	2,297,233	674,177	4%	**0.1%**	18
NM	765,019	730,062	770,542	756,340	759,157	721,219	812,994	767,038	777,408	448,155	2%	**0.0%**	19
UT	860,817	837,537	870,906	842,445	834,036	830,896	889,264	854,173	830,379	800,208	-4%	**-0.1%**	20
NC	4,720,961	4,712,882	4,686,449	4,634,788	4,532,773	4,648,325	4,626,257	4,682,560	4,752,567	3,529,067	1%	**-0.1%**	21
KS	1,385,560	1,361,471	1,359,793	1,358,771	1,337,193	1,295,846	1,382,822	1,372,605	1,366,490	885,208	-1%	**-0.1%**	22
VA	3,501,795	3,416,844	3,638,762	3,449,465	3,409,536	3,293,515	3,514,547	3,446,495	3,472,784	1,895,664	-1%	**-0.2%**	23
DC	622,109	584,753	595,005	601,567	599,213	615,423	615,547	611,140	595,346	483,191	-4%	**-0.3%**	24
SC	2,391,514	2,296,009	2,429,413	2,342,687	2,310,801	2,247,490	2,434,013	2,343,355	2,341,395	1,994,851	-2%	**-0.3%**	25
OK	1,945,806	2,025,458	1,987,106	1,999,194	1,931,363	1,889,134	1,916,544	1,905,415	1,892,813	1,602,447	-3%	**-0.3%**	26
IA	1,404,474	1,422,231	1,380,210	1,366,233	1,370,053	1,389,802	1,374,183	1,371,707	1,348,317	1,118,446	-4%	**-0.3%**	27
MA	3,511,870	3,440,396	3,365,692	3,412,396	3,332,239	3,405,606	3,359,144	3,418,138	3,474,748	3,110,494	-1%	**-0.4%**	28
SD	480,601	458,469	466,439	467,791	458,228	462,227	468,426	467,706	456,096	492,312	-5%	**-0.4%**	29
ME	623,516	622,660	612,484	608,919	596,522	626,367	606,747	604,364	590,898	546,548	-5%	**-0.4%**	30
IN	3,232,183	3,245,114	3,262,140	3,237,724	3,119,823	3,148,789	3,169,442	3,130,019	3,115,153	1,157,442	-4%	**-0.5%**	31
AR	1,488,404	1,441,193	1,466,380	1,431,886	1,395,500	1,407,086	1,456,542	1,439,177	1,443,282	956,119	-3%	**-0.5%**	32
MO	3,422,387	3,238,832	3,472,774	3,213,822	3,211,181	3,153,999	3,475,597	3,308,126	3,351,426	1,607,777	-2%	**-0.5%**	33
NE	907,711	891,017	886,565	898,811	850,902	842,313	872,382	874,399	876,520	542,938	-3%	**-0.5%**	34
CA	14,825,019	14,540,464	14,442,698	14,049,792	13,808,521	14,131,843	14,317,030	14,205,178	14,289,729	8,628,451	-4%	**-0.6%**	35
WI	2,323,338	2,297,030	2,280,543	2,199,785	2,228,566	2,248,174	2,212,111	2,216,117	2,234,787	1,322,894	-4%	**-0.7%**	36
KY	2,754,486	2,620,549	2,665,857	2,575,393	2,490,856	2,489,726	2,724,635	2,618,446	2,562,047	1,713,966	-7%	**-0.7%**	37
MI	5,088,109	5,012,382	5,012,976	4,865,093	4,802,119	4,787,733	4,838,107	4,781,209	4,700,209	3,914,442	-8%	**-0.9%**	38
AZ	2,819,369	2,697,701	2,763,464	2,639,135	2,699,790	2,655,640	2,768,782	2,643,867	2,677,263	1,171,798	-5%	**-0.9%**	39
OH	6,015,522	5,995,580	5,950,661	5,770,570	5,673,305	5,656,582	5,613,562	5,616,708	5,673,148	1,974,795	-6%	**-1.0%**	40
WV	1,188,826	1,176,358	1,189,070	1,130,279	1,095,694	1,089,238	1,063,963	1,090,474	1,117,270	689,385	-6%	**-1.2%**	41
MD	3,138,118	3,131,509	3,073,319	2,938,385	2,966,812	2,883,584	2,905,389	2,863,325	2,812,642	2,659,627	-10%	**-1.3%**	42
CT	1,785,427	1,794,358	1,733,046	1,770,671	1,697,910	1,690,443	1,630,544	1,614,909	1,612,834	1,548,358	-10%	**-1.4%**	43
MS	1,827,533	1,720,521	1,892,324	1,761,510	1,682,951	1,709,375	1,734,821	1,642,681	1,646,255	1,399,007	-10%	**-1.5%**	44
PA	7,644,619	7,528,047	7,291,373	7,016,280	6,880,096	6,806,438	6,755,301	6,865,321	6,605,541	6,418,052	-14%	**-1.5%**	45
NY	12,455,087	12,292,605	11,990,625	11,406,386	11,328,085	10,989,221	11,217,798	11,094,547	11,138,353	2,327,199	-11%	**-1.6%**	46
NJ	4,817,824	4,748,172	4,565,961	4,416,920	4,396,627	4,407,866	4,278,035	4,253,786	4,244,497	555,875	-12%	**-1.8%**	47
LA	2,706,573	2,529,634	2,625,090	2,510,911	2,409,905	2,294,566	2,468,175	2,382,164	2,343,736	1,313,438	-13%	**-1.8%**	48
IL	6,382,330	6,139,383	6,101,276	6,031,966	5,804,332	5,669,310	5,888,273	5,586,883	5,511,848	3,904,712	-14%	**-1.9%**	49
RI	594,423	577,989	533,809	519,672	524,043	520,596	502,862	507,158	506,741	439,639	-15%	**-2.2%**	50
WY	183,499	168,336	170,102	166,818	162,434	162,763	161,344	154,532	151,841	140,898	-17%	**-2.4%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 14.

Inpatient Days per 1,000 Residents, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**511**	**497**	**496**	**481**	**471**	**467**	**485**	**475**	**472**	**292**	**-8%**	**-1.0%**	
DC	1,091	1,001	998	986	961	969	955	929	**891**	712	-18%	-2.5%	1
WV	661	653	660	629	612	608	597	619	**638**	396	-4%	-0.4%	2
KY	655	620	629	604	584	581	635	608	**593**	396	-9%	-1.2%	3
ND	618	605	634	573	595	591	618	604	**587**	472	-5%	-0.6%	4
NY	660	649	630	597	590	570	584	574	**586**	124	-11%	-1.5%	5
AL	597	559	625	583	574	516	656	593	**582**	485	-3%	-0.3%	6
TN	613	584	617	584	572	568	596	591	**574**	461	-6%	-0.8%	7
MS	637	598	656	610	583	592	601	569	**572**	487	-10%	-1.3%	8
MO	590	556	596	549	547	535	589	559	**565**	270	-4%	-0.5%	9
FL	603	596	589	579	574	586	584	575	**554**	364	-8%	-1.1%	10
SD	611	579	583	576	558	558	560	559	**537**	572	-12%	-1.6%	11
PA	622	611	591	568	556	550	546	554	**533**	518	-14%	-1.9%	12
MA	555	541	525	529	512	519	511	516	**522**	464	-6%	-0.8%	13
LA	615	571	589	560	535	506	545	525	**519**	292	-16%	-2.1%	14
RI	589	574	530	515	517	513	496	499	**500**	434	-15%	-2.0%	15
OH	536	534	530	513	503	501	498	496	**500**	173	-7%	-0.9%	16
OK	535	553	539	536	515	499	504	501	**496**	419	-7%	-0.9%	17
MT	492	452	511	489	483	457	520	498	**495**	235	1%	0.1%	18
AR	525	506	513	499	485	488	503	495	**494**	326	-6%	-0.8%	19
DE	505	488	474	469	487	489	474	486	**491**	499	-3%	-0.4%	20
NV	460	454	434	448	441	442	458	481	**487**	162	6%	0.7%	21
NJ	559	550	526	507	502	502	488	482	**486**	64	-13%	-1.7%	22
KS	502	491	488	486	476	460	491	487	**485**	315	-3%	-0.4%	23
MI	527	519	519	503	496	494	499	492	**481**	399	-9%	-1.1%	24
IN	514	514	515	509	488	491	493	485	**480**	178	-7%	-0.8%	25
MD	558	552	537	509	510	494	496	486	**479**	455	-14%	-1.9%	26
SC	534	508	532	507	494	475	507	482	**475**	399	-11%	-1.5%	27
NC	511	504	496	487	471	478	471	471	**473**	348	-7%	-1.0%	28
NE	513	500	494	496	467	458	473	470	**469**	289	-8%	-1.1%	29
CT	515	518	498	509	488	486	471	464	**465**	448	-10%	-1.3%	30
GA	472	455	453	451	449	444	450	455	**462**	385	-2%	-0.3%	31
ME	483	482	474	471	461	485	469	465	**455**	421	-6%	-0.8%	32
IL	509	489	485	480	462	452	471	447	**443**	315	-13%	-1.7%	33
IA	476	480	464	457	456	460	453	450	**441**	365	-7%	-1.0%	34
NH	400	413	381	404	403	419	415	432	**434**	375	8%	1.0%	35
VA	455	439	463	434	426	409	435	423	**424**	231	-7%	-0.9%	36
TX	473	455	455	443	431	433	445	425	**423**	290	-11%	-1.4%	37
HI	404	406	394	402	389	403	403	406	**420**	277	4%	0.5%	38
MN	426	423	419	408	403	404	409	408	**419**	122	-2%	-0.2%	39
VT	361	373	366	370	365	381	381	390	**397**	390	10%	1.2%	40
WI	420	414	410	393	398	400	393	393	**395**	233	-6%	-0.8%	41
AK	279	282	277	348	340	350	370	376	**384**	55	38%	4.1%	42
AZ	451	427	433	408	412	399	410	386	**382**	163	-15%	-2.0%	43
NM	379	358	378	371	373	354	401	376	**380**	218	0%	0.0%	44
CA	406	394	388	375	364	369	372	367	**369**	223	-9%	-1.2%	45
WA	357	342	353	353	353	352	368	362	**364**	179	2%	0.2%	46
OR	369	314	396	349	355	314	410	366	**354**	192	-4%	-0.5%	47
CO	358	346	330	330	330	329	331	342	**332**	178	-7%	-0.9%	48
ID	307	295	301	305	303	313	314	312	**308**	234	0%	0.0%	49
WY	335	305	304	294	286	286	283	274	**271**	253	-19%	-2.6%	50
UT	316	303	311	296	288	282	296	280	**267**	253	-15%	-2.1%	51

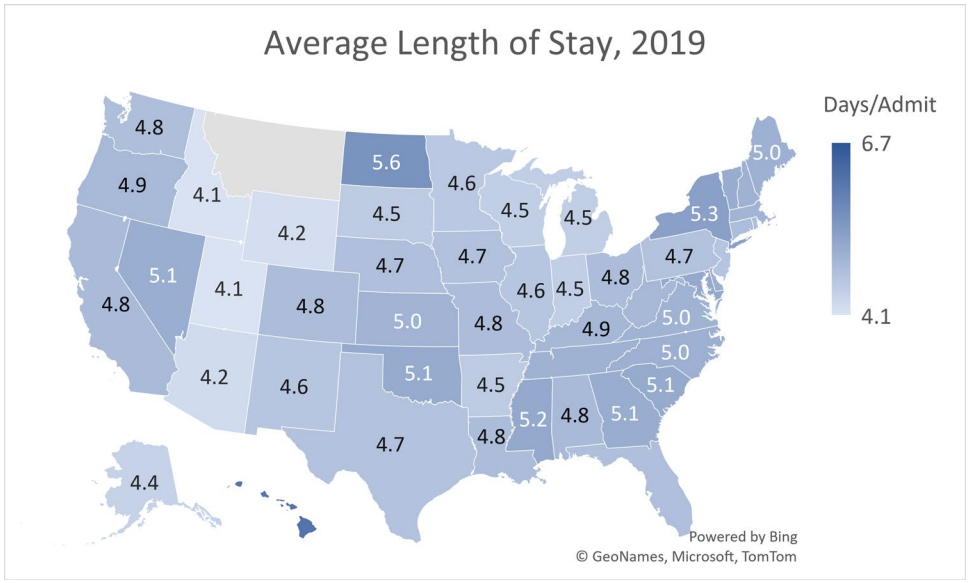
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

10. Average Length of Stay. The average number of inpatient days per discharge nationwide has remained roughly constant at about 4.7-4.8 days. However, North Dakota's average length of stay increased from 4.8 to 5.5 between 2010 and 2019, a rate of growth among the highest in the nation (see Table 15 and Figure 3). As a result, North Dakota's rank on average length of stay rose from 11th in 2010 to 3rd in 2019.

Figure 3.



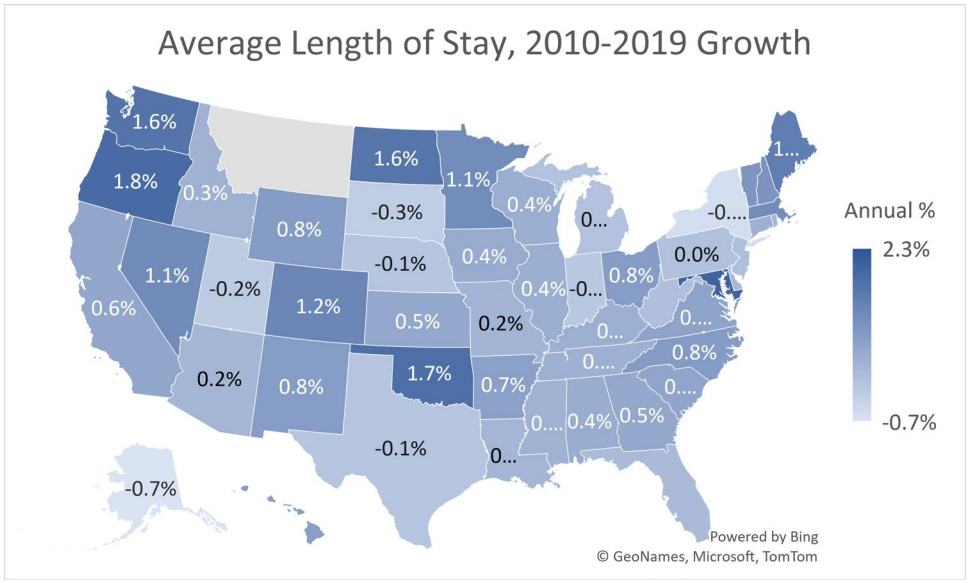


Table 15.

Average Length of Inpatient Stay (number of days), Ranked by 2019 Level							DRAFT				Pct Growth Avg Annual		
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**4.65**	**4.67**	**4.63**	**4.69**	**4.75**	**4.76**	**4.76**	**4.75**	**4.76**	**4.82**	**4%**	**0.4%**	
DC	5.45	5.44	5.34	6.59	5.59	5.70	5.77	5.88	5.98	**6.68**	23%	2.3%	1
HI	5.73	5.68	5.71	5.67	5.80	5.81	5.88	5.91	5.96	**6.11**	7%	0.7%	2
ND	4.82	4.56	4.95	5.02	5.22	5.28	5.47	5.23	5.21	**5.55**	15%	1.6%	3
NY	5.61	5.40	5.40	5.45	5.49	5.46	5.44	5.38	5.37	**5.30**	-5%	-0.6%	4
MS	5.02	4.99	5.01	5.00	5.06	5.15	5.06	4.92	4.88	**5.15**	3%	0.3%	5
MD	4.31	4.43	4.44	4.54	4.74	5.00	4.97	5.00	4.95	**5.14**	19%	2.0%	6
OK	4.38	4.68	4.65	4.74	4.75	4.78	4.76	4.77	4.74	**5.12**	17%	1.7%	7
SC	4.86	4.93	4.84	4.91	4.98	5.08	5.00	4.95	4.93	**5.12**	5%	0.6%	8
GA	4.85	4.89	4.85	4.97	4.97	5.05	4.96	4.94	5.03	**5.07**	5%	0.5%	9
VT	4.68	4.67	4.64	4.71	4.88	5.14	4.89	5.00	4.99	**5.07**	8%	0.9%	10
NV	4.57	4.64	4.72	4.70	4.83	4.85	4.89	4.98	4.89	**5.06**	11%	1.1%	11
NC	4.68	4.67	4.70	4.71	4.73	4.83	4.83	4.85	4.87	**5.02**	7%	0.8%	12
DE	4.93	4.82	4.75	4.44	4.64	5.00	4.95	4.92	4.95	**5.01**	2%	0.2%	13
ME	4.41	4.53	4.49	4.62	4.73	4.75	4.77	4.72	4.71	**5.00**	14%	1.4%	14
NH	4.59	4.72	4.73	4.84	4.84	4.88	4.67	4.78	4.89	**4.99**	9%	0.9%	15
TN	4.83	4.89	4.88	4.90	4.88	4.92	4.92	4.82	4.84	**4.98**	3%	0.3%	16
VA	4.70	4.66	4.70	4.73	4.91	4.87	4.80	4.77	4.79	**4.96**	6%	0.6%	17
KS	4.73	4.79	4.85	4.84	4.81	4.76	4.65	4.71	4.77	**4.96**	5%	0.5%	18
MA	4.47	4.56	4.57	4.72	4.81	4.78	4.76	4.77	4.81	**4.94**	10%	1.1%	19
KY	4.72	4.75	4.70	4.78	4.83	4.76	4.87	4.90	4.86	**4.88**	3%	0.4%	20
WV	4.85	4.74	4.70	4.77	4.94	4.89	4.88	4.91	5.07	**4.87**	0%	0.0%	21
OR	4.13	4.13	4.10	4.18	4.28	4.23	4.39	4.30	4.26	**4.86**	18%	1.8%	22
AL	4.65	4.78	4.69	4.84	4.93	4.96	4.96	4.92	4.88	**4.83**	4%	0.4%	23
CA	4.59	4.61	4.50	4.58	4.60	4.60	4.65	4.60	4.64	**4.82**	5%	0.6%	24
LA	4.69	4.59	4.71	4.82	4.87	4.86	4.86	4.84	4.76	**4.79**	2%	0.2%	25
CO	4.28	4.45	4.36	4.53	4.54	4.48	4.52	4.44	4.51	**4.78**	12%	1.2%	26
OH	4.46	4.44	4.45	4.40	4.49	4.53	4.49	4.47	4.51	**4.78**	7%	0.8%	27
MO	4.67	4.68	4.66	4.62	4.66	4.66	4.76	4.79	4.67	**4.78**	2%	0.2%	28
CT	4.62	4.77	4.64	4.84	4.84	4.83	4.60	4.64	4.73	**4.77**	3%	0.3%	29
WA	4.11	4.11	4.08	4.14	4.42	4.40	4.44	4.73	4.72	**4.75**	16%	1.6%	30
FL	4.69	4.74	4.68	4.70	4.73	4.80	4.77	4.77	4.76	**4.75**	1%	0.1%	31
NE	4.78	4.65	4.58	4.52	4.63	4.78	4.67	4.59	4.65	**4.74**	-1%	-0.1%	32
RI	4.65	5.05	4.80	4.85	4.75	4.77	4.70	4.62	4.83	**4.74**	2%	0.2%	33
IA	4.53	4.55	4.46	4.52	4.65	4.48	4.50	4.55	4.50	**4.72**	4%	0.4%	34
PA	4.69	4.69	4.70	4.75	4.70	4.66	4.65	4.68	4.69	**4.70**	0%	0.0%	35
TX	4.72	4.71	4.65	4.75	4.85	4.85	4.86	4.76	4.76	**4.69**	-1%	-0.1%	36
NJ	4.63	4.65	4.70	4.68	4.84	4.86	4.56	4.80	4.93	**4.64**	0%	0.0%	37
NM	4.32	4.34	4.35	4.32	4.36	4.44	4.58	4.48	4.60	**4.63**	7%	0.8%	38
IL	4.46	4.46	4.40	4.48	4.54	4.54	4.51	4.53	4.56	**4.61**	3%	0.4%	39
MN	4.15	4.20	4.20	4.20	4.51	4.52	4.57	4.42	4.52	**4.58**	10%	1.1%	40
SD	4.64	4.62	4.68	4.65	4.69	4.72	4.79	4.58	4.41	**4.53**	-2%	-0.3%	41
AR	4.26	4.41	4.37	4.42	4.46	4.47	4.40	4.46	4.49	**4.53**	6%	0.7%	42
MI	4.48	4.54	4.45	4.51	4.51	4.45	4.41	4.45	4.39	**4.47**	0%	0.0%	43
IN	4.53	4.50	4.52	4.61	4.63	4.58	4.58	4.57	4.51	**4.46**	-1%	-0.2%	44
WI	4.31	4.35	4.23	4.26	4.39	4.47	4.40	4.39	4.39	**4.46**	4%	0.4%	45
AK	4.69	4.74	4.63	4.95	4.97	5.13	5.28	5.32	5.35	**4.39**	-6%	-0.7%	46
AZ	4.16	4.14	4.09	4.19	4.23	4.22	4.35	4.36	4.33	**4.24**	2%	0.2%	47
WY	3.90	3.95	4.11	4.05	4.08	4.05	4.14	4.07	4.23	**4.18**	7%	0.8%	48
ID	3.99	3.94	3.80	3.94	4.00	4.05	4.01	3.98	4.05	**4.11**	3%	0.3%	49
UT	4.18	4.15	4.11	4.14	4.17	4.18	4.15	4.13	4.05	**4.09**	-2%	-0.2%	50
MT	5.13	5.27	5.04	5.32	5.39	5.46	5.26	5.22	5.14	*	0%	0.0%	

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete, but the ratio should be consistent with prior years -- average Annual Growth from 2010-2019. Montana growth 2010-2018.

11. ***Occupancy Rate.*** Table 16 shows that North Dakota had slightly lower-than-average statewide occupancy rate in the 2010-2019 period, with a 2019 rate of 54 percent, compared with a U.S. average of 62 percent. However, North Dakota's measured occupancy rate in the HCRIS data is somewhat higher than that of other rural states in the region, such as South Dakota, Montana, and Wyoming. Importantly, HCRIS and AHA measures of occupancy rates were quite different for some hospitals, so it is possible that the HCRIS measure shown here is somewhat uncertain, particularly in the absolute amount. Nevertheless, we believe the HCRIS measures are suitable for comparisons from state to state.

Figure 4.

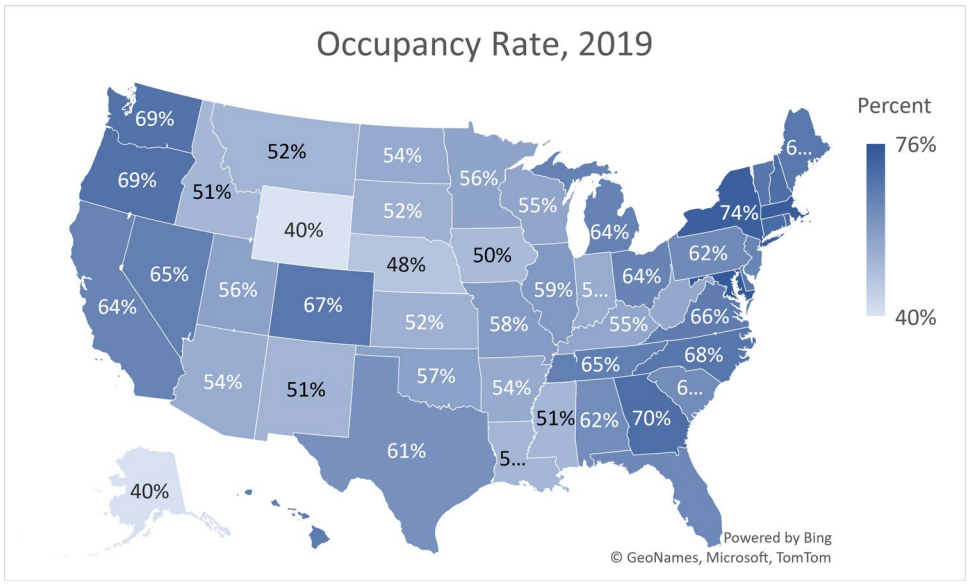


Table 16.

Occupancy Rate, Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**63%**	**62%**	**61%**	**60%**	**60%**	**61%**	**61%**	**61%**	**62%**	**62%**	**0%**	**-0.1%**	
DC	74%	71%	70%	71%	73%	75%	76%	76%	75%	**76%**	3%	0.3%	1
MD	76%	76%	75%	75%	74%	75%	75%	75%	73%	**75%**	-1%	-0.1%	2
MA	71%	71%	68%	68%	68%	70%	69%	70%	71%	**74%**	4%	0.4%	3
NY	78%	78%	76%	75%	74%	75%	75%	75%	75%	**74%**	-6%	-0.6%	4
RI	71%	69%	64%	62%	59%	63%	62%	62%	64%	**70%**	-1%	-0.1%	5
CT	73%	72%	71%	71%	69%	70%	67%	65%	67%	**70%**	-4%	-0.4%	6
NH	61%	63%	62%	63%	63%	66%	64%	67%	68%	**70%**	14%	1.5%	7
GA	64%	63%	62%	64%	65%	66%	66%	67%	69%	**70%**	9%	1.0%	8
OR	62%	61%	60%	60%	60%	62%	65%	65%	64%	**69%**	11%	1.1%	9
WA	66%	64%	63%	65%	65%	69%	69%	70%	69%	**69%**	4%	0.4%	10
VT	64%	64%	63%	66%	63%	65%	64%	65%	66%	**68%**	6%	0.6%	11
NC	67%	66%	66%	65%	64%	66%	65%	66%	66%	**68%**	1%	0.1%	12
CO	61%	60%	59%	59%	59%	60%	59%	59%	61%	**67%**	11%	1.1%	13
ME	57%	58%	56%	56%	58%	60%	61%	61%	62%	**67%**	18%	1.9%	14
DE	67%	65%	64%	67%	68%	69%	64%	65%	65%	**67%**	0%	0.0%	15
HI	63%	63%	71%	74%	73%	72%	71%	70%	66%	**66%**	5%	0.5%	16
VA	61%	63%	60%	61%	60%	63%	61%	64%	64%	**66%**	7%	0.8%	17
TN	59%	60%	58%	58%	58%	62%	62%	63%	63%	**65%**	10%	1.1%	18
NV	66%	67%	66%	66%	70%	71%	71%	72%	73%	**65%**	-1%	-0.1%	19
MI	64%	64%	63%	63%	63%	64%	62%	62%	63%	**64%**	1%	0.1%	20
OH	61%	61%	61%	60%	60%	61%	60%	59%	60%	**64%**	4%	0.5%	21
CA	64%	63%	60%	59%	58%	59%	60%	60%	60%	**64%**	1%	0.1%	22
NJ	72%	70%	69%	68%	68%	67%	67%	66%	67%	**64%**	-11%	-1.3%	23
FL	62%	62%	61%	61%	62%	65%	65%	65%	64%	**63%**	1%	0.1%	24
PA	67%	66%	63%	62%	60%	61%	61%	62%	62%	**62%**	-6%	-0.7%	25
SC	62%	62%	61%	60%	60%	61%	61%	61%	61%	**62%**	0%	0.0%	26
AL	56%	55%	54%	56%	56%	58%	58%	58%	59%	**62%**	11%	1.1%	27
TX	59%	58%	57%	58%	58%	60%	60%	60%	61%	**61%**	3%	0.3%	28
IL	61%	61%	59%	57%	57%	59%	57%	57%	57%	**59%**	-4%	-0.5%	29
MO	58%	57%	56%	55%	56%	58%	58%	57%	59%	**58%**	-1%	-0.1%	30
OK	53%	54%	51%	51%	51%	52%	50%	52%	52%	**57%**	7%	0.7%	31
UT	56%	57%	54%	54%	54%	56%	54%	54%	53%	**56%**	1%	0.1%	32
MN	58%	58%	57%	57%	57%	58%	59%	60%	61%	**56%**	-4%	-0.4%	33
WI	55%	55%	54%	54%	53%	54%	54%	54%	56%	**55%**	0%	0.0%	34
KY	60%	59%	58%	57%	55%	56%	58%	58%	57%	**55%**	-8%	-0.9%	35
WV	55%	57%	55%	54%	54%	53%	53%	53%	57%	**55%**	-2%	-0.2%	36
ND	54%	55%	55%	54%	55%	56%	54%	54%	53%	**54%**	0%	0.0%	37
AR	54%	54%	53%	51%	52%	52%	52%	52%	53%	**54%**	0%	0.0%	38
IN	57%	58%	57%	57%	55%	57%	57%	57%	57%	**54%**	-6%	-0.7%	39
AZ	63%	62%	59%	58%	57%	57%	58%	58%	59%	**54%**	-15%	-1.8%	40
SD	48%	48%	48%	46%	46%	48%	48%	48%	47%	**52%**	10%	1.1%	41
KS	50%	49%	49%	48%	48%	49%	50%	50%	51%	**52%**	6%	0.6%	42
MT	53%	53%	52%	54%	51%	52%	51%	52%	52%	**52%**	-3%	-0.4%	43
NM	57%	57%	55%	52%	52%	53%	56%	56%	57%	**51%**	-10%	-1.2%	44
LA	55%	53%	51%	50%	50%	49%	50%	51%	51%	**51%**	-7%	-0.8%	45
MS	51%	51%	48%	49%	48%	49%	47%	46%	49%	**51%**	0%	0.0%	46
ID	49%	49%	48%	50%	49%	51%	52%	53%	52%	**51%**	3%	0.4%	47
IA	50%	51%	50%	50%	50%	51%	51%	52%	51%	**50%**	0%	0.0%	48
NE	51%	50%	48%	47%	48%	49%	49%	50%	50%	**48%**	-8%	-0.9%	49
AK	53%	54%	52%	58%	56%	57%	59%	57%	58%	**40%**	-25%	-3.1%	50
WY	42%	39%	39%	38%	39%	39%	38%	37%	35%	**40%**	-5%	-0.6%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete.

12. ***Beds Per Capita.*** Table 17 shows North Dakota's inpatient beds per 1,000 people, ranked by the 2017 ratios for each state (2018 data was incomplete). Among the states, North Dakota was 5th highest in inpatient beds per resident, behind only Mississippi, DC, West Virginia, and South Dakota.

Figure 5.

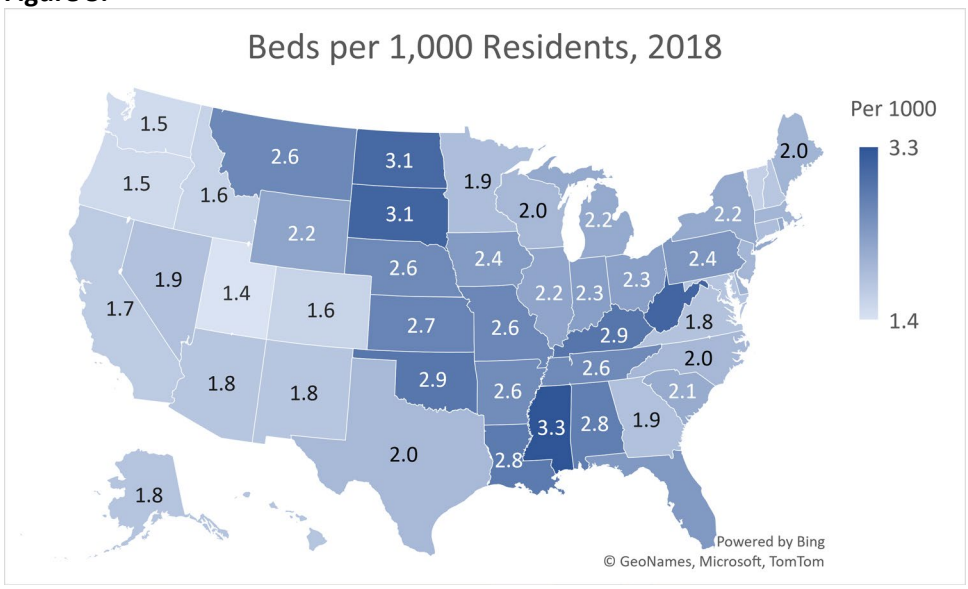


Table 17.

Inpatient Beds Per Thousand Residents, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**2.3**	**2.2**	**2.3**	**2.2**	**2.2**	**2.1**	**2.2**	**2.1**	**2.1**	**1.3**	**-6%**	**-0.7%**	
MS	3.5	3.3	3.8	3.5	3.6	3.4	3.6	3.4	**3.3**	2.7	-5%	-0.7%	1
DC	4.4	4.0	3.9	3.8	3.6	3.6	3.4	3.4	**3.2**	2.6	-26%	-3.7%	2
SD	3.4	3.4	3.3	3.4	3.3	3.2	3.2	3.2	**3.1**	3.3	-9%	-1.1%	3
WV	3.3	3.3	3.4	3.2	3.2	3.2	3.1	3.3	**3.1**	2.0	-7%	-1.0%	4
ND	3.1	3.1	3.1	3.1	3.0	2.9	3.1	3.0	**3.1**	2.5	-2%	-0.3%	5
KY	3.0	2.9	3.1	2.9	2.9	2.9	3.0	2.9	**2.9**	2.0	-5%	-0.6%	6
OK	2.8	2.9	3.0	2.9	2.8	2.6	2.8	2.8	**2.9**	2.1	2%	0.2%	7
LA	3.1	3.0	3.2	3.3	3.0	2.9	3.1	2.9	**2.8**	1.7	-10%	-1.3%	8
AL	3.0	2.9	3.2	2.8	2.9	2.6	3.3	2.8	**2.8**	2.2	-8%	-1.0%	9
KS	2.8	2.7	2.9	2.8	2.7	2.6	2.7	2.7	**2.7**	1.7	-4%	-0.5%	10
MO	2.8	2.7	2.9	2.8	2.7	2.6	2.8	2.7	**2.6**	1.3	-7%	-0.9%	11
MT	2.6	2.3	2.7	2.5	2.8	2.5	2.8	2.6	**2.6**	1.3	2%	0.3%	12
NE	2.7	2.7	2.9	3.1	2.7	2.6	2.7	2.6	**2.6**	1.7	-3%	-0.4%	13
TN	2.9	2.7	2.9	2.8	2.8	2.6	2.7	2.6	**2.6**	1.9	-10%	-1.3%	14
AR	2.6	2.6	2.7	2.7	2.7	2.6	2.7	2.7	**2.6**	1.8	-3%	-0.3%	15
PA	2.6	2.6	2.6	2.6	2.6	2.5	2.5	2.6	**2.4**	2.3	-5%	-0.6%	16
FL	2.7	2.7	2.6	2.6	2.6	2.5	2.5	2.5	**2.4**	1.6	-9%	-1.2%	17
IA	2.6	2.6	2.6	2.5	2.4	2.5	2.4	2.4	**2.4**	2.1	-9%	-1.1%	18
IN	2.5	2.4	2.5	2.5	2.4	2.4	2.4	2.3	**2.3**	0.9	-6%	-0.7%	19
OH	2.4	2.4	2.4	2.3	2.3	2.3	2.3	2.3	**2.3**	0.8	-5%	-0.7%	20
WY	2.2	2.1	2.2	2.1	2.1	2.0	2.0	2.1	**2.2**	1.8	2%	0.2%	21
IL	2.3	2.2	2.3	2.3	2.2	2.1	2.3	2.2	**2.2**	1.5	-2%	-0.3%	22
RI	2.3	2.3	2.3	2.3	2.8	2.2	2.2	2.2	**2.2**	1.7	-4%	-0.5%	23
NY	2.4	2.3	2.3	2.3	2.2	2.2	2.2	2.1	**2.2**	0.5	-7%	-1.0%	24
MI	2.3	2.2	2.3	2.2	2.2	2.2	2.2	2.2	**2.2**	1.7	-5%	-0.7%	25
SC	2.4	2.3	2.5	2.4	2.3	2.1	2.4	2.2	**2.1**	1.9	-10%	-1.3%	26
DE	2.1	2.1	2.0	2.0	2.0	2.0	2.0	2.1	**2.1**	2.1	0%	0.0%	27
ME	2.3	2.4	2.3	2.3	2.3	2.2	2.1	2.1	**2.0**	2.0	-14%	-1.8%	28
MA	2.1	2.1	2.1	2.3	2.1	2.0	2.0	2.0	**2.0**	1.7	-5%	-0.7%	29
NJ	2.2	2.2	2.1	2.1	2.1	2.1	2.1	2.0	**2.0**	0.3	-8%	-1.0%	30
NC	2.1	2.1	2.1	2.1	2.1	2.1	2.0	2.0	**2.0**	1.5	-6%	-0.8%	31
WI	2.1	2.1	2.1	2.1	2.1	2.0	2.0	2.0	**2.0**	1.2	-5%	-0.7%	32
TX	2.2	2.1	2.2	2.1	2.1	2.0	2.0	2.0	**2.0**	1.3	-12%	-1.6%	33
CT	1.9	2.0	1.9	2.0	1.9	1.9	1.6	2.0	**1.9**	1.8	-2%	-0.2%	34
MN	2.0	2.0	2.0	2.0	2.0	1.9	1.9	1.9	**1.9**	0.6	-6%	-0.8%	35
GA	2.1	2.0	2.0	2.0	1.9	1.9	2.0	1.9	**1.9**	1.6	-9%	-1.2%	36
NV	1.9	1.9	1.8	1.9	1.7	1.7	1.8	1.8	**1.9**	0.7	-2%	-0.3%	37
VA	2.0	1.9	2.1	2.0	2.0	1.8	2.0	1.8	**1.8**	1.0	-9%	-1.2%	38
AK	1.4	1.4	1.5	1.7	1.7	1.7	1.7	1.8	**1.8**	0.4	26%	2.9%	39
HI	1.8	1.8	1.5	1.5	1.5	1.5	1.5	1.6	**1.8**	1.2	3%	0.4%	40
MD	2.0	2.0	2.0	1.9	1.9	1.8	1.8	1.8	**1.8**	1.7	-12%	-1.6%	41
NM	1.8	1.8	1.9	2.0	1.9	1.8	2.0	1.9	**1.8**	1.2	-2%	-0.3%	42
AZ	2.0	1.9	2.0	2.0	2.1	2.1	2.0	1.9	**1.8**	0.9	-10%	-1.3%	43
NH	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.9	**1.8**	1.5	-1%	-0.2%	44
CA	1.8	1.7	1.8	1.8	1.7	1.7	1.7	1.7	**1.7**	1.0	-2%	-0.3%	45
VT	1.5	1.6	1.6	1.5	1.6	1.6	1.6	1.7	**1.7**	1.6	8%	0.9%	46
ID	1.7	1.6	1.7	1.7	1.7	1.7	1.7	1.6	**1.6**	1.3	-6%	-0.7%	47
CO	1.6	1.6	1.6	1.5	1.5	1.5	1.6	1.6	**1.6**	0.7	-2%	-0.2%	48
OR	1.7	1.4	1.8	1.6	1.6	1.4	1.8	1.5	**1.5**	0.8	-9%	-1.2%	49
WA	1.5	1.6	1.6	1.5	1.5	1.4	1.5	1.5	**1.5**	0.7	1%	0.1%	50
UT	1.6	1.5	1.6	1.5	1.5	1.4	1.5	1.4	**1.4**	1.2	-11%	-1.4%	51

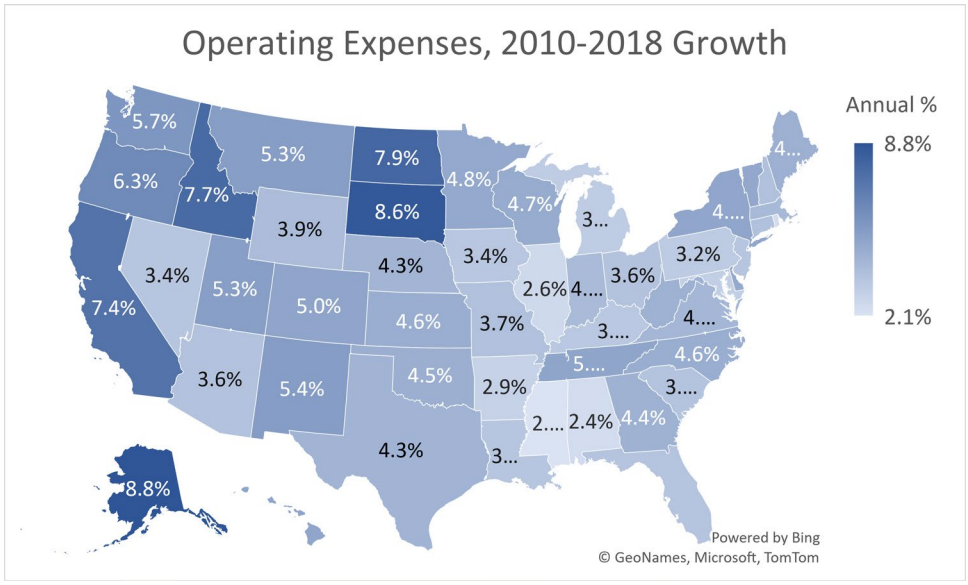
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

13. ***Operating Expenses.*** Overall operating expenses for North Dakota hospitals grew by an average of 7.9 percent annually between 2010 and 2018, well above the national average of 4.5 percent per year. Only South Dakota and Alaska had more rapid rates of growth in expenses during this period (see Tables 18-19 and Figure 6). North Dakota's hospital operating expenses per state resident were highest in the nation in 2018. Between 2010 and 2018, North Dakota overtook DC for the highest expenses per capita.

Figure 6.



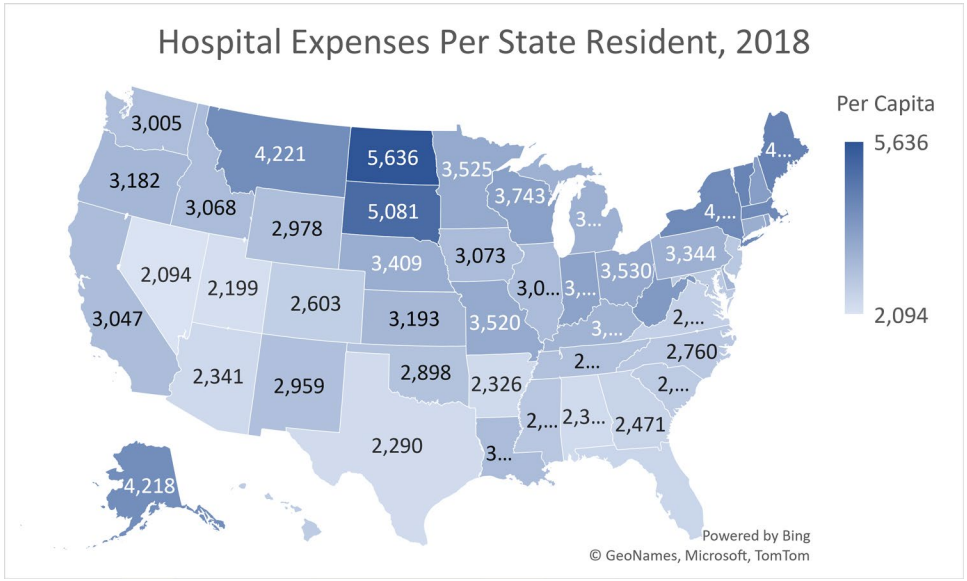


Table 18.

Operating Expenses (billions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**687.0**	**716.6**	**759.6**	**776.6**	**799.5**	**833.7**	**905.1**	**934.6**	**974.6**	**639.9**	**42%**	**4.5%**	
AK	1.5	1.6	1.7	2.3	2.4	2.5	2.7	2.8	3.0	1.1	96%	**8.8%**	1
SD	2.2	2.6	2.8	3.2	3.4	3.6	4.0	4.2	4.3	4.7	93%	**8.6%**	2
ND	2.2	2.3	3.0	2.9	3.3	3.4	3.8	3.9	4.1	3.4	84%	**7.9%**	3
ID	2.9	3.1	3.4	3.8	4.0	4.3	4.6	4.8	5.3	4.2	82%	**7.7%**	4
CA	66.8	81.6	86.1	89.9	90.6	99.3	106.1	111.0	118.0	76.7	77%	**7.4%**	5
OR	8.0	7.5	10.0	9.3	10.0	9.5	13.0	12.5	13.1	6.9	63%	**6.3%**	6
CO	9.8	10.1	10.2	10.8	11.5	12.2	13.0	14.5	14.5	7.7	48%	**5.0%**	7
MT	2.9	2.6	3.4	3.3	3.5	3.4	4.4	4.2	4.4	1.9	52%	**5.3%**	8
NM	4.0	4.0	4.3	4.8	4.9	5.1	5.7	5.9	6.1	4.1	52%	**5.4%**	9
WA	14.2	14.7	15.7	16.1	17.5	18.9	20.5	20.8	22.1	11.2	55%	**5.7%**	10
UT	4.5	4.5	4.9	5.0	5.2	5.5	6.3	6.5	6.8	6.9	51%	**5.3%**	11
WI	14.7	15.1	16.5	16.7	17.8	18.7	19.8	20.8	21.2	14.3	44%	**4.7%**	12
MN	13.3	13.8	14.9	15.3	15.9	16.6	17.9	18.7	19.4	6.3	46%	**4.8%**	13
KS	6.3	6.4	6.7	7.0	7.2	7.3	8.4	8.8	9.0	6.5	43%	**4.6%**	14
HI	2.5	2.6	2.6	2.7	2.9	3.1	3.3	3.4	3.6	2.7	47%	**5.0%**	15
NC	19.4	20.4	21.7	22.3	22.6	24.1	25.3	26.9	27.7	21.5	43%	**4.6%**	16
ME	4.1	4.3	4.6	4.6	4.7	5.1	5.4	5.7	5.9	5.4	42%	**4.5%**	17
TX	45.9	47.0	48.6	51.1	52.8	56.5	61.5	63.3	64.2	46.1	40%	**4.3%**	18
DE	2.1	2.2	2.3	2.2	2.5	2.6	2.8	2.9	3.0	3.2	45%	**4.8%**	19
NY	55.7	57.2	61.0	62.1	64.6	65.7	73.4	76.4	81.9	19.9	47%	**4.9%**	20
OK	7.8	8.2	8.8	9.4	9.2	10.0	10.4	10.7	11.1	8.3	43%	**4.5%**	21
NE	4.6	4.8	5.1	5.3	5.2	5.2	6.0	6.2	6.4	4.3	40%	**4.3%**	22
VT	1.8	1.9	2.0	2.1	2.2	2.2	2.4	2.5	2.7	2.7	46%	**4.8%**	23
WV	4.9	4.9	5.3	5.4	5.5	5.8	6.1	6.6	6.9	4.4	41%	**4.4%**	24
GA	17.9	18.0	18.4	19.2	20.3	21.1	22.9	24.1	25.2	22.5	41%	**4.4%**	25
TN	13.1	13.4	16.8	16.7	17.2	17.3	16.7	17.8	19.3	16.6	47%	**5.0%**	26
WY	1.2	1.2	1.3	1.4	1.4	1.5	1.6	1.6	1.7	1.6	36%	**3.9%**	27
MA	21.0	21.2	22.1	23.4	23.8	24.8	26.4	27.7	28.8	28.0	37%	**4.0%**	28
VA	15.2	15.5	16.9	16.7	17.6	17.6	19.5	19.8	21.0	12.7	38%	**4.2%**	29
AZ	12.3	12.2	13.2	13.3	14.9	15.0	15.9	16.1	16.4	8.3	33%	**3.6%**	30
PA	32.1	33.6	35.0	35.3	36.8	38.0	39.3	41.7	41.4	42.7	29%	**3.2%**	31
OH	30.2	31.6	32.9	33.1	33.8	35.1	37.3	38.7	40.1	14.2	33%	**3.6%**	32
MO	15.6	15.6	17.5	16.9	17.3	17.5	20.2	20.0	20.9	10.5	34%	**3.7%**	33
SC	10.1	9.9	10.6	10.9	11.1	11.4	12.6	12.9	13.3	11.9	32%	**3.6%**	34
KY	10.9	11.0	11.6	11.5	11.5	11.9	13.4	13.9	14.1	10.2	30%	**3.3%**	35
NH	3.7	4.0	3.6	3.9	4.0	4.2	4.5	4.7	5.0	4.9	34%	**3.7%**	36
DC	2.7	2.8	2.9	3.0	3.1	3.2	3.3	3.5	3.6	3.2	32%	**3.5%**	37
FL	38.1	40.0	39.5	39.5	40.8	44.1	46.7	48.2	50.3	37.3	32%	**3.5%**	38
CT	8.9	9.6	9.7	10.2	10.2	10.5	10.9	11.2	11.9	12.1	34%	**3.7%**	39
IN	17.5	17.8	19.2	19.6	19.5	20.0	21.5	22.1	24.0	8.0	37%	**4.0%**	40
IA	7.2	7.3	7.4	7.5	7.7	8.0	8.6	9.0	9.4	8.4	31%	**3.4%**	41
NJ	18.4	19.3	19.7	20.1	20.9	22.0	22.5	23.0	24.2	3.6	31%	**3.5%**	42
NV	4.8	4.8	5.0	5.2	5.0	5.2	5.5	5.9	6.2	2.6	31%	**3.4%**	43
LA	10.5	10.4	11.1	11.8	11.7	11.9	13.1	13.0	13.8	7.7	31%	**3.5%**	44
MI	25.4	25.5	26.8	26.8	27.2	27.9	30.5	31.4	32.5	26.4	28%	**3.2%**	45
MD	12.7	13.2	13.7	13.6	14.1	14.4	15.1	15.5	16.1	15.9	27%	**3.0%**	46
IL	31.2	31.1	32.4	33.4	33.8	35.1	38.3	37.0	38.2	29.8	23%	**2.6%**	47
AR	5.4	5.3	5.8	5.7	5.7	5.7	6.3	6.5	6.8	4.8	25%	**2.9%**	48
RI	3.1	3.1	3.2	3.2	3.3	3.3	3.5	3.6	3.7	3.4	21%	**2.4%**	49
MS	6.8	6.8	7.8	7.5	7.8	7.6	8.0	8.0	8.0	7.0	18%	**2.1%**	50
AL	9.0	8.8	10.1	9.6	9.7	8.8	11.0	10.5	10.9	9.7	21%	**2.4%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 19.

Annual Hospital Operating Expenses Per Resident, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**2,284**	**2,364**	**2,488**	**2,526**	**2,577**	**2,665**	**2,878**	**2,948**	**3,060**	**1,981**	**34%**	**3.7%**	
ND	3,458	3,523	4,464	4,243	4,682	4,729	5,259	5,398	**5,636**	4,615	63%	6.3%	1
DC	4,799	4,835	4,817	4,853	4,902	5,041	5,115	5,271	**5,400**	4,666	13%	1.5%	2
SD	2,837	3,252	3,436	3,949	4,110	4,325	4,788	5,026	**5,081**	5,484	79%	7.6%	3
ME	3,198	3,342	3,588	3,580	3,666	3,966	4,170	4,380	**4,507**	4,178	41%	4.4%	4
VT	3,048	3,111	3,281	3,498	3,587	3,731	3,953	4,129	**4,443**	4,476	46%	4.8%	5
MA	3,312	3,327	3,446	3,630	3,653	3,779	4,025	4,182	**4,319**	4,178	30%	3.4%	6
NY	2,952	3,022	3,203	3,246	3,363	3,412	3,818	3,956	**4,308**	1,063	46%	4.8%	7
MT	2,991	2,714	3,520	3,393	3,537	3,346	4,331	4,153	**4,221**	1,775	41%	4.4%	8
AK	2,231	2,351	2,424	3,234	3,326	3,525	3,769	4,000	**4,218**	1,528	89%	8.3%	9
WV	2,700	2,712	2,925	2,977	3,072	3,239	3,446	3,736	**3,918**	2,552	45%	4.8%	10
NH	2,926	3,116	2,849	3,064	3,111	3,254	3,483	3,656	**3,815**	3,684	30%	3.4%	11
WI	2,655	2,727	2,966	2,980	3,175	3,324	3,521	3,678	**3,743**	2,517	41%	4.4%	12
IN	2,790	2,823	3,036	3,079	3,050	3,120	3,343	3,423	**3,698**	1,224	33%	3.6%	13
RI	3,028	3,121	3,192	3,190	3,290	3,263	3,468	3,560	**3,636**	3,326	20%	2.3%	14
OH	2,694	2,814	2,932	2,946	2,995	3,111	3,303	3,421	**3,530**	1,243	31%	3.4%	15
MN	2,562	2,645	2,826	2,902	2,989	3,101	3,311	3,435	**3,525**	1,130	38%	4.1%	16
MO	2,695	2,683	2,993	2,889	2,949	2,971	3,421	3,384	**3,520**	1,765	31%	3.4%	17
CT	2,562	2,758	2,780	2,924	2,923	3,015	3,149	3,224	**3,424**	3,490	34%	3.7%	18
NE	2,577	2,705	2,821	2,935	2,825	2,842	3,278	3,360	**3,409**	2,302	32%	3.6%	19
PA	2,615	2,730	2,833	2,858	2,977	3,070	3,180	3,366	**3,344**	3,449	28%	3.1%	20
MI	2,627	2,637	2,776	2,775	2,810	2,874	3,143	3,226	**3,331**	2,692	27%	3.0%	21
KY	2,582	2,605	2,744	2,710	2,700	2,780	3,126	3,221	**3,272**	2,349	27%	3.0%	22
DE	2,398	2,444	2,565	2,503	2,723	2,849	2,991	3,087	**3,243**	3,425	35%	3.8%	23
KS	2,273	2,317	2,395	2,506	2,561	2,606	2,972	3,131	**3,193**	2,325	41%	4.3%	24
OR	2,136	1,984	2,621	2,411	2,581	2,398	3,238	3,069	**3,182**	1,665	49%	5.1%	25
IL	2,488	2,481	2,577	2,661	2,691	2,793	3,062	2,959	**3,074**	2,404	24%	2.7%	26
IA	2,441	2,456	2,491	2,505	2,579	2,653	2,835	2,964	**3,073**	2,743	26%	2.9%	27
ID	1,888	1,978	2,199	2,376	2,477	2,637	2,766	2,883	**3,068**	2,415	62%	6.3%	28
LA	2,392	2,346	2,499	2,625	2,590	2,628	2,887	2,865	**3,061**	1,705	28%	3.1%	29
CA	1,829	2,213	2,313	2,396	2,385	2,590	2,759	2,868	**3,047**	1,979	67%	6.6%	30
WA	2,167	2,212	2,330	2,364	2,536	2,698	2,877	2,870	**3,005**	1,492	39%	4.2%	31
WY	2,239	2,219	2,297	2,383	2,515	2,693	2,812	2,882	**2,978**	2,929	33%	3.6%	32
NM	1,971	1,967	2,114	2,355	2,405	2,492	2,822	2,871	**2,959**	2,015	50%	5.2%	33
TN	2,121	2,154	2,668	2,640	2,698	2,689	2,575	2,716	**2,937**	2,497	38%	4.2%	34
OK	2,135	2,244	2,377	2,528	2,460	2,632	2,745	2,802	**2,898**	2,170	36%	3.9%	35
MS	2,370	2,374	2,700	2,613	2,712	2,621	2,757	2,775	**2,786**	2,441	18%	2.0%	36
NJ	2,139	2,234	2,268	2,309	2,387	2,511	2,564	2,612	**2,773**	418	30%	3.3%	37
NC	2,097	2,183	2,304	2,344	2,349	2,480	2,574	2,705	**2,760**	2,117	32%	3.5%	38
MD	2,250	2,328	2,400	2,365	2,423	2,471	2,572	2,639	**2,734**	2,722	22%	2.5%	39
SC	2,246	2,188	2,321	2,351	2,379	2,412	2,619	2,642	**2,701**	2,383	20%	2.3%	40
HI	1,889	1,957	1,919	2,057	2,121	2,268	2,389	2,541	**2,672**	2,023	41%	4.4%	41
CO	1,992	2,021	2,018	2,103	2,199	2,288	2,417	2,653	**2,603**	1,366	31%	3.4%	42
VA	1,969	1,985	2,143	2,105	2,194	2,187	2,411	2,438	**2,567**	1,549	30%	3.4%	43
GA	1,898	1,890	1,911	1,979	2,068	2,133	2,294	2,380	**2,471**	2,186	30%	3.4%	44
FL	2,072	2,151	2,093	2,068	2,099	2,225	2,316	2,347	**2,415**	1,764	17%	1.9%	45
AZ	1,970	1,934	2,065	2,058	2,272	2,247	2,355	2,351	**2,341**	1,163	19%	2.2%	46
AR	1,912	1,870	2,018	1,972	1,974	1,972	2,174	2,238	**2,326**	1,645	22%	2.5%	47
AL	1,943	1,883	2,158	2,043	2,063	1,861	2,336	2,223	**2,301**	2,034	18%	2.1%	48
TX	1,866	1,879	1,915	1,981	2,010	2,111	2,265	2,290	**2,290**	1,620	23%	2.6%	49
UT	1,658	1,623	1,748	1,763	1,807	1,860	2,104	2,139	**2,199**	2,183	33%	3.6%	50
NV	1,792	1,787	1,856	1,876	1,779	1,822	1,899	2,007	**2,094**	848	17%	2.0%	51

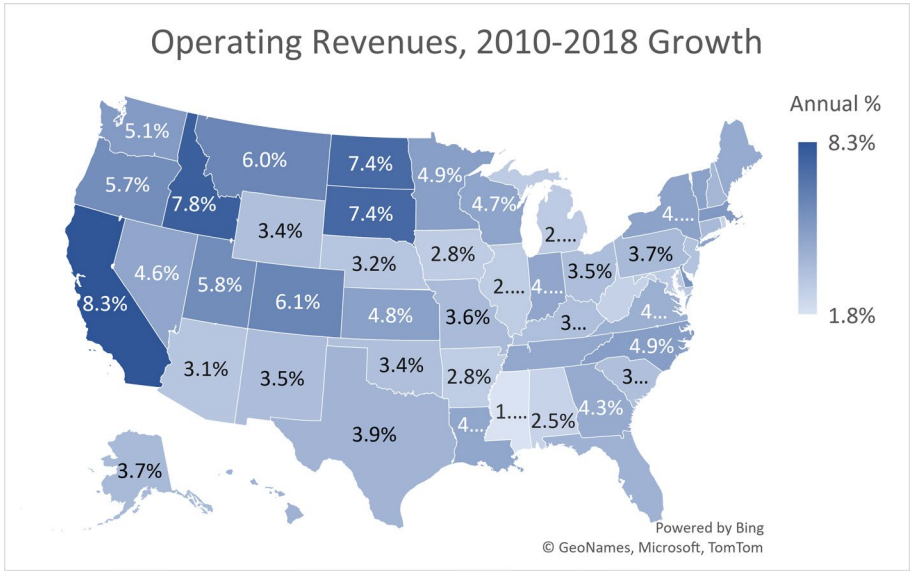
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

14. ***Operating Revenues.*** North Dakota hospitals' operating revenues grew from $2.3 billion in 2010 to $4.1 billion in 2018, a growth rate of 7.4 percent per year. That growth rate was considerably higher than the nationwide hospital revenue growth of 4.6 percent, trailing only South Dakota, Idaho and California among the states (see Table 20 and Figure 7). North Dakota's operating revenues per state resident ranked 2nd only to DC in 2018 (see Table 21). (As a regional referral center, DC has a focus of hospital beds for the region; North Dakota may also "import" some hospital patients from Minnesota.)

Figure 7.



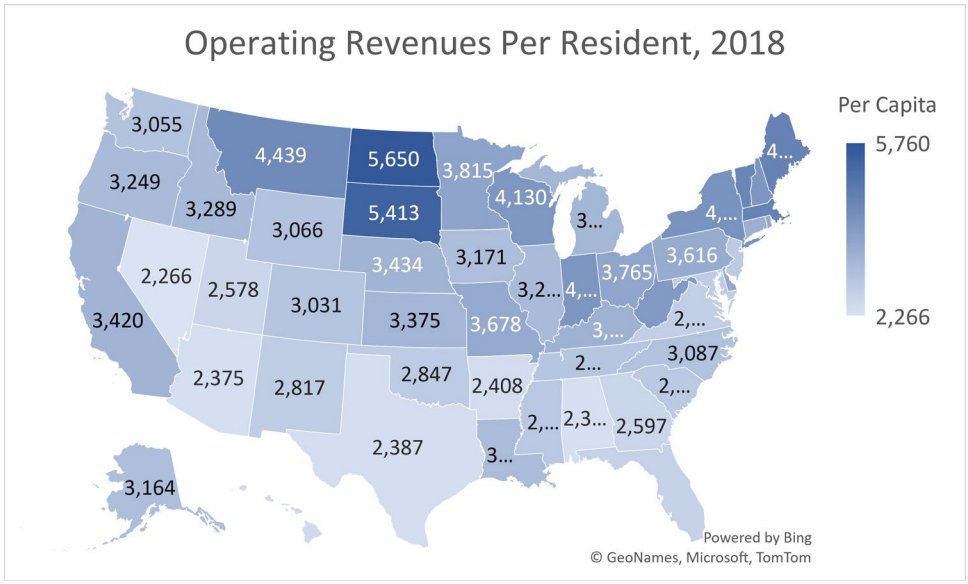


Table 20.

Operating Revenues (billions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**722.3**	**743.1**	**785.4**	**802.7**	**827.1**	**860.5**	**933.8**	**961.7**	**1,032.6**	**671.8**	**43%**	**4.6%**	
CA	69.9	74.1	77.3	84.2	84.1	87.8	93.5	96.7	132.5	78.6	90%	**8.3%**	1
ID	3.1	3.3	3.8	4.0	4.3	4.6	4.9	5.2	5.7	4.6	83%	**7.8%**	2
SD	2.6	2.9	3.1	3.4	3.6	3.9	4.1	4.4	4.6	5.1	77%	**7.4%**	3
ND	2.3	2.4	3.1	2.9	3.4	3.7	3.9	3.9	4.1	3.5	76%	**7.4%**	4
CO	10.5	10.7	11.1	11.7	12.7	13.8	14.7	16.3	16.8	9.4	60%	**6.1%**	5
MT	2.9	2.8	3.5	3.4	3.6	3.4	4.3	4.4	4.6	1.9	60%	**6.0%**	6
UT	5.1	5.8	5.7	5.8	6.3	6.5	7.4	7.6	8.0	8.0	57%	**5.8%**	7
OR	8.6	7.8	10.4	11.1	10.3	9.8	13.1	12.4	13.4	7.3	56%	**5.7%**	8
DE	2.3	2.5	2.5	2.5	2.8	2.9	3.0	3.3	3.4	3.5	52%	**5.4%**	9
MA	20.6	20.5	21.9	22.5	22.7	24.5	27.1	28.1	30.8	27.9	50%	**5.2%**	10
WA	15.1	15.7	16.3	17.8	18.6	19.6	20.2	21.4	22.5	12.0	49%	**5.1%**	11
NC	21.1	22.0	23.8	24.0	24.2	26.8	28.0	29.9	31.0	23.8	47%	**4.9%**	12
MN	14.3	14.9	15.8	16.3	17.1	18.0	18.9	20.0	20.9	6.4	47%	**4.9%**	13
KS	6.5	6.0	7.2	7.4	7.6	7.8	8.9	9.2	9.5	6.8	46%	**4.8%**	14
VT	1.9	1.9	2.0	2.2	2.2	2.4	2.3	2.6	2.7	2.7	46%	**4.8%**	15
NY	55.7	58.2	59.9	61.5	64.4	66.3	74.1	76.0	80.7	20.9	45%	**4.7%**	16
WI	16.3	16.6	18.2	19.0	19.9	20.8	21.6	22.7	23.4	15.7	44%	**4.7%**	17
IN	18.8	20.2	22.4	21.9	22.5	23.2	24.4	25.4	26.9	9.0	43%	**4.6%**	18
NV	4.7	4.8	5.0	5.4	5.1	5.6	5.8	6.3	6.8	2.6	43%	**4.6%**	19
LA	10.2	11.1	11.9	11.9	12.1	12.5	13.7	13.8	14.6	8.5	43%	**4.6%**	20
TN	13.8	14.7	17.3	15.8	16.1	16.1	17.4	18.9	19.6	16.4	42%	**4.5%**	21
ME	4.3	4.5	4.7	4.8	4.9	5.2	5.5	6.0	6.0	5.4	41%	**4.4%**	22
GA	18.9	20.0	19.6	20.2	20.5	22.0	24.0	25.1	26.5	23.7	41%	**4.3%**	23
VA	16.3	17.0	18.2	18.0	18.9	19.7	21.7	21.1	22.5	14.1	38%	**4.2%**	24
FL	40.7	43.0	42.3	42.8	45.3	48.0	50.8	53.7	55.8	40.1	37%	**4.0%**	25
HI	2.4	2.2	2.2	2.4	2.5	2.7	3.0	3.0	3.3	2.8	37%	**4.0%**	26
TX	49.1	50.7	52.0	52.9	56.1	60.1	64.1	64.5	66.9	48.1	36%	**3.9%**	27
NH	4.0	4.2	3.9	4.2	4.4	4.5	4.8	5.2	5.4	5.1	35%	**3.8%**	28
PA	33.5	35.6	36.6	37.2	38.0	39.8	41.8	43.8	44.8	45.5	34%	**3.7%**	29
AK	1.7	1.7	1.7	1.8	1.9	1.9	2.0	2.1	2.2	0.8	34%	**3.7%**	30
CT	9.2	9.6	10.2	10.5	10.6	10.7	11.3	11.5	12.3	12.4	33%	**3.7%**	31
MO	16.4	17.1	18.5	17.9	18.2	18.3	21.3	20.9	21.8	11.3	33%	**3.6%**	32
NM	4.4	4.2	4.5	4.5	4.7	5.0	5.6	5.6	5.8	3.7	32%	**3.5%**	33
OH	32.5	33.3	35.4	36.2	36.6	37.9	40.8	42.1	42.8	15.7	32%	**3.5%**	34
KY	11.4	11.7	11.9	11.8	12.1	12.8	14.3	14.5	15.0	10.7	31%	**3.5%**	35
WY	1.3	1.3	1.4	1.4	1.5	1.6	1.7	1.7	1.7	1.7	31%	**3.4%**	36
OK	8.3	8.4	9.1	9.2	9.4	9.8	10.3	10.6	10.9	8.7	31%	**3.4%**	37
SC	11.0	10.7	11.6	11.8	12.4	12.6	13.8	13.8	14.3	12.7	31%	**3.4%**	38
NJ	19.3	19.9	20.5	20.9	21.1	22.9	23.8	24.6	25.0	3.6	29%	**3.3%**	39
NE	5.0	5.4	5.4	5.8	5.8	5.8	6.5	6.7	6.4	4.6	28%	**3.2%**	40
AZ	13.0	10.7	13.6	13.2	14.5	13.5	15.7	16.1	16.6	7.8	28%	**3.1%**	41
DC	3.0	2.9	3.0	3.1	3.1	3.3	3.5	3.7	3.8	3.3	26%	**3.0%**	42
MD	13.0	13.8	14.2	14.2	14.9	15.0	15.6	16.2	16.5	16.4	26%	**2.9%**	43
MI	26.2	26.6	27.7	27.6	28.6	29.3	31.9	33.1	32.8	28.0	25%	**2.9%**	44
IA	7.8	7.9	8.1	8.1	8.4	8.8	9.3	9.5	9.7	8.7	25%	**2.8%**	45
IL	32.4	32.3	33.6	35.0	36.3	36.6	40.0	39.2	40.4	30.9	25%	**2.8%**	46
AR	5.6	5.4	6.0	5.7	5.8	6.0	6.6	6.7	7.0	4.9	25%	**2.8%**	47
WV	5.8	4.9	5.5	5.5	5.6	6.0	6.4	6.8	7.1	4.6	23%	**2.6%**	48
AL	9.2	8.7	10.5	10.0	10.0	9.3	11.4	10.7	11.2	10.2	22%	**2.5%**	49
RI	3.1	3.1	3.2	3.2	3.3	3.3	3.5	3.6	3.7	3.3	22%	**2.5%**	50
MS	7.3	7.2	8.3	7.8	8.1	7.9	8.3	8.1	8.4	7.2	15%	**1.8%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 21.

Annual Operating Revenues Per Resident, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**2,401**	**2,452**	**2,572**	**2,610**	**2,666**	**2,751**	**2,969**	**3,033**	**3,242**	**2,080**	**35%**	**3.8%**	
DC	5,340	4,975	5,016	5,137	4,911	5,249	5,437	5,599	**5,760**	4,813	8%	1.0%	1
ND	3,614	3,722	4,568	4,193	4,751	5,088	5,376	5,416	**5,650**	4,712	56%	5.7%	2
SD	3,291	3,703	3,856	4,229	4,392	4,684	4,923	5,234	**5,413**	5,923	65%	6.4%	3
MA	3,247	3,226	3,416	3,487	3,495	3,741	4,121	4,238	**4,630**	4,170	43%	4.5%	4
ME	3,302	3,470	3,638	3,704	3,750	4,018	4,270	4,606	**4,618**	4,160	40%	4.3%	5
VT	3,126	3,158	3,359	3,659	3,735	3,909	3,838	4,267	**4,540**	4,569	45%	4.8%	6
MT	2,981	2,860	3,591	3,467	3,618	3,420	4,189	4,352	**4,439**	1,776	49%	5.1%	7
NY	2,953	3,071	3,144	3,215	3,352	3,442	3,853	3,937	**4,244**	1,115	44%	4.6%	8
IN	2,994	3,194	3,534	3,434	3,519	3,623	3,795	3,938	**4,154**	1,378	39%	4.2%	9
NH	3,151	3,268	3,048	3,280	3,405	3,483	3,722	4,011	**4,143**	3,885	31%	3.5%	10
WI	2,937	2,990	3,272	3,398	3,552	3,698	3,850	4,026	**4,130**	2,758	41%	4.4%	11
WV	3,223	2,727	3,055	3,069	3,104	3,343	3,596	3,853	**4,054**	2,630	26%	2.9%	12
MN	2,751	2,855	2,999	3,077	3,217	3,353	3,511	3,680	**3,815**	1,161	39%	4.2%	13
OH	2,897	2,967	3,157	3,223	3,248	3,359	3,618	3,717	**3,765**	1,379	30%	3.3%	14
MO	2,828	2,930	3,179	3,064	3,092	3,112	3,607	3,527	**3,678**	1,905	30%	3.3%	15
DE	2,598	2,814	2,781	2,815	3,118	3,113	3,225	3,506	**3,668**	3,761	41%	4.4%	16
RI	3,024	3,098	3,196	3,144	3,301	3,264	3,435	3,550	**3,661**	3,271	21%	2.4%	17
PA	2,727	2,886	2,962	3,012	3,076	3,211	3,378	3,535	**3,616**	3,670	33%	3.6%	18
CT	2,659	2,770	2,932	3,021	3,060	3,089	3,261	3,310	**3,541**	3,593	33%	3.6%	19
KY	2,712	2,768	2,819	2,774	2,826	2,980	3,324	3,355	**3,465**	2,467	28%	3.1%	20
NE	2,824	3,026	3,022	3,203	3,199	3,173	3,534	3,593	**3,434**	2,425	22%	2.5%	21
CA	1,914	2,011	2,076	2,245	2,213	2,290	2,433	2,498	**3,420**	2,027	79%	7.5%	22
KS	2,357	2,182	2,567	2,657	2,712	2,776	3,153	3,274	**3,375**	2,421	43%	4.6%	23
MI	2,711	2,760	2,867	2,861	2,951	3,028	3,291	3,410	**3,361**	2,848	24%	2.7%	24
ID	2,013	2,164	2,404	2,544	2,667	2,859	2,992	3,080	**3,289**	2,626	63%	6.3%	25
IL	2,582	2,572	2,675	2,783	2,887	2,918	3,203	3,136	**3,250**	2,496	26%	2.9%	26
OR	2,277	2,049	2,712	2,892	2,644	2,488	3,272	3,055	**3,249**	1,744	43%	4.5%	27
LA	2,325	2,508	2,667	2,649	2,686	2,752	3,025	3,039	**3,235**	1,888	39%	4.2%	28
IA	2,632	2,677	2,715	2,713	2,810	2,926	3,052	3,112	**3,171**	2,828	20%	2.4%	29
AK	2,453	2,476	2,431	2,499	2,624	2,756	2,859	2,914	**3,164**	1,089	29%	3.2%	30
NC	2,280	2,347	2,520	2,523	2,515	2,757	2,852	3,003	**3,087**	2,345	35%	3.9%	31
WY	2,397	2,375	2,466	2,517	2,600	2,838	2,905	2,992	**3,066**	2,990	28%	3.1%	32
WA	2,302	2,362	2,425	2,618	2,707	2,794	2,841	2,956	**3,055**	1,595	33%	3.6%	33
CO	2,135	2,154	2,201	2,289	2,430	2,593	2,729	2,982	**3,031**	1,667	42%	4.5%	34
TN	2,233	2,367	2,756	2,507	2,527	2,502	2,693	2,897	**2,981**	2,478	33%	3.7%	35
MS	2,551	2,516	2,877	2,702	2,795	2,749	2,869	2,821	**2,925**	2,516	15%	1.7%	36
SC	2,453	2,378	2,529	2,553	2,646	2,652	2,871	2,845	**2,908**	2,551	19%	2.1%	37
NJ	2,238	2,306	2,358	2,397	2,412	2,612	2,717	2,786	**2,862**	411	28%	3.1%	38
OK	2,289	2,299	2,471	2,462	2,510	2,581	2,707	2,780	**2,847**	2,275	24%	2.8%	39
NM	2,166	2,059	2,226	2,192	2,312	2,469	2,748	2,766	**2,817**	1,782	30%	3.3%	40
MD	2,320	2,436	2,485	2,456	2,566	2,572	2,657	2,753	**2,802**	2,809	21%	2.4%	41
VA	2,114	2,178	2,309	2,265	2,358	2,447	2,681	2,594	**2,756**	1,716	30%	3.4%	42
FL	2,213	2,313	2,242	2,242	2,332	2,424	2,520	2,615	**2,678**	1,897	21%	2.4%	43
GA	2,004	2,099	2,039	2,082	2,091	2,217	2,401	2,478	**2,597**	2,301	30%	3.3%	44
UT	1,877	2,084	2,037	2,043	2,163	2,196	2,482	2,489	**2,578**	2,530	37%	4.0%	45
HI	1,868	1,663	1,644	1,810	1,838	1,998	2,164	2,213	**2,460**	2,087	32%	3.5%	46
AR	1,990	1,901	2,089	2,003	2,030	2,095	2,294	2,317	**2,408**	1,666	21%	2.4%	47
TX	1,999	2,026	2,049	2,054	2,133	2,246	2,358	2,337	**2,387**	1,692	19%	2.2%	48
AZ	2,076	1,687	2,124	2,038	2,219	2,030	2,323	2,359	**2,375**	1,086	14%	1.7%	49
AL	1,972	1,853	2,232	2,129	2,121	1,958	2,419	2,253	**2,356**	2,132	19%	2.2%	50
NV	1,778	1,793	1,835	1,974	1,839	1,953	1,996	2,143	**2,266**	872	27%	3.1%	51

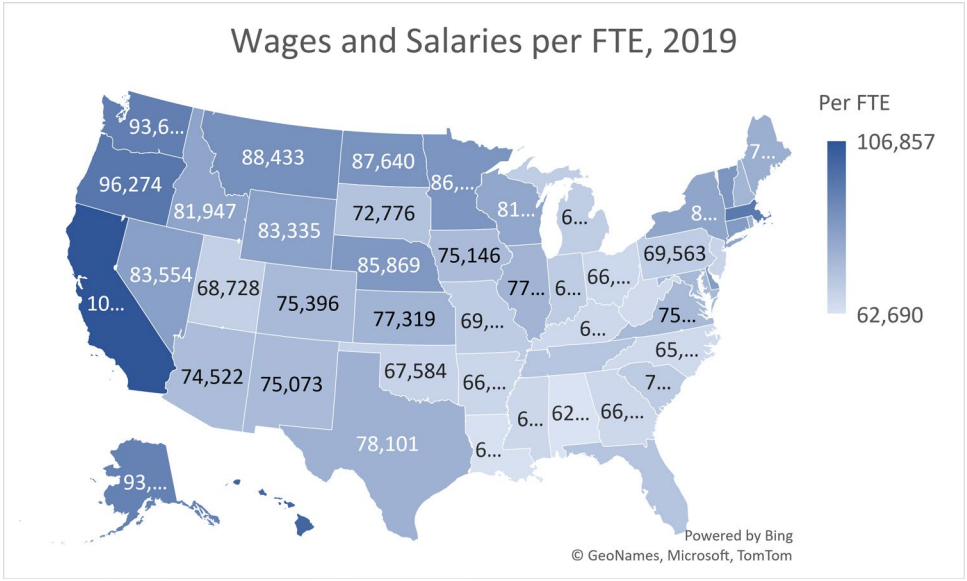
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

15. Average Salaries per FTE. Among the states, North Dakota had the 8th highest average salaries in 2019 at $87,640 per FTE, and about $10,000 higher than the national average (see Figure 8 and Table 22). From 2010 to 2019, average salaries in North Dakota grew by 2.9 percent per year; the national average growth rate in that period was 2.1 percent.

Figure 8.



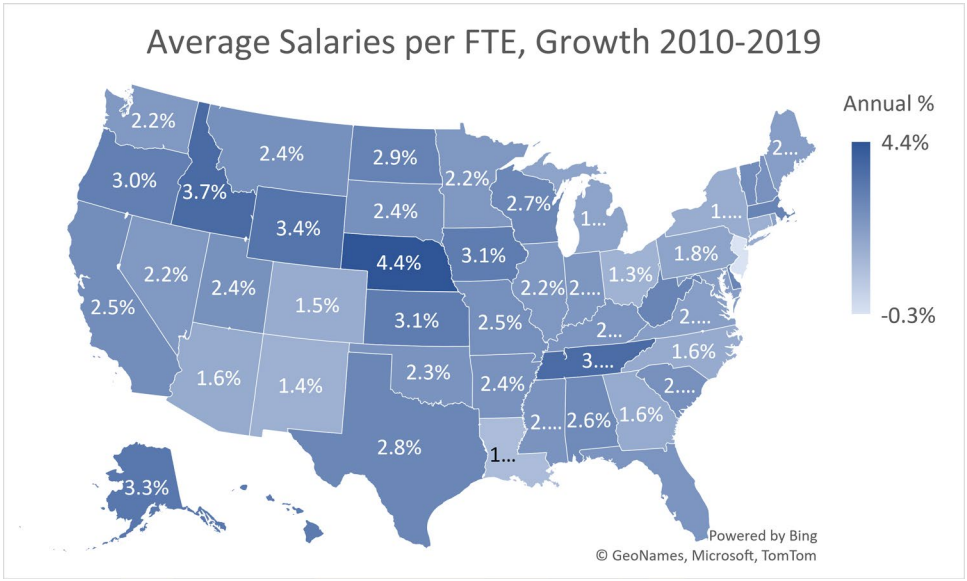


Table 22.

Average Salary per Full-Time Equivalent (FTE) Employee, Ranked by 2019 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2010-2019	Avg Annual Growth	Rank
US	**64,269**	**65,722**	**67,299**	**68,502**	**70,122**	**71,944**	**73,382**	**75,589**	**77,549**	**77,494**	**21%**	**2.1%**	
CA	85,342	87,462	88,168	91,449	93,509	96,217	100,792	103,736	106,015	**106,857**	25%	2.5%	1
HI	76,669	78,693	81,208	81,480	82,796	86,086	91,390	94,600	91,095	**101,450**	32%	3.2%	2
OR	73,818	77,031	81,816	82,026	86,050	88,509	94,944	92,210	94,811	**96,274**	30%	3.0%	3
MA	74,132	77,438	80,014	77,769	83,545	85,690	86,024	84,241	88,767	**95,379**	29%	2.8%	4
WA	77,240	73,833	77,846	77,106	81,929	83,627	87,427	89,541	90,434	**93,666**	21%	2.2%	5
AK	69,630	72,562	73,308	96,538	78,699	74,443	70,007	76,296	85,392	**93,009**	34%	3.3%	6
MT	71,213	73,440	66,366	72,433	71,982	71,502	78,750	81,060	83,193	**88,433**	24%	2.4%	7
ND	67,765	66,493	67,672	65,387	79,756	81,258	82,891	86,792	90,678	**87,640**	29%	2.9%	8
MN	71,372	73,221	74,534	77,215	81,348	83,285	84,840	86,400	88,930	**86,858**	22%	2.2%	9
VT	69,010	73,118	72,006	74,639	77,064	79,480	81,232	83,842	84,724	**86,614**	26%	2.6%	10
NE	58,149	59,082	58,010	58,131	58,684	57,587	69,799	76,161	77,812	**85,869**	48%	4.4%	11
DC	70,572	67,838	71,857	73,869	77,063	79,323	78,489	80,851	84,022	**84,958**	20%	2.1%	12
CT	74,765	76,358	76,446	78,956	78,337	81,612	80,299	77,720	81,457	**84,817**	13%	1.4%	13
DE	66,035	67,562	67,961	72,716	73,880	75,631	77,580	79,621	81,332	**84,604**	28%	2.8%	14
NV	68,881	65,010	71,844	74,790	73,752	76,356	77,464	79,718	80,123	**83,554**	21%	2.2%	15
WY	61,848	64,376	62,994	65,822	69,539	73,540	75,347	78,922	76,559	**83,335**	35%	3.4%	16
ID	59,118	61,344	63,453	65,112	67,464	69,624	72,412	74,871	78,769	**81,947**	39%	3.7%	17
NY	71,422	72,990	75,850	76,860	79,841	79,109	82,998	86,182	89,700	**81,779**	15%	1.5%	18
WI	63,852	65,457	67,555	68,062	70,236	70,003	72,022	73,106	78,384	**81,483**	28%	2.7%	19
ME	66,019	68,435	70,999	73,419	65,419	72,564	74,856	78,881	81,116	**78,835**	19%	2.0%	20
RI	65,812	68,302	69,376	71,790	65,902	70,373	73,996	76,540	75,692	**78,107**	19%	1.9%	21
TX	61,011	61,893	64,056	65,687	67,717	69,177	70,111	72,294	73,910	**78,101**	28%	2.8%	22
KS	58,765	60,288	60,131	62,398	65,432	68,079	69,744	70,682	74,905	**77,319**	32%	3.1%	23
IL	63,523	66,626	65,360	66,165	66,877	71,224	71,133	72,160	72,582	**77,205**	22%	2.2%	24
NH	62,104	64,128	64,045	69,258	68,347	69,599	74,615	68,297	75,624	**76,807**	24%	2.4%	25
MD	63,472	64,158	64,838	66,677	67,081	68,428	69,999	73,481	74,227	**75,875**	20%	2.0%	26
VA	63,262	64,730	65,689	66,921	69,004	69,614	70,695	67,915	69,794	**75,534**	19%	2.0%	27
CO	65,751	67,157	66,423	72,194	73,004	75,266	76,662	77,274	80,554	**75,396**	15%	1.5%	28
IA	57,065	61,618	62,323	66,137	66,682	68,912	66,399	70,404	72,992	**75,146**	32%	3.1%	29
NM	66,211	66,705	67,502	69,102	68,410	69,936	70,736	72,252	75,479	**75,073**	13%	1.4%	30
AZ	64,658	66,835	67,775	70,170	69,682	67,533	72,442	72,718	75,852	**74,522**	15%	1.6%	31
SD	58,556	57,961	64,632	61,958	69,614	73,162	72,629	76,924	78,498	**72,776**	24%	2.4%	32
FL	58,903	59,773	60,203	58,645	62,807	66,790	66,945	69,498	71,252	**72,261**	23%	2.3%	33
TN	52,074	52,949	66,266	69,498	63,069	65,060	62,952	70,247	69,830	**71,976**	38%	3.7%	34
SC	56,550	57,009	58,878	57,953	61,397	62,855	63,029	66,990	69,290	**70,168**	24%	2.4%	35
MO	56,066	57,220	59,190	60,045	61,747	62,949	65,719	68,817	69,361	**69,882**	25%	2.5%	36
IN	57,054	58,118	59,529	62,511	61,516	64,214	65,639	68,903	71,379	**69,703**	22%	2.2%	37
PA	59,202	60,375	60,960	61,402	62,135	64,095	65,713	66,468	68,381	**69,563**	18%	1.8%	38
MI	59,081	61,556	61,422	63,539	64,758	67,066	68,671	71,962	69,611	**69,383**	17%	1.8%	39
UT	55,468	56,580	57,010	57,703	58,733	60,856	61,984	64,516	66,751	**68,728**	24%	2.4%	40
OK	54,942	57,809	58,183	61,849	64,145	63,239	66,899	64,461	64,051	**67,584**	23%	2.3%	41
NJ	69,112	69,343	71,007	71,257	73,133	75,430	75,236	78,622	80,462	**67,390**	-2%	-0.3%	42
AR	53,988	53,917	56,490	57,676	55,707	59,078	61,643	63,499	65,080	**66,818**	24%	2.4%	43
MS	53,902	55,217	55,068	56,078	55,916	58,469	59,248	62,926	66,230	**66,292**	23%	2.3%	44
OH	58,847	59,650	61,912	63,158	62,713	63,303	65,455	66,872	68,523	**66,185**	12%	1.3%	45
GA	57,342	58,910	59,056	61,162	63,531	65,075	64,868	67,775	68,882	**66,025**	15%	1.6%	46
KY	53,794	56,003	54,751	56,419	58,012	60,625	62,272	64,112	66,061	**66,010**	23%	2.3%	47
NC	56,944	58,384	59,685	59,719	60,093	61,300	63,536	65,385	66,916	**65,457**	15%	1.6%	48
WV	50,605	53,683	54,253	55,001	55,352	56,799	59,619	59,255	63,541	**65,092**	29%	2.8%	49
LA	57,945	59,089	63,723	59,073	63,467	64,047	62,703	66,449	61,570	**63,459**	10%	1.0%	50
AL	49,582	49,025	54,187	52,402	54,102	54,702	56,102	58,424	60,869	**62,690**	26%	2.6%	51

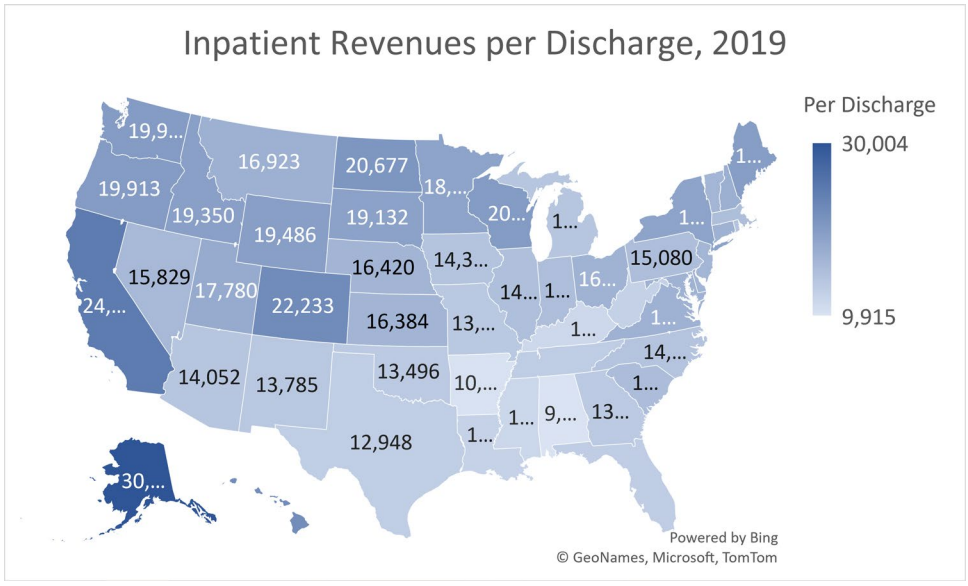
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

16. ***Inpatient Revenue Per Discharge.*** Although revenue or cost allocations are inherently uncertain, it has become customary to use charges as a tool to divide resource use among hospital units or services. To estimate hospital costs per discharge, we use inpatient vs. outpatient charges to allocate revenues to inpatient care, and then divide by the number of discharges.

    At over $20,000, North Dakota's inpatient revenue per discharge was 6th highest among states in 2019. Inpatient revenue per discharge grew by 5.7 percent per year, nearly double the national average of 3.0% (see Table 23 and Figure 9). In 2010, North Dakota's rank was 21st on this measure.

Figure 9.



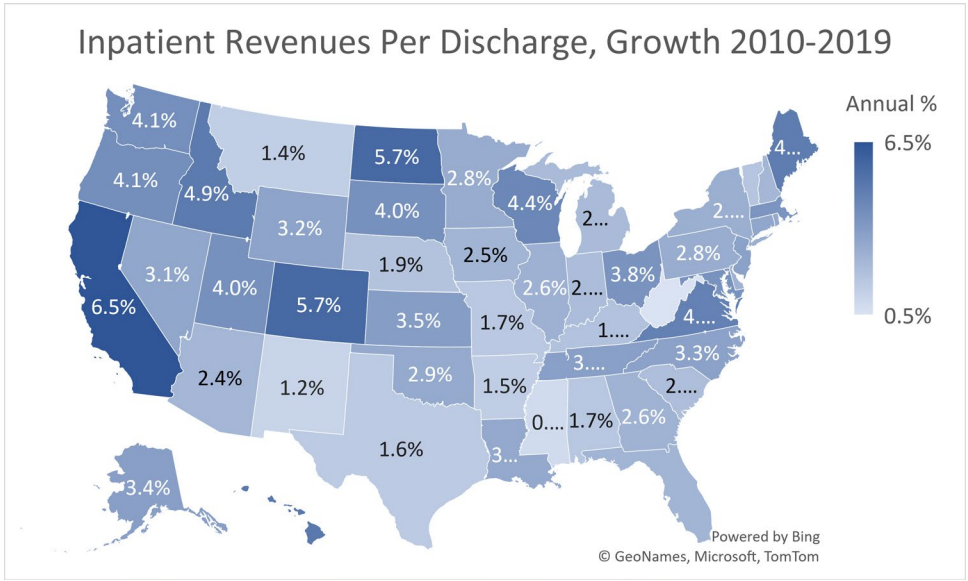


Table 23.

Inpatient Revenue per Discharge (approximated using charge ratios), Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**12,210**	**12,648**	**12,772**	**13,234**	**13,684**	**14,160**	**14,402**	**14,781**	**15,837**	**15,905**	**30%**	**3.0%**	
AK	22,253	22,725	22,085	19,430	21,176	22,829	23,489	23,530	25,043	**30,004**	35%	3.4%	1
DC	16,533	16,556	16,023	20,722	16,741	17,800	18,989	20,264	22,314	**25,172**	52%	4.8%	2
CA	13,879	14,957	15,060	16,908	16,875	17,059	17,721	17,961	25,008	**24,435**	76%	6.5%	3
CO	13,545	14,332	14,627	15,870	16,286	17,071	17,933	18,470	19,511	**22,233**	64%	5.7%	4
HI	14,231	12,241	13,004	13,197	14,387	15,222	16,185	16,339	17,583	**22,033**	55%	5.0%	5
ND	12,587	12,319	14,867	15,109	15,889	16,718	18,186	17,310	18,329	**20,677**	64%	5.7%	6
WI	13,645	13,997	15,093	15,913	16,692	17,429	17,618	17,828	17,978	**20,020**	47%	4.4%	7
WA	13,948	14,643	14,592	15,791	16,437	17,489	17,015	18,958	19,058	**19,949**	43%	4.1%	8
OR	13,893	14,204	15,190	18,387	16,050	16,118	17,426	17,057	18,252	**19,913**	43%	4.1%	9
ME	12,889	13,631	14,015	13,817	15,175	15,722	17,255	18,410	18,463	**19,686**	53%	4.8%	10
WY	14,701	15,390	16,131	16,444	16,703	17,820	18,260	18,074	18,990	**19,486**	33%	3.2%	11
ID	12,562	13,187	14,299	15,214	16,186	16,657	16,908	17,169	18,258	**19,350**	54%	4.9%	12
SD	13,446	15,654	15,995	16,705	16,714	18,147	18,956	18,591	18,522	**19,132**	42%	4.0%	13
NY	14,817	15,004	15,213	16,233	17,016	17,940	18,699	19,024	19,914	**18,896**	28%	2.7%	14
MN	14,603	15,350	16,043	16,359	18,056	18,370	19,301	19,159	19,866	**18,801**	29%	2.8%	15
UT	12,519	14,452	13,163	13,795	14,961	15,377	15,971	16,813	17,225	**17,780**	42%	4.0%	16
NH	13,874	14,285	14,158	14,822	15,081	15,194	15,511	16,620	17,075	**17,144**	24%	2.4%	17
MT	14,928	15,716	15,744	15,782	16,333	17,208	16,516	17,042	16,469	**16,923**	13%	1.4%	18
CT	12,828	13,797	13,627	14,176	14,464	14,632	14,439	14,840	16,058	**16,839**	31%	3.1%	19
VA	11,166	11,456	11,656	12,021	13,004	13,593	13,911	13,448	14,298	**16,792**	50%	4.6%	20
OH	11,922	12,270	12,522	12,677	13,132	13,714	14,370	14,372	14,807	**16,739**	40%	3.8%	21
MD	11,831	11,820	12,063	12,180	13,060	14,239	14,268	14,846	15,248	**16,709**	41%	3.9%	22
DE	13,091	13,110	13,992	13,011	13,959	15,679	15,807	15,746	16,111	**16,443**	26%	2.6%	23
NE	13,882	14,445	14,309	14,557	14,915	15,848	16,108	15,899	14,732	**16,420**	18%	1.9%	24
KS	12,072	11,388	12,711	13,022	13,328	13,744	13,746	14,520	14,975	**16,384**	36%	3.5%	25
VT	13,892	13,295	13,925	14,994	16,134	17,097	15,379	16,902	16,377	**16,310**	17%	1.8%	26
NJ	12,193	12,468	13,040	13,349	13,919	14,764	14,448	15,847	16,589	**16,294**	34%	3.3%	27
NV	12,053	12,322	13,163	13,376	13,035	13,681	13,515	14,012	14,417	**15,829**	31%	3.1%	28
SC	12,670	12,691	12,295	12,942	13,424	14,030	13,917	14,029	14,301	**15,251**	20%	2.1%	29
IN	12,495	12,988	13,936	13,791	14,850	14,525	14,688	15,096	15,845	**15,102**	21%	2.1%	30
PA	11,773	12,176	12,607	12,897	13,109	13,474	13,913	14,156	14,794	**15,080**	28%	2.8%	31
MA	10,764	11,331	11,881	12,100	12,625	12,796	13,560	13,722	14,856	**15,063**	40%	3.8%	32
IL	11,797	11,892	11,661	12,077	12,514	13,095	13,487	13,670	14,248	**14,921**	26%	2.6%	33
IA	11,500	11,484	11,604	11,617	12,069	12,039	12,491	12,762	12,945	**14,330**	25%	2.5%	34
RI	11,033	12,549	12,952	13,470	13,679	13,602	14,004	13,753	14,473	**14,301**	30%	2.9%	35
NC	10,663	10,855	11,593	11,529	11,675	12,604	12,824	13,357	13,691	**14,240**	34%	3.3%	36
AZ	11,327	11,729	11,654	11,582	12,117	11,364	12,603	13,898	14,019	**14,052**	24%	2.4%	37
MI	11,498	11,620	11,514	11,700	12,089	12,437	12,882	13,544	13,515	**13,995**	22%	2.2%	38
NM	12,399	12,046	12,182	11,713	12,184	13,399	13,566	13,012	14,495	**13,785**	11%	1.2%	39
MO	11,754	12,758	12,216	12,313	12,583	12,769	13,475	13,671	13,655	**13,643**	16%	1.7%	40
OK	10,397	10,213	10,701	10,149	10,972	11,688	11,904	12,363	12,523	**13,496**	30%	2.9%	41
GA	10,672	11,416	10,845	11,028	10,947	11,745	12,241	12,424	13,013	**13,405**	26%	2.6%	42
TN	9,689	10,667	11,161	10,557	10,740	10,687	10,822	11,502	12,209	**13,033**	35%	3.3%	43
FL	10,431	10,981	10,366	10,488	10,975	11,376	11,587	12,080	12,570	**13,000**	25%	2.5%	44
TX	11,229	11,490	11,269	11,536	12,320	12,677	12,829	12,828	13,152	**12,948**	15%	1.6%	45
WV	11,756	9,831	10,638	11,281	11,778	12,396	12,923	13,268	14,020	**12,348**	5%	0.5%	46
LA	9,403	10,235	10,574	10,911	11,538	12,342	12,232	12,304	12,540	**12,251**	30%	3.0%	47
MS	10,736	10,883	10,763	10,864	11,403	11,009	10,832	10,864	10,632	**11,623**	8%	0.9%	48
KY	9,656	9,974	9,745	10,040	10,234	10,587	10,917	11,199	11,409	**11,467**	19%	1.9%	49
AR	8,861	8,930	8,919	8,804	8,932	9,200	9,316	9,709	9,989	**10,094**	14%	1.5%	50
AL	8,493	8,509	8,671	8,892	8,947	9,110	8,912	9,050	9,331	**9,915**	17%	1.7%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

17. ***Commercial to Medicare Rate Ratio.*** We used a proxy measure of average commercial rates compared with Medicare rates. Among all hospitals in North Dakota, the average ratio in 2019 was 213 percent of Medicare rates, or more than twice Medicare payment rates (see Table 24 and Figure 10). For comparison, the commercial to Medicare rate ratio in 2018 ranged from a high of 247 percent in Colorado to 150 percent or below in New York, Texas, Maryland, Massachusetts, and a handful of other states. Over the 2010-2018 period, North Dakota's rank on this measure jumped from 30th to 7th.

Figure 10.

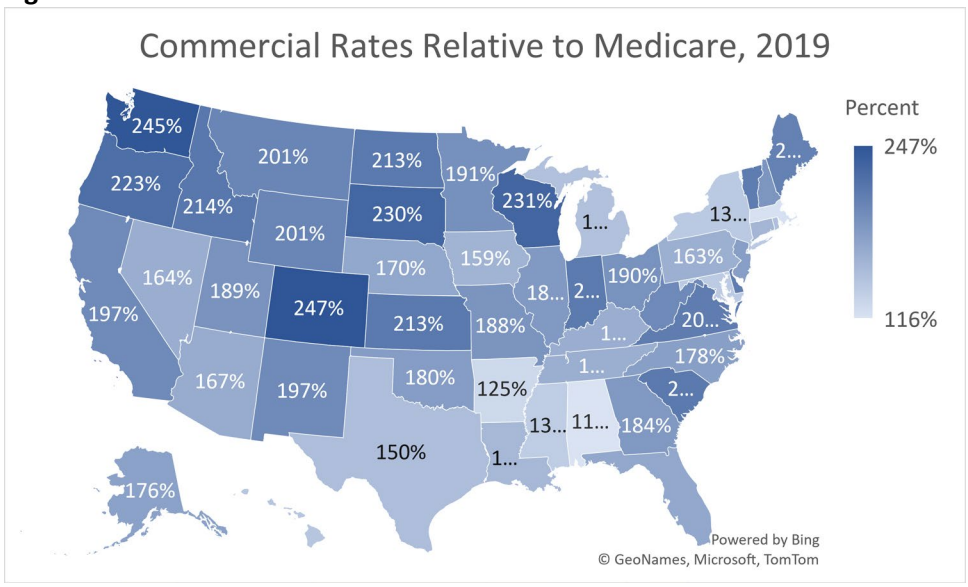


Table 24.

Commercial Rates Relative to Medicare, Ranked by 2019 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2011-2019	Avg Annual Growth	Rank
US		**167%**	**168%**	**162%**	**167%**	**174%**	**172%**	**173%**	**173%**	**172%**	**3%**	**0.4%**	
CO		198%	218%	213%	212%	231%	239%	244%	244%	**247%**	24%	2.8%	1
WA		191%	194%	182%	196%	215%	203%	216%	216%	**245%**	28%	3.1%	2
WI		196%	212%	217%	223%	233%	236%	235%	227%	**231%**	17%	2.0%	3
SD		225%	230%	216%	203%	222%	221%	224%	230%	**230%**	2%	0.3%	4
OR		196%	205%	182%	206%	211%	218%	208%	205%	**223%**	14%	1.6%	5
ID		213%	218%	222%	224%	225%	216%	226%	226%	**214%**	0%	0.1%	6
ND		170%	177%	166%	180%	190%	202%	191%	205%	**213%**	26%	2.9%	7
KS		170%	189%	184%	189%	195%	200%	200%	197%	**213%**	25%	2.9%	8
SC		202%	200%	211%	217%	224%	223%	218%	211%	**212%**	5%	0.6%	9
IN		210%	232%	221%	234%	225%	225%	229%	239%	**212%**	1%	0.1%	10
VT		191%	198%	220%	229%	238%	228%	228%	214%	**209%**	10%	1.2%	11
VA		186%	184%	177%	185%	196%	200%	187%	193%	**209%**	12%	1.5%	12
DE		187%	201%	199%	203%	214%	207%	206%	211%	**209%**	12%	1.4%	13
ME		230%	234%	201%	216%	221%	219%	229%	220%	**205%**	-11%	-1.4%	14
MT		215%	211%	196%	207%	209%	187%	198%	204%	**201%**	-6%	-0.8%	15
WY		300%	213%	219%	221%	225%	213%	212%	209%	**201%**	-33%	-4.9%	16
WV		165%	195%	181%	186%	199%	209%	211%	204%	**197%**	19%	2.2%	17
CA		154%	166%	162%	159%	184%	182%	178%	194%	**197%**	28%	3.1%	18
NM		186%	193%	173%	190%	192%	198%	169%	207%	**197%**	6%	0.7%	19
DC		154%	156%	150%	151%	161%	162%	169%	180%	**196%**	27%	3.1%	20
MN		169%	173%	174%	178%	185%	190%	189%	194%	**191%**	13%	1.6%	21
OH		181%	175%	170%	168%	172%	179%	177%	176%	**190%**	5%	0.6%	22
UT		162%	177%	180%	181%	185%	198%	196%	196%	**189%**	17%	2.0%	23
MO		178%	177%	167%	173%	180%	184%	184%	176%	**188%**	6%	0.7%	24
NH		208%	207%	200%	198%	205%	197%	201%	190%	**187%**	-10%	-1.3%	25
GA		175%	164%	157%	161%	168%	172%	178%	177%	**184%**	5%	0.6%	26
IL		184%	177%	175%	179%	187%	181%	187%	178%	**183%**	0%	-0.1%	27
OK		168%	177%	155%	169%	177%	173%	179%	176%	**180%**	7%	0.9%	28
NJ		182%	181%	182%	173%	176%	180%	196%	187%	**178%**	-2%	-0.2%	29
NC		173%	181%	170%	169%	182%	182%	187%	185%	**178%**	3%	0.3%	30
AK		207%	199%	160%	175%	185%	185%	175%	180%	**176%**	-15%	-2.0%	31
NE		219%	214%	212%	213%	206%	206%	206%	174%	**170%**	-22%	-3.1%	32
FL		180%	162%	159%	176%	179%	174%	179%	180%	**170%**	-5%	-0.7%	33
AZ		167%	171%	151%	170%	161%	162%	172%	170%	**167%**	0%	0.0%	34
NV		153%	117%	159%	153%	163%	146%	160%	162%	**164%**	7%	0.9%	35
KY		179%	172%	167%	164%	173%	171%	174%	173%	**164%**	-8%	-1.1%	36
TN		164%	177%	142%	154%	155%	152%	159%	163%	**164%**	0%	0.0%	37
PA		153%	157%	155%	154%	161%	164%	160%	163%	**163%**	6%	0.8%	38
IA		180%	177%	162%	162%	166%	164%	160%	158%	**159%**	-11%	-1.5%	39
CT		157%	167%	165%	161%	157%	163%	156%	166%	**157%**	0%	0.0%	40
LA		161%	148%	151%	146%	156%	156%	147%	144%	**155%**	-4%	-0.5%	41
TX		163%	159%	153%	165%	175%	168%	173%	160%	**150%**	-8%	-1.0%	42
RI		157%	166%	160%	148%	142%	140%	144%	134%	**148%**	-6%	-0.7%	43
MI		145%	145%	139%	140%	141%	143%	145%	147%	**147%**	1%	0.1%	44
HI		112%	122%	109%	110%	127%	123%	121%	126%	**143%**	27%	3.1%	45
NY		127%	128%	125%	133%	134%	141%	137%	140%	**139%**	9%	1.1%	46
MD		127%	128%	121%	122%	124%	124%	130%	135%	**138%**	9%	1.0%	47
MS		192%	186%	169%	187%	172%	154%	153%	137%	**136%**	-29%	-4.2%	48
AR		148%	145%	128%	134%	133%	132%	133%	127%	**125%**	-15%	-2.0%	49
MA		120%	115%	112%	115%	116%	135%	123%	136%	**118%**	-2%	-0.2%	50
AL		122%	130%	126%	118%	128%	121%	116%	116%	**116%**	-5%	-0.7%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete.

18. ***Medicare Case Mix Index.*** The average Medicare case mix index gives an idea of the intensity or complexity of the inpatient services provided in a state. North Dakota's 2019 measure of 1.74 is very close to the national average of 1.79, and has remained close to the national average since 2010 (see Figure 11 and Table 25).

Figure 11.

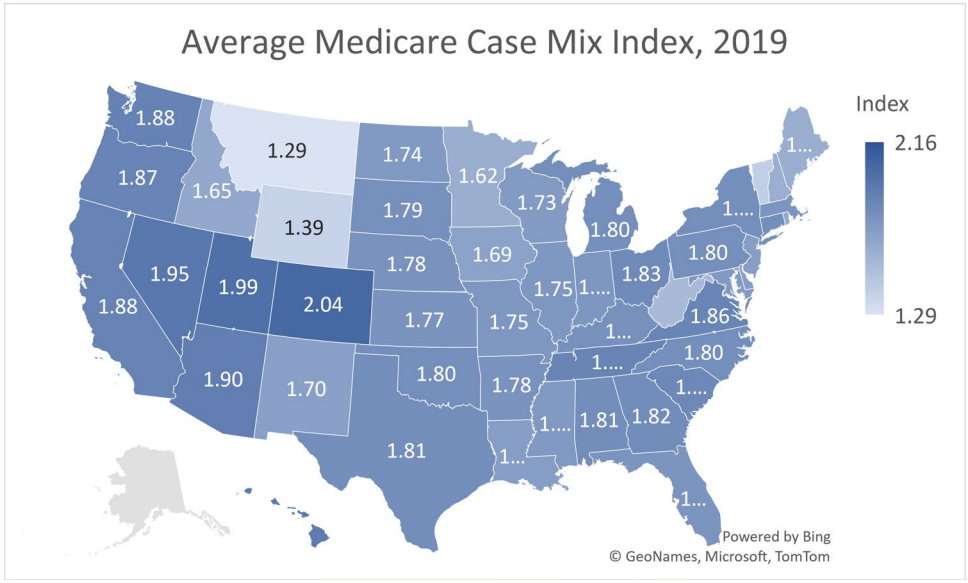


Table 25.

Average Medicare Case Mix Index, Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2019	Growth	Rank
US	**1.56**	**1.57**	**1.59**	**1.62**	**1.65**	**1.67**	**1.69**	**1.72**	**1.75**	**1.79**	**14%**	**1.6%**	
DC	1.76	1.81	1.76	1.72	1.83	1.88	1.95	2.02	2.09	**2.16**	19%	2.2%	1
CO	1.61	1.63	1.66	1.75	1.78	1.80	1.84	1.89	1.92	**2.04**	25%	2.9%	2
UT	1.71	1.76	1.77	1.78	1.86	1.86	1.90	1.93	1.98	**1.99**	13%	1.6%	3
NV	1.60	1.66	1.69	1.72	1.77	1.80	1.83	1.79	1.81	**1.95**	17%	2.0%	4
HI	1.61	1.61	1.67	1.66	1.68	1.70	1.78	1.83	1.85	**1.92**	19%	2.2%	5
AZ	1.68	1.67	1.74	1.74	1.78	1.81	1.89	1.90	1.94	**1.90**	14%	1.6%	6
WA	1.56	1.58	1.62	1.66	1.70	1.73	1.76	1.78	1.80	**1.88**	19%	2.2%	7
CA	1.60	1.63	1.67	1.68	1.71	1.72	1.76	1.79	1.82	**1.88**	15%	1.8%	8
OR	1.62	1.61	1.68	1.70	1.73	1.73	1.79	1.79	1.82	**1.87**	16%	1.9%	9
TN	1.62	1.65	1.68	1.72	1.74	1.75	1.77	1.83	1.85	**1.87**	13%	1.6%	10
VA	1.60	1.59	1.61	1.64	1.68	1.69	1.74	1.76	1.79	**1.86**	17%	2.0%	11
SC	1.61	1.62	1.65	1.69	1.71	1.70	1.75	1.78	1.80	**1.84**	14%	1.6%	12
OH	1.56	1.56	1.58	1.62	1.65	1.67	1.70	1.73	1.76	**1.83**	17%	2.0%	13
GA	1.59	1.60	1.64	1.67	1.69	1.70	1.74	1.77	1.78	**1.82**	14%	1.6%	14
AL	1.56	1.58	1.60	1.63	1.66	1.66	1.68	1.73	1.76	**1.81**	15%	1.7%	15
TX	1.60	1.61	1.61	1.64	1.67	1.69	1.73	1.74	1.79	**1.81**	12%	1.5%	16
CT	1.57	1.56	1.58	1.60	1.63	1.64	1.69	1.71	1.76	**1.81**	16%	1.8%	17
NY	1.53	1.54	1.55	1.59	1.64	1.66	1.70	1.72	1.75	**1.80**	17%	2.0%	18
OK	1.52	1.55	1.55	1.60	1.67	1.69	1.75	1.80	1.80	**1.80**	16%	1.9%	19
NC	1.58	1.60	1.64	1.67	1.69	1.70	1.76	1.77	1.78	**1.80**	12%	1.5%	20
MI	1.56	1.58	1.58	1.61	1.64	1.66	1.69	1.72	1.77	**1.80**	14%	1.7%	21
PA	1.58	1.59	1.60	1.64	1.67	1.68	1.72	1.74	1.78	**1.80**	13%	1.5%	22
SD	1.51	1.51	1.54	1.59	1.63	1.62	1.66	1.68	1.71	**1.79**	19%	2.2%	23
KY	1.49	1.50	1.50	1.56	1.59	1.62	1.67	1.70	1.73	**1.79**	19%	2.2%	24
NE	1.46	1.50	1.53	1.56	1.61	1.62	1.67	1.70	1.76	**1.78**	19%	2.2%	25
AR	1.46	1.49	1.48	1.53	1.56	1.60	1.64	1.69	1.73	**1.78**	20%	2.3%	26
KS	1.48	1.52	1.52	1.56	1.57	1.60	1.61	1.66	1.69	**1.77**	16%	1.9%	27
FL	1.57	1.58	1.59	1.61	1.62	1.63	1.68	1.71	1.75	**1.77**	12%	1.4%	28
MA	1.47	1.49	1.53	1.58	1.61	1.62	1.66	1.68	1.71	**1.77**	18%	2.1%	29
IN	1.52	1.52	1.52	1.56	1.61	1.62	1.67	1.70	1.72	**1.76**	16%	1.9%	30
MO	1.57	1.60	1.62	1.66	1.69	1.69	1.73	1.77	1.79	**1.75**	10%	1.2%	31
IL	1.49	1.51	1.51	1.56	1.60	1.62	1.65	1.68	1.72	**1.75**	16%	1.9%	32
MS	1.45	1.46	1.48	1.52	1.54	1.56	1.60	1.64	1.65	**1.74**	19%	2.2%	33
MD	1.49	1.52	1.55	1.56	1.58	1.61	1.63	1.68	1.70	**1.74**	15%	1.7%	34
ND	1.54	1.53	1.53	1.61	1.67	1.65	1.67	1.72	1.73	**1.74**	14%	1.6%	35
WI	1.49	1.50	1.51	1.54	1.59	1.59	1.63	1.65	1.67	**1.73**	15%	1.8%	36
LA	1.50	1.52	1.55	1.60	1.62	1.66	1.70	1.73	1.75	**1.71**	13%	1.5%	37
DE	1.52	1.54	1.63	1.64	1.68	1.70	1.74	1.74	1.74	**1.71**	11%	1.3%	38
NJ	1.55	1.56	1.58	1.60	1.65	1.66	1.71	1.74	1.75	**1.71**	10%	1.2%	39
NM	1.50	1.52	1.55	1.53	1.56	1.59	1.69	1.69	1.72	**1.70**	12%	1.4%	40
IA	1.40	1.42	1.45	1.47	1.50	1.51	1.55	1.57	1.61	**1.69**	19%	2.2%	41
ID	1.48	1.47	1.53	1.56	1.60	1.60	1.64	1.64	1.66	**1.65**	12%	1.4%	42
RI	1.45	1.49	1.52	1.55	1.55	1.54	1.57	1.62	1.62	**1.64**	10%	1.2%	43
MN	1.51	1.53	1.56	1.62	1.64	1.68	1.72	1.77	1.78	**1.62**	5%	0.7%	44
ME	1.37	1.38	1.43	1.44	1.44	1.45	1.51	1.56	1.58	**1.62**	17%	2.0%	45
NH	1.40	1.42	1.42	1.48	1.49	1.48	1.53	1.58	1.60	**1.61**	13%	1.5%	46
WV	1.46	1.44	1.45	1.51	1.54	1.54	1.58	1.63	1.68	**1.54**	7%	0.8%	47
VT	1.28	1.27	1.32	1.33	1.34	1.30	1.33	1.34	1.33	**1.41**	11%	1.3%	48
WY	1.18	1.21	1.25	1.25	1.27	1.30	1.35	1.35	1.35	**1.39**	14%	1.7%	49
MT	1.33	1.35	1.43	1.44	1.46	1.46	1.53	1.55	1.60	**1.29**	-4%	-0.5%	50
AK	1.49	1.52	1.52	1.52	1.61	1.65	1.66	1.66	1.67		12%	1.4%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Alaska growth rate is 2010-2018.

19. ***Medicare Revenues Per Enrollee.*** Medicare patient revenues per enrollee in North Dakota were 2nd highest in the nation in 2018. Figure 12 and Table 26 show the measure based on gross Medicare enrollment in the state (anyone with any Medicare enrollment). We also tested the concept using a "net" or much reduced enrollment measure (only Parts A and B, excluding dual Medicare-Medicaid eligible people). Under both measures, Medicare patient revenues per enrollee in North Dakota ranked number 2, behind only DC.

Figure 12.

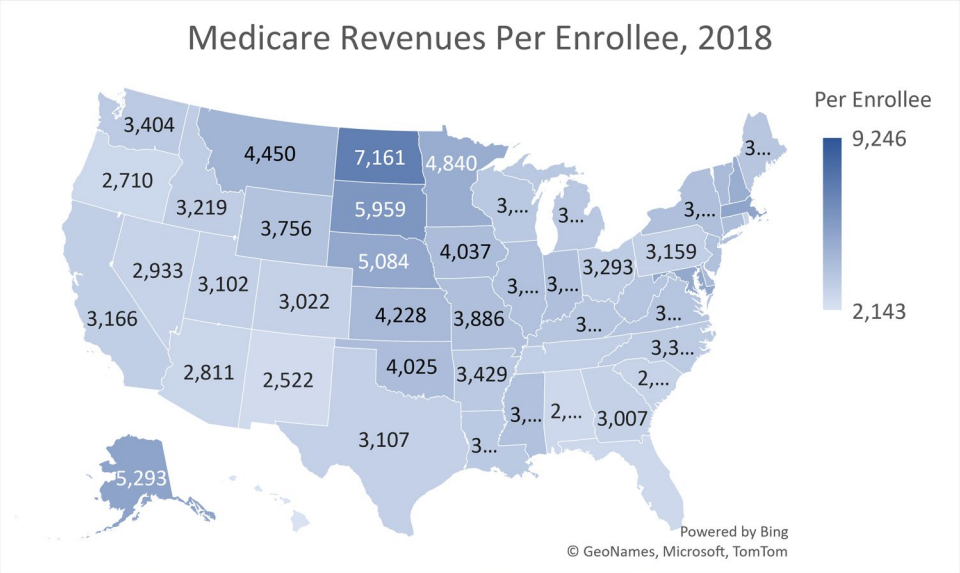


Table 26.

Annual Medicare Patient Revenues Per (Gross) Medicare Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**3,397**	**3,344**	**3,366**	**3,331**	**3,345**	**3,314**	**3,433**	**3,429**	**3,433**	**2,216**	**1%**	**0.1%**	
DC	8,687	8,545	8,547	8,429	8,397	8,713	8,800	9,214	**9,246**	7,584	6%	0.8%	1
ND	4,866	5,056	5,839	5,542	6,240	6,489	6,856	7,002	**7,161**	5,501	47%	4.9%	2
SD	4,425	4,400	4,492	4,788	5,119	5,365	5,672	5,896	**5,959**	6,194	35%	3.8%	3
AK	3,443	3,576	3,603	4,602	4,626	4,623	4,948	5,070	**5,293**	1,480	54%	5.5%	4
MA	4,446	4,440	4,744	4,844	4,787	4,954	5,047	5,058	**5,198**	4,922	17%	2.0%	5
NE	4,415	4,483	4,513	4,643	4,558	4,659	4,874	4,962	**5,084**	3,195	15%	1.8%	6
MD	5,265	5,254	5,211	5,023	5,238	5,184	5,310	5,239	**5,068**	4,821	-4%	-0.5%	7
MN	3,682	3,816	3,899	3,963	4,144	4,342	4,509	4,740	**4,840**	1,429	31%	3.5%	8
NH	3,957	4,123	3,858	4,238	4,334	4,461	4,573	4,700	**4,803**	4,243	21%	2.4%	9
MT	3,152	2,973	3,804	3,721	3,779	3,499	4,339	4,258	**4,450**	1,716	41%	4.4%	10
KS	3,830	3,767	3,774	3,886	4,021	3,964	4,284	4,249	**4,228**	2,881	10%	1.2%	11
VT	3,833	3,846	3,896	3,799	3,834	3,926	4,074	4,188	**4,124**	4,047	8%	0.9%	12
DE	3,818	3,948	3,905	3,886	4,100	4,168	4,183	4,188	**4,117**	4,123	8%	0.9%	13
IA	3,732	3,763	3,732	3,784	3,829	3,952	3,947	4,040	**4,037**	3,473	8%	1.0%	14
OK	3,368	3,388	3,383	3,453	3,555	3,625	3,780	3,863	**4,025**	2,962	20%	2.3%	15
CT	4,137	4,118	3,945	4,086	4,184	4,155	4,199	4,250	**4,007**	3,758	-3%	-0.4%	16
IN	3,925	3,845	3,815	3,820	3,862	3,886	3,858	3,888	**3,887**	1,493	-1%	-0.1%	17
NY	3,882	3,811	3,726	3,649	3,673	3,593	3,800	3,824	**3,887**	785	0%	0.0%	18
MO	3,918	3,783	4,060	3,820	3,829	3,726	4,036	3,807	**3,886**	1,830	-1%	-0.1%	19
MS	3,768	3,595	3,893	3,682	3,656	3,649	3,825	3,821	**3,857**	3,408	2%	0.3%	20
IL	4,193	4,106	4,165	4,173	3,986	3,704	3,914	3,801	**3,850**	2,889	-8%	-1.1%	21
NJ	3,943	3,915	3,691	3,641	3,844	4,037	3,941	3,848	**3,826**	473	-3%	-0.4%	22
WY	3,248	3,068	3,221	3,318	3,345	3,529	3,703	3,742	**3,756**	3,696	16%	1.8%	23
WV	3,414	3,344	3,451	3,324	3,293	3,367	3,393	3,547	**3,640**	2,360	7%	0.8%	24
VA	3,221	3,149	3,355	3,317	3,409	3,319	3,512	3,531	**3,636**	2,045	13%	1.5%	25
KY	3,937	3,740	3,847	3,613	3,526	3,422	3,714	3,624	**3,587**	2,513	-9%	-1.2%	26
ME	3,742	3,701	3,684	3,713	3,661	3,790	3,749	3,787	**3,575**	3,148	-4%	-0.6%	27
MI	4,137	3,995	3,936	3,815	3,786	3,702	3,762	3,682	**3,472**	2,778	-16%	-2.2%	28
WI	3,283	3,274	3,276	3,245	3,333	3,307	3,300	3,370	**3,463**	2,056	5%	0.7%	29
AR	3,330	3,203	3,312	3,208	3,173	3,167	3,361	3,369	**3,429**	2,335	3%	0.4%	30
LA	3,466	3,342	3,494	3,406	3,414	3,266	3,513	3,418	**3,416**	1,997	-1%	-0.2%	31
WA	2,950	2,912	2,993	3,127	3,178	3,232	3,350	3,361	**3,404**	1,639	15%	1.8%	32
NC	3,566	3,603	3,556	3,581	3,347	3,332	3,275	3,347	**3,344**	2,508	-6%	-0.8%	33
OH	3,337	3,283	3,197	3,129	3,164	3,046	3,242	3,310	**3,293**	1,155	-1%	-0.2%	34
ID	2,447	2,480	2,669	2,780	2,907	2,957	3,030	3,076	**3,219**	2,338	32%	3.5%	35
CA	2,958	2,965	2,971	2,999	2,976	3,002	3,071	3,115	**3,166**	2,168	7%	0.9%	36
PA	3,032	3,020	2,966	2,887	2,991	3,081	3,133	3,232	**3,159**	3,162	4%	0.5%	37
TN	3,417	3,229	3,398	3,222	3,189	3,098	3,160	3,248	**3,145**	2,533	-8%	-1.0%	38
TX	3,477	3,419	3,373	3,237	3,176	3,120	3,204	3,122	**3,107**	2,133	-11%	-1.4%	39
UT	2,476	2,433	2,549	2,647	2,806	2,818	2,970	2,993	**3,102**	2,971	25%	2.9%	40
CO	2,601	2,563	2,476	2,622	2,724	2,745	2,836	3,051	**3,022**	1,784	16%	1.9%	41
GA	3,267	3,129	3,104	3,118	3,101	3,007	3,000	2,991	**3,007**	2,585	-8%	-1.0%	42
SC	3,112	2,969	3,130	3,062	3,010	2,861	3,018	2,931	**2,965**	2,515	-5%	-0.6%	43
NV	2,586	2,641	2,562	2,720	2,703	2,774	2,780	2,886	**2,933**	1,009	13%	1.6%	44
RI	2,975	2,932	2,816	2,923	3,228	3,226	3,287	2,952	**2,887**	2,385	-3%	-0.4%	45
AZ	2,602	2,493	2,604	2,600	2,738	2,716	2,871	2,881	**2,811**	1,352	8%	1.0%	46
OR	2,222	2,093	2,514	2,395	2,456	2,295	2,756	2,643	**2,710**	1,602	22%	2.5%	47
FL	2,955	2,898	2,816	2,760	2,757	2,732	2,730	2,707	**2,679**	1,781	-9%	-1.2%	48
AL	3,049	2,961	3,240	3,026	3,199	2,725	3,265	2,795	**2,676**	2,239	-12%	-1.6%	49
NM	2,232	2,102	2,266	2,278	2,344	2,290	2,588	2,510	**2,522**	1,659	13%	1.5%	50
HI	1,999	1,950	1,813	1,891	1,837	1,921	1,989	2,058	**2,143**	1,699	7%	0.9%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

20. Medicare Inpatient Revenues. Medicare inpatient revenues in North Dakota grew by 4.5 percent annually between 2010 and 2018, several orders of magnitude higher than the national average of 1.2 percent per year (see Table 27).

Table 27.

Medicare Inpatient Revenues (millions)						DRAFT					Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**120,821**	**119,631**	**121,801**	**122,785**	**123,238**	**123,388**	**129,866**	**130,958**	**132,449**	**85,023**	**10%**	**1.2%**	
AK	165	175	180	233	244	250	278	289	306	58	86%	**8.0%**	1
NV	781	803	787	863	884	951	1,001	1,089	1,146	391	47%	**4.9%**	2
UT	491	494	525	560	602	615	668	680	706	695	44%	**4.6%**	3
MT	328	306	378	386	381	370	453	454	471	166	44%	**4.6%**	4
MN	2,007	2,095	2,167	2,256	2,327	2,464	2,612	2,778	2,869	762	43%	**4.6%**	5
ND	309	325	354	343	376	395	416	429	440	338	43%	**4.5%**	6
NH	523	561	522	595	616	648	682	722	744	649	42%	**4.5%**	7
ID	353	355	386	410	429	441	463	476	500	378	42%	**4.5%**	8
OR	980	918	1,147	1,101	1,153	1,078	1,364	1,307	1,346	770	37%	**4.0%**	9
CO	1,204	1,187	1,158	1,264	1,343	1,397	1,463	1,622	1,619	980	35%	**3.8%**	10
WA	2,083	2,042	2,160	2,301	2,329	2,422	2,581	2,608	2,633	1,314	26%	**3.0%**	11
SD	397	392	394	422	428	444	468	498	499	535	26%	**2.9%**	12
VA	2,768	2,743	2,977	2,995	3,060	3,003	3,278	3,304	3,456	1,957	25%	**2.8%**	13
NE	798	814	827	872	844	886	945	969	989	591	24%	**2.7%**	14
HI	319	316	301	327	318	338	360	377	394	304	23%	**2.7%**	15
MA	3,426	3,442	3,718	3,853	3,764	3,961	4,059	4,078	4,222	3,997	23%	**2.6%**	16
AZ	1,955	1,868	1,957	1,963	2,115	2,130	2,351	2,368	2,374	1,162	21%	**2.5%**	17
DE	441	455	454	467	505	515	529	542	531	533	20%	**2.4%**	18
NM	509	476	523	528	546	529	617	602	610	378	20%	**2.3%**	19
CA	11,382	11,533	11,822	12,185	12,113	12,358	12,944	13,307	13,615	9,137	20%	**2.3%**	20
DC	533	536	547	557	556	584	598	644	635	510	19%	**2.2%**	21
WY	186	168	179	187	187	201	217	217	219	224	18%	**2.0%**	22
VT	261	263	269	265	264	277	293	306	305	305	17%	**2.0%**	23
MD	3,156	3,211	3,264	3,218	3,444	3,442	3,585	3,580	3,677	3,482	17%	**1.9%**	24
KS	1,101	1,084	1,077	1,140	1,171	1,168	1,258	1,266	1,276	871	16%	**1.9%**	25
OK	1,484	1,483	1,465	1,491	1,507	1,531	1,614	1,657	1,716	1,351	16%	**1.8%**	26
IA	1,174	1,189	1,193	1,231	1,229	1,277	1,280	1,317	1,303	1,100	11%	**1.3%**	27
FL	7,942	7,875	7,815	7,881	8,007	8,158	8,354	8,436	8,488	5,620	7%	**0.8%**	28
PA	5,269	5,269	5,215	5,148	5,301	5,425	5,528	5,748	5,623	5,619	7%	**0.8%**	29
RI	408	403	391	414	459	469	481	439	434	356	6%	**0.8%**	30
SC	1,860	1,766	1,890	1,877	1,867	1,806	1,982	1,936	1,977	1,712	6%	**0.8%**	31
NY	9,307	9,279	9,190	9,182	9,137	9,007	9,514	9,639	9,862	1,981	6%	**0.7%**	32
WV	897	891	930	902	872	880	890	919	945	573	5%	**0.7%**	33
GA	3,127	3,018	3,032	3,070	3,079	3,029	3,111	3,173	3,287	2,831	5%	**0.6%**	34
WI	2,007	2,022	2,022	2,029	2,055	2,055	2,049	2,097	2,110	1,283	5%	**0.6%**	35
TX	8,055	7,942	8,008	7,895	7,835	7,820	8,222	8,202	8,464	5,825	5%	**0.6%**	36
IN	2,794	2,745	2,764	2,814	2,825	2,867	2,892	2,899	2,917	1,151	4%	**0.5%**	37
AR	1,266	1,226	1,252	1,240	1,207	1,207	1,282	1,300	1,318	859	4%	**0.5%**	38
LA	1,751	1,673	1,762	1,729	1,733	1,664	1,813	1,782	1,816	1,067	4%	**0.5%**	39
NJ	4,126	4,100	3,941	3,953	4,137	4,392	4,365	4,279	4,262	559	3%	**0.4%**	40
MO	2,835	2,732	2,938	2,821	2,824	2,772	2,993	2,852	2,916	1,292	3%	**0.4%**	41
MS	1,339	1,265	1,389	1,341	1,307	1,298	1,361	1,345	1,367	1,208	2%	**0.3%**	42
NC	3,970	4,006	4,000	4,113	3,845	3,861	3,882	3,968	4,035	3,131	2%	**0.2%**	43
OH	4,634	4,600	4,550	4,507	4,480	4,331	4,625	4,733	4,708	1,632	2%	**0.2%**	44
CT	1,802	1,810	1,728	1,841	1,840	1,807	1,835	1,877	1,800	1,696	0%	**0.0%**	45
TN	2,809	2,661	2,798	2,700	2,676	2,621	2,746	2,837	2,802	2,318	0%	**0.0%**	46
ME	615	596	590	609	593	619	616	634	599	542	-3%	**-0.3%**	47
IL	5,687	5,610	5,715	5,817	5,486	5,101	5,421	5,271	5,377	3,990	-5%	**-0.7%**	48
AL	1,936	1,876	2,075	1,959	2,095	1,754	2,179	1,884	1,829	1,531	-6%	**-0.7%**	49
KY	2,183	2,062	2,147	2,048	1,994	1,945	2,141	2,071	2,029	1,412	-7%	**-0.9%**	50
MI	5,090	4,969	4,931	4,880	4,848	4,822	4,929	4,903	4,623	3,769	-9%	**-1.2%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

21. ***Medicare Inpatient Revenue Per Discharge.*** On a per-discharge basis, Medicare inpatient revenue per discharge in North Dakota grew by 3.8 percent per year between 2010 and 2019, nearly a percentage point faster than the national average rate of 2.9 percent. However, the estimated level of Medicare inpatient revenues per discharge in North Dakota ($13,353) remained slightly below the national average ($14,448) in 2019 (see Table 28).

Figure 13.

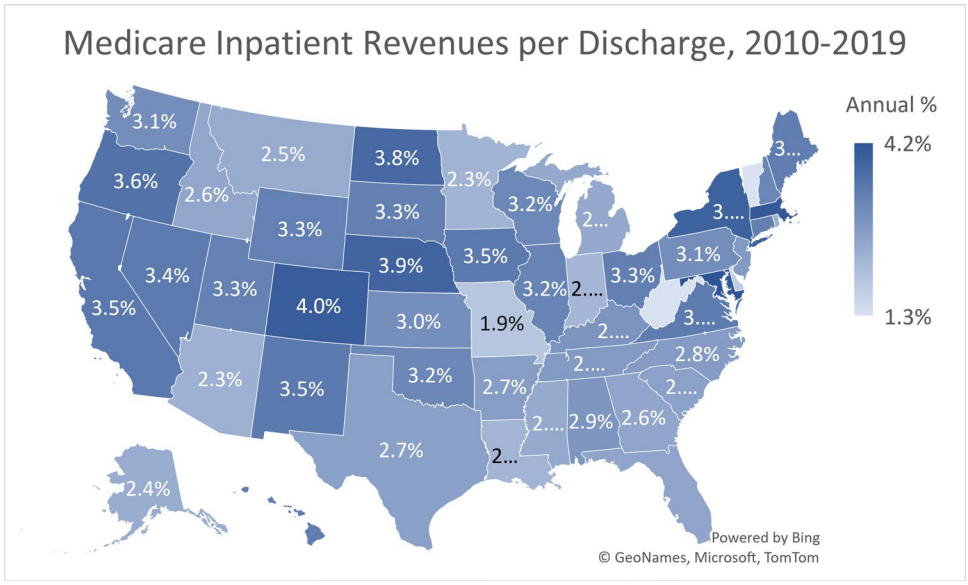


Table 28.

Medicare Inpatient Revenues Per Discharge DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2010-2019	Avg Annual Growth	Rank
US	**11,144**	**11,270**	**11,539**	**12,072**	**12,530**	**12,729**	**13,089**	**13,371**	**13,871**	**14,448**	**30%**	**2.9%**	
MD	12,126	12,548	13,141	13,769	14,604	14,908	15,543	15,822	16,740	17,573	45%	**4.2%**	1
MA	11,963	12,057	13,623	14,126	14,488	14,805	15,105	15,002	15,638	17,184	44%	**4.1%**	2
CO	11,302	11,385	11,751	12,533	13,013	13,265	13,584	14,196	14,735	16,149	43%	**4.0%**	3
NY	14,222	14,296	14,876	15,874	16,685	17,064	17,652	17,832	18,226	20,130	42%	**3.9%**	4
NE	10,644	10,893	11,321	11,572	12,140	12,337	12,784	13,068	13,367	15,017	41%	**3.9%**	5
ND	9,548	11,165	10,504	11,197	11,971	12,175	12,374	12,602	12,900	13,353	40%	**3.8%**	6
OR	12,545	12,675	13,206	13,989	14,613	14,677	15,517	15,679	16,142	17,260	38%	**3.6%**	7
CA	14,795	15,147	15,741	16,387	16,919	17,264	17,912	18,022	18,467	20,122	36%	**3.5%**	8
IA	9,343	9,501	9,996	10,296	10,619	10,740	11,252	11,463	11,789	12,689	36%	**3.5%**	9
NM	10,666	10,869	11,129	11,426	12,086	12,705	12,695	12,843	13,556	14,482	36%	**3.5%**	10
NV	11,879	12,088	12,392	12,809	13,446	13,965	14,283	14,161	14,680	16,098	36%	**3.4%**	11
VA	10,273	10,240	10,427	10,891	11,223	11,398	11,777	12,067	12,291	13,908	35%	**3.4%**	12
ME	10,276	10,149	10,491	10,858	10,953	11,177	11,785	12,288	12,747	13,850	35%	**3.4%**	13
HI	14,899	14,951	15,064	16,296	17,073	17,565	18,359	18,659	19,794	20,047	35%	**3.4%**	14
OH	10,347	10,377	10,641	11,168	11,587	11,919	12,159	12,293	12,777	13,915	34%	**3.3%**	15
SD	9,949	10,300	10,638	11,253	11,569	11,677	12,135	12,327	12,551	13,352	34%	**3.3%**	16
CT	13,096	13,117	13,312	14,096	14,895	14,665	15,352	15,475	16,063	17,574	34%	**3.3%**	17
WY	11,162	11,324	11,830	11,860	12,271	12,702	13,477	13,624	13,783	14,967	34%	**3.3%**	18
UT	11,852	11,965	11,933	12,405	13,578	13,830	13,861	14,199	14,969	15,869	34%	**3.3%**	19
IL	10,403	10,544	10,753	11,253	11,687	11,918	12,205	12,531	13,045	13,871	33%	**3.2%**	20
NH	10,965	11,303	11,187	12,026	12,220	12,421	12,644	12,953	13,768	14,569	33%	**3.2%**	21
OK	9,234	9,592	9,647	10,017	10,727	10,847	11,064	11,439	11,740	12,242	33%	**3.2%**	22
DC	15,550	16,501	15,862	16,117	16,800	17,254	18,331	19,028	19,878	20,605	33%	**3.2%**	23
WI	11,073	11,140	11,144	11,735	12,134	12,376	12,569	12,934	13,260	14,653	32%	**3.2%**	24
PA	10,899	10,991	11,213	11,585	12,296	12,512	12,929	13,236	13,801	14,286	31%	**3.1%**	25
WA	12,186	12,293	12,749	13,541	14,046	14,436	14,794	15,007	15,211	15,972	31%	**3.1%**	26
KS	9,529	9,685	9,830	10,205	10,515	10,625	10,673	11,060	11,428	12,467	31%	**3.0%**	27
KY	9,468	9,409	9,544	10,119	10,497	10,626	10,961	11,248	11,500	12,264	30%	**2.9%**	28
AL	9,018	9,239	9,169	9,595	10,542	9,955	9,876	10,304	10,818	11,664	29%	**2.9%**	29
NJ	11,525	11,635	11,953	12,451	13,032	13,503	13,926	14,244	14,802	14,783	28%	**2.8%**	30
TN	9,732	9,821	10,035	10,483	10,756	10,795	11,062	11,472	11,916	12,474	28%	**2.8%**	31
NC	10,607	10,653	10,843	11,324	11,611	11,642	12,053	12,238	12,731	13,561	28%	**2.8%**	32
AR	8,883	9,029	9,070	9,413	9,676	9,823	10,066	10,358	10,730	11,324	27%	**2.7%**	33
TX	10,577	10,598	10,790	11,225	11,629	11,629	11,987	12,094	12,945	13,415	27%	**2.7%**	34
SC	10,451	10,425	10,538	11,006	11,283	11,182	11,329	11,644	12,310	13,229	27%	**2.7%**	35
FL	10,095	10,175	10,221	10,588	10,769	10,906	11,250	11,514	11,978	12,701	26%	**2.6%**	36
GA	10,526	10,466	10,790	11,117	11,416	11,499	11,841	12,038	12,538	13,225	26%	**2.6%**	37
ID	10,504	10,660	11,120	11,533	12,250	12,080	12,261	12,317	12,541	13,178	25%	**2.6%**	38
MI	11,362	11,486	11,486	11,909	12,286	12,547	12,987	13,437	13,822	14,195	25%	**2.5%**	39
MS	8,957	9,047	9,259	9,645	9,807	9,717	9,862	10,003	10,094	11,183	25%	**2.5%**	40
MT	9,516	10,043	10,499	11,067	11,010	11,392	11,865	12,413	12,927	11,845	24%	**2.5%**	41
AK	15,453	15,777	16,046	17,968	18,939	19,059	19,734	20,159	20,103	19,176	24%	**2.4%**	42
RI	12,157	12,165	12,563	13,310	13,611	13,584	14,190	14,379	15,016	14,981	23%	**2.3%**	43
AZ	12,034	11,814	12,150	12,669	13,228	13,651	14,417	14,829	15,035	14,829	23%	**2.3%**	44
MN	11,680	12,054	12,480	13,192	13,751	14,110	14,605	14,898	15,045	14,329	23%	**2.3%**	45
LA	9,695	9,871	10,143	10,431	10,820	10,959	11,223	11,522	12,090	11,860	22%	**2.3%**	46
IN	10,029	9,843	10,140	10,677	11,156	11,271	11,646	11,849	12,313	12,227	22%	**2.2%**	47
MO	10,315	10,572	10,769	11,215	11,430	11,655	11,857	12,157	12,650	12,252	19%	**1.9%**	48
DE	11,736	11,787	11,953	12,152	12,630	12,583	13,333	13,509	13,685	13,760	17%	**1.8%**	49
WV	9,190	9,043	9,315	9,878	10,082	10,282	10,733	10,833	11,316	10,383	13%	**1.4%**	50
VT	12,674	12,484	12,813	12,724	13,126	13,035	13,281	13,620	13,685	14,292	13%	**1.3%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

22. ***Medicare Outpatient Revenues.*** North Dakota's outpatient revenues from Medicare grew by 11.8 percent per year in the 2010-2018 period, higher than the national average growth rate of 7.7 percent a year (see Table 29 and Figure 14).

Figure 14.

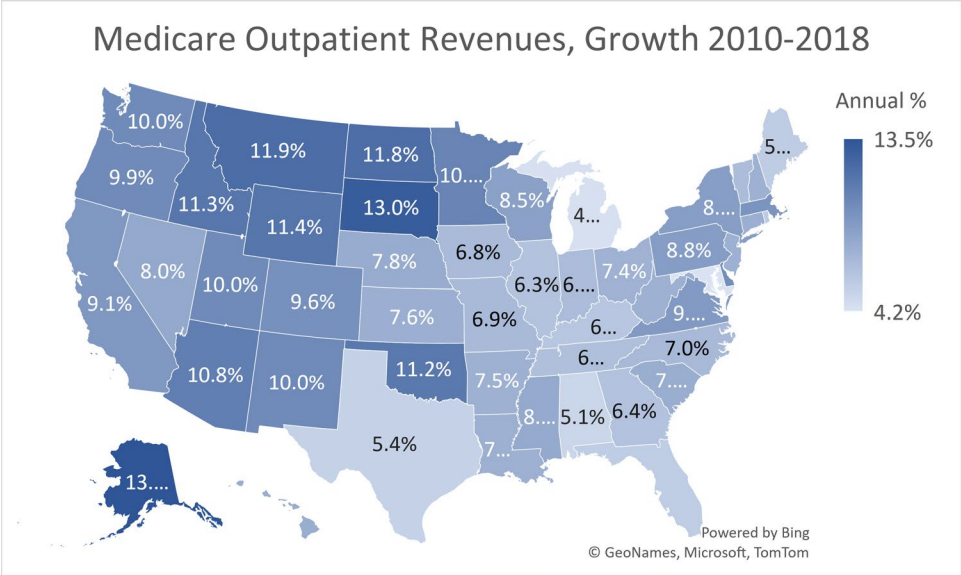


Table 29.

Medicare Outpatient Revenues (millions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**39,759**	**42,534**	**47,673**	**50,377**	**55,966**	**59,014**	**64,094**	**67,807**	**71,771**	**49,856**	**81%**	**7.7%**	
AK	619	668	816	830	931	883	1,047	932	921	808	175%	**13.5%**	1
SD	74	79	86	117	126	137	156	177	204	90	166%	**13.0%**	2
MT	530	574	691	768	881	961	1,037	1,167	1,200	627	146%	**11.9%**	3
ND	468	485	585	598	650	679	755	776	834	627	145%	**11.8%**	4
WY	2,869	3,125	3,427	3,711	4,202	4,615	4,913	5,274	5,773	4,442	137%	**11.4%**	5
ID	501	536	571	627	711	759	851	964	1,043	642	135%	**11.3%**	6
OK	487	527	597	646	755	813	860	906	876	854	133%	**11.2%**	7
AZ	141	163	181	185	210	237	253	269	297	324	126%	**10.8%**	8
MN	130	134	148	151	166	182	190	195	220	202	121%	**10.4%**	9
NM	2,140	2,268	2,419	2,479	2,728	2,860	3,015	3,189	3,334	2,480	115%	**10.0%**	10
UT	1,070	1,105	1,215	1,334	1,481	1,550	1,610	1,684	1,754	1,626	114%	**10.0%**	11
WA	98	101	102	107	118	132	141	157	178	160	114%	**10.0%**	12
OR	226	246	287	313	358	393	428	467	531	402	113%	**9.9%**	13
DE	1,877	1,987	2,288	2,462	2,597	2,553	2,831	2,899	3,070	2,451	110%	**9.7%**	14
CO	1,111	1,179	1,279	1,366	1,516	1,604	1,653	1,785	1,879	728	108%	**9.6%**	15
MA	689	738	792	846	919	982	1,028	1,100	1,169	1,068	104%	**9.3%**	16
CA	521	553	626	670	748	763	877	901	936	667	101%	**9.1%**	17
VA	775	820	932	937	989	1,007	1,125	1,176	1,244	918	99%	**9.0%**	18
PA	605	657	767	817	890	912	1,032	1,051	1,084	667	96%	**8.8%**	19
NY	375	409	449	472	504	543	562	587	585	524	95%	**8.7%**	20
WI	1,039	1,083	1,159	1,184	1,296	1,382	1,502	1,576	1,449	1,505	93%	**8.5%**	21
NV	1,254	1,353	1,602	1,757	1,926	2,067	2,230	2,374	2,560	2,537	85%	**8.0%**	22
MS	1,704	1,759	1,952	2,010	2,167	2,193	2,364	2,393	2,406	1,957	85%	**8.0%**	23
NE	883	978	1,093	1,165	1,356	1,503	1,629	1,807	1,953	695	82%	**7.8%**	24
HI	494	529	628	629	695	740	816	871	912	839	81%	**7.7%**	25
SC	1,036	1,101	1,334	1,329	1,437	1,461	1,690	1,652	1,766	951	81%	**7.7%**	26
KS	212	216	316	314	355	335	451	464	522	229	80%	**7.6%**	27
CT	400	433	478	513	550	575	624	666	729	512	80%	**7.6%**	28
LA	191	216	239	262	288	307	311	332	355	144	79%	**7.6%**	29
AR	364	387	399	450	493	528	564	598	649	615	78%	**7.5%**	30
NH	1,012	1,134	1,182	1,266	1,495	1,637	1,638	1,698	1,801	203	78%	**7.5%**	31
WV	197	207	241	265	299	323	378	394	424	320	78%	**7.5%**	32
NJ	2,034	2,143	2,405	2,544	2,918	3,009	3,443	3,678	3,972	863	78%	**7.5%**	33
OH	1,417	1,578	1,722	1,838	1,906	2,040	2,089	2,315	2,426	1,839	77%	**7.4%**	34
NC	194	211	289	287	348	371	413	440	474	381	71%	**7.0%**	35
MO	1,610	1,702	1,822	1,932	2,194	2,234	2,515	2,710	2,850	1,065	70%	**6.9%**	36
IA	511	576	670	758	859	932	1,005	1,071	1,192	833	70%	**6.8%**	37
DC	432	447	555	574	633	655	792	828	923	610	69%	**6.8%**	38
IN	1,454	1,601	1,790	1,894	2,147	2,383	2,560	2,752	2,853	3,006	69%	**6.8%**	39
VT	121	132	142	158	185	187	200	186	191	169	68%	**6.7%**	40
TN	611	652	758	797	866	888	957	1,014	1,108	987	66%	**6.5%**	41
GA	196	212	247	283	349	394	443	477	520	550	64%	**6.4%**	42
IL	825	861	1,050	1,069	1,168	1,207	1,253	1,369	1,366	1,112	64%	**6.3%**	43
KY	2,649	2,856	3,051	3,066	3,322	3,520	3,816	3,922	4,023	3,025	61%	**6.1%**	44
RI	230	233	265	288	332	360	398	433	493	493	57%	**5.8%**	45
ME	170	182	198	206	226	238	258	277	287	289	56%	**5.7%**	46
FL	950	985	1,147	1,217	1,411	1,479	1,601	1,737	1,888	1,123	56%	**5.7%**	47
TX	870	948	1,030	1,142	1,313	1,429	1,557	1,685	1,861	914	52%	**5.4%**	48
AL	356	369	420	440	481	522	542	599	634	461	49%	**5.1%**	49
MI	959	1,014	1,132	1,197	1,354	1,417	1,515	1,644	1,847	1,121	41%	**4.4%**	50
MD	76	86	98	107	120	133	147	164	180	182	39%	**4.2%**	51

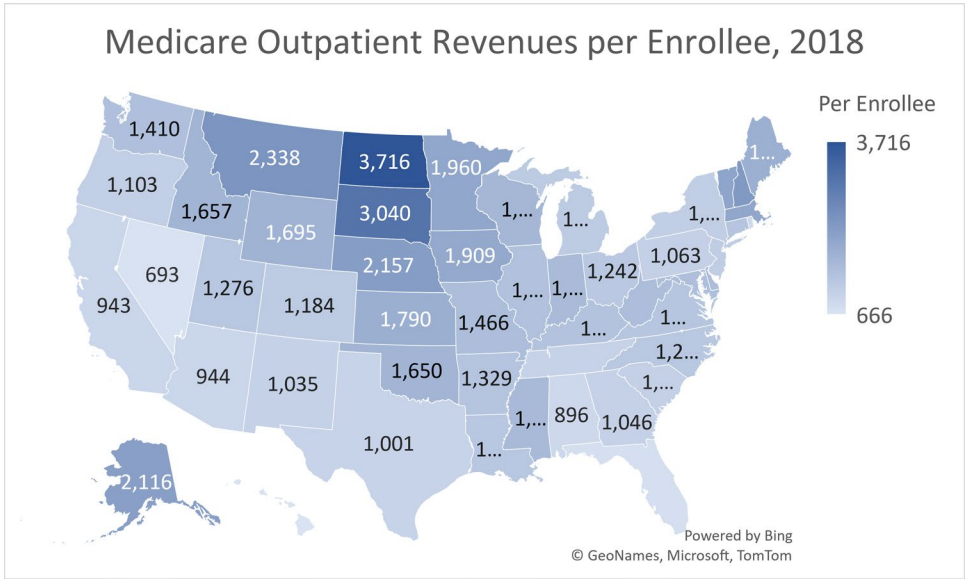
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

23. **Medicare Outpatient Revenues Per Enrollee.** On a per enrollee basis, Medicare reimbursements to North Dakota hospitals for outpatient care were highest in the nation in both 2010 and 2018, and were tied for the 2nd fastest growing in the 2010-2018 period (see Figure 15 and Table 30).

Figure 15.



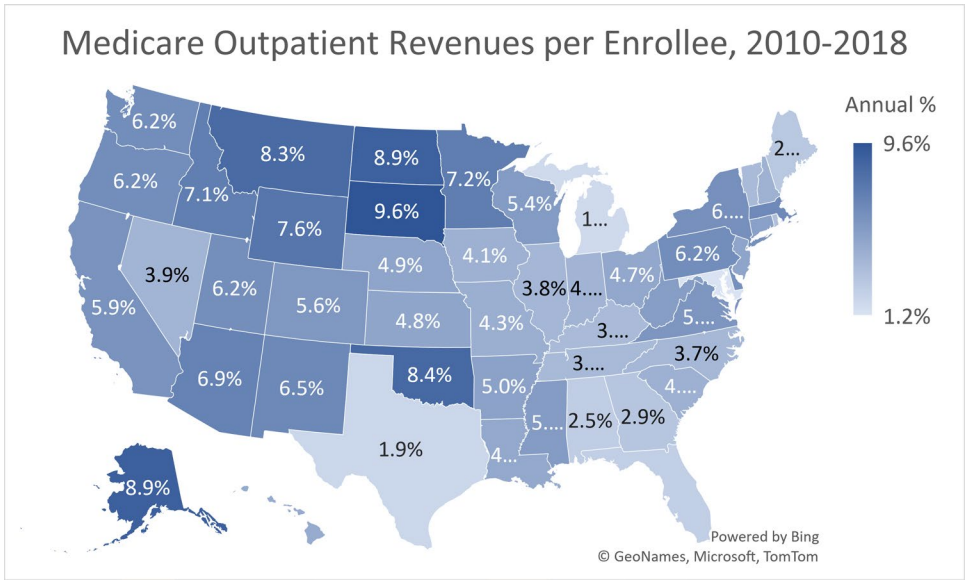


Table 30.

Medicare Outpatient Revenues Per (Gross) Medicare Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**841**	**877**	**947**	**969**	**1,045**	**1,072**	**1,134**	**1,170**	**1,207**	**819**	**43%**	**4.6%**	
ND	1,877	1,989	2,624	2,523	2,999	3,143	3,413	3,544	**3,716**	2,916	98%	8.9%	1
SD	1,460	1,544	1,728	1,921	2,301	2,521	2,759	2,886	**3,040**	3,142	108%	9.6%	2
DC	1,705	1,706	1,816	1,798	1,935	2,069	2,121	2,137	**2,380**	2,151	40%	4.3%	3
MT	1,237	1,230	1,731	1,670	1,824	1,663	2,165	2,152	**2,338**	996	89%	8.3%	4
NH	1,623	1,682	1,671	1,825	1,925	2,003	2,070	2,128	**2,238**	2,064	38%	4.1%	5
NE	1,474	1,557	1,652	1,720	1,797	1,834	1,940	2,023	**2,157**	1,483	46%	4.9%	6
AK	1,067	1,109	1,171	1,541	1,574	1,639	1,780	1,928	**2,116**	896	98%	8.9%	7
VT	1,513	1,574	1,653	1,659	1,769	1,814	1,910	1,987	**1,997**	1,970	32%	3.5%	8
MA	1,191	1,253	1,428	1,517	1,620	1,699	1,790	1,861	**1,962**	1,911	65%	6.4%	9
MN	1,125	1,214	1,307	1,350	1,526	1,645	1,731	1,868	**1,960**	682	74%	7.2%	10
IA	1,380	1,441	1,489	1,541	1,638	1,717	1,758	1,839	**1,909**	1,711	38%	4.1%	11
KS	1,230	1,272	1,388	1,438	1,568	1,567	1,760	1,766	**1,790**	1,249	46%	4.8%	12
ME	1,418	1,507	1,592	1,622	1,683	1,771	1,790	1,821	**1,767**	1,547	25%	2.8%	13
WY	942	1,033	1,140	1,208	1,306	1,407	1,492	1,608	**1,695**	1,658	80%	7.6%	14
ID	956	1,016	1,138	1,204	1,322	1,392	1,456	1,523	**1,657**	1,204	73%	7.1%	15
OK	863	947	1,062	1,164	1,291	1,371	1,451	1,517	**1,650**	1,130	91%	8.4%	16
WI	1,062	1,093	1,176	1,204	1,324	1,350	1,403	1,481	**1,617**	959	52%	5.4%	17
MS	1,016	1,060	1,212	1,176	1,270	1,325	1,434	1,501	**1,543**	1,396	52%	5.4%	18
IN	1,117	1,155	1,207	1,249	1,349	1,395	1,404	1,482	**1,523**	579	36%	4.0%	19
DE	927	1,042	1,112	1,102	1,202	1,314	1,353	1,388	**1,477**	1,558	59%	6.0%	20
MO	1,049	1,086	1,267	1,223	1,291	1,286	1,457	1,396	**1,466**	776	40%	4.3%	21
WV	970	978	1,074	1,090	1,170	1,254	1,284	1,399	**1,462**	1,052	51%	5.3%	22
MD	1,304	1,325	1,365	1,352	1,432	1,485	1,568	1,601	**1,432**	1,455	10%	1.2%	23
WA	869	923	966	1,037	1,146	1,199	1,261	1,319	**1,410**	673	62%	6.2%	24
IL	1,040	1,074	1,191	1,241	1,281	1,235	1,343	1,349	**1,399**	1,099	34%	3.8%	25
KY	1,031	1,064	1,165	1,134	1,169	1,167	1,279	1,312	**1,363**	990	32%	3.6%	26
AR	898	907	1,054	1,044	1,111	1,141	1,245	1,260	**1,329**	985	48%	5.0%	27
CT	880	929	1,013	1,061	1,218	1,289	1,340	1,383	**1,311**	1,259	49%	5.1%	28
VA	823	832	933	959	1,076	1,095	1,152	1,217	**1,284**	746	56%	5.7%	29
LA	890	942	1,059	1,093	1,158	1,156	1,274	1,269	**1,277**	768	43%	4.6%	30
UT	790	780	854	899	997	1,040	1,108	1,165	**1,276**	1,232	61%	6.2%	31
NC	938	1,018	1,070	1,106	1,109	1,152	1,146	1,233	**1,256**	928	34%	3.7%	32
OH	860	887	914	939	1,040	1,037	1,142	1,205	**1,242**	456	44%	4.7%	33
MI	1,038	1,045	1,116	1,113	1,169	1,157	1,220	1,208	**1,189**	949	15%	1.7%	34
CO	765	797	818	870	943	966	1,043	1,138	**1,184**	706	55%	5.6%	35
NJ	777	848	852	883	1,020	1,096	1,075	1,093	**1,136**	126	46%	4.9%	36
NY	696	715	773	792	889	900	1,010	1,056	**1,116**	238	60%	6.1%	37
OR	680	685	820	821	870	867	1,012	1,025	**1,103**	708	62%	6.2%	38
SC	770	801	896	913	954	943	983	1,007	**1,065**	920	38%	4.1%	39
PA	656	704	758	776	862	940	992	1,047	**1,063**	1,102	62%	6.2%	40
GA	833	838	888	944	1,007	1,018	1,023	1,037	**1,046**	943	26%	2.9%	41
NM	624	636	715	761	829	869	983	993	**1,035**	761	66%	6.5%	42
TN	775	790	927	914	969	976	990	1,057	**1,031**	821	33%	3.6%	43
TX	860	904	931	905	946	968	1,016	1,010	**1,001**	729	16%	1.9%	44
AZ	555	586	680	731	805	844	879	951	**944**	474	70%	6.9%	45
CA	595	632	668	700	767	816	845	884	**943**	709	58%	5.9%	46
AL	738	778	915	901	984	913	1,060	925	**896**	774	21%	2.5%	47
RI	682	721	752	806	927	921	965	880	**881**	767	29%	3.3%	48
FL	627	648	666	660	701	709	724	743	**755**	545	20%	2.4%	49
NV	509	559	597	634	665	676	658	674	**693**	272	36%	3.9%	50
HI	470	473	460	468	496	541	558	606	**666**	586	42%	4.5%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

24. Medicaid Total Revenues. Table 31 shows HCRIS Medicaid revenues, with North Dakota showing much higher than average growth (13.3% average annual growth in 2011-2018 vs. 5.0% nationally).

Table 31.

Medicaid Revenues (millions), Ranked by 2011-2018 Growth					DRAFT					Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2011-2018	Growth	Rank
US		**74,935**	**78,875**	**78,302**	**85,871**	**92,857**	**100,149**	**102,540**	**105,171**	**68,841**	**40%**	**5.0%**	
MT		150	196	178	207	197	362	446	429	178	185%	**16.2%**	1
CO		584	592	612	868	1,306	1,472	1,550	1,603	768	175%	**15.5%**	2
ND		129	152	141	192	225	302	313	310	260	140%	**13.3%**	3
HI		199	195	257	296	336	325	343	420	327	111%	**11.2%**	4
MD		1,588	1,776	1,816	2,215	2,728	2,903	3,205	3,256	3,111	105%	**10.8%**	5
NJ		1,574	1,670	1,685	2,313	2,763	2,706	3,218	3,216	482	104%	**10.7%**	6
KY		1,240	1,304	1,280	1,552	2,077	2,499	2,460	2,512	1,740	103%	**10.6%**	7
AK		188	196	198	221	248	316	368	374	134	99%	**10.3%**	8
OR		736	934	952	1,200	1,385	1,739	1,560	1,463	936	99%	**10.3%**	9
NV		384	304	382	518	586	785	744	758	216	98%	**10.2%**	10
CA		9,831	10,311	10,956	12,721	14,181	15,035	15,975	17,436	13,103	77%	**8.5%**	11
NH		146	130	142	151	214	263	259	258	260	76%	**8.4%**	12
NM		664	676	659	794	1,114	1,200	1,214	1,159	859	75%	**8.3%**	13
WA		1,318	1,424	1,642	2,041	2,118	2,397	2,235	2,270	1,145	72%	**8.1%**	14
IA		621	659	670	790	895	950	1,004	1,064	892	71%	**8.0%**	15
AR		267	456	297	408	475	527	504	439	374	64%	**7.3%**	16
IN		1,550	1,877	1,660	1,716	1,508	1,677	2,204	2,395	765	55%	**6.4%**	17
RI		344	356	351	426	473	486	541	530	488	54%	**6.4%**	18
DE		285	311	315	341	394	394	391	435	460	53%	**6.2%**	19
WV		553	614	595	698	753	763	820	818	445	48%	**5.8%**	20
PA		2,788	2,938	2,775	3,118	3,255	3,828	4,106	4,114	4,219	48%	**5.7%**	21
OH		2,763	2,808	2,841	3,353	3,861	3,999	4,085	4,011	1,423	45%	**5.5%**	22
MI		2,157	2,133	2,080	2,324	2,863	3,141	3,152	3,059	2,580	42%	**5.1%**	23
WI		953	1,019	948	1,166	1,400	1,316	1,305	1,340	957	41%	**5.0%**	24
MN		1,299	1,334	1,356	1,405	1,656	1,743	1,747	1,799	673	38%	**4.8%**	25
LA		1,528	1,504	1,175	1,465	1,229	1,454	1,854	2,111	1,323	38%	**4.7%**	26
IL		3,119	3,401	3,449	3,631	4,029	4,422	4,209	4,206	3,319	35%	**4.4%**	27
GA		1,636	1,897	1,841	1,919	1,923	2,082	1,988	2,180	1,632	33%	**4.2%**	28
CT		1,031	1,126	1,095	1,111	1,228	1,248	1,284	1,352	1,488	31%	**3.9%**	29
UT		417	434	430	497	511	535	533	538	606	29%	**3.7%**	30
MS		919	1,061	1,004	1,020	1,058	1,168	1,162	1,184	1,016	29%	**3.7%**	31
DC		477	460	468	540	644	614	631	610	464	28%	**3.6%**	32
AL		560	662	632	611	625	789	752	713	709	27%	**3.5%**	33
MA		2,433	2,425	2,497	2,880	2,932	3,097	3,178	3,092	2,682	27%	**3.5%**	34
NY		9,999	10,160	10,040	10,551	11,047	12,477	12,403	12,478	2,857	25%	**3.2%**	35
TN		1,400	1,678	1,725	1,439	1,412	1,652	1,711	1,700	1,312	21%	**2.8%**	36
ID		367	342	366	434	419	417	419	431	352	18%	**2.3%**	37
MO		1,588	1,693	1,721	1,649	1,655	1,843	1,731	1,864	853	17%	**2.3%**	38
KS		496	510	490	499	533	563	530	581	458	17%	**2.3%**	39
VA		1,362	1,520	1,554	1,500	1,607	1,449	1,508	1,547	1,457	14%	**1.8%**	40
SD		185	157	158	163	178	195	222	199	206	7%	**1.0%**	41
AZ		1,828	1,509	1,355	1,477	1,705	1,948	1,901	1,944	1,000	6%	**0.9%**	42
NC		1,972	2,087	2,128	2,021	2,118	2,160	2,160	2,096	1,811	6%	**0.9%**	43
TX		4,213	4,578	4,282	4,127	4,225	3,968	3,927	4,454	3,432	6%	**0.8%**	44
WY		85	83	87	83	82	83	84	86	75	1%	**0.1%**	45
NE		338	362	279	310	337	347	338	336	223	-1%	**-0.1%**	46
ME		422	456	442	393	406	392	394	410	410	-3%	**-0.4%**	47
SC		1,164	1,020	1,056	1,101	1,028	1,151	1,062	1,084	1,011	-7%	**-1.0%**	48
OK		757	795	819	820	782	795	803	684	614	-10%	**-1.4%**	49
VT		161	174	170	182	192	201	155	142	117	-12%	**-1.8%**	50
FL		4,166	4,416	4,252	4,418	3,944	3,959	3,840	3,638	2,604	-13%	**-1.9%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Average annual growth from 2011-2018.

25. ***Medicaid Inpatient Discharges and Days.*** North Dakota's growth in Medicaid inpatient discharges averaged 1.4 percent over the 2010-2018 period (see Table 32) and the number of inpatient days rose by 2.5 percent per year (see Table 33). These growth rates for overall Medicaid utilization are similar to those reported above from the AHA-style data, giving us confidence in their accuracy. However, Tables 31 and 32 also show that the HCRIS Medicaid utilization data for many other states shows very large declines in inpatient discharges and days over the 2010-2018 period. In some states, the reductions in Medicaid utilization were well over 10 percent *per year* during this period. These states showing huge reductions include large states like Florida, Illinois, and Texas, as well as many smaller and medium-sized states. For example, the percentage of Medicaid discharges as a share of total discharges in Kentucky is reported to have fallen from 17 percent in 2010 to 2 percent in 2018, which seems unlikely.

    There could be several reasons for the apparent decline in Medicaid inpatient use in these other states, including shifts from inpatient to outpatient care or mischaracterization of Medicaid managed care coverage as private or commercial coverage instead of Medicaid. HCRIS does not provide data on outpatient utilization, and we are investigating the labelling of Medicaid vs. Medicaid managed care data, but , at this point, we do not have a good reason why these other states are showing such precipitous apparent declines in Medicaid hospital utilization and (sometimes) hospital revenues.

Table 32.

Medicaid Inpatient Discharges, Ranked by 2011-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**4,765,032**	**4,525,821**	**4,344,378**	**4,085,608**	**3,870,595**	**3,501,682**	**3,428,371**	**3,103,971**	**2,884,663**	**1,800,895**	**-39%**	**-6.1%**	
MT	11,526	11,338	13,765	13,398	13,735	13,631	19,200	21,309	23,191	9,168	101%	**9.1%**	1
AK	9,521	8,194	8,068	12,744	12,650	12,843	16,443	16,690	17,628	2,616	85%	**8.0%**	2
CT	45,862	60,549	71,121	69,840	82,573	85,083	79,628	76,319	77,249	73,576	68%	**6.7%**	3
CO	62,610	59,695	58,283	58,495	75,282	87,383	92,574	93,947	89,568	44,458	43%	**4.6%**	4
NV	28,666	30,208	28,233	27,805	33,445	36,608	34,582	35,204	34,544	11,984	21%	**2.4%**	5
DE	16,473	17,918	17,505	16,648	17,157	20,441	19,220	19,006	19,278	19,840	17%	**2.0%**	6
ND	10,883	10,996	10,682	9,422	9,635	9,852	11,016	12,021	12,136	8,396	12%	**1.4%**	7
VT	8,381	8,913	8,405	8,517	8,798	9,236	9,407	8,973	9,075	9,201	8%	**1.0%**	8
ID	22,363	21,185	22,921	25,705	23,463	24,553	23,488	24,557	23,161	17,234	4%	**0.4%**	9
OR	61,880	50,541	73,590	56,409	65,718	43,943	71,627	64,452	63,336	31,704	2%	**0.3%**	10
AL	103,878	97,974	104,309	97,139	94,724	95,693	113,882	108,176	101,955	91,787	-2%	**-0.2%**	11
AR	48,751	45,828	47,184	45,552	47,735	42,923	45,532	47,043	45,511	33,072	-7%	**-0.9%**	12
NJ	59,127	57,282	47,888	42,009	55,857	63,550	61,714	63,880	53,216	11,641	-10%	**-1.3%**	13
NC	235,083	236,158	227,187	214,715	204,603	213,451	210,603	211,821	208,716	148,307	-11%	**-1.5%**	14
NM	18,684	16,454	18,126	19,248	18,539	16,568	19,842	14,713	16,171	11,223	-13%	**-1.8%**	15
SD	16,929	15,834	17,037	17,252	18,177	15,803	15,292	14,751	14,282	14,292	-16%	**-2.1%**	16
OK	92,783	91,143	89,287	95,497	91,532	87,606	81,354	80,113	77,052	64,782	-17%	**-2.3%**	17
GA	106,208	104,387	107,696	97,009	99,544	92,284	86,740	88,326	87,792	67,439	-17%	**-2.4%**	18
ME	27,006	25,471	26,797	25,183	20,672	21,288	18,231	20,979	20,614	18,697	-24%	**-3.3%**	19
MA	108,239	105,111	104,988	101,861	99,298	92,071	84,089	90,689	82,431	69,797	-24%	**-3.3%**	20
IA	56,524	53,692	56,933	56,127	56,138	57,243	53,987	32,561	41,823	29,440	-26%	**-3.7%**	21
HI	7,769	5,734	5,891	5,696	5,157	12,381	7,759	7,769	5,676	2,392	-27%	**-3.8%**	22
MS	85,972	76,296	86,126	83,674	76,202	76,954	64,687	59,024	60,618	47,317	-29%	**-4.3%**	23
MO	99,111	91,415	97,183	80,359	85,106	83,632	87,709	73,740	68,521	32,436	-31%	**-4.5%**	24
MD	98,505	96,726	96,020	97,920	88,976	84,727	72,850	69,000	67,181	54,264	-32%	**-4.7%**	25
AZ	186,267	164,353	144,943	134,149	150,762	153,523	132,149	124,945	124,699	30,486	-33%	**-4.9%**	26
MI	75,805	72,862	65,996	64,858	76,411	59,483	59,515	49,267	49,673	34,558	-34%	**-5.1%**	27
WI	53,224	54,693	48,992	59,287	46,948	50,403	39,088	39,203	33,779	16,198	-37%	**-5.5%**	28
VA	86,928	88,513	78,434	65,636	57,407	48,611	50,951	46,959	52,348	24,283	-40%	**-6.1%**	29
WY	7,146	6,265	6,380	5,669	5,364	5,115	4,716	4,839	4,257	3,830	-40%	**-6.3%**	30
WV	45,293	46,160	43,945	40,600	44,370	44,657	35,035	29,311	25,931	16,438	-43%	**-6.7%**	31
TX	305,819	248,797	254,521	247,063	244,319	201,712	217,935	174,870	161,568	109,598	-47%	**-7.7%**	32
NY	261,311	258,741	212,445	171,897	171,108	168,927	159,621	147,993	131,912	40,458	-50%	**-8.2%**	33
CA	539,446	508,613	433,573	364,295	382,111	389,776	344,986	294,077	269,903	165,636	-50%	**-8.3%**	34
DC	24,269	27,599	23,671	20,365	14,514	16,051	15,722	15,182	11,425	7,754	-53%	**-9.0%**	35
SC	60,548	51,497	46,949	48,673	34,156	26,711	30,529	28,325	28,133	28,399	-54%	**-9.1%**	36
MN	76,785	72,523	73,354	71,397	57,973	57,744	63,201	48,739	34,692	10,258	-55%	**-9.5%**	37
IL	309,231	295,244	291,925	280,864	264,388	219,044	192,368	150,536	134,176	67,114	-57%	**-9.9%**	38
OH	111,842	95,021	94,332	96,332	98,924	74,134	68,677	62,425	48,070	21,348	-57%	**-10.0%**	39
UT	33,877	33,282	32,645	33,834	23,072	19,226	15,724	15,259	14,293	14,763	-58%	**-10.2%**	40
PA	129,466	127,420	124,542	112,163	77,197	65,835	61,414	65,119	52,797	53,276	-59%	**-10.6%**	41
TN	129,618	123,280	133,730	137,574	79,946	80,634	80,323	75,687	48,380	39,384	-63%	**-11.6%**	42
IN	97,530	94,989	90,937	99,674	84,637	63,730	52,538	37,471	35,554	13,588	-64%	**-11.9%**	43
FL	337,346	337,275	336,749	341,453	317,532	173,538	137,969	125,412	118,641	90,606	-65%	**-12.2%**	44
NE	27,654	28,023	26,791	27,534	25,267	19,650	16,878	12,566	9,685	7,949	-65%	**-12.3%**	45
WA	109,613	107,125	96,617	92,292	67,720	61,508	57,258	41,118	37,078	11,804	-66%	**-12.7%**	46
RI	14,619	11,660	11,360	9,600	10,818	10,133	8,940	4,162	4,487	4,178	-69%	**-13.7%**	47
NH	14,210	13,251	12,132	12,655	8,877	7,177	5,755	4,300	3,763	3,568	-74%	**-15.3%**	48
KS	32,676	34,212	33,222	24,853	14,027	6,314	13,712	6,226	6,175	3,388	-81%	**-18.8%**	49
LA	153,627	136,473	119,113	91,286	72,063	41,773	27,782	37,081	28,713	20,481	-81%	**-18.9%**	50
KY	98,148	88,908	61,856	53,381	35,968	36,526	28,854	24,395	7,985	5,320	-92%	**-26.9%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Growth rates from 2010-2018.

Table 33.

Medicaid Inpatient Days, Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**21,959,788**	**20,986,536**	**20,114,574**	**18,550,884**	**18,600,168**	**16,958,588**	**16,615,756**	**15,619,890**	**15,039,721**	**9,351,985**	**-32%**	**-4.6%**	
CT	161,137	166,882	272,393	343,082	331,792	313,969	313,553	335,481	334,630	324,680	108%	**9.6%**	1
AK	46,515	48,945	44,816	61,848	67,097	67,544	85,728	90,134	90,774	9,869	95%	**8.7%**	2
MT	69,298	66,215	86,451	84,838	82,258	83,083	112,611	120,889	117,650	55,461	70%	**6.8%**	3
CO	303,427	289,183	285,357	283,980	371,559	423,989	447,275	471,510	481,960	274,099	59%	**6.0%**	4
DE	73,925	66,719	71,728	68,394	89,821	102,227	34,519	107,563	109,257	112,109	48%	**5.0%**	5
MA	375,723	320,639	349,606	335,895	374,309	454,928	454,609	478,181	477,327	404,302	27%	**3.0%**	6
ND	60,051	57,003	62,029	63,316	67,748	72,874	76,411	77,097	73,003	55,676	22%	**2.5%**	7
AR	159,763	161,808	169,106	177,300	200,362	153,178	170,555	180,590	185,734	134,463	16%	**1.9%**	8
NV	180,855	157,248	153,323	193,138	213,694	208,526	205,338	206,774	209,654	68,808	16%	**1.9%**	9
VT	35,542	39,277	35,637	37,144	37,107	39,677	39,337	38,733	40,431	46,256	14%	**1.6%**	10
NJ	306,790	333,251	312,306	250,805	323,473	365,709	343,348	375,097	339,281	49,116	11%	**1.3%**	11
ID	93,939	92,226	98,289	104,364	95,232	98,787	103,819	102,001	101,121	77,056	8%	**0.9%**	12
AL	496,250	493,069	544,364	517,891	504,196	454,203	571,667	529,803	522,641	443,915	5%	**0.6%**	13
OR	210,305	184,973	228,330	206,769	246,680	188,562	240,174	215,187	208,610	119,773	-1%	**-0.1%**	14
ME	112,822	119,868	118,441	111,356	97,504	105,475	96,343	114,301	110,644	81,998	-2%	**-0.2%**	15
OK	411,505	499,490	478,165	509,738	495,675	421,804	415,813	405,006	400,103	386,177	-3%	**-0.4%**	16
NC	965,375	964,707	955,312	817,306	900,093	880,273	894,991	911,061	919,307	670,669	-5%	**-0.6%**	17
GA	535,162	525,704	547,257	511,578	509,740	477,989	465,521	463,747	488,222	372,598	-9%	**-1.1%**	18
SD	86,747	84,941	87,645	89,575	86,245	78,202	83,110	81,145	78,493	85,408	-10%	**-1.2%**	19
WI	232,791	218,473	200,827	169,739	193,335	202,965	200,505	210,434	206,222	110,427	-11%	**-1.5%**	20
MN	237,208	274,345	250,284	264,461	254,266	236,822	271,233	231,037	207,616	62,989	-12%	**-1.7%**	21
MO	451,364	430,415	476,142	411,411	428,809	412,221	462,601	411,600	389,551	178,587	-14%	**-1.8%**	22
HI	35,640	32,043	31,139	26,436	30,130	34,800	32,161	31,465	29,134	16,267	-18%	**-2.5%**	23
AZ	762,198	684,816	488,267	487,930	604,659	649,911	619,991	602,344	607,446	163,238	-20%	**-2.8%**	24
MD	336,947	349,005	325,936	282,024	260,525	275,455	292,467	258,527	243,878	191,777	-28%	**-4.0%**	25
MS	408,067	377,547	432,674	399,580	379,317	371,911	354,895	312,097	293,437	255,424	-28%	**-4.0%**	26
DC	126,474	119,534	106,508	106,935	101,148	105,156	108,806	95,106	89,031	68,288	-30%	**-4.3%**	27
IA	261,691	271,083	270,251	259,346	265,571	266,414	243,035	144,005	179,136	124,219	-32%	**-4.6%**	28
MI	382,302	401,636	370,540	340,211	338,656	354,514	300,655	281,723	252,317	196,811	-34%	**-5.1%**	29
WY	24,292	21,587	26,892	25,258	22,841	22,394	22,079	20,025	15,856	14,094	-35%	**-5.2%**	30
WV	183,614	166,680	181,394	165,004	191,926	177,765	136,863	109,592	119,518	44,676	-35%	**-5.2%**	31
OH	445,640	412,720	439,304	416,532	467,605	373,312	321,832	323,953	277,568	106,459	-38%	**-5.7%**	32
TX	1,265,441	1,081,530	1,090,371	1,024,232	1,066,841	933,927	927,679	804,794	766,427	525,465	-39%	**-6.1%**	33
NM	76,827	72,619	56,359	69,015	64,319	59,094	47,913	44,124	46,191	31,874	-40%	**-6.2%**	34
NE	128,825	134,476	136,924	127,318	101,440	101,139	91,195	83,126	76,445	50,257	-41%	**-6.3%**	35
VA	433,795	406,134	401,637	320,324	310,083	298,595	277,513	279,996	248,909	136,431	-43%	**-6.7%**	36
UT	168,924	161,149	157,939	116,952	109,501	107,540	112,218	99,314	94,650	102,065	-44%	**-7.0%**	37
PA	532,613	512,380	525,445	393,321	386,669	357,541	345,486	307,262	295,647	285,490	-44%	**-7.1%**	38
RI	62,362	56,757	62,836	47,926	52,962	38,572	46,176	29,353	34,275	28,416	-45%	**-7.2%**	39
NY	1,633,178	1,559,374	1,285,166	1,058,164	1,076,549	1,034,258	1,067,800	952,183	883,019	290,753	-46%	**-7.4%**	40
CA	3,049,326	2,859,902	2,528,709	2,258,253	2,283,083	2,314,925	1,945,968	1,826,449	1,638,580	978,789	-46%	**-7.5%**	41
SC	308,556	244,246	228,699	231,285	170,877	159,922	159,190	168,768	164,051	154,721	-47%	**-7.6%**	42
TN	420,186	434,619	391,798	391,045	387,451	269,933	294,092	277,751	206,904	139,528	-51%	**-8.5%**	43
NH	54,770	55,536	51,647	55,319	35,906	35,413	23,918	26,909	26,149	15,924	-52%	**-8.8%**	44
FL	1,747,087	1,734,299	1,769,401	1,780,630	1,647,953	991,982	857,540	756,781	786,553	560,053	-55%	**-9.5%**	45
WA	421,906	387,630	386,165	350,501	303,335	283,146	236,233	197,927	188,497	78,331	-55%	**-9.6%**	46
IL	1,378,152	1,314,547	1,330,411	1,229,502	1,230,176	913,017	723,969	611,137	554,576	286,076	-60%	**-10.8%**	47
IN	394,132	327,187	342,448	361,507	321,910	286,026	201,592	170,006	153,603	61,351	-61%	**-11.1%**	48
KS	154,087	168,437	166,357	120,079	32,513	30,870	44,668	38,912	32,251	15,124	-79%	**-17.8%**	49
LA	713,055	628,808	530,005	388,577	291,031	193,409	120,047	97,953	128,419	74,417	-82%	**-19.3%**	50
KY	443,207	414,874	171,549	103,750	94,196	74,640	63,642	67,530	59,164	36,740	-87%	**-22.3%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Growth Rates from 2010-2018.

26. Medicaid Revenues Per Enrollee. Table 34 shows rankings of Medicaid revenues per enrollee. By this measure, North Dakota had the highest Medicaid hospital cost per enrollee in 2018.

However, it is fair to note that North Dakota hospitals' Medicaid revenues by this measure fluctuated widely from year to year, and state-to-state comparisons may be more uncertain than other measures.

Table 34.

Medicaid Revenues per Medicaid Enrollee, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth Avg Annual 2011-2018	Growth	Rank
US		**1,883**	**1,951**	**1,925**	**1,903**	**1,880**	**1,978**	**2,051**	**2,134**	**1,358**	**13%**	**1.8%**	
ND		2,696	4,884	3,591	3,905	4,206	5,589	6,441	**5,776**	4,358	114%	11.5%	1
DC		4,060	3,672	3,563	3,885	4,970	4,312	4,364	**4,123**	3,055	2%	0.2%	2
MD		2,673	2,804	2,815	2,844	3,482	3,641	4,013	**3,982**	3,692	49%	5.9%	3
NY		3,029	3,086	2,996	2,932	2,855	3,157	3,131	**3,240**	761	7%	1.0%	4
RI		2,755	3,100	3,195	2,633	2,824	3,068	3,202	**3,195**	2,972	16%	2.1%	5
NJ		1,907	1,973	1,999	2,408	2,466	2,408	2,898	**3,102**	497	63%	7.2%	6
ME		2,234	2,217	2,307	2,200	2,595	2,741	3,019	**3,098**	3,012	39%	4.8%	7
AK		2,183	2,462	2,707	2,606	2,269	2,946	2,884	**3,072**	1,147	41%	5.0%	8
MO		2,556	2,581	2,801	2,797	2,669	3,028	2,677	**2,924**	1,354	14%	1.9%	9
SD		2,421	2,065	1,923	2,245	2,478	2,617	3,183	**2,897**	2,981	20%	2.6%	10
MA		2,469	2,409	2,558	2,703	2,593	2,757	2,848	**2,852**	2,533	15%	2.1%	11
KY		2,091	2,377	2,377	2,059	2,396	2,756	2,674	**2,813**	2,004	34%	4.3%	12
IN		2,119	2,580	2,281	2,252	1,805	1,910	2,495	**2,805**	921	32%	4.1%	13
DE		2,097	2,143	2,160	2,603	2,615	2,910	3,032	**2,738**	2,340	31%	3.9%	14
CT		2,463	2,570	2,491	2,219	2,447	2,405	2,443	**2,547**	2,762	3%	0.5%	15
HI		1,419	1,113	1,562	1,681	1,855	1,828	1,932	**2,490**	2,035	75%	8.4%	16
WY		2,120	1,684	2,079	1,937	1,733	1,749	1,699	**2,447**	3,092	15%	2.1%	17
MT		1,787	1,865	1,629	1,885	1,716	2,249	2,974	**2,432**	862	36%	4.5%	18
IA		1,938	1,909	1,874	2,016	2,187	2,137	2,505	**2,431**	1,853	25%	3.3%	19
MS		1,805	2,016	1,961	1,955	1,895	2,199	2,271	**2,416**	2,152	34%	4.3%	20
MN		2,330	2,382	2,455	2,110	2,187	2,276	2,334	**2,364**	862	1%	0.2%	21
PA		1,839	2,017	1,996	2,197	1,994	2,140	2,279	**2,304**	2,371	25%	3.3%	22
IL		1,728	1,949	1,979	1,935	1,968	2,188	2,118	**2,279**	1,929	32%	4.0%	23
WV		2,097	2,763	2,312	2,012	2,009	1,843	2,107	**2,278**	1,338	9%	1.2%	24
UT		1,639	1,759	1,706	2,030	2,034	1,973	2,052	**2,263**	2,757	38%	4.7%	25
VA		2,387	2,605	2,502	2,405	2,328	2,217	2,251	**2,253**	2,046	-6%	-0.8%	26
OH		1,952	1,921	1,976	2,005	2,084	2,107	2,188	**2,213**	806	13%	1.8%	27
NH		1,956	1,523	1,735	2,177	2,243	2,463	2,242	**2,163**	2,089	11%	1.4%	28
KS		1,952	1,931	1,867	1,716	2,043	2,078	2,018	**2,152**	1,633	10%	1.4%	29
CA		1,737	1,777	1,839	1,782	1,671	1,726	1,889	**2,098**	1,600	21%	2.7%	30
OR		1,573	1,883	1,958	1,679	1,803	2,287	2,111	**2,055**	1,354	31%	3.9%	31
NM		1,660	1,751	1,566	1,667	1,989	2,139	2,110	**2,034**	1,515	22%	2.9%	32
WI		1,266	1,507	1,315	1,674	1,993	1,860	1,939	**2,033**	1,470	61%	7.0%	33
ID		2,208	1,857	2,034	2,333	2,000	1,970	1,885	**2,003**	1,678	-9%	-1.4%	34
NE		2,199	2,421	1,736	1,946	2,042	2,263	2,233	**1,956**	1,141	-11%	-1.7%	35
LA		2,093	1,951	1,627	2,003	1,556	1,593	1,797	**1,950**	1,163	-7%	-1.0%	36
CO		1,147	1,055	1,060	1,200	1,523	1,678	1,741	**1,912**	967	67%	7.6%	37
WA		1,715	1,888	2,134	2,078	1,791	1,991	1,880	**1,877**	926	9%	1.3%	38
MI		1,469	1,499	1,477	1,539	1,668	1,860	1,893	**1,823**	1,519	24%	3.1%	39
TN		1,557	1,908	1,895	1,496	1,457	1,590	1,710	**1,684**	1,286	8%	1.1%	40
GA		1,386	1,485	1,450	1,384	1,402	1,489	1,494	**1,612**	1,182	16%	2.2%	41
NV		1,653	1,278	1,526	1,394	1,301	1,691	1,593	**1,609**	452	-3%	-0.4%	42
NC		1,605	1,655	1,611	1,474	1,524	1,509	1,537	**1,511**	1,317	-6%	-0.9%	43
VT		1,582	1,605	1,464	1,588	1,704	1,751	1,247	**1,502**	1,653	-5%	-0.7%	44
SC		1,978	1,643	1,651	1,567	1,452	1,564	1,514	**1,490**	1,337	-25%	-4.0%	45
AZ		1,599	1,401	1,279	1,233	1,296	1,368	1,412	**1,399**	700	-12%	-1.9%	46
OK		1,555	1,596	1,661	1,653	1,516	1,445	1,491	**1,338**	1,263	-14%	-2.1%	47
FL		1,716	1,688	1,607	1,543	1,303	1,268	1,255	**1,224**	908	-29%	-4.7%	48
TX		1,241	1,303	1,225	1,144	1,134	1,053	1,073	**1,223**	945	-1%	-0.2%	49
AL		921	1,039	988	937	907	1,164	1,050	**1,087**	1,180	18%	2.4%	50
AR		599	1,037	653	773	830	878	813	**702**	590	17%	2.3%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2011-2018.

27. ***Private Patient Revenues Per Private Insurance Enrollee.*** We ranked states by non-Medicare and non-Medicaid (essentially private insurance) patient revenues per insured enrollee (employer plus non-group). By this measure, North Dakota ranked 3rd among the states in 2018 (see Figure 16 and Table 35).

Figure 16.

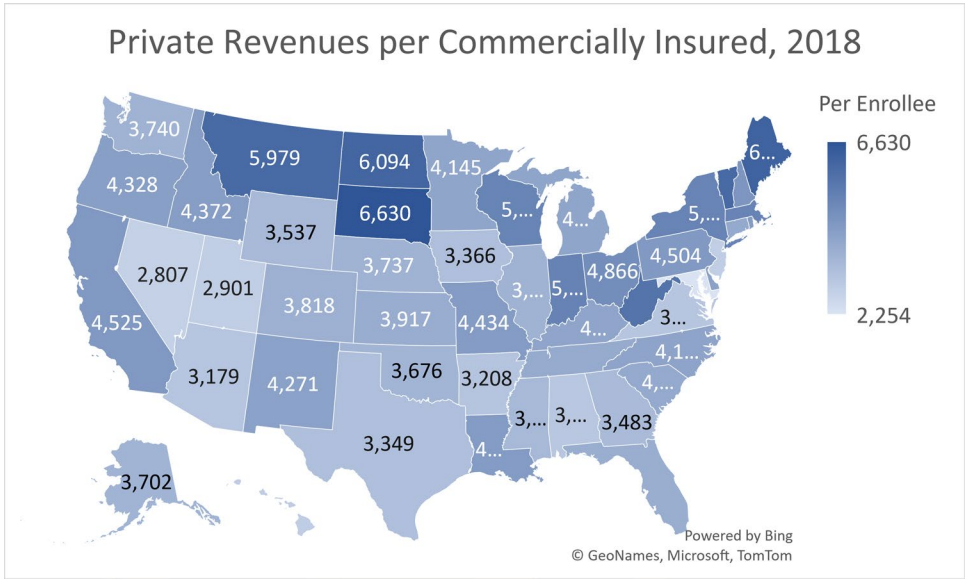


Table 35.

Private Revenues per Private Insurance Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2011-2018	Growth	Rank
US		**3,084**	**3,262**	**3,338**	**3,297**	**3,360**	**3,642**	**3,737**	**4,088**	**2,627**	**33%**	**4.1%**	
SD		4,572	4,797	5,544	5,369	5,926	5,878	6,230	**6,630**	7,497	45%	5.5%	1
ME		4,586	4,945	5,103	5,007	5,197	5,536	6,050	**6,185**	5,592	35%	4.4%	2
ND		4,180	5,134	4,728	5,132	5,674	5,830	5,646	**6,094**	5,328	46%	5.5%	3
VT		3,889	4,196	4,988	4,824	4,994	4,792	5,932	**5,982**	5,610	54%	6.3%	4
MT		4,119	5,343	5,069	4,965	4,583	5,553	5,697	**5,979**	2,457	45%	5.5%	5
DC		5,197	5,276	5,599	5,027	4,954	5,550	5,670	**5,944**	5,066	14%	1.9%	6
WV		3,607	3,929	4,109	4,100	4,358	5,025	5,424	**5,680**	3,703	57%	6.7%	7
IN		4,105	4,609	4,464	4,466	4,620	4,783	4,920	**5,204**	1,654	27%	3.4%	8
NY		3,545	3,645	3,826	3,955	4,086	4,591	4,714	**5,172**	1,464	46%	5.5%	9
MA		3,327	3,535	3,560	3,544	3,899	4,423	4,593	**5,169**	4,568	55%	6.5%	10
WI		3,813	4,169	4,458	4,486	4,545	4,803	5,006	**5,162**	3,535	35%	4.4%	11
OH		3,778	4,132	4,214	4,129	4,265	4,597	4,742	**4,866**	1,816	29%	3.7%	12
NH		3,709	3,578	3,764	3,785	3,752	4,035	4,443	**4,616**	4,402	24%	3.2%	13
CA		2,592	2,692	2,955	2,721	2,761	2,933	2,941	**4,525**	2,453	75%	8.3%	14
PA		3,607	3,678	3,782	3,761	3,899	4,145	4,332	**4,504**	4,591	25%	3.2%	15
LA		3,375	3,664	3,721	3,512	3,728	4,127	4,076	**4,449**	2,605	32%	4.0%	16
MO		3,539	3,907	3,681	3,610	3,596	4,199	4,226	**4,434**	2,394	25%	3.3%	17
RI		3,872	4,043	3,923	3,997	3,743	3,876	4,199	**4,391**	3,935	13%	1.8%	18
ID		2,758	3,227	3,427	3,377	3,658	3,824	4,051	**4,372**	3,565	58%	6.8%	19
OR		2,783	3,777	4,151	3,599	3,187	4,228	3,958	**4,328**	2,198	56%	6.5%	20
NM		3,310	3,460	3,642	3,596	3,643	3,974	4,095	**4,271**	2,514	29%	3.7%	21
DE		3,150	3,091	3,233	3,417	3,282	3,361	3,803	**4,249**	4,620	35%	4.4%	22
NC		3,018	3,368	3,330	3,288	3,615	3,773	4,025	**4,184**	3,140	39%	4.8%	23
KY		3,489	3,411	3,427	3,375	3,484	3,843	3,983	**4,158**	2,977	19%	2.5%	24
MI		3,355	3,529	3,519	3,543	3,583	3,909	4,112	**4,148**	3,609	24%	3.1%	25
MN		3,134	3,301	3,389	3,531	3,621	3,785	3,978	**4,145**	1,239	32%	4.1%	26
SC		3,212	3,543	3,564	3,705	3,593	3,878	3,928	**4,016**	3,528	25%	3.2%	27
CT		2,884	3,211	3,346	3,327	3,266	3,488	3,583	**4,009**	4,109	39%	4.8%	28
TN		3,075	3,598	3,208	3,262	3,156	3,409	3,719	**3,990**	3,443	30%	3.8%	29
KS		2,357	3,010	3,115	3,097	3,070	3,543	3,763	**3,917**	2,844	66%	7.5%	30
FL		3,396	3,260	3,332	3,328	3,412	3,564	3,769	**3,900**	2,786	15%	2.0%	31
CO		2,888	3,014	3,113	3,196	3,319	3,457	3,818	**3,818**	2,060	32%	4.1%	32
WA		3,051	3,077	3,343	3,281	3,384	3,354	3,549	**3,740**	2,028	23%	3.0%	33
NE		3,476	3,364	3,692	3,594	3,413	3,921	3,989	**3,737**	2,795	8%	1.0%	34
IL		3,000	3,098	3,250	3,351	3,344	3,661	3,610	**3,731**	2,831	24%	3.2%	35
AK		3,574	3,419	3,107	3,418	3,534	3,511	3,596	**3,702**	1,244	4%	0.5%	36
OK		3,124	3,429	3,322	3,213	3,309	3,503	3,618	**3,676**	2,938	18%	2.4%	37
MS		3,470	4,033	3,754	3,754	3,580	3,549	3,438	**3,547**	2,940	2%	0.3%	38
WY		2,937	3,171	3,003	3,117	3,386	3,488	3,686	**3,537**	3,224	20%	2.7%	39
GA		2,895	2,722	2,819	2,716	2,864	3,134	3,268	**3,483**	3,198	20%	2.7%	40
IA		2,930	2,984	2,982	2,967	3,045	3,231	3,208	**3,366**	3,160	15%	2.0%	41
TX		2,916	2,925	2,960	2,981	3,097	3,281	3,277	**3,349**	2,383	15%	2.0%	42
AR		2,570	2,742	2,739	2,599	2,631	2,888	2,991	**3,208**	2,189	25%	3.2%	43
AZ		2,127	3,072	2,909	3,100	2,598	3,070	3,084	**3,179**	1,420	49%	5.9%	44
VA		2,530	2,656	2,607	2,680	2,782	3,100	2,953	**3,162**	1,923	25%	3.2%	45
AL		2,278	2,835	2,741	2,585	2,405	2,930	2,877	**3,107**	2,830	36%	4.5%	46
HI		1,991	2,093	2,246	2,197	2,357	2,599	2,657	**2,919**	2,527	47%	5.6%	47
UT		2,611	2,471	2,449	2,511	2,488	2,809	2,821	**2,901**	2,800	11%	1.5%	48
NJ		2,467	2,581	2,677	2,472	2,641	2,795	2,829	**2,896**	427	17%	2.3%	49
NV		2,405	2,563	2,682	2,287	2,407	2,324	2,581	**2,807**	1,178	17%	2.2%	50
MD		2,216	2,272	2,246	2,241	2,058	2,085	2,160	**2,254**	2,365	2%	0.2%	51

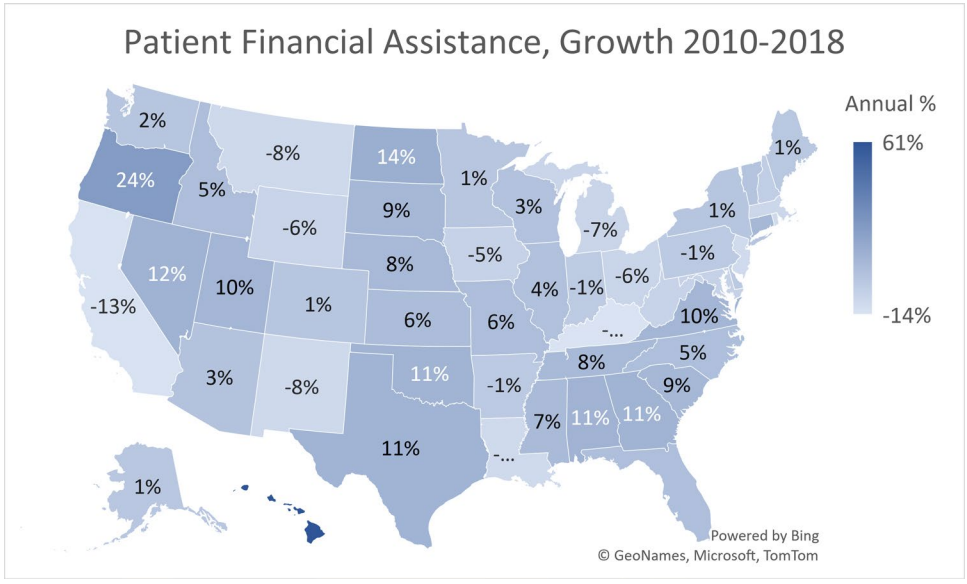
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2011-2018.

28. ***Patient Financial Assistance.*** HCRIS reported charity care is based on both uninsured and insured patients qualifying for hospitals' financial assistance programs, less partial payments received. The valuation of the assistance is adjusted to a cost basis using cost-to-charge ratios. As noted above, North Dakota hospitals' financial assistance has increased rapidly (see Table 36 and Figure 17). However, at 1.3 percent of net patient revenues, the level of assistance is low compared with most other states, and well below the national average of nearly 3 percent (see Table 37). Importantly, the valuation of patient financial assistance in the HCRIS data is quite volatile from year to year, and therefore may be more uncertain than other measures.

Figure 17.



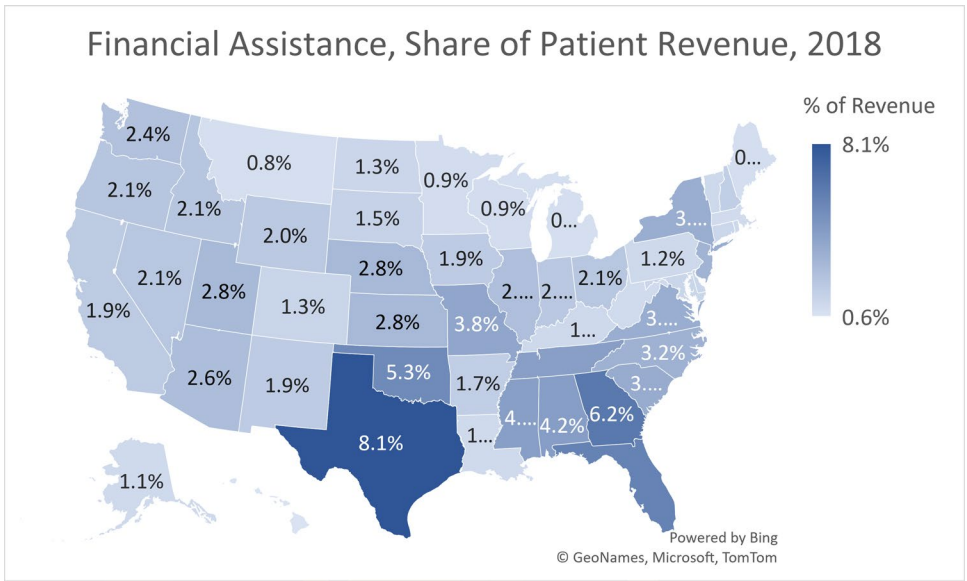


Table 36.

Patient Financial Assistance (Uninsured and Insured Patients), Ranked by 2011-2018 Growth DRAFT

State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Average Annual Growth	Rank
		Raw HCRIS Data (by calendar year, millions of dollars)										
US		**23,780**	**25,686**	**26,440**	**25,453**	**21,367**	**23,531**	**24,875**	**27,901**	**11,242**	**2%**	
HI		8	14	7	79	15	15	243	222	8	**61%**	1
OR		350	341	301	749	175	771	1,200	1,554	99	**24%**	2
ND		19	29	36	38	34	35	37	46	27	**14%**	3
NV		59	62	141	119	104	73	116	128	29	**12%**	4
AL		185	215	233	261	269	298	352	392	283	**11%**	5
OK		236	254	266	339	366	376	417	494	242	**11%**	6
GA		787	797	860	1,071	1,135	1,240	1,461	1,645	854	**11%**	7
TX		2,403	2,846	3,664	3,918	3,988	4,312	4,490	4,998	2,202	**11%**	8
VA		501	541	566	621	714	875	900	979	332	**10%**	9
UT		116	131	133	152	162	199	211	222	173	**10%**	10
CT		143	176	131	119	137	158	177	264	109	**9%**	11
SD		38	47	51	53	51	51	61	69	39	**9%**	12
SC		317	345	418	451	501	568	486	574	301	**9%**	13
NE		96	93	117	147	143	168	159	168	62	**8%**	14
TN		466	533	510	607	624	638	716	796	399	**8%**	15
MS		204	226	202	255	249	270	320	331	210	**7%**	16
KS		135	143	126	193	192	201	202	207	112	**6%**	17
MO		500	533	571	660	658	656	699	735	233	**6%**	18
ID		71	38	52	76	82	110	98	104	66	**5%**	19
NC		715	750	755	793	805	847	909	1,025	450	**5%**	20
FL		2,049	1,875	2,040	2,416	2,219	2,290	2,528	2,877	1,392	**5%**	21
IL		902	1,275	1,240	974	830	1,022	925	1,214	433	**4%**	22
WI		193	207	248	198	147	212	236	243	81	**3%**	23
AZ		221	348	440	374	253	247	217	273	130	**3%**	24
DC		26	31	28	38	36	30	32	31	14	**3%**	25
VT		22	20	18	22	20	19	24	26	19	**2%**	26
WA		359	419	487	304	233	280	342	405	176	**2%**	27
NY		1,439	1,389	1,410	1,653	1,542	1,513	1,524	1,595	390	**1%**	28
CO		226	251	261	199	216	214	204	249	67	**1%**	29
MN		191	169	148	111	99	119	177	209	36	**1%**	30
AK		36	46	48	61	58	26	37	38	4	**1%**	31
ME		73	76	78	99	84	84	88	77	30	**1%**	32
DE		45	55	54	42	37	32	37	44	20	**0%**	33
PA		481	579	573	549	507	449	411	462	249	**-1%**	34
AR		135	152	161	170	106	88	100	129	50	**-1%**	35
IN		577	697	701	714	440	549	494	532	111	**-1%**	36
NH		94	85	96	98	69	60	66	77	52	**-3%**	37
IA		213	260	225	164	98	110	129	151	84	**-5%**	38
MD		279	308	310	235	175	172	177	196	98	**-5%**	39
WV		115	127	127	77	62	85	76	78	34	**-5%**	40
WY		52	28	30	35	33	36	37	33	15	**-6%**	41
OH		1,113	1,148	1,138	797	485	651	647	700	173	**-6%**	42
MI		404	432	472	330	162	184	221	251	137	**-7%**	43
MA		452	444	463	366	336	356	254	263	179	**-7%**	44
MT		68	70	81	97	69	54	40	37	8	**-8%**	45
NM		158	169	167	127	89	81	78	85	39	**-8%**	46
LA		390	378	400	551	527	519	201	202	53	**-9%**	47
NJ		1,272	1,268	1,371	784	637	688	677	641	63	**-9%**	48
RI		68	97	97	60	40	40	33	34	25	**-9%**	49
CA		4,327	4,751	4,018	2,921	1,226	1,325	1,463	1,635	779	**-13%**	50
KY		451	418	371	185	128	134	145	160	69	**-14%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 2-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports.
Average annual growth rates from 2011-2018.

* 2019 data may be incomplete.

Table 37.

Patient Financial Assistance As a Percentage of Net Patient Revenues, Ranked by 2019 Level DRAFT

State	2011	2012	2013	2014	2015	2016	2017	2018	2019	Rank
	Raw HCRIS Data (by calendar year)									
US	**3.3%**	**3.5%**	**3.5%**	**3.2%**	**2.6%**	**2.7%**	**2.7%**	**2.8%**	**2.9%**	
TX	5.0%	5.9%	7.3%	7.3%	7.0%	7.3%	7.5%	8.0%	**8.1%**	1
GA	4.1%	4.3%	4.5%	5.3%	5.2%	5.4%	6.1%	6.4%	**6.2%**	2
FL	5.0%	4.7%	5.0%	5.4%	4.7%	4.6%	4.8%	5.2%	**5.7%**	3
OK	2.9%	3.0%	3.1%	3.7%	3.8%	3.8%	4.1%	4.6%	**5.3%**	4
AL	2.1%	2.3%	2.5%	2.7%	2.8%	3.0%	3.4%	3.6%	**4.2%**	5
MS	2.8%	3.0%	2.7%	3.3%	3.2%	3.5%	4.1%	4.2%	**4.2%**	6
TN	3.0%	3.4%	3.3%	3.9%	3.8%	3.7%	3.9%	4.1%	**4.2%**	7
MO	3.0%	3.2%	3.4%	3.8%	3.6%	3.4%	3.5%	3.5%	**3.8%**	8
SC	2.9%	3.1%	3.7%	3.7%	4.0%	4.4%	3.6%	4.1%	**3.5%**	9
NY	2.7%	2.6%	2.5%	2.8%	2.4%	2.3%	2.2%	2.2%	**3.4%**	10
VA	3.0%	3.2%	3.2%	3.3%	3.6%	4.3%	4.4%	4.5%	**3.4%**	11
NC	3.3%	3.3%	3.3%	3.3%	3.1%	3.1%	3.1%	3.4%	**3.2%**	12
NJ	6.7%	6.6%	6.9%	3.9%	3.0%	3.0%	2.9%	2.6%	**3.1%**	13
KS	2.2%	2.1%	1.8%	2.6%	2.5%	2.4%	2.3%	2.3%	**2.8%**	14
NE	1.9%	1.8%	2.2%	2.8%	2.5%	2.8%	2.7%	2.8%	**2.8%**	15
UT	2.1%	2.4%	2.3%	2.4%	2.4%	2.8%	2.8%	2.8%	**2.8%**	16
AZ	1.7%	2.7%	3.4%	2.9%	1.9%	1.7%	1.4%	1.7%	**2.6%**	17
IL	3.0%	4.1%	4.0%	3.0%	2.4%	2.8%	2.5%	3.1%	**2.5%**	18
WA	2.3%	2.7%	2.8%	1.7%	1.2%	1.5%	1.7%	1.9%	**2.4%**	19
OR	4.0%	3.8%	2.9%	7.2%	1.6%	6.8%	10.2%	12.1%	**2.1%**	20
ID	2.1%	1.0%	1.3%	1.8%	1.8%	2.3%	1.9%	1.9%	**2.1%**	21
NV	1.2%	1.3%	2.7%	2.3%	1.9%	1.3%	1.9%	1.9%	**2.1%**	22
OH	3.5%	3.5%	3.4%	2.3%	1.3%	1.7%	1.6%	1.7%	**2.1%**	23
IN	3.0%	3.4%	3.5%	3.4%	2.1%	2.5%	2.2%	2.2%	**2.0%**	24
WY	4.0%	2.0%	2.1%	2.4%	2.1%	2.3%	2.3%	2.0%	**2.0%**	25
CA	6.2%	6.6%	5.1%	3.6%	1.5%	1.5%	1.6%	1.3%	**1.9%**	26
IA	2.8%	3.4%	3.0%	2.0%	1.2%	1.3%	1.5%	1.6%	**1.9%**	27
NM	3.8%	4.0%	3.8%	2.7%	1.8%	1.5%	1.6%	1.5%	**1.9%**	28
AR	2.5%	2.7%	2.9%	3.0%	1.7%	1.4%	1.5%	1.9%	**1.7%**	29
NH	2.4%	2.1%	2.4%	2.4%	1.6%	1.3%	1.3%	1.5%	**1.7%**	30
SD	1.3%	1.5%	1.5%	1.5%	1.3%	1.3%	1.5%	1.6%	**1.5%**	31
CO	2.2%	2.3%	2.3%	1.6%	1.6%	1.5%	1.4%	1.5%	**1.3%**	32
MD	2.1%	2.3%	2.3%	1.7%	1.2%	1.1%	1.2%	1.3%	**1.3%**	33
DE	2.0%	2.3%	2.2%	1.6%	1.3%	1.1%	1.3%	1.4%	**1.3%**	34
ND	0.7%	1.0%	1.2%	1.2%	1.0%	0.9%	1.0%	1.2%	**1.3%**	35
CT	1.5%	1.8%	1.3%	1.2%	1.3%	1.5%	1.6%	2.3%	**1.3%**	36
RI	2.4%	3.3%	3.3%	2.0%	1.3%	1.3%	1.0%	1.0%	**1.2%**	37
VT	1.2%	1.0%	0.9%	1.0%	0.9%	0.9%	1.0%	1.2%	**1.2%**	38
PA	1.4%	1.6%	1.6%	1.5%	1.3%	1.1%	1.0%	1.1%	**1.2%**	39
KY	4.0%	3.7%	3.3%	1.6%	1.0%	1.0%	1.1%	1.1%	**1.2%**	40
LA	3.7%	3.6%	3.7%	4.8%	4.4%	4.2%	1.6%	1.5%	**1.1%**	41
AK	2.2%	2.8%	2.9%	3.4%	3.0%	1.3%	1.8%	1.7%	**1.1%**	42
WV	2.4%	2.4%	2.4%	1.4%	1.1%	1.4%	1.2%	1.2%	**1.0%**	43
MA	2.3%	2.2%	2.3%	1.7%	1.5%	1.5%	1.0%	1.0%	**1.0%**	44
DC	0.9%	1.1%	1.0%	1.3%	1.1%	0.9%	0.9%	0.8%	**0.9%**	45
MN	1.3%	1.1%	1.0%	0.7%	0.6%	0.7%	0.9%	1.0%	**0.9%**	46
WI	1.2%	1.2%	1.3%	1.0%	0.7%	1.0%	1.1%	1.1%	**0.9%**	47
ME	1.7%	1.7%	1.8%	2.2%	1.7%	1.6%	1.6%	1.4%	**0.9%**	48
MI	1.6%	1.7%	1.8%	1.2%	0.6%	0.6%	0.7%	0.8%	**0.8%**	49
MT	2.3%	2.4%	2.7%	3.0%	2.0%	1.5%	1.0%	0.9%	**0.8%**	50
HI	0.4%	0.7%	0.3%	3.2%	0.6%	0.5%	8.5%	7.4%	**0.6%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 2-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

III. Insurers – Historical Data 2010-2019

Key Findings and Illustrations

30. Individual Market Premiums – The NDID, NAIC, and CMS Data are in Rough Agreement on Overall Market Sizes and Trends
31. Premiums per Member Grew Rapidly in the Individual Market; Slower in Group Markets
32. Administrative Costs Grew Rapidly in the 2010-2018 Period
33. Pharmaceutical Benefit Claims, Net of Rebates, Grew Rapidly
34. Individual Market Baseline Reconstruction for 2019 and 2020

We gathered data on insurance benefits and claims from several sources: the CMS rate review data for 2020 (experience data through 2018), the NAIC supplemental exhibit (2010-2019), the NDID insurance market report (2014 through 2018), a data request to state insurers (through 2019 with some projections for 2020 and beyond; data request shown in Appendix D), and information from the state's 1332 reinsurance waiver request.

The following tables show our preliminary tabulations and estimates of statewide North Dakota premiums and benefits.

29. Individual Market Premiums – The NDID, NAIC, and CMS Data are in Rough Agreement on Overall Market Sizes and Trends. Table 38 indicates that the NDID Market Report, the NAIC supplemental exhibit, and the CMS rate review data are in reasonably good agreement for concepts they measure in common. ACA coverage has gradually expanded since its introduction in 2014 as a share of total individual market coverage. Individual market premiums grew very rapidly in 2014 and 2015 mostly due to the added benefits required for ACA coverage.

Table 38.

North Dakota Individual Market Aggregate Premiums, by Data Source (millions) **DRAFT**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Individual Market										
NDID Market Report					186	232	255	248	265	
NAIC Supplemental Exhibit	121	132	142	152	194	242	244	240	255	256
NDID/NovaRest 1332 Reinsurance Actuarial Report \a								227	259	
ACA Coverage										
CMS Rate Review Public Use File					94	157	202	200	219	
NDID Market Report					80	159	206	204	223	
NDID/NovaRest 1332 Reinsurance Actuarial Report \a								189	224	236

Source: Horizon Government Affairs.
\a 2018 is based on May 31

30. ***Premiums per Member Grew Rapidly in the Individual Market; Slower in Group Markets.*** Premiums per-member per-month (PMPM) in the individual market grew by about 8-9 percent annually in the 2014-2018 period, and about 4-5 percent per year in the small group and large group markets (see Table 39). A key reason for the difference was probably an influx of relatively older and sicker enrollees in the individual market during that period, as the individual market switched to guaranteed issue coverage (no coverage denials or limitations due to preexisting medical conditions).

Table 39.

North Dakota Premiums, by Market					**DRAFT**						Average Annual
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Growth*
					NDID Market Summary						
Premiums (millions)											
Individual Market					186	232	255	248	265		9.1%
Small Group Market					362	370	369	378	375		0.9%
Member Months											
Individual Market					571,655	627,815	631,775	608,929	567,055		-0.2%
Small Group Market					967,648	912,400	883,940	884,349	848,472		-3.2%
Premiums PMPM											
Individual Market					326	369	404	407	467		9.4%
Small Group Market					375	405	417	427	442		4.2%
					NAIC Supplemental Exhibit						
Premiums (millions)											
Individual Market	121	132	142	152	194	242	244	240	255	256	5.7%
Small Group Market	290	243	266	282	291	303	295	300	319	340	3.1%
Large Group Market	453	557	603	650	702	722	735	753	806	851	3.9%
Member Months											
Individual Market	535,780	530,932	544,927	756,912	582,131	667,548	620,560	594,515	549,367	518,591	-2.3%
Small Group Market	995,164	776,463	810,831	845,028	788,308	757,106	741,852	710,767	713,623	732,478	-1.5%
Large Group Market	1,437,007	1,706,714	1,786,130	1,860,455	1,913,878	1,857,512	1,828,600	1,795,950	1,832,387	1,874,147	-0.4%
Premiums PMPM											
Individual Market	226	249	260	201	333	363	393	404	465	493	8.1%
Small Group Market	291	313	328	334	369	401	397	422	447	464	4.7%
Large Group Market	315	326	338	349	367	388	402	419	440	454	4.4%
Covered Lives											
Individual Market	47,687	44,416	47,038	66,023	49,075	54,151	49,718	47,192	43,333	40,957	-3.6%
Small Group Market	79,378	65,789	69,893	73,909	64,497	64,424	62,179	60,381	60,028	61,351	-1.0%
Large Group Market	120,348	142,944	149,561	158,836	160,820	149,872	151,322	149,111	154,872	156,685	-0.5%
					NDID/NovaRest 1332 Reinsurance Actuarial Report (ACA only) \a						
Individual Market											
Premiums								189	224	237	
Member Months								467,822	474,576	469,583	
Premiums PMPM								404	472	504	
Covered Lives								39,068	39,545	39,103	
Memorandum:											
CMS Individual Market PMPM (ACA Coverage)			225	230	318	362	401	404	468	516	471

Source: Horizon Government Affairs.

* Growth rate may be 2014-2018 or 2014-2019 depending on data availability for 2019.

31. Administrative Costs Grew Rapidly in the 2010-2019 Period. In the individual market, general and administrative costs (including claims processing) grew by about 5.6 percent per year in the 2010-2019 period, more slowly than benefit costs (7.0%) and premiums (8.7%). However, administrative costs grew much more rapidly than claims costs in the group markets, according to preliminary data from the NAIC (see Table 40).

Table 40.

Insurance Premiums vs. Benefits and Administrative Costs, by Market, NAIC Data **DRAFT**
(costs in millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Average Annual Growth 2010-2019
Premiums											
Individual Market	121	132	142	152	194	242	244	240	255	256	8.7%
Small Group Market	290	243	266	282	291	303	295	300	319	340	1.8%
Large Group Market	453	557	603	650	702	722	735	753	806	851	7.3%
Benefits											
Individual Market	121	120	133	138	175	213	227	226	223	222	7.0%
Small Group Market	254	192	225	259	239	245	251	247	281	290	1.5%
Large Group Market	416	512	555	597	635	667	680	689	739	791	7.4%
General and Administrative Costs, Claims Processing											
Individual Market	14	13	15	13	14	19	21	20	25	23	5.6%
Small Group Market	19	16	19	22	21	21	24	27	42	41	8.9%
Large Group Market	20	28	33	42	40	42	42	43	57	64	14.0%
Taxes and Assessments											
Individual Market	2	1	0	2	8	18	12	9	9	10	18.4%
Small Group Market	6	11	7	3	18	20	13	9	3	2	-10.4%
Large Group Market	4	7	6	5	18	31	23	11	16	-5	
Defined Expenses for Health Quality											
Individual Market	1	1	1	1	1	1	1	1	1	1	2.8%
Small Group Market	1	1	1	1	1	1	1	1	1	1	-0.1%
Large Group Market	2	3	4	3	3	6	7	5	5	5	10.8%
Other and Reinsurance (net)											
Individual Market	-4	0	0	1	-8	-14	-2	-6	-2	1	
Small Group Market	3	0	0	0	5	-1	-2	-1	0	0	
Large Group Market	2	-1	-2	9	-1	29	-23	-11	-7	-6	
Net Underwriting Gain (+) or Loss (-)											
Individual Market	-12	-2	-7	-2	4	5	-15	-9	-1	-2	
Small Group Market	7	23	14	-4	7	16	6	16	-9	6	
Large Group Market	9	8	6	-7	8	-53	8	17	-4	2	

Source: Horizon Government Affairs, based on data from NAIC.
* Preliminary

32. Pharmaceutical Benefit Claims, Net of Rebates, Grew Faster Than Non-Pharmacy Costs. Based on the NAIC data, net pharmacy claims grew more rapidly than non-pharmacy costs in all markets. For example, in the individual market, net pharmacy claims grew by 11.8 percent per year, compared with average annual growth of 6.0 percent for non-pharmacy claims over the 2010-2019 period (see Table 41).

Table 41.

Benefits Costs, By Type, NAIC Data (costs in millions)						**DRAFT**					Average Annual Growth
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2019
Non-Pharmaceutical Claims											
Individual Market	107	105	117	120	148	181	188	183	179	181	6.0%
Small Group Market	222	168	199	230	209	212	216	207	238	243	1.0%
Large Group Market	361	447	483	517	540	563	577	582	620	672	7.1%
Pharmaceutical Claims											
Individual Market	15	16	17	20	28	37	45	47	50	51	14.7%
Small Group Market	33	26	27	31	31	40	42	43	47	55	5.8%
Large Group Market	57	68	78	87	104	119	122	124	141	152	11.5%
Rebates											
Individual Market	1	1	1	2	1	5	5	7	10	13	35.2%
Small Group Market	2	2	2	2	2	6	6	7	10	14	25.7%
Large Group Market	2	3	6	7	8	15	20	22	28	39	37.0%
Net, Pharmaceutical Claims											
Individual Market	14	15	16	18	27	32	40	40	39	38	11.8%
Small Group Market	32	24	25	29	29	34	35	36	37	42	3.1%
Large Group Market	55	65	72	80	96	104	103	102	113	113	8.4%
Total, Incurred Claims											
Individual Market	121	120	133	138	175	213	227	226	223	222	7.0%
Small Group Market	254	192	225	259	239	245	251	247	281	290	1.5%
Large Group Market	416	512	555	597	635	667	680	689	739	791	7.4%

Source: Horizon Government Affairs, data from NAIC.
Note: Claims costs do not sum exactly to totals for 2017-2019.
* Preliminary

33. Individual Market Baseline Reconstruction for 2019 and 2020. Table 42 shows our baseline reconstruction for the Individual Market in 2019 and 2020. This table is particularly uncertain and subject to change. It assumes 2020 premiums will be about 9 percent lower than 2019, due to the state's new reinsurance program. The reduction in enrollment is due mostly to the Covid-19 recession, based in preliminary data submitted by the state's health plans. Absent the recession, we had expected enrollment in the individual market to increase, based on preliminary data from CMS on 2020 plan selections, and due to the reinsurance and resulting premium reduction.

Table 42.

Individual Coverage Baseline Estimates (HGA)				DRAFT			
	2014	2015	2016	2017	2018	2019	2020e
On Exchange		**Covered Lives**					
APTC Only		7,223	7,731	7,360	7,798	9,964	10,123
APTC/CSR		7,021	8,234	9,039	9,095	8,604	7,867
No Subsidy		2,407	2,726	2,948	2,749	2,693	2,559
Total, On Exchange		16,651	18,691	19,347	19,642	21,261	20,549
Off Exchange		19,678	21,736	21,023	17,750	15,224	14,324
Total, ACA	19,738	36,329	40,427	40,370	37,392	36,485	34,873
Transitional and Grandfathered	28,619	16,905	10,756	8,598	7,902	7,262	6,674
Total, Individual	48,356	53,234	51,183	48,968	45,294	43,747	41,547
Individual Market		**Premiums PMPM**					
On Exchange (CMS)	334	363	403	398	450	496	453
Total ACA (NDID/Novarest)	342	371	412	407	476	523	478
Total, Individual Market	326	369	404	407	467	512	468
Individual Market		**Growth**					
On Exchange (CMS)		9%	11%	-1%	13%	10%	-9%
Total ACA (NDID/Novarest)		9%	11%	-1%	17%	10%	-9%
Total, Individual Market		13%	9%	1%	15%	10%	-9%
Individual Market		**Aggregate Premiums (millions)**					
On Exchange (CMS)		72	90	92	106	127	112
Total ACA (NDID/Novarest)		162	200	197	214	229	200
Total, Individual Market	189	236	248	239	254	269	233
Memorandum							
Average Deductible, Individual Market		2,300	2,500	2,900	3,600	4,000	4,500
Loss Ratio, Individual Market		89%	89%	97%	95%	90%	87%

Source: Preliminary HGA estimates based on data from the NAIC, NDID/Novarest, CMS.

IV. Insurers – 50 State Data

Contents: Measures Compared	Figure	Table	Rank (highest to lowest)		
			Level		
			2014	2019	Growth
35. Individual Market Premiums (PMPM)	18	43	15	35	43
36. Individual Market Claims	19	44	21	26	38
37. Individual Market Admin. Costs	20	45	50	38	5
38. Small Group Market Premiums		46	30	30	22
39. Small Group Market Claims		47	22	27	25
40. Small Group Market Admin. Costs	21	48	50	24	1
41. Large Group Market Premiums		49	32	18	12
42. Large Group Market Claims		50	30	16	13
43. Large Group Market Admin. Costs		51	49	41	3

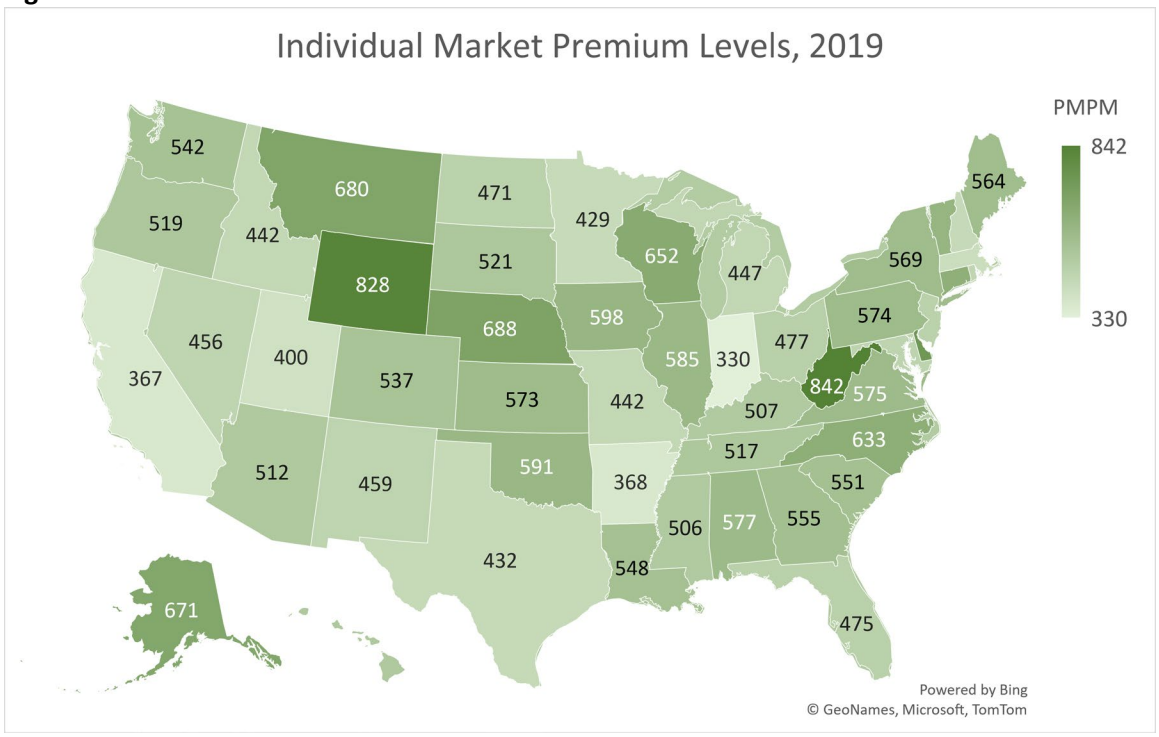
Source. HGA based on data from the National Association of Insurance Commissioners.
Notes: Growth is based on 2014 to 2019, except as noted in tables. All measures are based on PMPM (per-member per-month).

The data below show overall premiums and claims and other measures from the NAIC supplemental exhibit. These data are much more stable and comprehensive than the CMS Rate Review data, and we believe they are most appropriate for state-to-state market comparisons. However, there is still the possibility that the NAIC data could have volatility due to carriers entering or departing state markets. Importantly, the NAIC's "large group" category does not include self-funded (ERISA) benefit plans.

Despite North Dakota's relatively high and rapidly growing hospital and pharmaceutical costs, North Dakota's statewide premiums and claims per member month are about average, in the individual, small group, and large group markets.

34. **Individual Market Premiums.**

Figure 18.



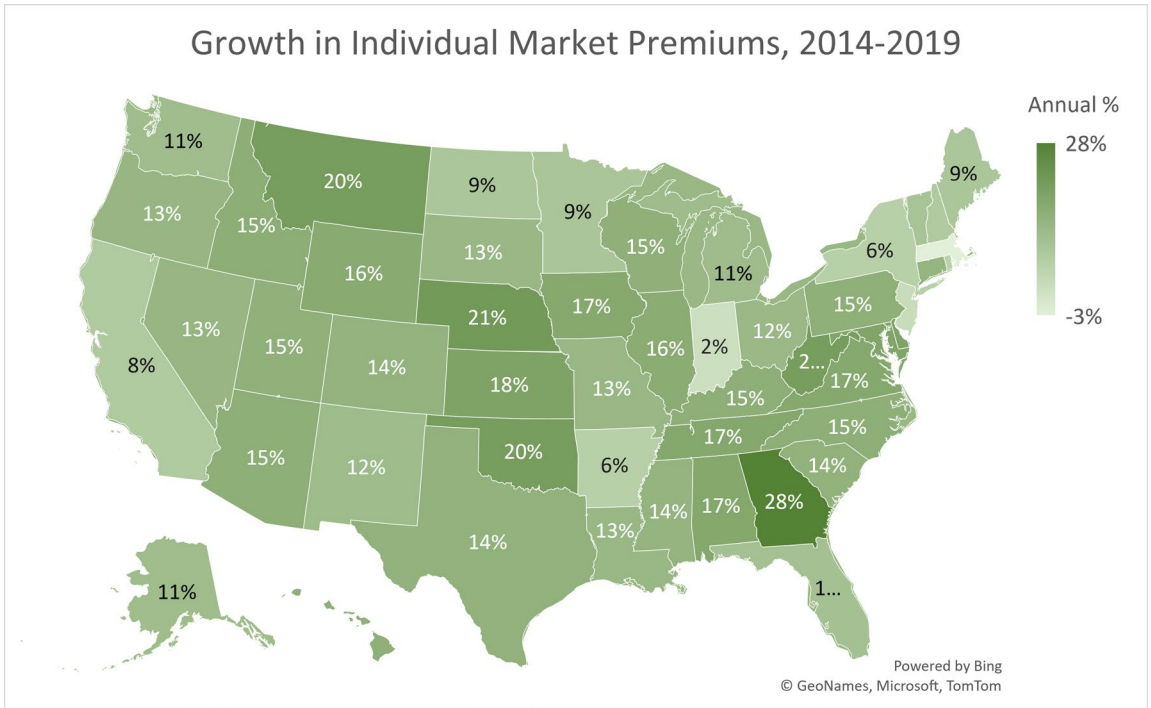


Table 43.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

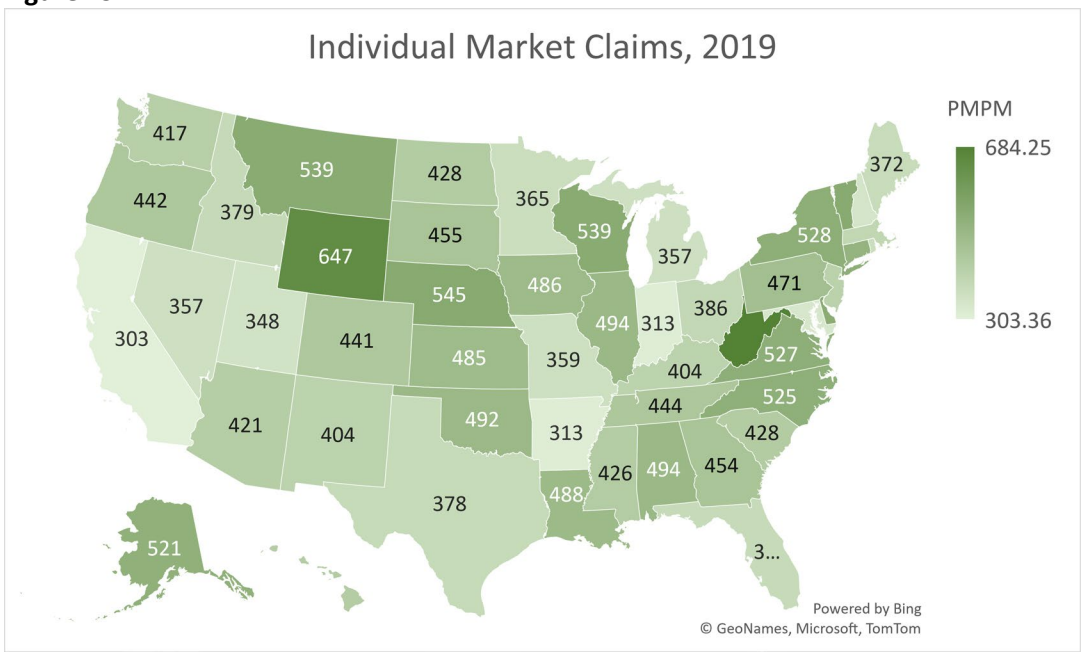
Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**203**	**212**	**221**	**195**	**275**	**309**	**348**	**413**	**508**	**499**	**13%**	
WV	245	254	270	199	338	424	482	609	740	**842**	20%	1
WY	254	255	260	263	388	467	503	582	813	**828**	16%	2
DE	228	247	284	224	320	361	450	591	729	**740**	18%	3
NE	222	217	226	223	265	317	351	479	628	**688**	21%	4
MT	187	203	217	217	272	317	368	530	643	**680**	20%	5
AK	280	306	318	316	391	493	727	800	590	**671**	11%	6
WI	211	216	226	221	327	370	409	463	663	**652**	15%	7
NC	201	224	224	148	313	332	399	531	632	**633**	15%	8
CT	255	252	260	264	334	376	377	431	628	**626**	13%	9
VT	371	321	381	405	385	443	458	501	522	**601**	9%	10
IA	217	231	240	243	275	335	344	413	544	**598**	17%	11
OK	185	184	196	173	236	282	331	510	594	**591**	20%	12
IL	215	219	236	220	280	323	353	455	576	**585**	16%	13
AL	153	163	178	144	261	299	369	490	554	**577**	17%	14
VA	216	244	223	205	264	276	327	370	545	**575**	17%	15
PA	215	224	241	221	285	340	379	552	569	**574**	15%	16
KS	184	198	216	136	247	270	320	411	518	**573**	18%	17
NY	442	314	407	397	423	454	503	495	536	**569**	6%	18
ME	289	300	299	265	369	391	388	473	642	**564**	9%	19
GA	199	190	182	192	163	214	285	402	545	**555**	28%	20
SC	204	203	214	169	281	267	371	443	529	**551**	14%	21
LA	219	221	234	218	300	352	404	474	553	**548**	13%	22
WA	213	238	251	254	318	339	347	382	454	**542**	11%	23
CO	173	198	207	202	279	286	352	396	517	**537**	14%	24
SD	207	219	224	238	288	250	349	425	494	**521**	13%	25
OR	205	219	215	203	280	270	354	408	382	**519**	13%	26
TN	193	198	203	166	234	269	336	450	598	**517**	17%	27
AZ	202	199	204	183	253	271	283	467	495	**512**	15%	28
HI	220	241	251	262	254	256	327	412	501	**511**	15%	29
KY	202	210	212	200	249	275	327	363	462	**507**	15%	30
DC	248	232	240	261	238	242	323	361	434	**506**	16%	31
MS	193	191	192	155	266	306	326	376	494	**506**	14%	32
OH	167	189	211	181	266	298	339	366	424	**477**	12%	33
FL	216	217	222	211	293	329	351	408	504	**475**	10%	34
ND	221	245	257	196	310	332	373	388	447	**471**	9%	35
NJ	361	347	406	386	413	410	453	467	489	**470**	3%	36
MD	183	185	193	194	203	230	277	340	524	**460**	18%	37
NM	185	207	198	168	264	426	310	358	485	**459**	12%	38
NV	197	200	193	183	246	301	326	338	441	**456**	13%	39
RI	182	355	355	338	347	313	344	347	415	**450**	5%	40
MI	193	204	200	187	260	297	338	351	432	**447**	11%	41
MO	180	180	188	170	242	283	334	392	519	**442**	13%	42
ID	142	167	176	174	216	265	303	374	429	**442**	15%	43
TX	183	202	206	130	222	302	314	359	499	**432**	14%	44
NH	244	265	276	244	298	333	346	431	527	**431**	8%	45
MN	201	221	226	229	278	275	357	495	450	**429**	9%	46
MA	347	353	448	403	480	384	355	360	404	**414**	-3%	47
UT	154	159	159	158	202	214	259	298	422	**400**	15%	48
AR	163	172	181	117	274	291	321	357	376	**368**	6%	49
CA	164	179	191	197	252	338	350	357	307	**367**	8%	50
IN	195	177	224	208	303	364	369	397	449	**330**	2%	51

Source: HGA calculations, based on data from the NAIC.

35. Individual Market Claims

Figure 19.



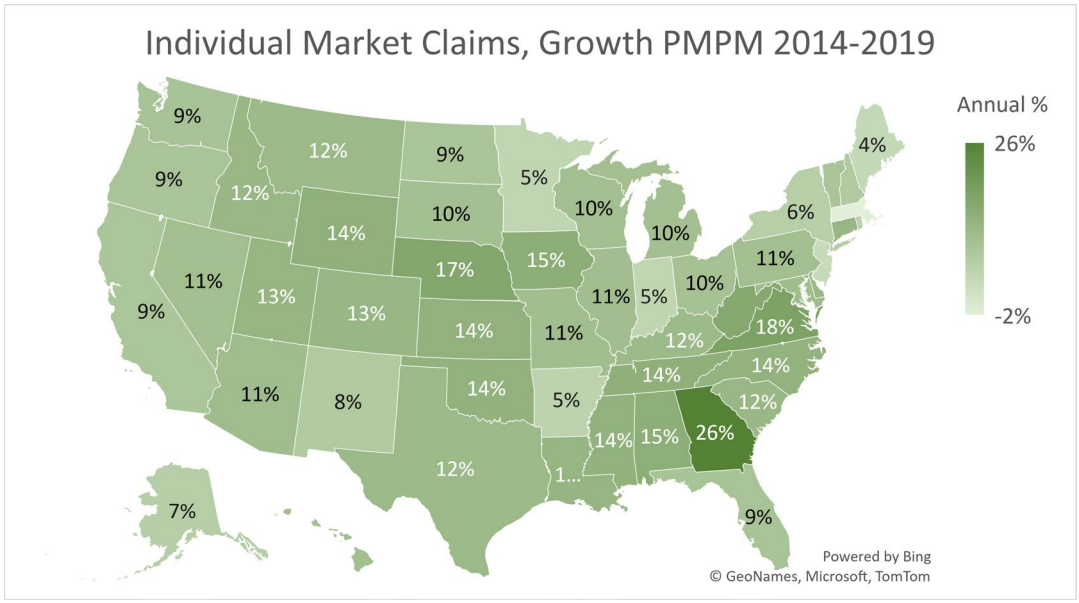


Table 44.

NAIC Supplemental Exhibit DRAFT

Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

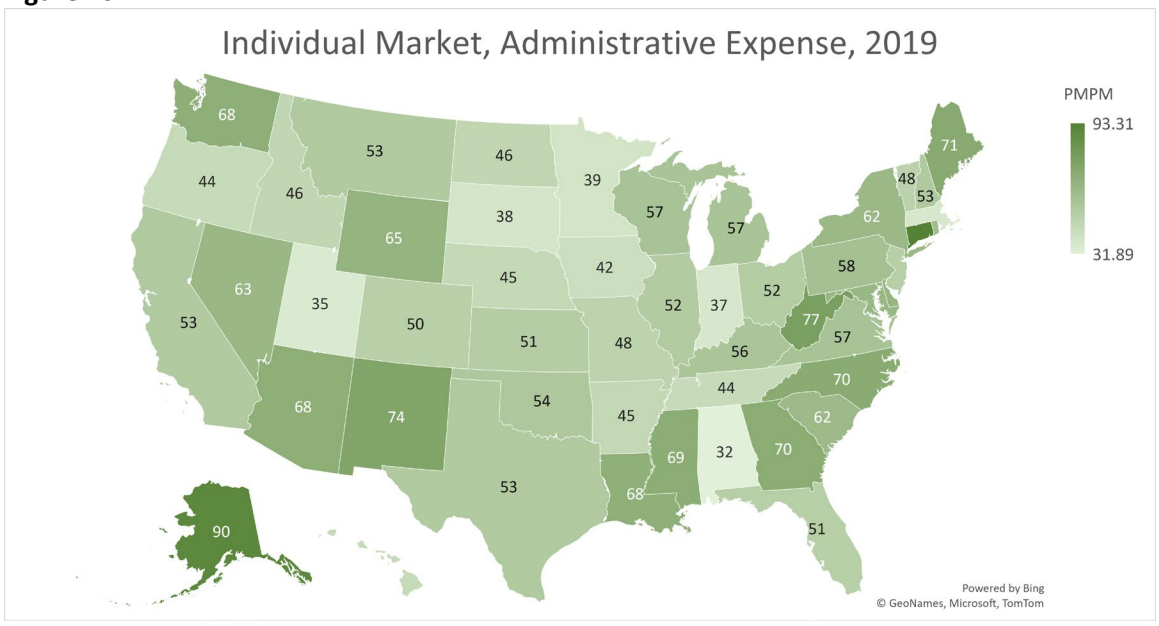
Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**163**	**178**	**188**	**167**	**250**	**295**	**326**	**352**	**398**	**415**	**11%**	
WV	163	198	236	178	323	451	475	509	622	**684**	16%	1
WY	207	198	202	211	334	426	549	525	618	**647**	14%	2
NE	178	188	201	197	251	329	336	414	516	**545**	17%	3
VT	332	292	377	372	353	371	429	453	508	**543**	9%	4
WI	162	181	195	189	328	377	387	432	514	**539**	10%	5
MT	149	168	195	192	309	364	382	430	405	**539**	12%	6
DE	175	187	238	180	302	408	452	530	522	**535**	12%	7
NY	409	282	401	382	388	414	501	480	491	**528**	6%	8
VA	159	203	186	171	230	251	308	350	423	**527**	18%	9
NC	186	187	192	126	277	333	341	402	482	**525**	14%	10
AK	225	249	239	231	378	512	613	604	554	**521**	7%	11
DC	201	315	239	254	253	240	339	416	494	**518**	15%	12
CT	192	209	224	224	281	345	425	400	333	**511**	13%	13
IL	161	176	193	187	296	300	342	364	406	**494**	11%	14
AL	139	150	165	141	249	318	362	400	457	**494**	15%	15
OK	134	143	154	150	259	269	323	379	431	**492**	14%	16
LA	173	176	192	176	267	329	360	379	429	**488**	13%	17
IA	190	201	214	208	242	288	328	353	443	**486**	15%	18
KS	147	164	183	115	253	274	328	379	449	**485**	14%	19
PA	186	203	226	202	285	354	369	445	438	**471**	11%	20
SD	178	185	224	218	279	317	333	373	438	**455**	10%	21
GA	154	157	151	142	140	215	270	349	427	**454**	26%	22
TN	145	166	162	140	226	271	327	361	404	**444**	14%	23
OR	179	200	195	192	285	286	356	388	405	**442**	9%	24
CO	137	166	177	171	242	304	344	365	428	**441**	13%	25
ND	217	225	242	181	277	294	362	369	402	**428**	9%	26
SC	138	158	172	130	239	239	353	383	408	**428**	12%	27
MS	140	151	160	123	224	264	293	306	386	**426**	14%	28
HI	207	217	241	252	258	308	426	378	420	**425**	10%	29
AZ	148	159	159	146	249	265	286	339	379	**421**	11%	30
WA	179	207	211	210	265	289	332	350	362	**417**	9%	31
NJ	341	295	358	363	345	350	407	415	418	**407**	3%	32
NM	155	208	173	178	278	352	299	313	370	**404**	8%	33
KY	155	161	170	153	233	246	298	313	386	**404**	12%	34
MA	369	365	462	409	436	348	373	351	371	**391**	-2%	35
OH	123	154	186	148	239	286	308	319	348	**386**	10%	36
ID	106	138	144	141	211	337	304	312	358	**379**	12%	37
TX	127	161	170	116	215	296	304	302	355	**378**	12%	38
FL	165	178	179	170	240	285	292	346	396	**375**	9%	39
ME	231	267	255	206	308	351	381	421	494	**372**	4%	40
MN	189	192	213	190	290	334	381	367	303	**365**	5%	41
RI	163	287	341	327	278	253	279	323	319	**364**	6%	42
MO	126	144	155	135	214	252	292	301	397	**359**	11%	43
NV	141	159	156	150	216	271	296	300	325	**357**	11%	44
MI	166	184	166	161	219	243	302	297	318	**357**	10%	45
UT	125	129	127	134	189	308	287	265	359	**348**	13%	46
NH	171	194	200	176	235	280	332	361	386	**340**	8%	47
MD	143	154	158	162	196	209	256	320	443	**333**	11%	48
IN	143	143	190	171	249	348	315	336	385	**313**	5%	49
AR	123	145	146	96	241	260	305	315	306	**313**	5%	50
CA	132	142	157	174	200	331	326	310	277	**303**	9%	51

Source: HGA calculations, based on data from the NAIC.

36. Individual Market Administrative Costs

Figure 20.



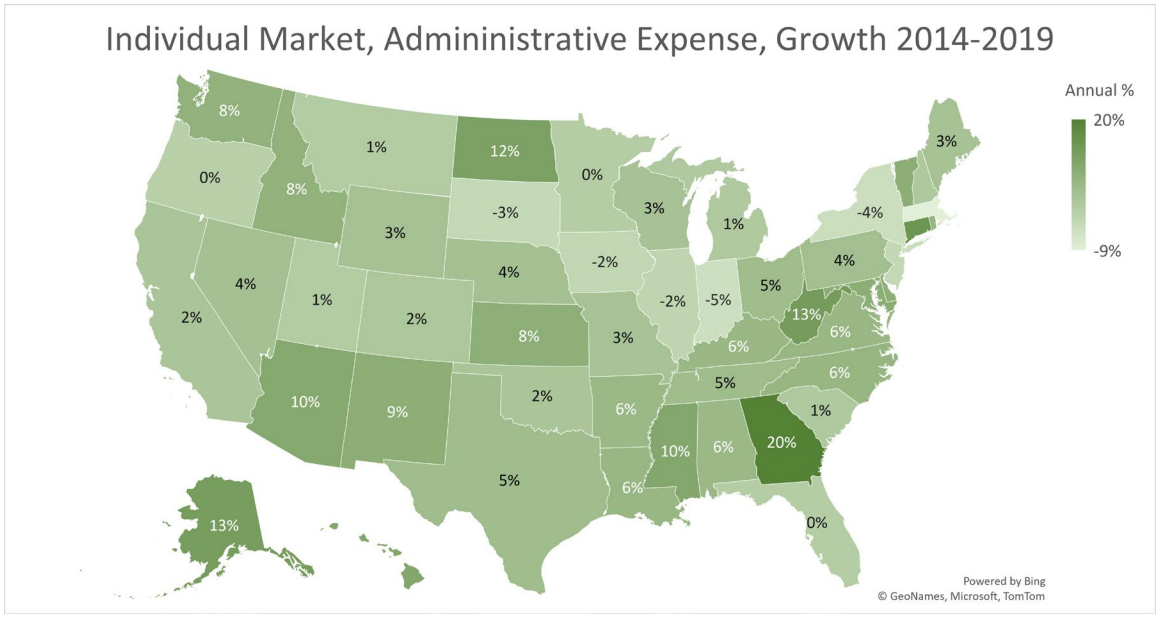


Table 45.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**40**	**37**	**38**	**36**	**46**	**46**	**47**	**50**	**53**	**54**	**3%**	
CT	41	36	35	38	46	53	55	41	59	**93**	15%	1
AK	47	48	49	56	49	39	47	67	70	**90**	13%	2
DC	54	64	49	58	52	46	66	59	77	**81**	9%	3
WV	44	42	37	31	41	43	49	59	64	**77**	13%	4
NM	37	32	36	36	49	71	46	60	59	**74**	9%	5
ME	42	40	41	41	60	15	18	55	62	**71**	3%	6
NC	37	32	34	29	51	49	59	58	67	**70**	6%	7
GA	40	35	34	35	27	32	36	44	59	**70**	20%	8
MS	37	38	37	29	42	48	45	57		**69**	10%	9
AZ	42	39	38	35	43	47	43	66	57	**68**	10%	10
WA	39	42	43	48	48	45	45	50	55	**68**	8%	11
LA	42	33	35	36	50	51	52	66	64	**68**	6%	12
WY	44	37	37	45	55	53	42	42	73	**65**	3%	13
DE	45	34	37	35	43	45	44	55	52	**64**	8%	14
MD	38	36	37	40	42	46	55	61	76	**63**	9%	15
NV	47	40	37	36	53	51	46	36	53	**63**	4%	16
NY	37	33	38	42	77	63	66	71	60	**62**	-4%	17
SC	53	42	43	41	58	44	43	46	55	**62**	1%	18
RI	27	53	56	47	44	47	62	53	53	**61**	7%	19
PA	36	33	35	39	48	50	47	58	58	**58**	4%	20
VA	35	24	34	35	42	44	43	49	50	**57**	6%	21
WI	46	43	46	47	48	55	55	58	52	**57**	3%	22
MI	38	38	40	41	53	55	56	50	54	**57**	1%	23
KY	39	37	37	39	42	39	38	38	51	**56**	6%	24
OK	42	34	36	37	48	42	53	58	55	**54**	2%	25
NH	46	44	46	44	50	74	57	53	60	**53**	1%	26
MT	44	40	37	43	52	51	56	54	52	**53**	1%	27
TX	46	38	40	29	42	45	48	52	55	**53**	5%	28
CA	40	39	39	36	47	54	53	52	58	**53**	2%	29
IL	48	41	42	48	58	48	51	55	56	**52**	-2%	30
OH	43	39	35	30	41	44	41	48	51	**52**	5%	31
KS	36	35	36	25	34	32	38	40	54	**51**	8%	32
FL	47	44	43	47	50	52	51	52	55	**51**	0%	33
NJ	50	53	45	40	57	63	62	61	53	**50**	-3%	34
CO	40	38	38	39	45	40	53	53	55	**50**	2%	35
VT	40	36	32	33	32	38	40	40	48	**48**	9%	36
MO	42	38	37	35	41	40	49	49	72	**48**	3%	37
ND	28	25	28	18	26	30	35	35	47	**46**	12%	38
ID	32	34	37	36	32	38	39	42	45	**46**	8%	39
AR	34	37	36	23	34	31	33	39	47	**45**	6%	40
NE	41	33	34	34	37	44	48	48	49	**45**	4%	41
OR	40	37	39	37	45	49	43	42	43	**44**	0%	42
HI	22	23	22	25	27	30	35	41	40	**44**	10%	43
TN	41	37	35	31	35	38	39	50	39	**44**	5%	44
IA	38	35	36	44	47	36	40	45	48	**42**	-2%	45
MN	31	30	32	38	38	43	47	44	42	**39**	0%	46
SD	36	34	35	35	44	39	37	40	38	**38**	-3%	47
IN	43	31	35	35	47	53	52	50	57	**37**	-5%	48
MA	44	55	44	40	59	44	39	38	37	**37**	-9%	49
UT	28	32	32	37	34	35	32	35	34	**35**	1%	50
AL	17	17	18	18	24	28	29	26	28	**32**	6%	51

Source: HGA calculations, based on data from the NAIC.

37. Small Group Market Premiums

Table 46.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

Small Group Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**318**	**321**	**329**	**341**	**347**	**365**	**384**	**418**	**447**	**473**	**6%**	
AK	370	502	533	538	544	547	622	642	219	**762**	7%	1
NY	363	350	365	396	400	431	465	512	552	**591**	8%	2
DE	356	364	342	369	386	426	483	468	522	**577**	8%	3
NJ	338	350	361	380	371	426	378	471	538	**574**	9%	4
CT	377	402	427	443	396	402	421	441	502	**567**	7%	5
WY	355	336	392	398	392	402	447	470	510	**553**	7%	6
WV	353	356	351	369	403	402	415	475	508	**551**	6%	7
MA	379	412	411	420	414	428	461	479	497	**516**	5%	8
IL	337	352	372	382	390	398	432	459	495	**515**	6%	9
RI	372	377	402	418	437	440	450	473	492	**515**	3%	10
FL	350	359	365	373	380	393	416	450	478	**507**	6%	11
TX	293	300	298	307	321	340	361	415	456	**506**	10%	12
MO	290	297	310	339	334	368	401	419	468	**504**	9%	13
IN	302	315	329	356	358	380	403	438	453	**504**	7%	14
NH	388	401	409	422	424	435	440	443	474	**498**	3%	15
PA	342	309	322	320	356	438	445	498	460	**495**	7%	16
WI	319	338	336	350	368	365	402	435	458	**495**	6%	17
OH	279	297	309	326	333	344	372	397	441	**494**	8%	18
VT	305	320	352	379	379	392	420	473	487	**494**	5%	19
CA	274	278	292	309	320	312	314	375	429	**490**	9%	20
DC	346	351	310	378	357	333	363	372	464	**489**	6%	21
KY	299	300	310	315	313	337	362	398	435	**488**	9%	22
NE	309	322	336	346	312	360	363	404	447	**485**	9%	23
NM	333	347	363	333	382	457	410	414	446	**478**	5%	24
LA	318	340	351	377	378	390	409	432	453	**476**	5%	25
KS	239	290	294	301	311	331	364	412	495	**474**	9%	26
VA	320	319	319	335	344	327	365	390	451	**464**	6%	27
SD	310	329	343	348	363	359	341	420	445	**462**	5%	28
HI	306	299	311	339	343	365	388	418	432	**461**	6%	29
ND	285	299	320	330	341	373	379	409	442	**459**	6%	30
ME	306	294	298	322	325	332	347	362	396	**458**	7%	31
MN	336	331	335	348	340	362	379	407	438	**444**	5%	32
CO	332	333	344	351	357	348	369	399	403	**436**	4%	33
MT	303	324	340	317	347	354	350	413	413	**431**	4%	34
WA	330	315	326	340	341	363	364	391	415	**430**	5%	35
OR	318	334	342	346	361	368	389	393	407	**430**	4%	36
OK	302	306	318	322	335	355	369	402	413	**420**	5%	37
IA	274	290	299	315	322	333	348	377	400	**419**	5%	38
SC	304	316	328	343	338	399	360	368	392	**418**	4%	39
MD	326	330	316	349	346	325	330	334	422	**415**	4%	40
AL	297	315	324	333	349	359	374	412	401	**408**	3%	41
AZ	250	250	251	247	258	272	286	299	365	**400**	9%	42
MI	336	321	330	345	329	365	380	394	399	**399**	4%	43
NV	298	269	290	280	295	312	324	344	384	**390**	6%	44
TN	283	283	298	311	302	316	352	373	381	**390**	5%	45
NC	319	334	341	346	343	375	367	376	375	**389**	3%	46
MS	283	297	297	276	319	321	343	360	362	**382**	4%	47
GA	261	268	270	265	281	279	270	298	339	**378**	6%	48
AR	278	287	280	291	292	324	346	392	363	**377**	5%	49
ID	241	258	271	276	275	297	324	347	344	**359**	5%	50
UT	237	244	253	264	260	264	275	312	333	**341**	6%	51

Source: HGA calculations, based on data from the NAIC.

38. Small Group Market Claims

Table 47.

NAIC Supplemental Exhibit DRAFT

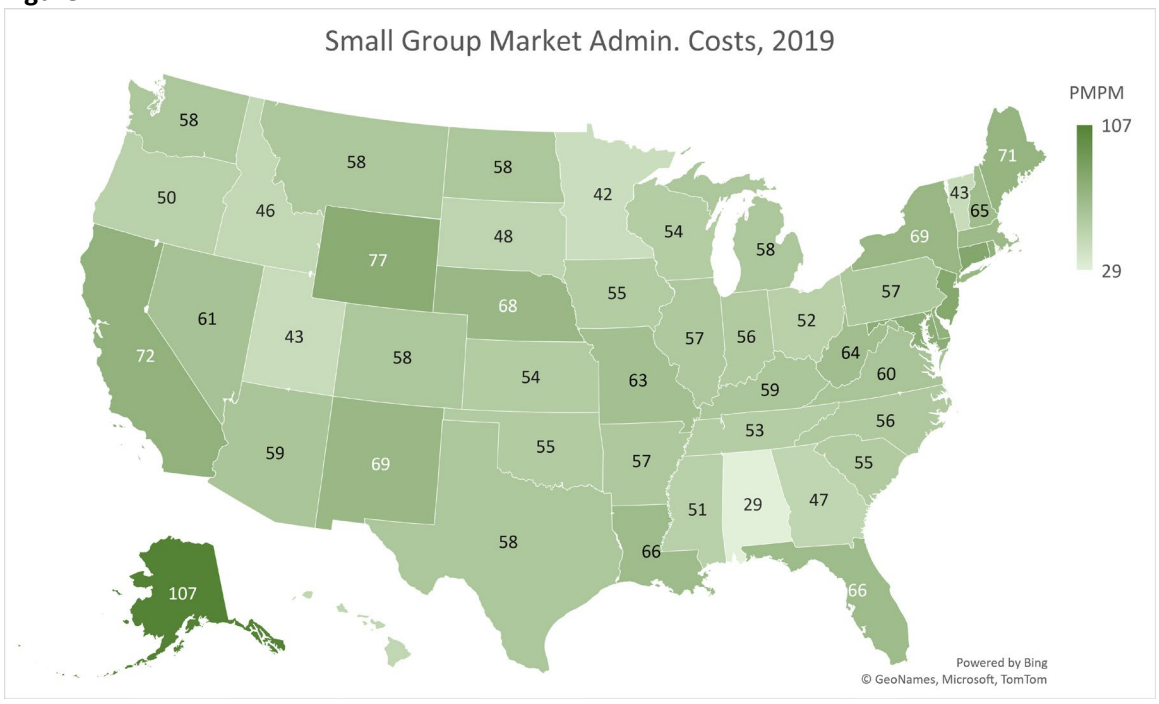
Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

Small Group Market	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**264**	**266**	**275**	**285**	**295**	**310**	**327**	**348**	**370**	**393**	**6%**	
NY	323	311	324	346	354	373	403	444	477	**511**	8%	1
CT	308	324	348	361	335	340	372	397	402	**483**	8%	2
WV	280	289	300	304	336	345	356	383	427	**475**	7%	3
NJ	285	289	299	314	313	354	323	384	422	**470**	8%	4
WY	285	259	287	329	327	342	386	390	399	**469**	7%	5
VT	272	276	313	348	344	379	409	425	439	**467**	6%	6
AK	308	397	434	434	459	492	552	505	439	**467**	0%	7
DE	280	300	278	291	324	333	387	391	431	**453**	7%	8
MA	335	348	360	367	380	394	396	420	424	**443**	3%	9
KS	197	244	257	253	280	308	326	351	427	**416**	8%	10
KY	235	245	255	260	268	284	306	340	348	**415**	9%	11
IN	236	250	264	283	293	314	339	360	370	**415**	7%	12
OH	231	246	255	267	279	288	312	327	360	**414**	8%	13
IL	268	285	308	313	326	343	366	378	398	**414**	5%	14
RI	350	277	345	356	363	351	389	400	402	**413**	3%	15
MO	223	234	248	272	276	303	335	340	378	**412**	8%	16
NH	355	337	345	359	350	361	387	391	410	**411**	3%	17
WI	263	290	291	299	324	316	337	354	371	**411**	5%	18
PA	287	259	280	282	318	372	371	431	380	**410**	5%	19
FL	275	289	291	298	311	313	331	357	386	**408**	6%	20
TX	235	240	246	255	272	300	317	337	374	**407**	8%	21
NM	268	290	307	291	323	386	365	378	369	**404**	5%	22
HI	264	259	275	301	299	316	339	366	387	**402**	6%	23
LA	260	283	286	306	317	338	351	354	370	**400**	5%	24
NE	236	263	277	284	261	307	318	341	383	**397**	9%	25
DC	271	278	256	316	286	272	298	296	388	**396**	7%	26
ND	258	247	277	306	303	322	336	346	394	**393**	5%	27
CA	227	231	245	253	264	252	272	311	338	**388**	8%	28
ME	262	253	249	271	279	282	304	318	347	**382**	6%	29
MN	286	281	295	311	303	317	344	369	391	**379**	5%	30
VA	246	256	259	275	283	269	300	320	358	**378**	6%	31
OR	270	287	285	294	300	305	344	344	351	**377**	5%	32
AL	264	270	292	299	313	336	338	342	352	**372**	3%	33
SD	275	287	293	293	323	303	313	354	374	**368**	3%	34
WA	281	266	278	287	299	308	317	319	339	**363**	4%	35
MT	243	256	284	270	303	331	320	349	337	**359**	3%	36
CO	276	278	285	293	295	285	295	323	345	**355**	4%	37
OK	234	241	254	261	284	319	322	317	333	**348**	4%	38
SC	246	254	263	269	271	325	305	303	316	**344**	5%	39
MD	255	265	259	282	269	251	267	270	339	**339**	5%	40
MS	251	260	271	242	270	277	303	299	314	**332**	4%	41
MI	283	268	272	276	255	291	310	314	326	**332**	5%	42
GA	209	217	217	222	233	233	225	244	281	**332**	7%	43
IA	225	232	243	258	270	285	301	308	330	**330**	4%	44
NC	263	275	280	287	294	310	305	302	307	**319**	2%	45
TN	225	225	236	245	240	258	289	283	295	**317**	6%	46
AZ	191	198	203	199	215	222	242	240	285	**314**	8%	47
NV	230	208	226	223	253	263	271	282	307	**313**	4%	48
ID	196	214	226	230	244	243	282	284	291	**303**	4%	49
AR	215	225	228	240	247	273	286	322	300	**302**	4%	50
UT	187	200	200	216	224	254	235	256	273	**289**	5%	51

Source: HGA calculations, based on data from the NAIC.

39. Small Group Market Administrative Costs

Figure 21.



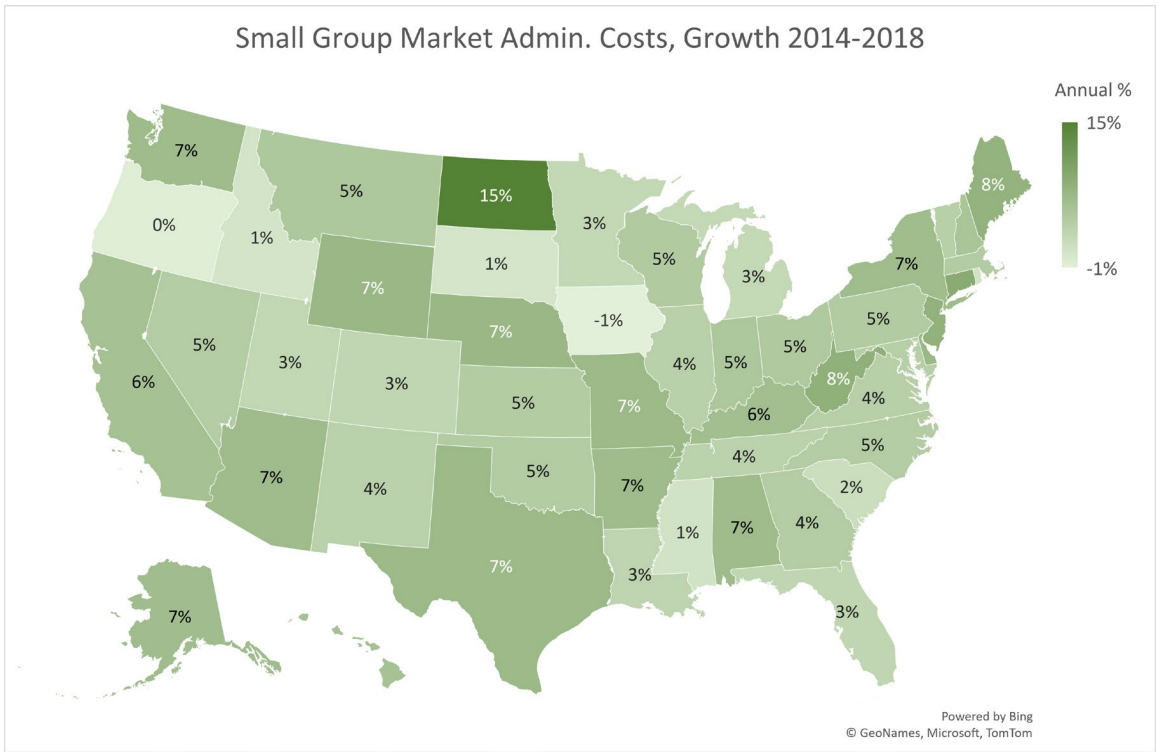


Table 48.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Small Group Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**44**	**44**	**44**	**45**	**46**	**49**	**50**	**55**	**58**	**59**	**5%**	
AK	53	67	73	78	77	76	73	95	29	**107**	7%	1
CT	44	54	52	54	52	63	97	68	76	**80**	9%	2
NJ	52	60	55	55	53	71	62	77	74	**79**	8%	3
WY	58	54	61	61	54	51	45	46	74	**77**	7%	4
DC	49	52	48	60	65	60	69	62	76	**76**	3%	5
MD	51	58	54	60	62	60	68	64	78	**75**	4%	6
DE	49	42	45	54	51	54	58	61	60	**73**	7%	7
RI	47	50	53	58	68	64	70	69	70	**73**	1%	8
CA	43	48	53	53	54	54	41	67	72	**72**	6%	9
ME	34	35	40	45	48	45	37	54	63	**71**	8%	10
NY	37	46	44	47	50	52	52	61	65	**69**	7%	11
NM	50	52	57	51	57	68	60	59	70	**69**	4%	12
NE	53	42	44	45	48	51	51	55	70	**68**	7%	13
MA	40	53	49	52	53	54	53	55	64	**67**	5%	14
FL	51	54	54	50	56	57	59	62	62	**66**	3%	15
LA	52	45	48	54	56	59	70	62	63	**66**	3%	16
NH	43	46	45	47	50	50	48	55	61	**65**	6%	17
WV	47	44	37	39	43	38	39	56	51	**64**	8%	18
MO	42	41	39	43	44	48	51	53	60	**63**	7%	19
NV	62	47	48	49	49	51	48	54	58	**61**	5%	20
VA	40	40	41	44	49	48	50	55	64	**60**	4%	21
AZ	43	43	42	43	42	44	42	53	64	**59**	7%	22
KY	47	42	41	40	43	42	46	50	56	**59**	6%	23
ND	21	22	25	28	29	30	35	40	61	**58**	15%	24
MI	49	45	48	54	51	58	56	56	57	**58**	3%	25
CO	46	43	43	46	49	51	55	55	59	**58**	3%	26
WA	48	40	40	40	41	47	49	55	54	**58**	7%	27
TX	46	42	41	45	41	42	46	52	56	**58**	7%	28
MT	52	52	46	43	45	47	51	51	55	**58**	5%	29
PA	41	38	41	41	45	62	55	61	60	**57**	5%	30
AR	49	46	39	39	41	44	48	57	55	**57**	7%	31
IL	52	48	45	47	47	45	47	53	57	**57**	4%	32
NC	48	43	42	44	45	48	51	57	54	**56**	5%	33
IN	44	39	39	43	43	48	45	50	52	**56**	5%	34
OK	47	45	45	48	44	44	44	53	52	**55**	5%	35
SC	48	45	44	49	50	55	50	48	54	**55**	2%	36
IA	43	41	42	50	56	50	51	50	51	**55**	-1%	37
KS	34	38	40	45	43	46	48	48	58	**54**	5%	38
WI	43	39	39	40	43	44	46	51	51	**54**	5%	39
TN	46	44	47	45	44	46	51	73	70	**53**	4%	40
OH	43	40	38	40	40	41	45	52	49	**52**	5%	41
MS	36	42	43	41	48	49	47	50	47	**51**	1%	42
OR	43	40	41	42	51	55	51	47	49	**50**	0%	43
SD	34	36	36	36	46	41	39	47	47	**48**	1%	44
GA	43	41	39	37	38	38	35	42	47	**47**	4%	45
HI	36	32	31	36	35	37	40	45	42	**47**	6%	46
ID	38	39	41	41	43	39	38	40	41	**46**	1%	47
VT	47	43	43	45	35	33	34	36	43	**43**	4%	48
UT	40	39	39	39	37	41	41	41	42	**43**	3%	49
MN	34	35	37	40	36	40	44	43	43	**42**	3%	50
AL	17	17	17	19	21	23	22	29	28	**29**	7%	51

Source: HGA calculations, based on data from the NAIC.

40. Large Group Premiums

Table 49.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**317**	**320**	**326**	**333**	**358**	**368**	**381**	**388**	**406**	**426**	**4%**	
AK	541	470	508	509	563	582	599	638	711	**739**	6%	1
NH	416	438	438	443	464	476	502	538	555	**594**	5%	2
VT	360	370	380	398	395	425	445	488	483	**546**	7%	3
MA	403	423	430	430	437	450	473	502	516	**545**	5%	4
NJ	364	381	392	414	459	462	433	482	504	**532**	3%	5
ME	392	406	413	427	427	437	455	483	498	**528**	4%	6
WY	351	386	422	436	388	401	424	421	492	**527**	6%	7
DE	327	351	375	350	371	342	408	396	436	**524**	7%	8
WV	370	377	400	418	399	417	417	453	487	**516**	5%	9
CT	392	400	410	409	405	417	463	-89	460	**512**	5%	10
MT	314	329	333	362	375	397	413	441	478	**490**	5%	11
MD	312	373	378	385	385	402	428	447	457	**490**	5%	12
NY	260	269	275	274	387	432	442	460	470	**487**	5%	13
NM	321	347	356	372	374	399	446	413	444	**483**	5%	14
OR	346	367	380	394	395	404	426	442	454	**480**	4%	15
RI	371	377	385	388	409	408	413	439	440	**461**	2%	16
NC	337	344	361	363	387	392	391	387	422	**459**	3%	17
ND	312	322	334	346	352	370	387	412	430	**455**	5%	18
WI	373	397	397	407	410	413	415	416	436	**454**	2%	19
SD	325	343	354	363	368	395	382	418	434	**452**	4%	20
LA	341	363	349	363	372	393	405	419	428	**448**	4%	21
NE	335	374	377	379	401	372	392	395	430	**447**	2%	22
CO	334	370	377	388	394	407	417	430	416	**446**	2%	23
IN	357	389	362	355	437	396	404	419	417	**444**	0%	24
PA	316	335	334	336	331	359	373	368	422	**444**	6%	25
IL	333	336	331	364	363	351	385	409	426	**439**	4%	26
OK	333	332	339	343	360	370	374	391	408	**435**	4%	27
MI	310	314	316	320	309	330	344	365	376	**429**	7%	28
WA	332	343	355	369	373	384	392	404	410	**427**	3%	29
SC	289	270	271	329	340	337	362	383	399	**425**	5%	30
FL	352	358	367	372	383	392	380	391	404	**423**	2%	31
DC	315	251	283	326	329	342	365	377	400	**423**	5%	32
VA	339	358	355	314	377	297	414	424	409	**422**	2%	33
GA	311	324	343	351	378	391	398	386	392	**422**	2%	34
IA	314	328	339	346	352	353	380	388	404	**418**	4%	35
ID	290	290	302	311	316	337	347	363	393	**417**	6%	36
TN	274	334	331	335	355	368	365	373	390	**414**	3%	37
OH	312	337	345	354	365	388	398	401	393	**414**	3%	38
AL	308	314	323	328	339	351	374	385	389	**411**	4%	39
KY	315	333	336	341	350	368	380	399	386	**407**	3%	40
UT	272	297	304	317	333	343	354	365	374	**398**	4%	41
AZ	323	261	286	285	287	296	297	299	378	**391**	6%	42
MO	384	345	349	344	349	366	334	352	356	**382**	2%	43
MN	251	290	306	316	318	334	344	346	331	**377**	4%	44
MS	307	305	311	331	328	344	348	357	362	**374**	3%	45
HI	243	273	280	284	297	304	322	341	359	**374**	5%	46
TX	295	291	299	310	319	336	342	342	359	**367**	3%	47
NV	271	230	279	288	293	305	320	335	332	**352**	4%	48
AR	271	278	290	311	310	318	327	368	327	**351**	2%	49
KS	273	308	329	328	328	331	267	284	290	**313**	-1%	50
CA	291	249	204	220	240	256	235	295	256	**301**	5%	51

Source: HGA calculations, based on data from the NAIC.

41. Large Group Claims

Table 50.

NAIC Supplemental Exhibit DRAFT

Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**280**	**283**	**290**	**295**	**321**	**331**	**342**	**346**	**361**	**380**	**3%**	
AK	485	435	475	474	533	563	575	594	669	**662**	4%	1
NH	379	393	393	394	412	419	457	465	483	**512**	4%	2
VT	312	327	343	362	361	395	407	459	456	**492**	6%	3
MA	364	369	383	384	396	411	431	446	454	**482**	4%	4
WV	336	332	361	392	364	395	391	408	451	**471**	5%	5
NJ	313	324	334	356	410	412	388	423	448	**468**	3%	6
ME	354	366	373	386	394	404	417	439	444	**475**	4%	7
MT	288	305	307	330	334	368	376	394	441	**443**	6%	8
WY	330	352	385	400	356	373	404	392	429	**485**	6%	9
NY	228	240	245	242	345	380	393	401	412	**427**	4%	10
NM	290	316	323	339	344	356	419	383	409	**442**	5%	11
MD	273	332	341	342	344	356	378	398	405	**442**	5%	12
OR	313	328	340	349	344	354	375	390	405	**425**	4%	13
WI	338	364	365	375	373	378	382	379	401	**417**	2%	14
CO	296	329	338	345	350	362	381	396	398	**400**	3%	15
ND	291	299	310	326	326	373	357	376	398	**417**	5%	16
SD	298	310	323	336	337	343	364	379	397	**413**	4%	17
CT	340	342	362	354	370	381	413	218	397	**461**	5%	18
NE	297	340	338	337	359	336	357	347	392	**393**	2%	19
DE	290	311	333	304	334	310	356	342	389	**462**	7%	20
RI	318	310	345	341	357	358	375	389	387	**407**	3%	21
NC	292	301	322	325	347	355	354	339	380	**414**	4%	22
IL	300	298	294	323	332	325	347	361	379	**392**	3%	23
PA	276	294	295	300	297	326	335	321	372	**402**	6%	24
LA	305	323	316	319	330	354	357	360	370	**398**	4%	25
IA	279	290	298	298	316	332	340	348	370	**368**	3%	26
IN	314	352	327	320	396	361	364	377	369	**389**	0%	27
VA	300	318	320	281	341	266	374	380	368	**380**	2%	28
FL	304	312	322	327	344	350	336	342	366	**375**	2%	29
AL	280	286	300	301	319	336	351	350	365	**388**	4%	30
GA	280	288	313	324	352	355	359	350	359	**392**	2%	31
WA	289	301	315	323	333	342	347	352	358	**376**	3%	32
OK	298	292	300	303	323	335	337	350	357	**388**	4%	33
SC	262	240	244	297	302	302	321	339	354	**370**	4%	34
ID	264	260	275	280	286	312	316	319	353	**371**	5%	35
OH	274	299	317	320	333	350	359	356	351	**364**	2%	36
DC	268	220	248	281	288	295	314	333	347	**367**	5%	37
TN	239	291	289	293	318	329	327	325	339	**358**	2%	38
KY	272	294	293	295	307	332	342	349	338	**355**	3%	39
UT	243	270	274	283	302	310	319	325	333	**356**	3%	40
MS	277	278	285	309	295	308	318	318	331	**349**	3%	41
AZ	281	226	244	246	255	264	265	262	329	**331**	5%	42
MI	279	277	277	281	270	294	305	313	327	**373**	7%	43
MO	335	298	307	300	308	329	293	315	319	**336**	2%	44
HI	231	252	258	264	272	282	291	315	318	**337**	4%	45
TX	262	257	266	278	287	306	314	304	312	**337**	3%	46
AR	238	245	258	274	279	290	297	327	292	**313**	2%	47
MN	222	254	280	284	287	297	310	313	287	**334**	3%	48
NV	229	198	235	250	263	270	287	285	285	**303**	3%	49
KS	244	274	296	290	296	302	235	250	259	**275**	-1%	50
CA	249	213	173	187	208	225	205	259	228	**269**	5%	51

Source: HGA calculations, based on data from the NAIC.

42. Large Group Administrative Costs

Table 51.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**31**	**29**	**30**	**31**	**33**	**34**	**35**	**35**	**38**	**41**	**4%**	
WY	27	29	29	32	29	25	22	25	55	**51**	12%	1
LA	35	31	29	36	38	39	40	50	51	**51**	6%	2
NJ	46	38	42	41	40	39	40	46	48	**56**	7%	3
SC	33	24	25	34	34	34	34	42	47	**48**	7%	4
AZ	40	31	32	32	28	29	32	33	47	**46**	11%	5
NY	26	24	23	25	39	42	40	45	46	**50**	5%	6
NH	37	37	37	39	38	39	41	43	46	**51**	6%	7
MA	36	39	39	39	41	40	41	41	46	**52**	5%	8
RI	48	43	41	44	55	46	42	45	45	**47**	-3%	9
VT	42	39	35	34	35	39	39	42	45	**47**	6%	10
KY	34	30	31	33	34	37	38	41	44	**45**	6%	11
NC	36	34	33	33	34	36	37	43	43	**47**	7%	12
NE	34	34	35	35	38	35	34	36	43	**54**	8%	13
MT	31	29	28	38	30	32	34	40	42	**44**	8%	14
AK	45	34	29	28	30	28	35	43	42	**55**	13%	15
MD	26	34	34	37	39	40	44	41	42	**43**	2%	16
MI	29	31	33	38	37	41	40	40	41	**49**	6%	17
DE	36	36	33	38	33	29	31	29	41	**41**	4%	18
PA	32	31	31	32	34	33	32	34	41	**40**	3%	19
NM	33	37	38	42	36	34	41	37	39	**47**	5%	20
OR	29	29	32	34	33	34	36	35	38	**40**	4%	21
MO	41	35	33	33	34	33	35	35	38	**40**	4%	22
WA	31	33	35	36	35	36	34	40	38	**44**	5%	23
CT	37	36	40	41	38	99	112	-152	38	**56**	8%	24
WI	31	32	33	35	37	37	37	38	37	**41**	2%	25
ID	28	29	29	29	28	31	33	34	37	**41**	8%	26
AR	27	32	30	31	32	33	34	41	37	**39**	4%	27
OK	34	31	31	31	33	32	33	36	37	**40**	4%	28
OH	36	29	29	30	29	33	34	39	37	**38**	5%	29
IN	29	26	26	25	31	32	34	33	36	**40**	5%	30
NV	51	27	31	30	29	31	32	34	36	**40**	7%	31
TN	31	37	38	34	36	36	36	35	36	**47**	5%	32
WV	33	31	31	33	35	30	27	29	36	**36**	1%	33
ME	29	28	31	32	30	31	31	35	36	**39**	6%	34
MS	27	29	30	33	36	40	38	39	36	**39**	1%	35
FL	37	36	37	32	37	33	33	35	36	**39**	1%	36
GA	32	31	31	32	30	31	35	34	35	**37**	5%	37
VA	27	27	27	25	31	23	34	34	35	**37**	3%	38
DC	42	24	27	32	28	29	32	45	35	**38**	6%	39
CO	30	33	31	33	36	35	35	36	35	**35**	-1%	40
ND	15	18	21	24	22	26	26	27	34	**37**	11%	41
IL	28	25	25	28	26	25	29	30	34	**35**	6%	42
SD	23	26	25	25	34	25	29	32	34	**37**	2%	43
MN	23	24	26	29	26	31	33	31	33	**33**	5%	44
IA	31	31	32	28	33	31	36	33	33	**35**	1%	45
TX	29	29	28	27	27	27	29	33	33	**34**	4%	46
KS	25	31	35	33	32	31	27	30	30	**33**	0%	47
UT	27	26	25	26	26	27	29	31	30	**32**	5%	48
HI	21	19	21	22	22	24	26	30	29	**34**	9%	49
CA	35	30	24	26	25	26	23	33	27	**34**	6%	50
AL	16	16	17	18	18	20	20	22	24	**26**	7%	51

Source: HGA calculations, based on data from the NAIC.

V. Current Market Status, Covid-19 Update, Baseline Projections to 2024

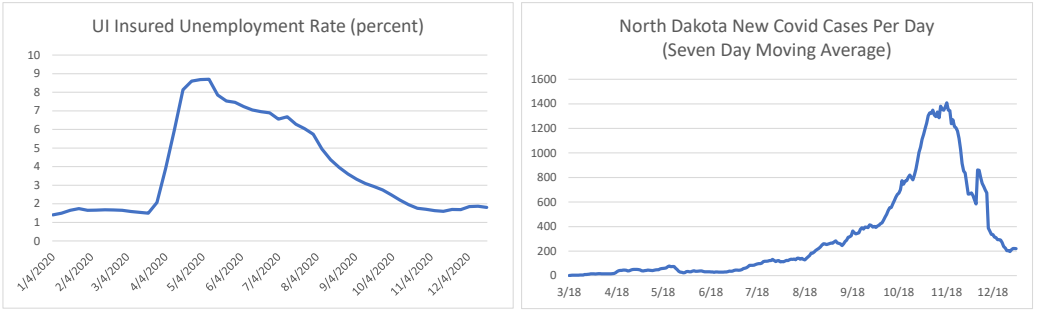
To estimate the impact of alternative policies, we begin by creating a benchmark or "baseline" estimate of the status quo. These baseline projections are not necessarily intended to be forecasts of the future. In light of the Covid-19 pandemic, any projections at this time are particularly uncertain. Nevertheless, working out a coherent set of projections is a key first step toward evaluating the impact of policy changes.

For North Dakota's hospital and insurance claims baselines we started by looking at the impact of the Covid-19 pandemic and the national recession on the state's overall economy and the state budget. In general, we project that rates of growth in both North Dakota's economy and its health sector will be quite subdued for an extended period.

Covid-19 and Impact on Unemployment. As of late July, North Dakota's total active caseload was about 1,000 cases and the number of new cases diagnosed over the prior week was about 120 per day. Statewide, only 42 patients were hospitalized. However, the number of cases rose steadily in July and the test positivity rate increased to nearly 7 percent.[23] The July 26 federal report to the states showed North Dakota in the "Red Zone" (highest risk) for outbreak.[24]

Between March 14th and July 11th, more than 80,000 North Dakota residents filed initial unemployment insurance (UI) claims.[25] For perspective, during the full year 2019 only 25,000 initial claims were filed. The state's insured unemployment rate (the ratio of people receiving unemployment benefits to those covered by the unemployment compensation system) rose to nearly 9 percent in April before returning to less than 2 percent in November (see Figure 22). However, the return to full employment corresponded with a large increase in the number of Covid cases.

Figure 22.



Sources: U.S. Dept. of Labor. https://oui.doleta.gov/unemploy/wkclaims/report.asp and NYTimes Covid Database https://raw.githubusercontent.com/nytimes/covid-19-data/master/us-states.csv (accessed Jan 3, 2021).

[23] https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases (accessed July 25, 2020) and https://coronavirus.jhu.edu/testing/individual-states/north-dakota (accessed July 25, 2020).
[24] https://www.nytimes.com/interactive/2020/07/28/us/states-report-virus-response-july-26.html
[25] US Dept of Labor, https://oui.doleta.gov/unemploy/claims.asp (accessed July 27, 2020).

State Budget Impact of the Covid-19 Recession and Oil Price Changes. Table 52 shows our rough approximated model of the state's main expenditure and revenue categories. We used data from the National Association of State Budget Officers (NASBO)[26], supplemented with some data from the state's biennial reports.[27] Although this budgetary model is highly simplified, one relationship sort of jumps off the page: the correlation between the annual percent change in state oil and gas revenues and that of total state expenditures (see Figure 23).

Table 52.

Approximated North Dakota Main Sources and Uses of State Funds (for modeling only) DRAFT

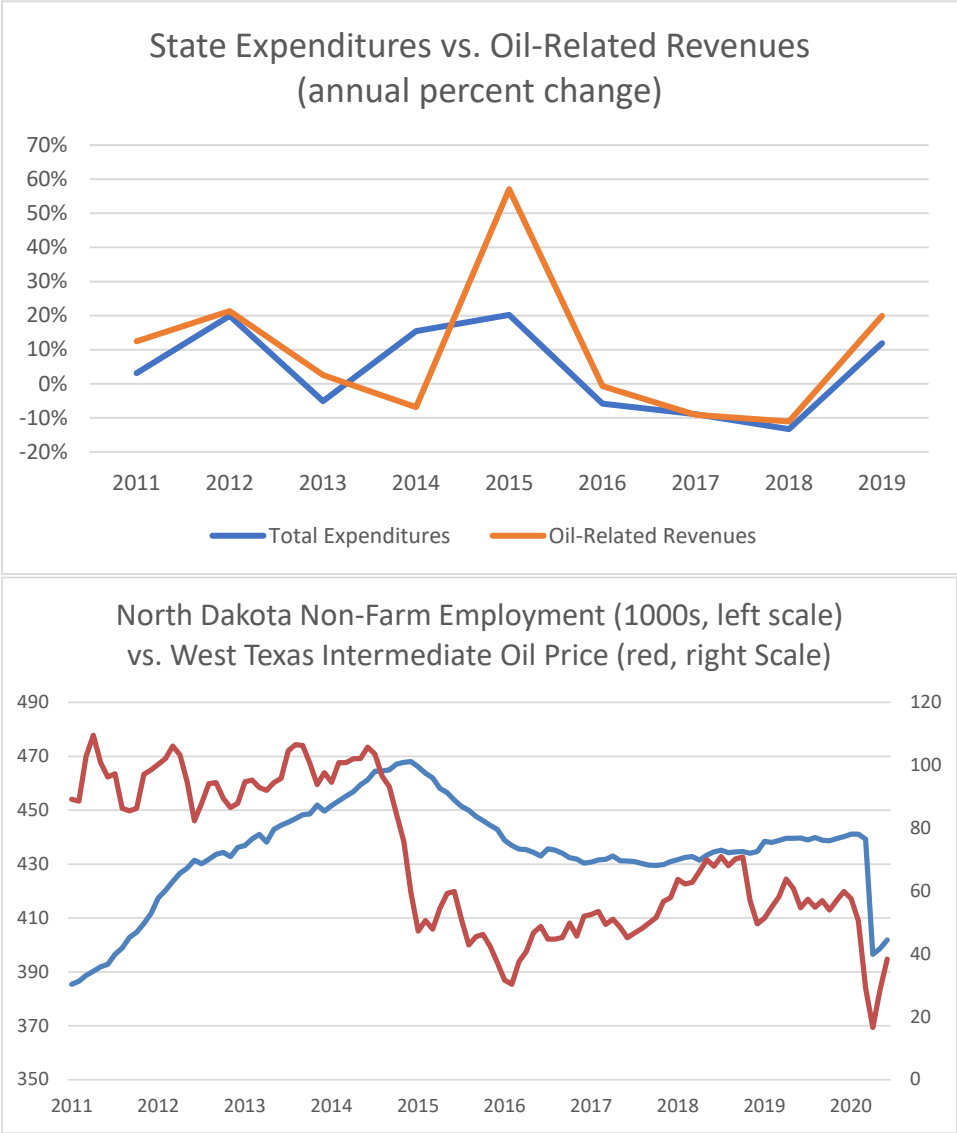
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Main State Expenditures					**Million of Dollars**					
Education	1,831	1,825	1,898	1,943	2,180	2,256	2,430	2,395	2,330	2,793
Medicaid	662	716	730	782	849	1,110	1,146	1,112	1,220	1,199
Transportation	546	620	987	918	1,252	1,668	1,826	969	679	645
Capital Expenditures	579	580	928	749	957	1,062	1,015	860	534	673
Other Expenditures	1,248	1,277	1,477	1,320	1,354	1,827	1,042	1,456	1,126	1,281
Total	4,866	5,018	6,020	5,712	6,592	7,923	7,459	6,792	5,889	6,591
Main Sources of State Revenues										
Oil Related Revenues	1,394	1,568	1,902	1,950	1,816	2,853	2,832	2,574	2,289	2,746
General Tax Revenues										
Sales Taxes	610	782	1,154	1,296	1,350	1,405	1,031	908	944	1,079
Income Taxes	302	428	430	616	514	536	354	313	364	414
Corporate Income Tax	88	147	199	187	239	196	98	69	92	148
Other Revenues	1,441	1,561	2,321	2,449	2,688	2,679	2,444	2,337	2,258	2,411
Total, General Fund	1,529	1,708	2,520	2,636	2,927	2,875	2,542	2,406	2,350	2,559
Federal Medicaid Spending	467	493	419	421	455	672	730	689	754	726
Federal Transport Spending	328	360	533	353	306	295	246	303	255	318
Federal Education Spending	388	308	294	259	245	142	257	257	258	355
Other Federal Funding	674	653	638	503	517	604	374	367	205	240
Total	4,780	5,090	6,306	6,122	6,266	7,441	6,981	6,596	6,111	6,944
Surplus (+) or Deficit (-)	-86	72	286	410	-326	-482	-478	-196	222	353
Main State Expenditures					**Annual Percent Change**					
Education		0%	4%	2%	12%	3%	8%	-1%	-3%	20%
Medicaid		8%	2%	7%	9%	31%	3%	-3%	10%	-2%
Transportation		14%	59%	-7%	36%	33%	9%	-47%	-30%	-5%
Capital Expenditures		0%	60%	-19%	28%	11%	-4%	-15%	-38%	26%
Other Expenditures		2%	16%	-11%	3%	35%	-43%	40%	-23%	14%
Total		3%	20%	-5%	15%	20%	-6%	-9%	-13%	12%
Main Sources of State Revenues										
Oil Related Revenues		12%	21%	3%	-7%	57%	-1%	-9%	-11%	20%
General Tax Revenues										
Sales Taxes		28%	48%	12%	4%	4%	-27%	-12%	4%	14%
Income Taxes		42%	0%	43%	-17%	4%	-34%	-12%	16%	14%
Corporate Income Tax		67%	35%	-6%	28%	-18%	-50%	-30%	33%	61%
Other Revenues		8%	49%	6%	10%	0%	-9%	-4%	-3%	7%
Total, General Tax Revenues		12%	48%	5%	11%	-2%	-12%	-5%	-2%	9%
Federal Medicaid Spending		6%	-15%	0%	8%	48%	9%	-6%	9%	-4%
Federal Transport Spending		10%	48%	-34%	-13%	-4%	-17%	23%	-16%	25%
Federal Education Spending		-21%	-5%	-12%	-5%	-42%	81%	0%	0%	38%
Other Federal Funding		-3%	-2%	-21%	3%	17%	-38%	-2%	-44%	17%
Total		6%	24%	-3%	2%	19%	-6%	-6%	-7%	14%

Source: HGA based on data from NASBO -- DRAFT for modeling only

[26] https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives

[27] https://www.legis.nd.gov/files/fiscal/2019-21/docs/2019-21_state_budget_actions.pdf

Figure 23.



Source: HGA based on data from NASBO, St. Louis Fed, BLS.

Hospital Financial Status Pre- and Post- Covid-19. Nationally, estimates of the potential costs of Covid-19 care over the course of the pandemic are as high as $160 billion.[28] However, when other analyses accounted for the possibility of reduced or deferred elective or unrelated care, they estimated a net health expenditure *savings* of $75 to $575 billion in 2020 alone.[29]

Of course, this huge range of costs and savings illustrate the uncertainty. Much will depend on whether a cure or vaccine is found, and whether the cost would be borne by government or private payers.

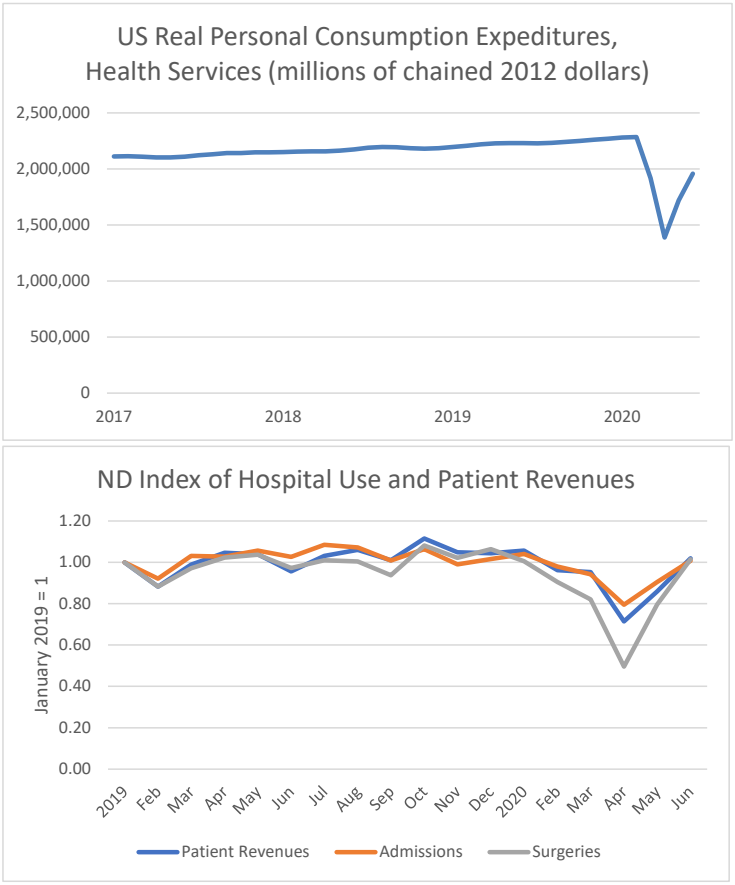
[28] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00426
[29] https://us.milliman.com/en/insight/estimating-the-impact-of-covid19-on-healthcare-costs-in-2020

In the first quarter of 2020, the nationwide reductions in health spending from reduced or deferred care were much larger than the cost of Covid-19 care. Based on initial GDP estimates, U.S. personal consumption expenditures for health care fell by about 15 percent between February 2020 and June 2020 (see Figure 24).[30]

The pandemic and recession have also hurt total payrolls, including the health sector. Nationwide, hospitals and outpatient centers shed 2 percent of payrolls between June 2019 and June 2020, with larger percentage losses for other types of health services. Among all industries, jobs were down 9 percent during that period (see Table 53).

However, in North Dakota, hospital admissions and patient revenues had mostly bounced back to prior levels by June 2020. And during the state's surge in Covid cases in September through November 2020, HGA estimates that claims costs in the state were likely running about 5-10 percent higher than in those same months in 2019.

Figure 24.



Sources: US: Bureau of Economic Analysis; ND Horizon Government Affairs.
Note: ND index of patient revenues does not include federal emergency funding or other sources of non-patient revenues.

[30] https://apps.bea.gov/iTable/iTable.cfm?reqid=19&step=3&isuri=1&1910=x&0=-99&1921=underlying&1903=2015&1904=2016&1905=2018&1906=m&1911=0 (accessed July 30, 2020).

Table 53.

U.S. Totals, Change in Jobs, June 2019 to June 2020

Millions of payroll jobs

	June 2019	June 2020	Job Loss	Percent
Total Nonfarm Payrolls (all industries)	**150,759**	**137,802**	**-12,957**	**-9%**
Health Care	16,250	15,603	-647	-4%
Ambulatory Health Care Services	7,681	7,295	-386	-5%
Offices of Physicians	2,670	2,570	-100	-4%
Offices of Dentists	967	875	-92	-10%
Offices of Other Health Practitioners	966	866	-100	-10%
Outpatient Care Centers	961	937	-24	-2%
Medical and Diagnostic Laboratories	282	266	-16	-6%
Home Health Care Services	1,523	1,483	-40	-3%
Other Ambulatory Health Care Services	312	299	-13	-4%
Hospitals	5,192	5,112	-80	-2%
Nursing and Residential Care Facilities	3,378	3,197	-182	-5%

Source: Bureau of Labor Statistics.

At this point, our assumption is that the state's Covid-19 costs and the short-term savings from deferred or delayed care approximately netted out in 2020, and that final year-end results will likely show that claims costs for the year came close to pre-Covid expectations. The outlook for 2021 remains uncertain, but for this report, we have not changed our assumptions about future hospital costs compared with the September interim report. Likewise, we have only adjusted our assumptions on future insurance costs slightly, based on the latest approved rates for 2021.

Table 54 shows our baseline reconstruction of the state's 9 largest hospitals' aggregated results from 2015-2019 and our preliminary pre-Covid-19 baselines to 2024. We assumed some slowing in hospital wage and benefit growth, and a slowing of the growth of non-patient revenues (including philanthropy) that had been propping up the hospital sector's margins in 2018 and 2019. Note we are assuming a somewhat lower total margin for the sector (3-4%) than had been achieved in the mid-2010s (5-6%).

Table 54.

Baseline Hospital Cost and Revenue Projections -- Large ND Hospitals
Aggregate Revenues and Expenses (AHA Data vs. HCRIS), All Nine Reporting Hospitals

(by calendar year, in millions)	2015	2016	2017	2018	2019	2020	2021	DRAFT PROJECTED 2022	2023	2024
AHA Data					**AHA-Style Data**					
Payroll	1,360	1,467	1,561	1,631	1,681	1,756	1,835	1,917	2,002	2,092
Benefits	242	271	288	298	309	325	343	361	380	401
Total, Wages and Benefits	1,602	1,739	1,850	1,929	1,990	2,082	2,177	2,278	2,382	2,492
Interest Expense	42	43	46	49	47	50	52	54	56	59
Other Expenses	1,395	1,459	1,532	1,649	1,747	1,813	1,900	2,010	2,127	2,250
Total, Expenses	3,038	3,240	3,428	3,627	3,784	3,944	4,129	4,342	4,565	4,801
Patient Revenues	3,072	3,221	3,360	3,495	3,598	3,669	3,854	4,048	4,252	4,466
Non-Patient, Non-Oper. Rev.	170	183	203	256	327	387	424	464	507	555
Total, Revenues	3,241	3,404	3,563	3,751	3,925	4,057	4,278	4,512	4,759	5,021
Margin	203	164	135	124	140	112	149	170	194	220
Margin %	6%	5%	4%	3%	4%	3%	3%	4%	4%	4%
					Growth Rate					
Payroll	8%	8%	6%	4%	3%	4%	4%	4%	4%	4%
Benefits	10%	12%	6%	3%	4%	5%	5%	5%	5%	5%
Total, Wages and Benefits	8%	9%	6%	4%	3%	5%	5%	5%	5%	5%
Interest Expense	8%	2%	9%	6%	-4%	4%	4%	4%	4%	4%
Other Expenses	6%	5%	5%	8%	6%	4%	5%	6%	6%	6%
Total, Expenses	7%	7%	6%	6%	4%	4%	5%	5%	5%	5%
Patient Revenues	9%	5%	4%	4%	3%	2%	5%	5%	5%	5%
Non-Patient, Non-Oper. Rev.	-15%	8%	11%	26%	27%	19%	9%	9%	9%	9%
Total, Revenues	7%	5%	5%	5%	5%	3%	5%	5%	5%	5%
Margin	8%	-19%	-17%	-9%	13%	-20%	32%	14%	14%	14%
Medicare Cost Reports					**HCRIS Data**					
Total Wages and Benefits	1,572	1,650	1,711	1,744	1,800	1,882	1,969	2,059	2,154	2,253
Interest Expense	42	43	48	52	50	53	55	57	60	62
Other Expenses	1,537	1,667	1,766	1,851	1,960	2,035	2,132	2,256	2,387	2,525
Operating Expenses	3,152	3,361	3,526	3,647	3,810	3,970	4,156	4,373	4,601	4,841
Patient Revenues	3,190	3,323	3,419	3,532	3,636	3,708	3,895	4,091	4,297	4,514
Non-Patient, Non-Oper. Rev.	155	192	230	239	305	361	395	432	473	517
Total, Revenues	3,344	3,514	3,649	3,771	3,941	4,070	4,290	4,523	4,770	5,031
Margin	155	192	230	239	131	100	134	151	169	190
Margin %	5%	5%	6%	6%	3%	2%	3%	3%	4%	4%

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019.

Table 55 below shows the underlying utilization assumptions behind the revenues and expenses projected in Table 56. We followed recent trends in North Dakota's expected hospital utilization, with very slow growth in admissions, approximately zero growth in inpatient days, and a slow downward trend in average length of stay. Medicare utilization will likely grow faster than that of Medicaid and private insurance enrollees.

Currently, we estimate that hospital patient revenues are growing more slowly than expenses in North Dakota. To re-balance revenues and expenses within the projection period from 2020 to 2024, we lowered the recent average growth of wages and benefits by one percentage point per year, to about 4.5 percent per year, and reduced the growth of "other" expenses considerably in 2020 and 2021. On the other hand, we assumed the growth of interest expenses would be about 1 percentage point higher per year during the projection period, reflecting current capital expenditure trends (but also assuming very low interest rates). Finally, we lowered the growth of non-patient revenues from its recent extraordinary growth rate of over 25 percent per year to 18 percent in 2020 and about 10 percent in 2021-2024.

The bottom line is that recent revenue growth has been lower than recent expense growth, particularly if we assume the growth of non-patient revenues slows from recent extremely high rates. Thus, to maintain margins, we expect North Dakota hospitals will be required to lower their rate of growth in expenses. We reflect this in the projections.

As a group, the state's hospitals seem to be in good financial condition. However, the hospital sector's financial outlook likely worsened in 2019, and several individual hospitals seem to be in precarious financial situation. Moreover, there are large construction projects in place or in the pipeline that could further squeeze hospital's finances in coming years, with an uncertain payoff down the road.

Table 55.

Baseline Hospital Cost and Revenue Projections -- Large ND Hospitals
Aggregate Utilization Measures (AHA Data vs. HCRIS)

Nine Responding Plans									DRAFT PROJECTED	
(by calendar year)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Admissions					**AHA Historical Data**					
Medicare	32,892	33,266	34,081	34,850	35,016	35,569	36,131	36,702	37,282	37,871
Medicaid	13,287	15,540	15,659	16,227	16,447	17,381	18,367	19,410	20,511	21,676
Private/Other	34,288	29,914	30,295	30,009	31,147	31,575	32,009	32,449	32,895	33,347
Total	80,467	78,719	80,034	81,085	82,610	83,166	83,726	84,289	84,857	85,428
Days										
Medicare	179,089	175,646	172,764	175,152	173,370	173,687	174,004	174,321	174,640	174,959
Medicaid	73,616	83,832	84,841	86,288	86,551	90,250	94,106	98,127	102,321	106,693
Private/Other	125,119	119,596	113,605	114,437	120,147	119,035	117,933	116,842	115,761	114,690
Total	379,124	379,073	371,210	375,877	380,068	380,338	380,609	380,880	381,151	381,422
Inpatient Surgeries	24,696	24,635	24,718	24,202	24,156	24,156	24,156	24,156	24,156	24,156
ED Visits	256,880	253,005	246,322	244,994	247,200	247,200	247,200	247,200	247,200	247,200
Outpatient Visits	2,156,467	2,171,771	2,109,200	2,061,083	2,013,684	2,013,684	2,013,684	2,013,684	2,013,684	2,013,684
Outpatient Surgeries	68,218	68,734	69,183	69,905	69,564	69,564	69,564	69,564	69,564	69,564
Beds	1,638	1,631	1,668	1,700	1,675	1,675	1,675	1,675	1,675	1,675
Occupancy Rate	63.4%	63.7%	61.0%	60.6%	62.2%	62.2%	62.3%	62.3%	62.3%	62.4%
Average Length of Stay (days per admission)										
Medicare	5.4	5.3	5.1	5.0	5.0	4.9	4.8	4.7	4.7	4.6
Medicaid	5.5	5.4	5.4	5.3	5.3	5.2	5.1	5.1	5.0	4.9
Private/Other	3.6	4.0	3.8	3.8	3.9	3.8	3.7	3.6	3.5	3.4
Weighted Average	4.7	4.8	4.6	4.6	4.6	4.6	4.5	4.5	4.5	4.5
Overall Utilization Index, 2010	1.15	1.14	1.13	1.13	1.13	1.14	1.14	1.14	1.14	1.14
Admissions					**HCRIS Data**					
Medicare	28,782	29,288	30,106	30,354	30,499	30,981	31,470	31,968	32,473	32,986
Medicaid	10,145	11,133	10,850	11,555	11,712	12,377	13,079	13,822	14,606	15,435
Private/Other	35,500	35,670	36,442	35,008	36,336	36,836	37,342	37,855	38,375	38,903
Total	74,428	76,092	77,398	76,917	78,364	78,892	79,422	79,957	80,495	81,037
Days										
Medicare	147,385	149,090	148,579	148,875	147,360	147,629	147,899	148,169	148,439	148,711
Medicaid	70,929	73,126	71,768	69,828	70,042	73,035	76,156	79,410	82,803	86,341
Private/Other	130,901	130,184	130,771	132,611	139,228	137,939	136,663	135,398	134,145	132,904
Total	349,215	352,400	351,118	351,315	355,232	355,485	355,738	355,991	356,244	356,497
Beds	1,436	1,452	1,475	1,475	1,472	1,472	1,472	1,472	1,472	1,472
Occupancy Rate	66.6%	66.5%	65.2%	65.2%	66.1%	66.1%	66.2%	66.2%	66.3%	66.3%
Average Length of Stay (days per admission)										
Medicare	5.1	5.1	4.9	4.9	4.8	4.8	4.7	4.6	4.6	4.5
Medicaid	7.0	6.6	6.6	6.0	6.0	5.9	5.8	5.7	5.7	5.6
Private/Other	3.7	3.6	3.6	3.8	3.8	3.7	3.7	3.6	3.5	3.4
Weighted Average	4.7	4.6	4.5	4.6	4.5	4.5	4.5	4.5	4.4	4.4

Source: Horizon Government Affairs. HCRIS data via RAND, vintage 11-4-19.
Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.
\a Overall utilization composite index is calculated by HGA using data from the AHA survey responses. It is not an AHA calculation.

Preliminary Individual Insurance Market Projections. Tables 56-59 below show how these projections of hospital spending fold into our projections of insurance coverage and individual market claims and premiums. Tables 56 and 57 summarize the individual, small group, and large group (non-ERISA) markets. These are the markets regulated by the state. Table 58 and 59 show additional detail on the individual market.

Our baseline projects that premiums will increase by about 5 percent per year beginning in 2021. Note that in the individual market we account for North Dakota's state-led reinsurance program within the claims account – that program is the primary reason premiums are expected to be about 9 percent lower in 2020 than in 2019. We estimate that the Covid-19 recession will reduce private coverage in all markets in 2020, but that the magnitude of the coverage losses in North Dakota will be relatively small, less than 5 percent. Based on CMS data from 2020 open enrollment, we had assumed an increase in individual market coverage in 2020, due to the reductions in premiums associated with North Dakota's reinsurance program. However, we now expect slightly declining enrollment due to affordability issues, particularly among unsubsidized enrollees with ACA coverage.

HGA conducted an interview with a pandemic modeling expert at a large health insurer outside the state. They also expected considerable deferrals of care, but were cautious about the 2021 outlook, particularly regarding the cost of possible Covid-19 vaccines and treatments. In general, her expectation was that about half of delayed care would be simply deferred, and would resume in 2021. However, in her model some deferred or delayed care would result in worse outcomes; other patients would simply decide not to get their previously anticipated care.

On balance, we have made only slight adjustments to premiums for 2021 and later years, compared with the September report. In particular, we slightly reduced expected premium growth in the small group market for 2021, based on the latest approved rates from NDID.[31]

Table 56.

Baseline Enrollment Model			DRAFT							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
					Number of Covered Lives					
Individual	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Small Group Employer	64,424	62,179	60,381	60,028	61,351	59,314	58,531	57,173	55,846	54,550
Large Group Employer	149,872	151,322	149,111	154,872	156,685	152,178	152,365	152,553	153,504	154,461
Large Group ERISA	190,304	189,799	211,608	200,800	201,187	197,551	195,957	196,335	196,713	197,093
Medicaid	65,540	67,264	63,206	68,963	73,767	75,170	76,599	78,056	79,540	81,053
Medicare	105,960	107,637	109,495	112,338	114,549	116,803	119,102	121,447	123,837	126,274
Military	18,200	18,600	11,700	16,500	15,100	15,100	15,100	15,100	15,100	15,100
Other Coverage	18,866	20,917	17,032	15,506	14,645	13,832	13,064	12,339	11,654	11,006
Uninsured	60,000	57,000	54,500	56,300	49,969	60,915	61,565	60,654	58,788	56,728
Total Population	726,400	725,900	726,000	730,600	731,000	732,410	733,822	735,237	736,655	738,076
Memorandum:										
Estimated Medicaid Expansion Population				21,100	22,570	26,373	24,576	25,044	25,520	26,005

Source: Horizon Government Affairs.

[31] https://www.insurance.nd.gov/news/godfread-announces-approved-2021-health-insurance-rates.

Table 57.

Baseline State Premiums Model DRAFT

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
					Covered Lives					
Individual Market	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Small Group	64,424	62,179	60,381	60,028	61,351	59,314	58,531	57,173	55,846	54,550
Large Group	149,872	151,322	149,111	154,872	156,685	152,178	152,365	152,553	153,504	154,461
					Premiums (millions)					
Individual Market	236	248	239	254	269	233	240	255	272	290
Small Group	303	295	300	319	344	354	355	363	375	387
Large Group	722	735	753	806	848	889	935	984	1,041	1,101
					Premiums PMPM					
Individual Market	369	404	407	467	512	468	481	511	543	577
Small Group	401	397	422	447	467	498	506	529	559	591
Large Group	388	402	419	440	451	487	511	538	565	594
					Growth PMPM					
Individual Market	13.1%	9.5%	0.8%	14.6%	9.9%	-8.7%	2.8%	6.3%	6.2%	6.2%
Small Group	8.4%	-0.8%	6.3%	5.9%	4.4%	6.6%	1.6%	4.6%	5.6%	5.6%
Large Group	5.9%	3.4%	4.4%	4.8%	2.5%	7.9%	5.1%	5.1%	5.1%	5.1%

Source: Horizon Government Affairs.

Table 58.

Individual Coverage Baseline Estimates (HGA) DRAFT

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Individual Market										
ACA										
On Exchange					**Covered Lives**					
APTC Only	7,223	7,731	7,360	7,798	9,964	10,123	10,285	10,449	10,615	10,785
APTC/CSR	7,021	8,234	9,039	9,095	8,604	7,867	7,993	8,120	8,250	8,381
No Subsidy	2,407	2,726	2,948	2,749	2,693	2,559	2,585	2,611	2,638	2,665
Total, On Exchange	16,651	18,691	19,347	19,642	21,261	20,549	20,862	21,180	21,503	21,831
Off Exchange	19,678	21,736	21,023	17,750	15,224	14,324	14,542	14,764	14,989	15,218
Total, ACA	36,329	40,427	40,370	37,392	36,485	34,873	35,404	35,944	36,492	37,049
Transitional and Grandfathei	16,905	10,756	8,598	7,902	7,262	6,674	6,134	5,637	5,181	4,761
Total, Individual	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Individual Market					**Premiums PMPM**					
On Exchange (CMS)	363	403	398	450	496	453	466	495	526	559
Total ACA (NDID/Novarest)	371	412	407	476	523	478	491	522	555	589
Total, Individual Market	369	404	407	467	512	468	481	511	543	577
Individual Market					**Growth**					
On Exchange (CMS)	9%	11%	-1%	13%	10%	-9%	3%	6%	6%	6%
Total ACA (NDID/Novarest)	9%	11%	-1%	17%	10%	-9%	3%	6%	6%	6%
Total, Individual Market	13%	9%	1%	15%	10%	-9%	3%	6%	6%	6%
Individual Market					**Aggregate Premiums (millions)**					
On Exchange (CMS)	72	90	92	106	127	112	117	126	136	146
Total ACA (NDID/Novarest)	162	200	197	214	229	200	209	225	243	262
Total, Individual Market	236	248	239	254	269	233	240	255	272	290
Memorandum -- Individual Market Model Parameters										
Average Deductible, Individu	2,300	2,500	2,900	3,600	4,000	4,500	4,800	5,100	5,400	5,700
Loss Ratio, Individual Market	89%	89%	97%	95%	90%	87%	87%	87%	87%	87%

Source: Horizon Government Affairs Baseline for modeling only -- not a prediction.

Table 59.

Individual Market Accounting Model DRAFT
(millions of dollars)

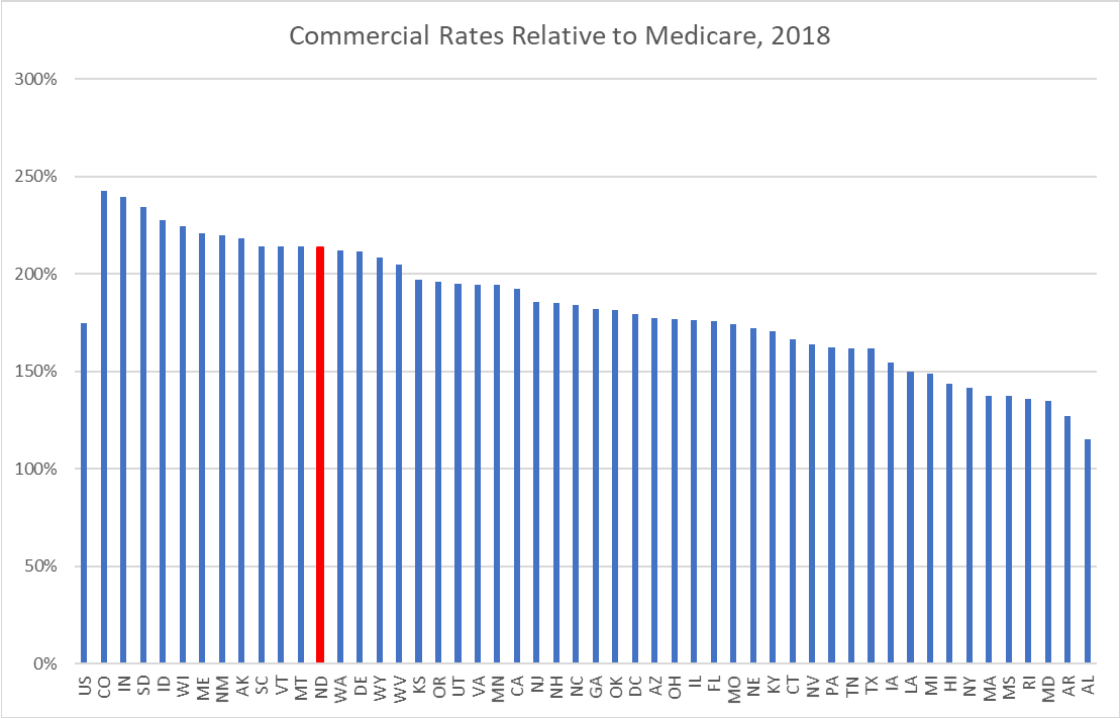
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Premiums	236	248	239	254	269	233	240	255	272	290
Claims										
Non-Pharmaceutical	181	188	183	179	193	155	164	174	185	196
Pharmaceutical Claims	37	45	47	50						
Rebates	5	5	7	10						
Net, Pharmaceutical Claims	32	40	40	39	41	42	45	48	52	56
Total, Incurred Claims	213	227	226	223	234	197	209	222	237	252
General and Administrative Costs, Claims Processing	19	21	20	25	26	27	28	28	29	30
Taxes and Assessments	18	12	9	9	9	9	9	9	9	9
Defined Expenses for Health Quality	1	1	1	1	1	1	1	1	1	1
Other and Reinsurance (net)	-14	-2	-6	-2	-2	-2	-2	-2	-2	-2
Net Underwriting Gain (+) or Loss (-)	5	-15	-9	-1	1	2	-5	-3	-2	-1
Memo										
Loss Ratio	90%	92%	95%	88%	87%	84%	87%	87%	87%	87%
Private/Medicare Rate Ratio	1.94	2.05	1.94	2.07	2.12	2.16	2.21	2.26	2.31	2.37

Source: Horizon Government Affairs, based on data from NAIC.

National Policy Outlook. Post-Covid-19, federal health policy remains extremely uncertain. Our preliminary baseline projections of North Dakota health costs will assume no major policy changes at the federal level that would affect the state's health markets before 2024.

However, in the longer run, the mismatch between Medicare and commercial rates is unstable, and likely unsustainable. North Dakota's rates are among the highest in the country (see Figure 25). Under Democratic control of the White House and Congress, we would expect legislation expanding subsidies for ACA coverage, and regulations rolling back some of the Trump Administration's relaxations of rules on state-based 1332 waivers. Less likely policy changes could include allowing commercial plans to use some multiple of Medicare rates, and/or allowing health plans to offer Medicare or MA-type coverage to broader populations, again using some multiple of Medicare rates. Even less likely would be a more direct Medicare "buy-in" for some of the population (perhaps for people aged 55+ or in the individual market).

Figure 25.



Source: HGA based on HCRIS/Rand data.

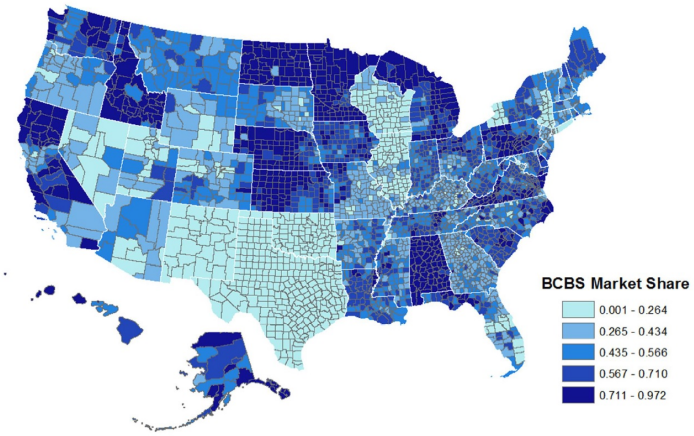
Competition and Markets. Although several insurers serve the North Dakota market, the dominant presence is Blue Cross Blue Shield of North Dakota (see Figure 26), particularly in the individual market. Two metro areas (Bismarck and Fargo) host two hospitals; other cities and towns in North Dakota have at most one. Sanford Health Group owns the state's two fastest-growing hospitals, and accounts for more than 50 percent of the state's hospital expenses among the state's 6 large acute care facilities (see Figure 27).

From an outsider's perspective at least, there may be some areas of concern in the state's health care markets. Sanford Health is operating under a Corporate Integrity Agreement with the federal Department of Health and Human Services Office of Inspector General, resulting from whistleblower claims of unnecessary surgeries and self-dealing.[32] BCBS was recently fined following a market conduct exam, based on findings of improper payments for telehealth, mental health, and other services.[33]

[32] See https://www.justice.gov/opa/pr/sanford-health-entities-pay-2025-million-settle-false-claims-act-allegations-regarding and https://oig.hhs.gov/fraud/cia/agreements/Sanford_Health_Sanford_Clinic_and_Sanford_Medical_Center_10252019.pdf (PDF).

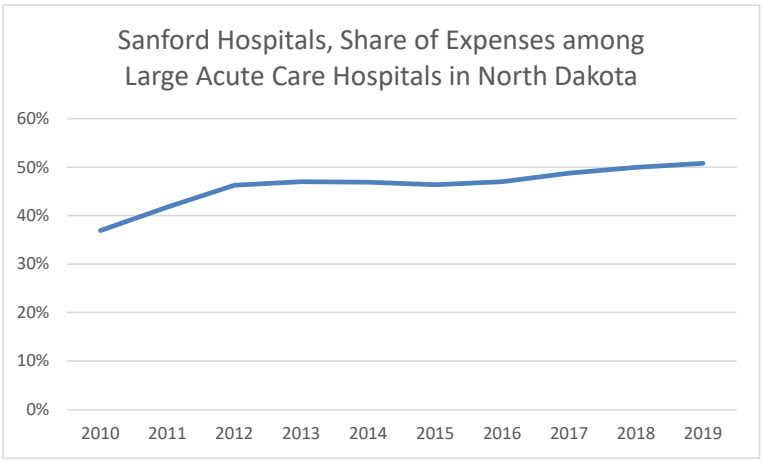
[33] See https://www.insurance.nd.gov/news/insurance-commissioner-fines-blue-cross-blue-shield-north-dakota-125000-result-market-conduct and https://www.nd.gov/ndins/sites/www/files/documents/Enforcement/Market%20Conduct%20Exams/2018-19%20BCBSND%20Exam%20Report%20-%20Signed%20-%20FINAL.pdf.

Figure 26.
Estimated Blue Cross Blue Shield Market Share, by County



Source: Cooper et al. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" The Quarterly Journal of Economics (2019), 51–107. doi:10.1093/qje/qjy020 (Oxford University Press), Supplemental Appendices, page 81. Data from HealthLeaders Interstudy and U.S. Census.

Figure 27.



Source: Horizon Government Affairs.

North Dakota has a limited managed care footprint and relatively low use of value-based payment methods, population health efforts or care coordination programs. Based on our interviews, the state seems mostly stuck in a fee-for-service reimbursement regime, with providers competing to offer lucrative elective surgeries and insurers concentrating on holding down reimbursement rates across the board, with little regard for value of specific providers or patient outcomes from various care patterns.

Certainly, North Dakota is not unique in this regard. On a nationwide basis, the Covid-19

pandemic has exposed problems with existing markets for health care delivery and financing. For example, the lack of telehealth infrastructure and financing may be a symptom of broader market dysfunction – call it market "lethargy" or market "stagnation" – the inability of existing markets to produce the sort of dynamism we expect from competitive systems.

In general, we assume that competitive markets produce efficient and desirable outcomes. In theory, and in practice in most industries, competitive market outcomes provide choices and value. However, it's not clear that North Dakota has benefited to the fullest extent from competitive efficiencies and innovations.

So a key question for North Dakota is: Are competitive markets in health care possible? If so, can we strengthen them? If not, can the state work with health care providers and insurers to approximate competitive-style outcomes under a more collaborative system? What degree of public transparency and/or cooperation could lead to more dynamic outcomes without falling into the trap of over-regulation?

Early on in this project, we interviewed representatives from a coalition of hospitals attempting to develop a plan to convert North Dakota's health system from an old-fashioned fee-for-service and hospital-dominated approach to better population health and care management.

The Covid-19 crisis might be a very good spur to revisit those efforts. Hospitals accustomed to competing for lucrative patients or physicians may need to refocus their efforts on population health and monitoring, using common data. The state's dominant insurer may need to develop population-health and outcomes-based global reimbursement systems rather than simply paying under the same fee-for-service regime year after year.

We believe that the Covid-19 emergency has the potential to spark a more serious discussion of how North Dakota could re-wire its existing health system, while also maintaining and encouraging new competition. The idea of getting more competitive results, either through additional competition, better directed competition, or public-private cooperation and transparency runs through the policy alternatives discussed below.

VI. Policy Alternatives and Options

In this section, we describe several policy alternatives for consideration by North Dakota policymakers. For some of the policies, we have also provided preliminary cost and impact modeling in the subsequent section below.

Some of the policy alternatives suggested are mutually exclusive. Ultimately, policy choices reflect value judgements, and it is not our job to substitute our judgment for that of the North Dakota's Legislature, the Governor or Insurance Commissioner. We have provided, what we hope, is sufficient information for policymakers and stakeholders to start charting a path forward toward lowering health insurance premiums, lowering overall health care costs, and providing better population health for North Dakotans. Below you will find 15 policy alternatives in five themes, as shown below**.**

Important Disclosures – Horizon Government Affairs represents clients and coalition members who provide real-time benefit and pricing information for prescription drugs and who provide telehealth services; expansion of both services is recommended below. JWHammer LLC has clients that could potentially offer services to North Dakota under these recommendations. Additional disclosures are noted in the footnote.[34]

Utilization & Care Management

1. **Benchmark Plan Revisions - Optimized Medication Plans**
2. **Private Insurance (Group) Mandate - Optimized Medication Plans**
3. **Integrated Health Homes**
4. **Strict Managed Care/Value-Based Benefit Design**

Prices, Coverage and Insurance Initiatives

5. **Caps on Out-of Network Rates**
6. **Telehealth**
7. **Private Reinsurance**

Transparency

8. **Direct To Consumer Pricing**

[34] Horizon Government Affairs (HGA) is a Washington, D.C.-based government affairs consulting firm that serves a number of clients in the health care industry and operates a number of coalitions that are similarly focused on health care issues. Horizon is not aware of, nor do we have reason to believe, that any of the recommendations included in this report would substantially benefit any of our clients or coalition members. None of the recommendations included herein have been generated for the purpose of directly or indirectly benefitting HGA's direct clients or coalition members. Additional information on HGA is available at horizondc.com. Information on our coalitions, including member organizations are available at the following websites: Council for Affordable Health Coverage (www.cahc.net), Health Innovation Alliance (www.health-innovation.org), Health Benefits Institute (www.thehealthbenefitsinstitute.org). J W Hammer, LLC is a Springfield, IL based law and consulting firm that serves clients in multiple industries and states, including clients that may or may not respond to the state's future requests for proposals that may be the result of this report, including but not limited to Aon and Affinity. It is unclear whether Hammer's clients may or may not substantially benefit from recommendations included herein. None of the recommendations included herein have been generated solely for the purpose of directly or indirectly benefitting Hammer's direct clients. Additional information regarding J W Hammer, LLC is available at www.jwhammerllc.com.

9. **Public Policy Price Disclosures**
10. **Right To Shop**

Program Integrity

11. **Medicaid Integrity Audit**
12. **State Group Health Integrity Audit**
13. **State Group Health Waiver**
14. **Coordination Of Benefits**

Crisis & Pandemic Planning

15. **Risk Assessments**

Utilization and Care Management. Health care policy analysts have long touted the potential for wellness and preventive care to help Americans avoid disease. But gaps in coverage remain for many individuals managing a chronic health condition or conditions. While preventive care is provided at no cost on almost all health plans, those managing chronic medical conditions may have significant medical expenses. For example, a colonoscopy for someone who is 50 and healthy will be provided at no cost, but for an individual with ulcerative colitis they may be facing up to a $5,500 bill in North Dakota, if they have not yet met their deductible. But in some cases, chronic care management may be one area with the greatest return on investment. Medication and diet adherence for a diabetic, for example, leads to a longer, healthier life. For an insurer, it means fewer expensive complications.

Consumers with chronic medical conditions should be incentivized to manage their own care. It is well known that medication nonadherence and the related hospital admissions and emergency department visits are a significant cost driver of health care costs, particularly under fee-for-service insurance arrangements. For example, a comprehensive population study of Medicare beneficiaries in the fee-for-service program with diabetes, heart failure, hypertension, or hyperlipidemia found that avoidable healthcare costs due to medication nonadherence totaled nearly $30 billion.[35] Aligning the interests of the insurer, consumer and medical provider are key to this effort. North Dakota should (1) mitigate risk, (2) analyze and deploy a medication adherence and disease management strategy of investing targeted resources in the comorbid populations (two or more disease states and six or more medications), and (3) re-evaluate pricing structures. These efforts will lead to a measurable return on investment and measurably better health outcomes for North Dakotans.

1. **ACA Benchmark Plan Revisions - Optimized Medication Plans:** The continued release of academic studies regarding medication nonadherence highlights the need to focus on medication adherence as the greatest cost driver to utilization. The Lloyd et. al. report cited above specifically identified medication nonadherence as costing "billions of . . .expenditures, millions in hospital days and thousands of emergency department visits, that could have been avoided." She further goes on to state that "medication is a cornerstone of disease management. . . However, adherence to medications for most chronic conditions remains suboptimal – an

[35] Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program?. Med Care. 2019;57(3):218-224. doi:10.1097/MLR.0000000000001067

important gap in care that represents a ***major opportunity for cost savings and health improvement*** for the 150 million American adults, 60% of the population, living with a chronic illness." (*emphasis added).* The estimated annual cost of prescription drug-related morbidity and mortality resulting from nonoptimized medication therapy has ranged as high as $528.4 billion in 2016 US dollars.[36] If addressed appropriately, the state can reasonably expect to see lower hospital-related utilization and substantial cost savings. The state would be the first in the nation to seriously address this issue if it was implemented across all payers.

Implementation:
Insurers. In the individual and small group market, North Dakota should consider revising their ACA Benchmark Plan to include a robust "medication optimization program" as a new mandate AND specifically enumerate that home delivery or mail order dose-packaged medication are proactively offered though the ACA-qualified health plans or QHPs. The medication optimization program would allow consumers to have a comprehensive review of all their prescription drugs to assure that the consumer is on the correct dosages the correct medication and to review any unfavorable drug interactions.

CMS has indicated that once approval is received for essential health benefit changes, there is a presumption that the "generosity test" has been met. The new "mandate" is then an EHB (essential health benefit), which indicates that it is not a "mandate". After passage of the ACA, new mandates require cost defrayal by the state. This is the only vehicle to expand coverage for North Dakotans purchasing health insurance in the individual market, without financial obligation by the state. Once the Benchmark Plan includes the new mandate, insurers will reap a 3:1 ROI and North Dakota consumers will see lower premiums and increased health.

Additionally, the state should work with CMS to ensure medication optimization is treated as a preventive health service. This will ensure that access is affordable, and that plans – especially high deductible plans – can cover the service without requiring a deductible be met.

Action Item: File Revised Benchmark Plan for Individual Market
Time to Completion: 12-24 months

2. **Private Insurance (Group) Mandate - Optimized Medication Plans:** Similar to the ACA Benchmark Plan revisions discussed above, North Dakota could pass legislation requiring all small and large group, including non-ACA plans, to offer an optimization program.

Insurers. North Dakota should require the same mandate for inclusion of "clinical pharmacist driven medication optimization coupled with dose-packaged

[36] https://www.pharmacytimes.com/contributor/timothy-aungst-pharmd/2018/06/does-nonadherence-really-cost-the-health-care-system-300-billion-annually; and Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. Ann Pharmacother. 2018;1060028018765159. doi: 10.1177/1060028018765159.

medication" by all small and large group plans as well. According to one source, "[t]he data from the delivery of this service are positive, with a demonstrated ROI as high as 12:1 with an average of 3:1–5:1. ROI reflects an ability to decrease hospital admissions, physician visits, and emergency department admissions and reduce the use of unnecessary and inappropriate medications."[37] There is no reason insurers shouldn't be deploying these resources to the comorbid populations. Prior to passage of a requirement, the insurance department could issue a bulletin requiring all insurers to address medication adherence and medication optimization in their plan filings.

State Government. North Dakota should also consider revising their state employee benefits to include a robust "medication optimization program" as a new inclusion in the plans offered to state employees. A well-designed, clinical pharmacist-led medication optimization plan and follow-up can reduce total medical cost by a third. In subsequent years, the state would reap the benefits of a state employee population that is using fewer sick days and driving down health care costs, which drive premiums.

Action Item: Legislation or Commissioner Bulletin to implement the mandate. Revise the fully insured employee benefit plan or bargain through negotiations AND pass legislation or issue a Bulletin for the non-Erisa group market

Time to Completion: 18-24 months for passage and implementation of optimization requirements. Less than 12 months to issue bulletin, and receive reports.

Medical Community. Medication optimization should become a priority in the medical community. Hospital systems, physicians, and pharmacists should routinely discuss medication optimization with their patients. Patients with multiple conditions should regularly have their medication reviewed in order to ensure patient compliance, drug interactions, and changing medical history. Medical and pharmacy schools should develop courses to educate medical providers on medication optimization.

Action Item: Legislation to require North Dakota Pharmacy and Medical School to offer medication optimization courses. Hospital systems and pharmacies should be encouraged to require their employees to routinely discuss the issue with their patients.

Time to Completion: 18-24 months for passage and creation of courses. Less than 12 months to issue guidance to medical providers.

3. **Integrated Health Homes:** Our health system has become increasingly byzantine in its complexity and a consumer's ability to manage their own health care. In most cases requiring treatment of acute care conditions, this administrative difficulty

[37] https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

does not lead to significantly poorer health outcomes. For the chronically ill, the issue is very different.

The chronically ill face many issues. Many have a number of medical issues, and these co-morbidities mean that managing the conditions separately creates problems. Multiple medications mean managing potential adverse drug interactions. The issue is even more severe for consumers with rarer medical conditions whose interactions may not be understood by most medical providers.

CMS has approved integrated health homes that have a component of medication adherence. This provides a sizable match to the state if efficacy is shown. The Medicaid population needs to be engaged in the process for outcomes to improve. Success means not only a lower budget line item, but better health for Medicaid recipients. If health has been an impediment for maintaining a job (as it sometimes is), it also means the potential for a better life.

One of the policy solutions is to create integrated health homes that will work systemically with the chronically ill Medicaid population to develop a medication regimen that is error and contraindication free, and then support the patients to adherence. The most effective model is to include a clinical pharmacist team. North Dakota should look at a narrower Illinois integrated health homes (IHH) model (which was developed based upon the Oklahoma model). It is a model of engagement and adherence to behavioral/physical health and medication regimens. Most importantly, quality metrics can be set, such as reduction of ED visits, claims etc. for the IHHs. The state should procure a vendor to assist in crafting a medication adherence program through the IHH model. The program should include collection of data to verify that Medicaid recipients are filling needed prescriptions, follow-up to ensure prescriptions are taken appropriately, and a review of all medications for the most chronically ill to ensure the prescriptions are in the right amount and if more than one that there are no negative interactions. If the program works correctly, it could ensure that Medicaid patients have fewer increases in severity for their chronic illness, and in some cases may allow ill patients to recover enough to re-join the workforce.

Implementation: The state should file a State Plan Amendment (SPA) with the federal government to seek 90%/10% match funds for an eight-quarter program to provide medication optimization services. In addition to medication optimization, the integrated health homes should connect Medicaid beneficiaries with social services and accountability services with their current providers. North Dakota should reference Illinois or Oklahoma's integrated health home models for reference. North Dakota should also procure an integrated health home project manager or director.

Action Item: State Plan Amendment & Approp Funding to Medicaid Dept
Time to Completion: 18-48 months

4. **Strict Managed Care/Value-based Benefit Design.** The state should encourage the use of value-based design in the state employee health plan and consider providing incentives for adherence. In addition, the state should consider hiring a vendor to assist state workers in managing their prescriptions and helping with adherence. In the long run, the program should reduce claims, and lead to a healthier workforce with less absenteeism.

   The State of North Dakota originally passed Medicaid expansion in 2013, providing coverage to residents up to 138% of poverty. The program is administered by Sanford Health Plan which won the RFP to administer the program. Despite lower than expected enrollment, the costs have been significantly higher than expected.

   The program created a two-tiered system. Those under 100% of poverty receive a traditional Medicaid managed care program. Those over 100% of poverty receive a program that pays commercial rates to medical providers.

   While strongly supported by the hospitals, there have been some significant concerns raised about the program. It requires Medicaid to run two separate programs which increases administrative costs. By splitting the pool, it makes it more difficult to manage the underlying claims costs both by making each pool less credible (since they are both small pools) and ensuring the larger pool is potentially attractive to managed care organizations. The differing benefit levels also create a sense of unfairness – it is hard to defend providing better benefits to those making more money.

   Two options exist:

   Limit Medicaid expansion to 100% of poverty. Currently North Dakota has expanded eligibility to Medicaid to 138% of poverty. However, the Affordable Care Act provides subsidies to all individuals over 100% of poverty.

   By limiting expansion to 100% of poverty, North Dakota would still be providing coverage to everyone in poverty, but allowing those over 100% of poverty to enroll in private market health insurance. For those enrolling in the exchange between 100% -138% of poverty it is very likely that in addition to enhanced cost sharing in silver plans, the consumers would be eligible to enroll in a bronze plan at no cost.[38]

   However, the savings to North Dakota is limited. The expansion population is effectively covered at less than 90 percent federal matching rate, which means $1 million savings to North Dakota requires more than $10 million in cuts.

   Re-form Medicaid expansion as a single combined pool in an exclusively managed care model. The importance of a medical home is highlighted above,

[38] https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/

but several states have begun using a similar managed care model in Medicaid. The idea is to eliminate a fee-for-service program in its entirety and require insurers to fully manage the health of Medicaid recipients. For some areas, a managed care program has led to extensive efforts to investigate social determinants of health, such as addressing food deserts or transportation limitations among patients.

This proposal could also require the Medicaid population to adjust to considerable changes with new requirements, and new provider networks. But the program could be offered to all Medicaid enrollees making it simpler to understand.

Implementation: The proposed program will require significant changes. By creating a single Medicaid program, the agency will be able to better manage care, offer better contracts to quality providers, and have economies of that do not come from divided pools. It also creates a more equitable program by treating all Medicaid recipients the same – regardless of income. This includes better use of value-based design inside Medicaid. The current program has a 90 percent federal match, which means state savings will be less.

Value based benefit design isn't just about waiving co-pays or deductibles. It is about determining the services that provide the best value and provide consumers with better health outcomes at lower overall costs. For example, a benefit design that ensures diabetics can afford the right dose of insulin and regards high value care will find that the cost of their diabetic population will fall.

***State Government*.** This is an area in which the state can lead. North Dakota state employees typically work with the state for a long period of time and are a large stable population. Implementing value-based design will allow the state employee health plan to assist state employee with managing their cost and care. The rewards for the state are not just in lower health care cost. If done correctly, it should also lead to a more productive, healthier workforce. For North Dakota employers and insurers, the state's leadership can provide concrete examples for success.

***Medicaid*.** Combining Medicaid into a single pool just makes logical sense. There will be resistance because of the loss of some federal revenue, but the program will be easier and less costly to manage, be fair for all recipients, and by pooling the risks together make it easier for Medicaid recipients. The Medicaid program can still use its limited levers to encourage the use of high value services. For example, one option would be removing fee-for-service as an option and requiring Medicaid recipients to receive care through an MCO with a required medical home. A number of states have used the MCO model to improve the costs in the program over time. However, with a small population, a strong rural component and a significant Native American population, the population may be too diverse to successfully implement a full managed care model statewide. Therefore, Medicaid could attempt to break the state into sections and try to attract MCOs to bid for care of local populations.

***Insurers*.** Insurers have begun to experiment with value-based design. However, in the highly regulated individual and small group markets, the rules are more complicated. State mandated benefits may favor low-value care or require lower cost sharing for some low value services. There is also a balancing act between providing additional incentives for high value care and concern that insurers are creating discriminatory benefit designs.

Action Item: Legislation, Major project planning across multiple state agencies
Time to Completion: 12-48 months

Prices, Coverage, and Insurance Initiatives. The following sections address pricing reforms that have the potential to restrain the ever-upward push of commercial rates, improve coverage for tele-health services, and consider an alternative method of providing reinsurance coverage. The rate cap policy is explained in more detail by researchers from RAND, who offer it as a less disruptive alternative to broader rate setting or public option proposals.[39] Preliminary estimates of the potential savings are shown below in the cost estimates section.

5. **Caps on Out of Network Rates for Private Coverage and the Uninsured.** Medicare's payment rates are commonly used as a benchmark for insurers. As shown above, commercial payment rates relative to Medicare have been rising in North Dakota. This policy would effectively stem the ever-upward drift of commercial payment rates relative to those paid by Medicare by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates.
This policy would not directly affect rates for in-network providers. However, it would put downward pressure on in-network rates over time. If insurers would otherwise face in-network rates higher than the cap, they could switch the provider to out-of-network status and pay a lower amount. (Of course, there are other benefits to in-network status, such as data disclosures and quality measures, so some insurers may have an incentive to pay in-network providers more than the out-of-network cap in order to retain high-quality providers in their networks.)

   Setting the initial rate cap quite high, such as at 220 percent of Medicare, would not severely disrupt provider payments. (For context, we estimate that state average was 207 percent in 2018 (see Table 9 above) and we estimate that the statewide average would be about 220 by 2021, when the policy would take effect. If applied at the provider level, setting an out-of-network rate cap may also have a positive effect on surprise billing by limiting rates charged by out-of-network providers operating in a hospital setting. As we suggest below under the transparency section, we recommend that the state monitor prices regularly and issue regular reports.

   Implementation:
   ***State Government*.** Setting a rate cap for out-of-network services could allow the state employee plan (NDPERS) to bid for lower-cost coverage, by letting the state

[39] Erin Lindsey Duffy, Christopher Whaley, Chapin White, *The Price and Spending Impacts of Limits on Payments to Hospitals for Out-of-Network Care*, RAND (March 20,2020)
https://www.rand.org/pubs/research_reports/RR4378.html

offer coverage without any required network. Because the state would have access to detailed data about claims patterns and trends, it would allow a direct way to monitor the impact of the cap on premiums and healthcare providers in various parts of the state.

***Private Insurance Market*.** Rate caps are intended to help new insurers enter markets and create networks. Likewise, policymakers can use rate caps to ensure competitive rates even in areas without a competitive market for providers. Therefore, rate caps, could be viewed as alternative to more rigid price setting regulations when competitive outcomes are difficult to achieve. The ACA's network adequacy rules can make hospital negotiations difficult. Setting maximum hospital rates provides a benchmark for negotiations with insurers. If done right, it could lower the barrier to entry for insurers to compete in the North Dakota health insurance market currently dominated by one insurer.

Action Item: Legislation with set benchmarks.
Time to Completion: 12 months with implementation.

6. **Telehealth:** If structured properly, telehealth services may increase access to needed care while also controlling costs. In a rural state like North Dakota, telehealth can provide the opportunity to access medical specialists without time consuming travel. For those with mental health issues, telehealth can be an important lifeline. With more frequent visits and early interventions available, telehealth can help avoid costly delays in care (such as undiagnosed conditions that become worse with time) and, in situations where an in-person visit may not be required, virtual encounters may be priced at a lower rate than in-person care (if there is no state mandate requiring payment parity).

   For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000+ percent increase in telehealth visits in the midwestern U.S. between April 2019 and April 2020.[40] Consumers are increasingly becoming accustomed to telehealth, but the current increase in availability of telehealth services is largely based on temporary regulatory waivers.

   Implementation:
   ***State Government & Insurers*.** There are a number of issues that states should examine to create a permanent infrastructure that supports widespread adoption and utilization of telehealth:

   Licensure. Many states have significant licensing barriers that control providers' ability to use telehealth. Provider licensing boards should be encouraged to embrace telehealth, allowing providers to establish relationships remotely as long as necessary conditions are met and the standard of care is upheld. State boards should consider the interstate compacts available (e.g., FSMB and

[40] https://www.fairhealth.org/states-by-the-numbers/telehealth

NCSBN compacts, among others), as well as other flexibilities that may enhance providers ability to practice telemedicine.

Payment. Currently, many states are mandating that telehealth providers be paid on par for the same services. These requirements, often referred to as "payment parity" or "reimbursement parity" laws effectively drive up the price insurers are required to pay by limiting their ability to freely contract for services. These laws stifle competition by not allowing insurers and providers to set different rates based on the delivery of service.

Software. Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.

Scope of practice. The pandemic has allowed many new types of service to be delivered by telehealth. States should look closely at their telehealth practice requirements and permanently modernize the statutes.

Insurance. States should create a legal framework that would allow businesses and consumers to purchase an insurance product providing telehealth services.

Action Item: Legislative and regulatory study, legislation.

Time to Completion: 6-18 months

7. **Private Reinsurance:** The Governor signed HB 1106 enabling North Dakota's Reinsurance Association of North Dakota (RAND) to implement a non-private reinsurance program to reduce healthcare costs for individual taxpayers participating in the State's healthcare marketplace. To supplement the cost-saving efforts of the 1332 waiver program, the State should evaluate purchasing private reinsurance to further reduce costs for individual taxpayers participating in the State's healthcare marketplace. Private reinsurance can assist driving down/stabilizing rates and preventing spikes providing consistency for taxpayers/users. For example, Aon, a private reinsurer, has proposed such a system, which is shown in Appendix E.

   Using reinsurance to transfer the budgetary/program volatility, creates immediate opportunities for the State of North Dakota including:
   - Transferring volatility away from the existing RAND program into the private market
   - Reducing the future "known, unknowns", thereby allowing greater funding flexibility with the safety and security of knowing that protection is in place in the event of a higher-than-normal claims year
   - Providing stability in rates from payers as a pre-arranged amount of funding is known
   - Predictable cash flows for insurers and the state as there is no need, once coverage is purchased, to adjust the reimbursement levels to carriers based on higher-than-expected claim numbers and amounts

- Adjudication and claims processing is handled by the reinsurer, removing some of the operations of running the program in house

In addition, given the current Covid-19 health crisis there is likely to be further pressure on the individual health market. According to a recent Kaiser Family Foundation report, "It is likely that the most significant impacts of the coronavirus outbreak and economic crisis on the individual market will not be evident nationally until data from the second and third quarters of 2020 become available." These solutions can help mitigate impacts stemming from the global pandemic.

Action Item: Legislation & Outside Resources for Data and Reinsurance Management
Time to Completion: 6-18 months

Transparency. Too often, price transparency is seen as a panacea to our health system and blame for our opaque pricing system is assigned to hospitals, insurance companies, government policy, consumer disinterest, and an overly complicated health care system. The truth is, there is more than enough blame to go around.

The most important issue to understand about price transparency is that it is a means to an end. Transparency is necessary to encourage competition. Competition stimulates innovation – lower prices and better quality. Competition is the ultimate consumer protection because it allows a consumer to walk away from a transaction to find a better partner. Without competition, the alternative to competition is and should be, increased government oversight. When entities act like a monopoly, it may be necessary for government to regulate it like a monopoly.

The Trump administration had a number of initiatives that if implemented will significantly increase transparency for patients. These include availability of hospital and insurer information on pricing. The recent Covid-19 legislation also requires new disclosures which will help many patients with one of the biggest problems, surprise billing. While these changes are an important first step, we believe North Dakota can build on the approach to ensure consumers have access to the information they need before receiving care.

8. **Direct to Consumer Pricing: Disclosure of Consumer Prices.** We used a secret shopper to compare prices at several hospitals in North Dakota for three common procedures: colonoscopy, normal vaginal delivery, and caesarian section (see Table 60). What we found was drastically different estimates. For colonoscopy, the prices quoted ranged from a high of $5,509 to a low of $1,775, a difference of more than 300 percent. For vaginal childbirth, the range from highest quoted price to lowest was nearly 350 percent, and for delivery by Caesarian Section, prices ranged from about $5,000 to more than $31,000, a difference of more than 600 percent.

Table 60.

Hospital-Reported Prices for Selected Common Procedures

	Colonoscopy	Normal Vaginal Delivery	Caesarian Section
Trinity Hospital - St.Josephs (Minot)	2,980	4,343	5,058
St.Alexius Medical Center (Bismarck)	1,775	4,895	9,675
Sanford Medical Center (Fargo)	3,843	15,056	22,376
Sanford Medical Center (Bismarck)	5,509	13,603	20,386
Altru Health System (Grand Forks)	2,064	12,239	19,269
Jamestown Regional Medical Center	2,100	13,000	25,000
Innovis Health (Fargo)	4,700	11,000	31,000
Ratio of Highest to Lowest (Percent)	**310%**	**347%**	**613%**

Source: JWHammer LLC.

In general, consumer-facing price disclosures by hospitals are too complicated or obscure to be useful, particularly if the prices disclosed are full charges or so-called "chargemaster" amounts or if the price quotes are based on discrete (often obscure) technical codes instead of commonly known procedures, such as hip replacement or appendectomy. These amounts often have little resemblance to actual reimbursements by insurers. In order for a price disclosure to be useful to a consumer, it must meet certain criteria:

1. The disclosure must be **actionable**. Disclosures that are delivered at the time of service don't allow the consumer to shop.
2. The disclosure must be **personal**. General pricing disclosures don't reflect the likely costs based on the consumer's insurance plan or other service variables. This may mean that the referring or treating physician be required to provide billing codes.
3. The disclosure must be **understandable**. The consumer needs to understand what is covered by the price disclosure. Since most hospital-based physicians bills separately, the consumer should be made aware of other possible bills that may accompany the disclosed amount.

Implementation:

Hospital and Clinics. Rather than disclosing chargemaster amounts or prices based on inscrutable procedure costs, we recommend that hospitals and other large health care providers, including clinics and outpatient surgery centers, ***disclose their prices to uninsured patients as a function of Medicare rates***. For example, a hospital could simply state that its walk-up rates for patients without insurance were "100% of Medicare rates" or "200% of Medicare" or whatever amount they wished to charge. However, patients could then shop based on one number, a simple percentage, and could be confident that they would only be charged what Medicare would pay plus the stated markup. Note, that we would not require providers to disclose their reimbursement rates with insurers, which could be higher or lower than the function of Medicare rates quoted to uninsured patients. However, it is clear that insured patients with high

deductibles might not be happy if their carrier's negotiated rates were higher than the walk-up rates charged to the uninsured. This dynamic would help drive intramarket competition and prices down over time.

Action Item: Legislation
Time to Completion: 12 months

State Government. We recommend that the state health or insurance departments publish and ***publicize lists of Medicare rates for common bundles of services, starting with the most common procedures that patients may face, such as childbirth, knee or hip replacement***, and so on. For example, consumers with a choice of hospital could look at the hospitals stated rates relative to Medicare, and then compute their costs based on the Medicare reimbursement rates. For example, if the state's analysis of certain procedure showed an average Medicare reimbursement rate of $1,000, a patient would have a better idea what to expect in absolute costs from a hospital that charged 150 percent of Medicare ($1,500) vs. one that charged 200 percent of Medicare ($2,000).

Another recommendation is that the state ***operate a price disclosure website***, similar to the website offered by the Wisconsin Hospital Association (https://www.wipricepoint.org/Home.aspx) The website allows consumers to shop prices at any time and uses a series of questions to drill down on the procedure and the consumer's insurance coverage. The Wisconsin website uses chargemaster prices – in line with our recommendations above, we would ideally recommend that an analogous North Dakota use prices for the uninsured based on a stated percentage of Medicare rates.
Action Item: Internal Project Plans
Time to Completion: 12-24 Months

Insurers. Consumers will be unable to meaningfully shop until real-time benefit tools become more widely available. We encourage North Dakota policymakers to ***require the state's health plans to expand their out-of-pocket calculators to include real-time benefit information***, so that patients would know exactly where they stand on their deductibles and could assess their out-of-pocket costs while still at the doctor's office, pharmacy, or hospital. Real-time benefit tools are especially important for consumer and medical providers evaluating their prescription drug options including cash payment prices. We recommend that state law and insurance regulations clarify that health plans would be allowed to give patients financial rewards for using real-time out-of-pocket benefit calculators. We acknowledge that providing real-time cost calculators can be particularly difficult in cases where providers are not in insurers' networks, and estimated payments on unadjudicated claims from out-of-network providers may be more difficult to estimate in advance. This work is hard and complex, but it is also necessary in an era where most patients have substantial deductibles. In summary, insurers should have a similar

responsibility as providers for educating consumers on their possible costs, what their insurance will cover, and reviewing options that will help save the consumer money.

Action Item: Bulletin or Legislation
Time to Completion: 6-12 months

9. **Public Policy Price Disclosures:** Another key element of transparency is disclosure to taxpayers and state policymakers. Most health care providers benefit from tax advantages, municipal bond funding for construction, and receive direct subsidies and reimbursements from federal, state, and local governments. They are essentially public/private entities, and it is certainly in the public's interest to balance private-led innovation against public health and financial responsibilities. In general, we do not recommend all-payer claims databases (APCDs) for North Dakota. For one, with such a dominant insurer, the price and reimbursement data in those databases could be very sensitive. But even more importantly, we believe that states that have mandated APCDs have produced relatively little actionable information relative to the investment.

   Implementation:

   State Government*.** We recommend that ***North Dakota staff a position (or otherwise contract for) dedicated to tracking the state's health care costs, using data collected from insurers, hospitals, and other health care providers. Best case scenario would require a continuous transmission of information similar to the data compiled in this report. The data could be gathered from providers and insurers in the same formats as disclosures those entities already make to the AHA and the NAIC. Further, it could be supplemented or cross-checked against publicly available data. The state's providers and insurers would be required to provide to the Insurance Commissioner. Legislative action may be required to continue to require providers to supply same.

   Action Item: Internal Project Plan & Legislation
   Time to Completion: 6 months

10. **Right to Shop:** As highlighted above, there is significant cost variation for common procedures across North Dakota providers. Consumers often are referred by the medical provider to the most convenient care delivery center – often the local hospital. There may be cheaper alternatives with equal or even better quality outcomes, especially for services like colonoscopies or MRIs. Right to Shop legislation would allow insurers to make a cash payment back to a consumer when the consumer has shopped for and chosen a less expensive option.

    For consumers there is a trade-off. In some cases, the less expensive service may require some travel or other care coordination. However, many find the cash payment incentive enough to spend the time and energy finding the best quality

and cost-effective treatment. New Hampshire implemented the program in their state employee program and has saved an estimated $11 million in 3 years[41].

Implementation:

Insurers. A number of states have passed "Right to Shop" legislation. Insurers should be allowed the option of encouraging consumer shopping by providing direct consumer incentives.

***State Government*.** The New Hampshire program for state employees appears to have been a success. The state of North Dakota could consider a similar program in an effort to lead on the issue and provide data to the private industry.

Action Item: Legislation
Time to Completion: 6-12 months

Program Integrity. State governments are often the largest purchasers of health care in any given state. The state provides health care coverage to both its state employees and those on Medicaid. This provides an opportunity for the state to lead on a number of health care issues, help change the dynamics for the private market, and to provide data on success or failure. But there are landmines for the state to consider. Often, those eligible to be covered under state programs may also be eligible for other coverage, leading to confusion on the correct payer. Poorly designed state-run benefit programs can replace existing private dollars, leading to private market crowd-out and an inefficient use of taxpayer dollars. In implementing benefit programs, North Dakota should endeavor to cover only those intended to be eligible for the program.

Program integrity does just that. Program Integrity focuses on ensuring that consumers have coverage for their health needs from the correct payer and is an important tool to maximize taxpayer resources. Program integrity issues are almost unavoidable without a consistent outside focus. Whether it is mission creep, shifting priorities or just loss of focus, states stray away from dedicating time and resources to program integrity. Program integrity can provide quick and consistent wins. Through the use of risk-based contracts, states have the option to outsource program integrity initiatives. Because private companies do not get paid unless there are recoveries, there is very little downside to the state.

Market-wide, it is imperative that consumers are covered by the correct payer. Program integrity issues exist in Medicaid, the commercial market and the state group health population. For example, we understand that Pennsylvania is currently addressing their state employee population, and we believe a majority of Fortune 100 companies have done this for their employees. This is the perfect opportunity for high utilizers to be transitioned to the correct payer, rather than the state. Any savings accrued in the state employee health plan and

[41] Josh Archambault and Nic Horton. Right To Shop: The Next Big Thing In Health Care. Forbes. Aug 5, 2016. Available from: https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#31bda24b4f60.

Medicaid could result in a substantial return back to the state. Savings in the commercial population would drive down health insurance rates for all private consumers.

11. **Medicaid Integrity Audit:** When a consumer receives financial assistance, North Dakota law allows for full assignment of benefits with no time limit.[42] It is important for the state to periodically audit Medicaid enrollees receiving benefits for other options to receive benefits. In some cases, children may be eligible for coverage under a non-custodial parent. Some recipients have opted out of their employer coverage. In other cases, the care received was reimbursed as part of another lawsuit. Contingency fee contracts provide vendors the opportunity to find savings for the state. The state also has an opportunity to build program integrity requirements into the RFP for the Medicaid expansion.
    Action Item: Legislation and completion of an RFP process.
    Time to Completion: 12-18 months

12. **State Group Health Integrity Audit:** North Dakota's health insurance benefits are generous and encourage full family coverage. However, State employees and their families may be covered by a variety of health insurance plans including private health insurance coverage, Medicare, and rarely Medicaid. North Dakota could consider a similar audit and consider what – if any – ongoing procedural changes are necessary to ensure program integrity.
    Action Item:
    Time to Completion:

13. **State Group Health Waiver**: The state currently provides no-cost health insurance to state employees and their families.[43] In some cases, the employee may also be covered under their spouse's plan. The offer of "free" health insurance can and does lead to double coverage. One option is to provide a small bonus to state employees who choose to opt entirely out of coverage. It provides an option to avoid double coverage, provides the employee an additional benefit, and reduces costs**.**
    Action Item: Legislation
    Time to Completion: Less than 12 months**.**

14. **Coordination of Benefits:** Coordination of Benefits rules in health insurance clarify which insurer is responsible to pay for certain benefits. The rules work entirely automatically and are a great example of program integrity. The NAIC adopted changes to the model coordination of benefits rule in 2013 but North Dakota's rule dates to 2006. North Dakota should consider the merits of updating the rule.
    Action Item: Updated Regulation.
    Time to Completion: 12 months**.**

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[42] https://www.legis.nd.gov/information/acdata/pdf/75-02-02.1.pdf

[43] https://www.ndhealth.gov/HumanResources/Benefits.htm#:~:text=The%20State%20of%20North%20Dakota%20offers%20state%20employees,medical%20and%20child%20care%20expenses%29%20Employee%20Assistance%20Program.

Employer Coverage. The focus on insurance costs at the state and national level has primarily been on individual market ACA coverage which is a small percentage of the population. The vast majority of consumers receive coverage through their employer. As employer coverage continues to erode because of rising costs, states need to find new solutions to help employers.

15. **Study Combined Individual and Small Group Market :** Most states have an unstable individual market, but North Dakota appears to be in good shape. A number of states have combined their individual and small group markets to make it easier for small employers to offer coverage. For example, employers offering coverage in the District of Columbia Exchange set their subsidy level (an amount or plan level) and the employee chooses coverage. It provides administrative simplicity for the small employer and choice of benefits for the employee.

    Implementation:

    State: A one-year study would need to be completed with all stakeholders including insurers, employers, agents, and others. The study would have to consider the impact on the individual and small group markets separately and together.

    Action Item: Legislation
    Time to Completion: 12-24 months

Crisis & Pandemic Planning. It seems clear that some hospitals and insurers nationally were caught flat-footed by the pandemic. However, the Covid-19 crisis shouldn't have been complete surprise, based on our experience with numerous prior pandemics. Based on our preliminary analysis, the effects on North Dakota hospitals haven't been as dramatic as in harder-hit states. But this pandemic is not yet over.

16. **Risk Assessments:**
    Insurer Own Risk Solvency Assessment. Domestic insurers are required to file a highly confidential report that details the risks to their solvency called the Own Risk Solvency Assessment or ORSA. This board level report is expected to detail all of the potential risks facing an insurer. One option for future pandemic planning is to recommend that health insurers include discussions of pandemic risks.

    Implementation:

    Insurers: ORSA reports are required to be filed with insurers domiciled in the state. It is likely most insurers will include pandemic issues in their ORSA reports in the immediate aftermath of this pandemic. The important issue will be maintaining pandemic planning in the coming years. The insurance department should add the issue in their ORSA reviews and in any 5-year financial exams.

    Action Item: Insurance Department Bulletin
    Time to Completion: 24-36 months

Hospital Own Risk Assessment. Hospitals and hospital systems have been forced to lead throughout this pandemic. In many ways, hospitals have become the main point of contact for public health initiatives. Nationally, it has been clear that public health officials have needed to develop new reporting mechanisms to understand the availability of hospital beds, ICU's, and important equipment. We hope and expect those efforts will be made permanent. But public health issues need more attention and planning, especially at the local level. We are suggesting that the state mandate that hospitals and hospital systems conduct their own version of a risk assessment. These critical reports should be reviewed at the board level. The analysis should be highly confidential, and should consider financial, health, and disaster issues that could negatively impact the hospital and public health in the community.

Implementation:

Hospital: Insurer required ORSA reports were developed to ensure all insurers – from the smallest town mutual to the largest multinational insurer – had a framework to critically evaluate all possible risks facing the insurer. The report must be reviewed by the insurer's board. We are proposing a similar structure here that would require an evaluation by the hospital and its board. Over time, this annual evaluation will impact hospital operations and will foster ongoing discussions regarding hospital's public health obligations.

Action Item: Legislation, legislative study.
Time to Completion: 18-36 months

VII. Cost and Impact Discussion

For some of the policy alternatives noted above we have prepared preliminary cost estimates and discussion. Based on initial feedback from state policymakers, we would refine or expand this analysis for the final report.

Historically, public and private efforts to contain health costs have followed recessions. This makes sense, because a large share of health costs is paid directly by governments, whose revenues are constrained during recessions, and indirectly (via private insurers) by employers and employees, whose profits and wages are also squeezed in bad times. After the recession of the early 1980s, Congress enacted the PPS program, which cut Medicare's hospital payments, particularly for extended stays. Following the recession of the early 1990s, managed care programs flourished with strong employer support, with the goal of restraining private health costs. After the Great Recession of 2008, the growth of Medicare fees was constrained via sequestration.

It may seem odd to discuss cost containment during a pandemic, when many health care providers are pushed to heroic limits. However, the pandemic won't last forever, and nuts and bolts discussions of the growth of health costs vs. affordability for government, employer, and consumer budgets will inevitably return to the spotlight.

Option: Cap Patients' and Insurers' Responsibility for Out-of-Network Charges. In March 2020, researchers at RAND published a report demonstrating the savings and impact of capping hospitals rates for out-of-network services.[44] Medicare's payment rates are commonly used as a benchmark for insurers. This policy would effectively stem the ever-upward drift of commercial payment rates relative to those paid by Medicare by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates.

This policy would not directly affect rates for in-network providers. However, it would put downward pressure on in-network rates over time. If insurers would otherwise face in-network rates higher than the cap, they could switch the provider to out-of-network status and pay a lower amount. (Of course, there are other benefits to in-network status, such as data disclosures and quality measures, so some insurers may have an incentive to pay in-network providers more than the out-of-network cap in order to retain high-quality providers in their networks.)

We would view an out-of-network cap as potentially the least disruptive approach to limiting rates, compared with other policy alternatives such as public rate setting regime or public option alternative. We would recommend that the initial out-of-network rate cap be set quite high, such as at 220 percent of Medicare, so that provider payments would not be severely

[44] Erin Lindsey Duffy, Christopher Whaley, Chapin White, *The Price and Spending Impacts of Limits on Payments to Hospitals for Out-of-Network Care*, RAND (March 20,2020) https://www.rand.org/pubs/research_reports/RR4378.html

disrupted. For context, we estimate that state average was 207 percent in 2018 (see Table 9 above), and we estimate that the statewide average would be about 220 percent by 2021, when the policy would take effect. The cap could be held constant or gradually lowered over time to give healthcare providers time to adjust.

Table 61 below shows the potential impact for a flat cap that remained at 220 percent from 2021 through 2024. Claims would be reduced by $7 million in the individual market and $29 million in the large group (insured) market by 2024, and premiums would be lowered by 2-3%, by that year. In dollars, premiums would be lowered by $166-187 per year or about $15 per member per month by 2024.

Table 62 shows an option where the cap was gradually lowered from 220 percent in 2021 to 190 percent in 2024. Under this option, claims costs and premium reductions would be larger, with premiums falling by approximately $500 per year or about $40 PMPM by 2024.

Table 61.

Cost Impact -- Cap Out-of-Network Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
				Option 1 -- Flat Cap			
Cap Level				220%	220%	220%	220%
Reduction in Claims Cost (millions)							
Individual Market				-1	-2	-5	-7
Small Group Market				-1	-4	-7	-10
Large Group Insured Market				-2	-10	-19	-29
Percentage Reduction in Premiums							
Individual Market				0%	-1%	-2%	-2%
Small Group Market				0%	-1%	-2%	-2%
Large Group Insured Market				0%	-1%	-2%	-3%
Per-Capita Reduction in Premiums (annual)							
Individual Market				-12	-59	-110	-166
Small Group Market				-13	-65	-122	-184
Large Group Insured Market				-14	-67	-125	-187
Reduction in Premiums (PMPM)							
Individual Market				-1	-5	-9	-14
Small Group Market				-1	-5	-10	-15
Large Group Insured Market				-1	-6	-10	-16
Federal Tax/ACA Subsidy Savings (millions)							
Individual Market				0	-1	-1	-2
Small Group Market				0	-1	-2	-3
Large Group Insured Market				-1	-3	-6	-9
Total				**-1**	**-5**	**-9**	**-14**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change. PMPM = per member per month.

Table 62.

Cost Impact -- Cap Out-of-Network Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
					Option 2 -- Declining Cap		
Cap Level				220%	210%	200%	190%
Reduction in Claims Cost (millions)							
Individual Market				-1	-6	-13	-19
Small Group Market				-1	-10	-19	-28
Large Group Insured Market				-2	-26	-53	-81
Percentage Reduction in Premiums							
Individual Market				0%	-2%	-5%	-7%
Small Group Market				0%	-3%	-5%	-7%
Large Group Insured Market				0%	-3%	-5%	-7%
Per-Capita Reduction in Premiums (annual)							
Individual Market				-12	-151	-302	-463
Small Group Market				-13	-169	-335	-514
Large Group Insured Market				-14	-173	-342	-522
Reduction in Premiums (PMPM)							
Individual Market				-1	-13	-25	-39
Small Group Market				-1	-14	-28	-43
Large Group Insured Market				-1	-14	-29	-44
Federal Tax/ACA Subsidy Savings (millions)							
Individual Market				0	-2	-4	-6
Small Group Market				0	-3	-6	-8
Large Group Insured Market				-1	-8	-16	-24
Total				**-1**	**-13**	**-25**	**-38**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change. PMPM = per member per month.

The large group market in these estimates only includes “insured” health plans under state regulation, not so-called “self-funded” coverage operating under the federal ERISA program. The estimates also do not include NDPERS coverage.

Under both options, there would be federal savings as well, in both the individual market due to reduced ACA subsidies, and in the group markets due to revenue impacts. (When premiums are reduced for group coverage, federal tax analysts estimate that tax revenues increase, due to dollars being shifted from non-taxable employee benefits to taxable wages and profits.)

It would be a longshot, but it would be possible that North Dakota could apply via an ACA Section 1332 waiver to recoup the federal savings, at least from reduced ACA subsidies in the Individual market. Such a waiver application might have a more likely chance of success under a possible Biden Administration, which would be moving toward capping rates (or setting them) as a percent of Medicare as general policy.

Option: Re-Pricing Payment Rates for the Medicaid Expansion Population.
Medicaid expansion in North Dakota pays healthcare providers at rates more typical for commercial payers than those usually used for Medicaid enrollees not part of the expansion program. This option illustrates the magnitude of possible savings from bringing those rates down to those used in the rest of North Dakota's Medicaid program.

We used two methods of approximating the estimate – one using per-capita costs, one using payment rate ratios. Each has advantages and disadvantages. A disadvantage to the per-capita method implicitly assumes that the expansion has the same morbidity profile as the regular Medicaid (non-institutionalized) population. The ratio method is limited by our lack of data on the ratios of hospital costs to the overall. Given the uncertainties, we show both methods as a range of possibilities.

Since the state share of costs for the Medicaid expansion population is very small, the savings from this proposal would mostly accrue to the federal government (see Table 63). We estimate a range of state savings from $5 to $8 million in 2021, growing to $6 to $9 million in 2024.

Table 63.

Re-Price Medicaid Expansion at Regular Medicaid Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
				Medicaid Expansion, Baseline Assumptions			
Expansion Enrollment	21,100	22,570	26,373	24,576	25,044	25,520	26,005
Cost per Enrollee (annual)	$14,107	$12,961	$14,530	$14,618	$15,062	$15,520	$15,992
Expansion Cost, Fed + State (n	298	293	383	359	377	396	416
State Share	8%	8%	10%	10%	10%	10%	10%
State Cost, Baseline	23	23	38	35	37	39	41
				Potential Savings in Millions			
Total Savings -- Per-capita Method				-81	-85	-89	-93
State Share				**-8**	**-8**	**-9**	**-9**
Total Savings -- Ratio Method				-53	-57	-61	-65
State Share				**-5**	**-6**	**-6**	**-6**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change.

Option: Require Stricter Managed Care and Full Risk Health Plans in Medicaid. The Congressional Budget Office has issued two recent reports on potential savings from managed care in Medicare[45] and Medicaid.[46] To be fair, neither report directly specifies CBO's estimate of savings from tighter management of care by Medicaid or Medicare managed care organizations (MCOs). Nevertheless, we infer that the reports imply a potential savings of about 10 percent over time from the conversion of fee-for-service coverage to a strict managed care approach, and perhaps half of that potential savings from the conversion of loosely managed care to a

[45] Congressional Budget Office, A Premium Support System for Medicare: Updated Analysis of Illustrative Options (October 5, 2017) https://www.cbo.gov/publication/53077
[46] Congressional Budget Office, Exploring the Growth of Medicaid Managed Care (August 7, 2018) https://www.cbo.gov/publication/54235

stricter model.

We applied those potential savings amounts to North Dakota's Medicaid program, assuming the greater savings potential from the conversion of the non-expansion enrollee populations to strictly managed care, and the lesser savings from converting the current Medicaid expansion MCO to a stricter model. We assumed a phase-in period of five years, and that the additional administrative and implementation costs for the more tightly managed MCO model in Medicaid would add $10 million in costs per year for the non-expansion population and $5 million for the expansion population. We also assumed that those costs would be effectively eligible for federal matching at the usual rates.

Table 64 illustrates these potential costs (+) and savings (-), both for the Medicaid program as a whole in North Dakota and the state's share of those costs. We estimate that the net savings for North Dakota would be low at first, but would grow to about $25 million by the year 2024. Notably, by using overall savings estimates from Medicare bids and the experience of other state Medicaid managed care programs, we do not make explicit assumptions about exactly how these savings are achieved by MCOs. In theory, these savings estimates could be achieved by a variety of means, including improved Medicaid adherence, better access to primary care, and other methods.

Table 64.

Tighter Managed Care and Population Health Requirements in Medicaid		DRAFT		
	2021	2022	2023	2024
	Medicaid Claims Cost Savings (millions)			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	-12	-25	-39	-55
State Share	-5	-12	-19	-27
Expansion MCO	-4	-8	-12	-17
State Share	0	-1	-1	-2
	Health Plans' Implementation and Administrative Costs			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	10	10	10	10
State Share	3	3	3	3
Expansion MCO	5	5	5	5
State Share	0	0	0	0
	Net Cost (+) or Savings (-)			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	-2	-15	-29	-45
State Share	-2	-9	-16	-23
Expansion MCO	1	-3	-7	-12
State Share	0	0	-1	-1
Net State Cost (+) or Savings (-)	**-2**	**-9**	**-17**	**-25**

Source: Horizon Government Affairs.

Note: Assumes administrative and care coordination costs of Medicaid health plans would qualify for federal match. FFS = fee for service. MCO = Managed Care Organization. Components may not sum to totals due to rounding.

Appendix A – Hospital Data Request for AHA-Style Data

General info and Q&A calls Nov 7, Nov 12, Nov 21, Nov 26, and Dec 5, 2019. Hospitals returned data in December 2019 and January 2020.

Hospital Name											
		Example:	ST ALEXIUS MEDICAL CENTER								
Point of Contact for Your Hospital's Data Response											
	Name	Example:	Jane Smith								
	Email		jsmith@emailaddress.org								
	Cell		701 000 0000								
	Office		701 000 9999								
Hospital Fiscal or Reporting Year for Current Year and Projected Years											
	Begin Date	End Date									
Example:	Jan 1 2019	Dec 31 2019									
Table 1.							Current Year				
North Dakota Hospitals, Beds and Utilization, Baseline Historical 2010 to 20				<==		Historical	Estimated	Projected	==>		
All Participating Hospitals	2018 AHA	2010	2011	2017	2018		2019	2020	2021	2022	2023	2024
Hospital Fiscal Years as Reported to AHA	Definition						(or current year)					
Total licensed Beds	E.1.a.						Yr over Yr % Chg					
Beds set up and staffed for use (eoy)	E.1.b.						Yr over Yr % Chg					
Admissions (exclude newborns, etc.	E.1.e.						Yr over Yr % Chg					
Inpatient Days	E.1.f.						Yr over Yr % Chg					
ED visits	E.1.g.						Yr over Yr % Chg					
Total outpatient visits	E.1.h.						Yr over Yr % Chg					
Inpatient surgical operations	E.1.i.						Yr over Yr % Chg					
Outpatient surgical operations	E.1.k.						Yr over Yr % Chg					
Medicare inpatient discharges	E.2.a1.						Yr over Yr % Chg					
Medicare inpatient days	E.2.b1.						Yr over Yr % Chg					
Medicaid discharges (total)	E.2.c1						Yr over Yr % Chg					
Medicaid inpatient days	E.2.d1						Yr over Yr % Chg					
Source: Horizon Government Affairs.												
Notes:												
Estimated data for current year should be based on observed growth over same months in prior fiscal year.												
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.												
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.												
Data exclude nursing home units/facilities.												

Table 2.									
North Dakota Hospitals, Key Financial Indicators, Baseline Historical 2010 to 2024 (projected, curre						Current Year			
				<==	Historical	Estimated	Projected	==>	
Hospital Fiscal Years as Reported to AHA	2018 AHA	2010	2011	2017	2018	2019	2020	2021	2022
	Definition					(current year)			
Net Patient Revenue	E.3.a.	As Reported to AHA				Yr over Yr % Chg	Projected		
Tax Appropriations	E.3.b.					Yr over Yr % Chg			
Other Operating Revenue	E.3.c.					Yr over Yr % Chg			
Nonoperating Revenue	E.3.d.					Yr over Yr % Chg			
Total Revenue	E.3.e.					Yr over Yr % Chg			
Payroll Expense	E.3.f.					Yr over Yr % Chg			
Employee Benefits	E.3.g.					Yr over Yr % Chg			
Depreciation	E.3.h.					Yr over Yr % Chg			
Interest Expense	E.3.i.					Yr over Yr % Chg			
Pharmacy Expense	E.3.j.					Yr over Yr % Chg			
Supply Expense (other than pharmacy)	E.3.k.					Yr over Yr % Chg			
All Other Expenses	E.3.l.					Yr over Yr % Chg			
Total Expenses	E.3.m.					Yr over Yr % Chg			
Total Gross Inpatient Revenue	E.4.a.					Yr over Yr % Chg			
Total Gross Outpatient Revenue	E.4.c.					Yr over Yr % Chg			
Total Gross Patient Revenue	E.4.b.					Yr over Yr % Chg			
Bad Debt	E.5.a.					Yr over Yr % Chg			
Financial Assistance	E.5.b.					Yr over Yr % Chg			
Medicare Gross Revenue	E.6.a.(1)(c)(1)					Yr over Yr % Chg			
Medicare Net Revenue	E.6.a.(1)(c)(2)					Yr over Yr % Chg			
Medicaid Gross Revenue	E.6.a.(2)(g)(1)					Yr over Yr % Chg			
Medicaid Net Revenue	E.6.a.(2)(g)(2)					Yr over Yr % Chg			
Self Pay Gross Revenue	E.6.b.(1)(1)					Yr over Yr % Chg			
Self Pay Net Revenue	E.6.b.(1)(2)					Yr over Yr % Chg			
Third Party Payers Gross Revenue	E.6.b.(2)(c)(1)					Yr over Yr % Chg			
Third Party Payers Net Revenue	E.6.b.(2)(c)(2)					Yr over Yr % Chg			
All Other Non-Government Gross Reven	E.6.b.(3)(1)					Yr over Yr % Chg			
All Other Non-Government Net Revenue	E.6.b.(3)(2)					Yr over Yr % Chg			
Total Margin	E.7.a.					Year to Date			
Operating Margin	E.7.b.					Year to Date			
Medicare Margin	E.7.d.					Year to Date			
Medicaid Margin	E.7.e.					Year to Date			
Total Capital Expenses	E.9.					Yr over Yr % Chg			
Source: Horizon Government Affairs.									
Notes:									
Estimated data for current year should be based on observed growth over same months in prior fiscal year (Yr over Yr % Chg) or Year to Date as marked									
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.									
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.									
Data exclude nursing home units/facilities.									

Table 3.						
North Dakota Hospitals, Privileged Physicians, Baseline Historical 2010 to 2018						
				<==	Historical	
Hospital Fiscal Years as Reported to AHA	2018 AHA	2010	2011	2017	2018	
	Definition				(or most recent year)	
		Total Employed				
Primary Care	E.12.a.(1)	As Reported to AHA				
Emergency Medicine	E.12.b.(1)					
Hospitalist	E.12.c.(1)					
Intensivist	E.12.d.(1)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(1)					
Other Specialist	E.12.f.(1)					
Total	E.12.g.(1)					
		Total Individual Contract				
Primary Care	E.12.a.(2)					
Emergency Medicine	E.12.b.(2)					
Hospitalist	E.12.c.(2)					
Intensivist	E.12.d.(2)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(2)					
Other Specialist	E.12.f.(2)					
Total	E.12.g.(2)					
		Total Group Contract				
Primary Care	E.12.a.(3)					
Emergency Medicine	E.12.b.(3)					
Hospitalist	E.12.c.(3)					
Intensivist	E.12.d.(3)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(3)					
Other Specialist	E.12.f.(3)					
Total	E.12.g.(3)					
		Not Employed or Under Contract				
Primary Care	E.12.a.(4)					
Emergency Medicine	E.12.b.(4)					
Hospitalist	E.12.c.(4)					
Intensivist	E.12.d.(4)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(4)					
Other Specialist	E.12.f.(4)					
Total	E.12.g.(4)					
		Total, Privileged				
Primary Care	E.12.a.(5)					
Emergency Medicine	E.12.b.(5)					
Hospitalist	E.12.c.(5)					
Intensivist	E.12.d.(5)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(5)					
Other Specialist	E.12.f.(5)					
Total	E.12.g.(5)					
Source: Horizon Government Affairs.						
Notes:						
Estimated data for current year should be based on observed growth over same months in prior fiscal year.						
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.						
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.						
Data exclude nursing home units/facilities.						

Appendix B – Information from IRS Form 990s and Financial Statements/Prospectuses

We looked at both form 990s and other financial statements to cross-check our data. Note, this is not a complete analysis. However, here are some preliminary notes on the data gathering process from these sources:

- **Financial Statements:** We found a fair share of financial statements, but there will be several years that has no information for some hospitals as there was no publicly available documentation for those respective years. As discussed previously, for the hospitals that are doing business under the Catholic Health Initiatives, this section is left unfilled.

- **Schedule H:** For Schedule H, which provides information of hospitals' bad debt, financial assistance and community benefits, it appears that submission of this document began in FY2013. Thus, there will be no data entries for 2010-2012.

- **Municipal Revenue Bonds:** For this section, there is still work to do based on differences in issued prices reported in the Schedule K (990) and on the Electronic Municipal Market Access (EMMA) platform—next step includes understanding the differences in reporting requirements for both sources. Additionally, as in the case with Trinity, a revenue bond reported on the Schedule K couldn't be found on EMMA when entering the CUSIP# considering that it was a recently issued revenue bond. Moreover, some hospitals did not have Schedule K submissions and/or other type of revenue bond information, so this section will be unfilled for those hospitals. Further fact-checking is required for this section before deriving any conclusions.

- **Public Benefits:** We are studying public benefits and will add a section describing those and presenting data from hospitals in future progress reports. A section highlighting major hospitals' Financial Assistance Programs under IRS 501(r)(4) is included below.

ALTRU HEALTH SYSTEM

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**404,376,500**	**431,707,747**	**468,848,735**	**479,576,615**	**498,703,511**	**522,975,652**	**541,032,394**	**563,948,218**
Contributions and grants	1,769,870	2,217,753	2,240,058	2,714,445	3,676,190	4,371,202	3,111,765	2,878,464
Program service revenue	398,290,568	424,145,122	463,961,841	467,457,435	489,329,541	516,692,202	542,028,176	555,999,359
Investment income	3,874,572	4,921,726	2,230,007	9,018,944	5,382,811	1,754,115	(4,271,017)	4,914,964
Other revenue	441,490	423,146	416,829	385,791	314,969	158,133	163,470	155,431
Expenses	**381,071,295**	**414,810,580**	**453,809,727**	**471,698,614**	**477,657,709**	**504,285,525**	**535,095,068**	**565,165,343**
Grants	68,673	106,934	267,360	244,179	288,959	31,740	1,023,468	1,062,049
Salaries/Emp. Benefits	235,908,618	249,507,009	273,143,881	285,707,820	296,361,790	307,765,281	323,595,510	338,818,207
Other expenses	145,094,004	165,196,637	180,398,486	185,746,615	181,006,960	196,488,504	210,476,090	225,285,087
Revenue less expenses	23,305,205	16,897,167	15,039,008	7,878,001	21,045,802	18,690,127	5,937,326	(1,217,125)
Total Assets	371,999,674	380,667,327	453,496,991	455,613,013	470,129,714	480,240,011	478,270,432	548,207,089
Total Liabilities	227,020,666	235,692,188	290,811,356	269,648,753	274,517,289	268,918,642	262,658,959	282,364,561
Net assets or fund balances	144,979,008	144,975,139	162,685,635	185,964,260	195,612,425	211,321,369	215,611,473	265,842,528
Bad Debt Expense				23,893,645	16,447,811	11,511,135	9,148,528	9,480,521
Medicare								
Revenue Received (incl. DSH & IME)				104,577,110	110,421,745	123,534,578	124,341,171	130,670,289
Allowable Cost of Care re: payments				307,658,779	330,642,790	349,787,424	375,910,924	394,057,285
Surplus (Shortfall)	0	0	0	(203,081,669)	(220,221,045)	(226,252,846)	(251,569,753)	(263,386,996)

Source: Altru Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Orthopedics	21,812,238	22,086,073	22,977,684	20,328,051	18,649,827	19,766,131	33,267,692	34,412,616
Cardiology	18,032,640	18,626,589	16,608,949	16,291,841	12,727,072	15,469,228	16,200,213	16,480,769
General Surgery	14,066,914	14,155,204	14,245,444	14,998,322	15,407,955	17,470,919	17,401,971	16,511,963
Other program services	340,903,727	366,084,337	403,083,516	415,694,194	440,998,320	457,919,380	462,967,410	484,206,695
Total	**394,815,519**	**420,952,203**	**456,915,593**	**467,312,408**	**487,783,174**	**510,625,658**	**529,837,286**	**551,612,043**
Expenses								
Orthopedics	17,555,778	18,652,584	16,961,112	14,464,727	12,495,038	11,641,749	17,176,606	19,028,382
Cardiology	13,608,082	16,539,952	12,212,587	12,807,551	9,722,848	11,849,885	10,714,406	10,567,623
General Surgery	9,242,009	10,324,126	9,821,228	10,809,208	10,412,263	11,872,371	10,688,470	8,016,521
Other program services	307,524,870	332,278,022	353,323,575	389,356,930	396,729,210	416,660,541	438,579,076	455,745,935
Total	**347,930,739**	**377,794,684**	**392,318,502**	**427,438,416**	**429,359,359**	**452,024,546**	**477,158,558**	**493,358,461**

Source: Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				5.72%	6.29%	4.39%	4.39%	3.98%
Financial Assistance at cost				3,566,208	3,354,429	2,773,818	2,445,008	2,119,706
Medicaid				22,016,320	25,804,508	18,314,583	20,016,397	19,447,748
Costs of other				1,376,658	887,259	1,055,047	1,017,567	896,723
Total	0	0	0	26,959,186	30,046,196	22,143,448	23,478,972	22,464,177
Other Benefits, net				0.33%	0.38%	0.43%	0.35%	0.36%
Community health improvement services and community benefit operations				834,664	1,053,906	1,041,072	907,359	1,159,720
Health professions education				475,189	460,451	631,029	663,027	608,719
Subsidized health services				0	0	0	0	0
Research				227,035	236,175	281,840	222,189	78,498
Cash and in-kind contributions for community benefit				8,707	41,530	133,052	107,375	147,000
Total, Other benefits	0	0	0	1,545,595	1,792,062	2,086,993	1,899,950	1,993,937
Total, Overall	0	0	0	28,504,781	31,838,258	24,230,441	25,378,922	24,458,114
%, Total Expense	0.00%	0.00%	0.00%	6.05%	6.67%	4.82%	4.74%	4.34%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Principal Amount	Issue Price	Description of purpose
City of Grand Forks	38546WCC2	5/1/2012	37855000	117025978	Refund Bonds issued in 1997, amd 2010A/2010B
City of Grand Forks	38546WCR9	7/12/2017		65233846	Refund bonds issued in 2005; finance facilities, imfrastructure, equipment
City of Grand Forks		9/6/2017		21720835	Refund binds issued in 2007

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Abdel Ahmed	1,647,335
Mickey Syrquin	1,096,754
Mohamed Chebaclo	1,050,573
Ikechukwu Onyeka	974,234
Ronald Brockman	901,315
Donald Debeltz MD	488,584
Casey Ryan MD	482,691
James Hargreaves DO	432,117
Matthew Roller MD	430,382
David Molmen	420,142

2011	
Name/Title	Compensation
Abdel Ahmed	1,772,882
Mickey Syrquin	1,084,630
Ikechukwu Onyeka	1,080,120
Srinivas Pulagam	991,465
Randall Smith	949,994
James Hargreaves DO	583,760
Bradley Belluk MD	528,424
Casey Ryan MD	523,082
David Molmen	496,947
Matthew Roller MD	452,907

2012	
Name/Title	Compensation
Abdel Ahmed, *Physician*	1,857,653
Mickey Syrquin, *Physician*	1,073,900
Ikechukwu Onyeka, *Physician*	1,044,641
Barry Bjorgaard, *Physician*	1,016,076
Randall Smith, *Physician*	887,745
Casey Ryan MD, *Board Member/Pre*	559,562
David Molmen, *Board Member/CEO*	540,235
Bradley Belluk MD, *Board Member/I*	521,348
Matthew Roller MD, *Baord Member/*	442,147
Dwight Thompson, *CFO/Treasurer*	392,025

2013	
Name/Title	Compensation
Abdel Ahmed, *Physician*	1,861,365
Ikechukwu Onyeka, *Physician*	1,137,914
Srinivas Pulagam, *Physician*	999,728
Charles Owens, *Physician*	887,777
Randall Smith, *Physician*	874,330
Casey Ryan MD, *Board Member/President/Physician*	580,384
David Molmen, *Board Member/CEO*	573,431
Scott Charette MD, *Medical Director Surgical Care*	572,715
Bradley Belluk MD, *Board Member/Physician*	515,048
Dwight Thompson, *CFO/Treasurer*	465,290

2014	
Name/Title Name/Title	Compensation
Ikechukwu Onyeka, *Phsyician*	1,187,870
Charles Wood, *Physician*	1,034,294
Srinivas Pulagam, *Physician*	1,033,191
Rabeea Aboufakher, *Physician*	944,870
Abdel Ahmed, *Physician*	921,341
Casey Ryan MD, *Board Member/President/Physician*	691,056
David Molmen, *Board Member/CEO*	645,753
Scott Charette, *Medical Director Surgical*	549,182
Matthew Roller MD, *Board Member/Physician*	523,041
Bradley Belluk MD, *Board Member/Physician*	520,951

2015	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,216,893
David Molmen, *CEO*	1,081,280
Rabeea Aboufakher, *Physician*	988,595
Abdel Ahmed, *Physician*	911,630
Srinivas Pulagam, *Physician*	916,590
Charles Owens, *Physician*	887,114
Eric Lunn, *Board Member/Physician*	701,728
Bradley Wehe, *Board Member/COO*	658,672
Dwight Thompson, *CFO/Treasurer*	653,892
Scott Charette, *Medical Director Surgical*	633,204

2016	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,365,472
David Molmen, *CEO*	1,090,019
Rabeea Aboufakher, *Physician*	997,739
Atilla Dalmi, *Physician*	971,018
Darin Leetun, *Physician*	936,051
Dwight Thompson, CFO/Treasurer	763,197
Eric Lunn, *Board Member/Physician*	758,465
Scott Charette, *Medical Director Surgical*	699,246
Bradley Wehe, *Board Member/COO*	678,098
Colleen Swank MD, *Chief Medical Officer*	589,528

2017	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,426,413
Rabeea Aboufakher, *Physician*	1,187,637
Atilla Dalmi, *Physician*	1,014,939
Charles Owen, *Physician*	938,958
Sunil Kartham, *Physician*	923,415
Abdel Ahmed, *Physician*	911,630
David Molmen, *CEO*	846,935
Dwight Thompson, *CFO/Treasurer*	754,671
Jeremy Gardner, *Medical Director*	712,205
Scott Charette, *Medical Director Surgical*	657,869

Source: Altru Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?
Assets									
Current Assets		$ 320,178,922	$ 280,054,731	$ 270,730,636				$ 240,610,408	$ 226,672,418
Limited Use Assets		29,810,407	30,396,027	27,415,232				18,368,259	30,376,301
Property, Plant & Equipment		203,335,952	198,434,986	205,623,938				142,526,810	135,558,001
Other Assets		8,865,990	9,274,539	7,226,506				4,551,519	4,244,817
Total Assets	**-**	**562,191,271**	**518,160,283**	**510,996,312**	**-**	**-**	**-**	**406,056,996**	**396,851,537**
Liabilities and Net Assets									
Current Liabilities		55,746,269	63,662,106	58,623,991				54,300,051	52,487,196
Long-Term Liabilities		225,475,903	201,358,056	208,689,758				184,584,345	177,271,800
Total Liabilities		281,222,172	265,020,162	267,313,749	-	-	-	238,884,396	229,758,996
Net Assets		280,969,099	253,140,121	243,682,563				167,172,600	167,092,541
Total Liabilities & Net Assets	$ -	$ 562,191,271	$ 518,160,283	$ 510,996,312	$ -	$ -	$ -	$ 406,056,996	$ 396,851,537

Income Statement

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?
Unrestricted Operating Revenue									
Patient Service Revenue		$ 533,215,486	$ 522,763,865	$ 500,727,804				$ 414,545,592	$ 390,262,581
Provision for Bad Debts		(9,880,302)	(9,255,097)	(11,570,421)				(29,151,584)	(18,618,905)
Net Patient Revenue	-	523,335,184	513,508,768	489,157,383	-	-	-	385,394,008	371,643,676
Other Operating Revenue		41,401,503	37,804,757	37,598,553				22,001,873	19,734,977
Total Operating Revenue	-	564,736,687	551,313,525	526,755,936	-	-	-	407,395,881	391,378,653
Unrestricted Operating Expenses									
Patient care Services		85,070,813	86,168,011	79,906,192				55,609,884	51,332,616
Clinic Professional Services		186,666,225	177,825,264	158,737,640				123,798,591	113,260,706
Other Professional Services		92,495,448	92,121,844	89,858,055				79,307,432	79,538,883
Other Services		4,342,418	4,084,427	4,677,166				4,333,329	4,729,977
General Services		25,289,048	24,816,414	25,187,722				19,435,031	18,104,304
Administrtive Services		72,889,707	60,240,576	54,568,811				35,961,439	32,119,365
Amoritization of Other Costs		141,713	146,752	123,135				609,858	687,734
Real Estate Taxes		881,513	945,225	926,935				673,660	602,360
Interest		8,602,086	8,719,051	8,903,109				6,549,921	6,530,463
Depreciation		26,829,770	27,304,334	28,391,468				20,792,774	18,630,076
Insurance		2,495,461	2,651,344	2,702,743				2,082,579	2,941,450
Employee Benefits and Payroll Taxes		58,259,505	52,456,799	52,939,889				46,045,786	42,901,413
Total Operating Expense	-	563,963,707	537,480,041	506,922,865	-	-	-	395,200,284	371,379,347
Net Income from Operations		**772,980**	**13,833,484**	**19,833,071**	**-**	**-**	**-**	**12,195,597**	**19,999,306**
Other Income - Primary Investments		7,355,366	3,591,792	2,124,815				5,899,511	4,615,985
Other Expense - Impairment		-	(7,071,248)	-				-	-
Other Expense		(269,688)	(269,688)	(269,688)				(1,086)	(44,531)
Cash Balance Settlement Expense		(3,463,026)	-	-				-	-
Loss on Advance Bond Refunding		(1,408,850)	-	-				-	-
Total Other Income (Expense)		2,213,802	(3,749,144)	1,855,127	-	-	-	5,898,425	4,571,454
Excess Revnue over Expense		**2,986,782**	**10,084,340**	**21,688,198**	**-**	**-**	**-**	**18,094,022**	**24,570,760**
Unrealized Gain/(Loss) on Investments		13,724,411	5,855,499	(2,344,648)				(1,908,999)	6,666,992
Increase in Unrestricted Net Assets	$ -	$ 16,711,193	$ 15,939,839	$ 19,343,550	$ -	$ -	$ -	$ 16,185,023	$ 31,237,752

Source: Altru Audited Financial Statements, 2010-2017

INNOVIS HEALTH LLC

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As: Essentia Health West

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**259,370,424**	**272,859,742**	**300,121,459**	**333,821,248**	**356,239,221**	**363,725,628**	**373,471,417**	**370,391,230**
Contributions and grants	37,133	45,813	272,147	296,483	197,882	367,535	166,865	156,981
Program service revenue	259,134,360	270,973,139	297,713,532	330,732,484	351,579,702	359,254,512	371,245,879	368,689,895
Investment income	(2,182,423)	(704,791)	(359,139)	(1,796,536)	(96,797)	(753,709)	162,661	(682,038)
Other revenue	2,381,354	2,545,581	2,494,919	4,588,817	4,558,434	4,857,290	1,896,012	2,226,392
Expenses	**260,636,475**	**285,329,352**	**303,482,084**	**325,006,503**	**333,859,123**	**362,753,939**	**376,194,458**	**378,942,827**
Grants	250,000	577,502	527,425	580,046	567,432	446,638	402,654	388,694
Salaries/Emp. Benefits	144,171,719	151,490,833	157,665,642	163,270,817	167,140,007	182,217,515	194,258,048	199,752,589
Other expenses	116,214,756	133,261,017	145,289,017	161,155,640	166,151,684	180,089,786	181,533,756	178,801,544
Revenue less expenses	(1,266,051)	(12,469,610)	(3,360,625)	8,814,745	22,380,098	971,689	(2,723,041)	(8,551,597)
Total Assets	206,182,462	220,177,623	202,614,626	220,061,557	294,543,640	303,736,083	287,530,202	280,506,448
Total Liabilities	201,905,639	230,886,064	215,571,832	224,983,615	277,168,617	289,568,679	276,854,758	277,532,422
Net assets or fund balances	4,276,823	(10,708,441)	(12,957,206)	(4,922,058)	17,375,023	14,167,404	10,675,444	2,974,026
Bad Debt Expense				26,536,766	20,695,964	12,002,754	12,093,910	8,803,788
Medicare								
Revenue Received (incl. DSH & IME)				68,203,119	71,182,090	73,859,989	78,229,343	83,132,595
Allowable Cost of Care re: payments				70,710,482	69,188,290	86,061,965	93,020,318	103,573,835
Surplus (Shortfall)	0	0	0	(2,507,363)	1,993,800	(12,201,976)	(14,790,975)	(20,441,240)

Source: Innovis Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Overall	259,134,360	270,973,139	297,713,532	330,732,484	351,579,702	359,254,512	371,245,879	368,689,895
Total	**259,134,360**	**270,973,139**	**297,713,532**	**330,732,484**	**351,579,702**	**359,254,512**	**371,245,879**	**368,689,895**
Expenses								
Overall	203,073,962	205,275,235	228,102,956	266,993,571	272,849,081	304,828,012	330,236,114	337,757,025
Total	**203,073,962**	**205,275,235**	**228,102,956**	**266,993,571**	**272,849,081**	**304,828,012**	**330,236,114**	**337,757,025**

Source: Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				3.93%	2.20%	2.58%	3.51%	3.68%
Financial Assistance at cost				2,880,985	3,252,865	3,558,757	4,204,613	4,958,133
Medicaid				8,826,766	3,640,169	5,523,278	8,601,379	8,671,851
Costs of other				0	0	0	0	0
Total	0	0	0	11,707,751	6,893,034	9,082,035	12,805,992	13,629,984
Other Benefits, net				0.35%	0.34%	0.40%	0.48%	0.52%
Community health improvement services and community benefit operations				112,109	170,840	283,980	477,500	204,586
Health professions education				935,927	905,859	1,114,965	1,123,161	1,622,873
Subsidized health services				0	0	0	1,071	0
Research				0	0	0	0	0
Cash and in-kind contributions for community benefit				0	0	4,175	130,227	78,360
Total, Other benefits	0	0	0	1,048,036	1,076,699	1,403,120	1,731,959	1,905,819
Total, Overall	0	0	0	12,755,787	7,969,733	10,485,155	14,537,951	15,535,803
%, Total Expense	0.00%	0.00%	0.00%	4.28%	2.54%	2.98%	3.99%	4.20%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount at Issuance	Issue Price	Description of Purpose
MN AG & ECON DEVEL BRD	604920Z43	2008-05-02	2/15/2038	4.75%	4,410,000	42,909,274	SRS 2008E Bonds
CASS COUNTY ND	148047AU7	7/12/2017	2/15/2037	5.125%	61,100,000	59,573,111	SRS 2008A REOFF
WI HEALTH AND EDUCATION FACILITI	97710BSD5	2/25/2010	2/15/2030	5.125%	12,975,000	12,854,722	SRS 2008B REOFF
MN AG & ECON DEVEL BRD	6049202H0	2/25/2010	2/15/2030	5.000%	52,860,000	165,717,405	SRS 2008C REOFF
CASS COUNTY ND	148047AX1	6/3/2014	2/15/2044	4.790%	45,000,000	45,000,000	SRS 2014-ND Bonds

Source: Schedule K (Form 990); EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Daniel Smith MD, *Surgeon*	1,333,094
Jerome Sampson MD, *Radiologist*	1,163,114
Aaron Wright MD, *Radiologist*	1,075,630
Marc Eichler MD, *Neurosurgeon*	1,021,337
Francis Cormier MD, *Orthopedic Surgeon*	994,342
Timothy Mahoney MD, *Clinical Services C*	879,821
Gregory Glasner MD, *President*	786,910
Kevin Pitzer, *Chief Administrative Officer*	583,363
Richard Vetter MD, *Clinical Services Chie*	566,434
Michael Briggs MD, *Clinical Services Chie*	391,355

2011	
Name/Title	Compensation
Bradford Selland MD	1,091,597
Daniel Smith MD	1,048,431
Jerome Sampson MD	915,887
Aaron Wright MD	913,766
Francis Comier MD	897,042
Timothy Mahoney	Timothy Mahoney	732,287
Gregory Glasner I	Gregory Glasner I	709,258
Kevin Pitzer	556,994
Richard Vetter MD	490,604
Robert Wroblewski MD	392,583

2012	
Name/Title	Compensation
Bradford Selland MD	1,368,964
Daniel Smith MD	1,217,613
Francis Comier MD	1,048,221
Jerome Sampson MD	907,524
Aaron Wright MD	819,831
Timothy Mahoney MD	641,513
Gregory Glasner MD	606,533
Kevin Pitzer	487,418
Richard Vetter MD	480,101
Robert Wroblewski MD	408,083

2013	
Name/Title	Compensation
Michael Hill MD, *Physician*	1,289,918
Daniel Smith MD, *Physician*	1,128,453
Francis Cornier MD, *Physician*	1,024,015
Jerome Sampson MD, *Physician*	981,513
Bradford Selland MD, *Physician*	873,536
Gregory Glasner MD, *President & CMO*	713,333
Timothy Mahoney MD, *Clinical Services C*	706,836
Richard Vetter MD, *Clinical Services Chie*	537,639
Peter Jacobson, *West SVP/Pres EH St M*	456,531
Michael Briggs MD, *Clinical Services Chie*	429,205

2014	
Name/Title	Compensation
Michael Hill MD, *Physician*	1,195,989
Daniel Smith MD, *Physician*	1,128,521
Abdul Baker MD, *Physician*	1,084,725
Saeed Ally MD, *Physician*	1,034,325
Jerome Sampson MD, *Physician*	1,004,529
Gregory Glasner MD, *President & C*	694,700
Timothy Mahoney MD, *Clinical Serv*	651,180
Richard Vetter MD, *Clinical Services*	488,650
Doug Vang, *SVP Hospital OPS Thru*	486,377
Peter Jacobson, *West SVP/Pres EH*	450,949

2015	
Name/Title	Compensation
Abdul Baker MD, *Physician*	1,503,276
Daniel Smith MD, *Physician*	1,219,301
Saeed Ally MD, *Physician*	1,107,273
Jerome Sampson MD, *Physician*	1,061,399
Mickey Syrquin MD, *Physician*	1,013,848
Gregory Glasner MD, *President & C*	674,665
Timothy Sayler, *Chief Operating Offi*	671,509
Robert Wroblewski MD, *Board Direc*	589,013
Peter Jacobson, *SVP Regional & Pr*	501,365
Richard Vetter MD, *Primary Care Cl*	495,036

2016	
Name/Title	Compensation
Abdul Baker MD, *Physician*	2,037,310
Daniel Smith MD, *Physician*	1,276,615
Benjamin Smith MD, *Physician*	1,142,473
Mitchell Crider MD, *Physician*	1,076,262
Jerome Sampson MD, *Physician*	1,001,146
Gregory Glasner MD, *President*	824,161
Robert Wroblewski MD, *Board Director*	565,547
Timothy Sayler, *Chief Operating Officer*	562,514
Richard Vetter MD, *Physician Chief, Primary Care Services,*	495,633
Stefanie Gefroh Ellison MD, *Physician Chief, Hospital Base*	461,981

2017	
Name/Title	Compensation
Daniel Smith MD, *Physician*	1,225,020
Abdul Baker MD, *Physician*	1,150,604
Mitchel Crider MD, *Physician Leade*	1,039,185
Benjamin Smith MD, *Physician*	990,603
Sumit Tiwari MD, *Physician*	986,901
Gregory Glasner MD, *President*	740,185
Timothy Sayler, *Chief Operating Off*	581,894
Robert Wroblewski MD, *Board Direc*	544,076
Scott Johnson MD, *Chief Medical O*	541,023
Richard Vetter MD, *Physician Leade*	536,160

Source: Innovis Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Assets										
Current Assets	$ 419,422	$ 401,767		$ 418,945	$ 397,664					
Limited Use Assets	1,810,901	1,113,331		654,605	514,292					
Property, Plant & Equipment	739,073	714,760		619,867	591,094					
Other Assets	109,846	109,932		121,942	126,735					
Total Assets	**3,079,242**	**2,339,790**	**-**	**1,815,359**	**1,629,785**	**-**	**-**	**-**	**-**	**-**
Liabilities and Net Assets										
Current Liabilities	277,666	251,730		235,192	214,458					
Long-Term Liabilities										
Total Liabilities	1,732,172	1,076,602		1,014,017	931,586	-	-	-	-	-
Net Assets	1,347,070	1,263,188		801,342	698,199					
Total Liabilities & Net Assets	$ 3,079,242	$ 2,339,790	$ -	$ 1,815,359	$ 1,629,785	$ -	$ -	$ -	$ -	$ -

Income Statement

Period ending date	6/29/2018	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Operating Revenue										
Patient Service Revenue	$ 2,102,254	$ 2,010,148		$ 1,894,389	$ 1,817,193					
Provision for Bad Debts	-	-		61,176	62,792					
Net Patient Revenue	2,102,254	2,010,148	-	1,955,565	1,879,985	-	-	-	-	-
Other Operating Revenue	65,933	56,128		-	-					
Total Operating Revenue	2,168,187	2,066,276	-	1,955,565	1,879,985	-	-	-	-	-
Unrestricted Operating Expenses										
Salaries, wages and related benefits	1,346,976	1,299,906		1,205,914	1,156,448					
Supplies	358,651	336,662		312,897	292,713					
Purchased services and professional fees	83,247	83,946		71,987	70,828					
Utilities and maintenance	72,891	71,059		-	-					
Professional liability and general insuranc	15,960	23,039		-	-					
Depreciation and amortization	91,068	91,462		86,664	80,323					
Interest	25,725	25,456		-	-					
Provider and other taxes	34,914	31,928		-	-					
Other	78,354	79,868		218,636	214,335					
Campus replacement and other costs	6,931	11,986		-	-					
Total Operating Expense	2,114,717	2,055,312	-	1,896,098	1,814,647	-	-	-	-	-
Net Income from Operations	**53,470**	**10,964**	**-**	**59,467**	**65,338**	**-**	**-**	**-**	**-**	**-**
Investment income on funds	19,510	15,299								
Net realized gains on investments	35,066	19,724							-	-
Net change in unrealized gains and losse	(3,066)	53,092								
(Loss) Gains on swap agreements	(2,680)	3,457		-	-				-	-
Other, net	(4,013)	(1,383)		(50,792)	16,948				-	-
Total nonoperating gains, net	44,817	90,189	-	(50,792)	16,948	-	-	-	-	-
Excess Revnue over Expense	**98,287**	**101,153**	**-**	**8,675**	**82,286**	**-**	**-**	**-**	**-**	**-**
Pension and other postretirment liability a	(16,977)	18,380								
Other, net	1,236	876								
Increase in Net Assets	$ 82,546	$ 120,409	$ -	$ 8,675	$ 82,286	$ -	$ -	$ -	$ -	$ -

Source: Essentia Audited Financial Statements, 2010-2017

SANFORD (Group, includes other states)

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**2,379,772,843**	**2,820,513,337**	**3,405,373,090**	**3,652,696,559**	**3,411,016,895**	**3,621,661,130**	**3,741,477,877**	**3,924,093,992**
Contributions and grants	50,707,291	59,295,812	68,966,991	55,758,028	59,401,173	55,386,334	70,015,308	72,701,349
Program service revenue	2,316,427,369	2,755,702,179	3,329,759,934	3,589,720,396	3,338,667,965	3,553,249,301	3,669,768,613	3,844,742,598
Investment income	10,847,236	3,651,009	4,594,569	2,764,588	8,788,377	8,700,289	(1,365,155)	3,638,552
Other revenue	1,790,947	1,864,337	2,051,596	4,453,547	4,159,380	4,325,206	3,059,111	3,011,493
Expenses	**2,323,983,967**	**2,747,993,308**	**3,362,393,616**	**3,550,243,043**	**3,207,510,050**	**3,409,148,116**	**3,602,772,824**	**3,811,087,565**
Grants	15,705,354	18,934,965	19,010,601	10,658,800	11,403,756	14,409,710	22,990,888	29,331,220
Salaries/Emp. Benefits	1,263,960,872	1,440,771,373	1,829,378,640	1,888,740,884	1,981,169,107	2,090,504,437	2,181,401,280	2,285,593,789
Other expenses	1,044,317,741	1,288,286,970	1,514,004,375	1,650,843,359	1,214,937,187	1,304,233,969	1,398,380,656	1,496,162,556
Revenue less expenses	55,788,876	72,520,029	42,979,474	102,453,516	203,506,845	212,513,014	138,705,053	113,006,427
Total Assets	1,577,600,190	1,897,147,387	2,311,855,171	2,335,827,341	2,518,921,978	2,665,510,312	2,760,585,976	2,835,813,206
Total Liabilities	845,339,675	1,059,466,486	1,233,964,385	1,222,181,413	1,456,837,768	1,574,793,011	1,598,658,494	1,553,506,154
Net assets or fund balances	732,260,515	837,680,901	1,077,890,786	1,113,645,928	1,062,084,210	1,090,717,301	1,161,927,482	1,282,307,052
Bad Debt Expense				69,429,822	55,641,853	36,726,460	49,187,478	50,285,952
Medicare								
Revenue Received (incl. DSH & IME)				667,477,189	713,108,245	760,987,356	822,234,978	881,110,124
Allowable Cost of Care re: payments				673,131,137	702,648,689	774,759,500	848,058,095	936,620,572
Surplus (Shortfall)	0	0	0	(5,653,948)	10,459,556	(13,772,144)	(25,823,117)	(55,510,448)

Source: Sanford Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Sanford	-	2,754,593,768	3,326,970,820	3,586,460,338	3,336,037,044	3,548,886,392	3,666,072,736	3,769,499,749
Medical Education	-	0	0	0	0	0	0	3,873,734
Sanford Research	-	2,269,852	2,096,148	3,260,058	2,630,921	4,362,909	3,695,877	4,203,667
Sanford USD Medical Center	1,105,072,720	-	-	-	-	-	-	-
Sanford Clinic	739,677,830	-	-	-	-	-	-	-
Sanford Health Network	274,274,309	-	-	-	-	-	-	-
Other program services	198,549,869	-	-	-	-	-	-	-
Total	**2,317,574,728**	**2,756,863,620**	**3,329,066,968**	**3,589,720,396**	**3,338,667,965**	**3,553,249,301**	**3,669,768,613**	**3,777,577,150**
Expenses								
Sanford	-	2,314,517,695	2,840,430,011	2,922,714,702	2,760,546,120	2,904,255,181	3,126,592,371	3,244,372,653
Medical Education	-	5,293,670	6,281,978	6,808,460	7,517,291	8,684,420	11,696,380	24,181,248
Sanford Research	-	24,498,548	27,967,031	26,414,384	2,862,045	27,694,832	13,860,412	25,803,175
Sanford USD Medical Center	780,703,971	-	-	-	-	-	-	-
Sanford Clinic	747,128,357	-	-	-	-	-	-	-
Sanford Health Network	187,326,236	-	-	-	-	-	-	-
Other program services	257,549,591	-	-	-	-	-	-	-
Total	**1,972,708,155**	**2,344,309,913**	**2,874,679,020**	**2,955,937,546**	**2,770,925,456**	**2,940,634,433**	**3,152,149,163**	**3,294,357,076**

Source: Sanford Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				3.78%	4.84%	5.65%	7.14%	6.43%
Financial Assistance at cost				50,811,514	58,264,928	67,179,952	65,358,134	72,271,034
Medicaid				77,143,970	96,981,543	125,449,580	192,160,446	172,511,011
Costs of other				0	0	0	0	0
Total	0	0	0	127,955,484	155,246,471	192,629,532	257,518,580	244,782,045
Other Benefits, net				5.46%	6.21%	2.75%	4.04%	3.28%
Community health improvement services and community benefit operations				4,441,285	6,108,204	6,935,625	7,903,786	9,711,726
Health professions education				12,621,370	11,426,524	11,319,584	14,836,321	20,307,514
Subsidized health services				140,325,856	159,720,237	48,562,992	95,223,586	61,359,678
Research				18,131,505	13,458,712	16,547,656	15,549,489	14,101,052
Cash and in-kind contributions for community benefit				9,769,166	8,311,960	10,724,280	12,335,806	19,912,155
Total, Other benefits	0	0	0	185,289,182	199,025,637	94,090,137	145,848,988	125,392,125
Total, Overall	0	0	0	313,244,666	354,272,108	286,719,669	403,367,568	370,174,170
%, Total Expense	0.00%	0.00%	0.00%	9.24%	11.05%	8.40%	11.18%	9.71%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount at Issuance	Issue Price	Description of Purpose
South Dakota Health and Educational Facil	83755VHY3	9/14/2004	11/1/2034	5.25%	18,050,000	70,073,989	2004: New construction of healthcare facilities
South Dakota Health and Educational Facil	83755VNZ3	9/29/2009	11/1/2040	5.50%	39,965,000	71,015,042	2009:New construction and remodeling of healthcare facilities
City of Fargo	307479CK9	2/9/2011	11/1/2031	6.25%	56,935,000	134,069,821	2011: Refunding bonds issued 12/5/1996, 11/8/2000, and 6/18/2002
South Dakota Health and Educational Facil	83755VVM3	11/1/2012	11/1/2042	4.00%	20,000,000	128,733,641	2012E: New construction and remodeling of healthcare facilities
Affiliates:							
City of Chamberlain	83755VWA8	8/5/2014	11/1/2034	4.00%	52,000,000	52,083,720	2014A: Current refund 2004A issued 9/14/2004
South Dakota Health and Educational Fa	83755VXE9	10/28/2014	11/1/2044	4.00%	50,000,000	207,014,209	2014B: New construction and remodeling of healthcare facilities
South Dakota Health and Educational Fa	83755VZW7	10/21/2015	11/1/2045	5.00%	50,600,000	192,641,206	2015: New construction and advanced refunding of bonds issued 4/19/07, 5/22/07
South Dakota Health and Educational Fa	-	10/28/2016	-	-	-	50,000,000	2016: New construction, equipment and improvements

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Tomasz P Stys	2,306,869
Scott Pham	2,306,488
Kelby K Krabbenhoft	1,859,865
Adam T Stys	1,831,798
Wilson T Asfora	1,808,633
Marian S Petrasko	1,699,080
John C Vanderwoude	1,215,261
Rebecca Nelson	1,087,793
David Link	1,000,871
Bill Marlette	825,817

2011	
Name/Title	Compensation
Tomasz P Stys	2,119,950
Scott Pham	2,083,575
Kelby K Krabbenhoft	2,071,070
William C Brunner	2,064,305
Wilson T Asfora	2,028,099
Adam T Stys	1,906,183
John C Vanderwoude	1,212,025
Rebecca Nelson	1,070,917
David Link	992,503
Bill Marlette	806,339

2012	
Name/Title	Compensation
William C Brunner, *Physician*	2,121,005
Kelby K Krabbenhoft, *Sanford Healt*	2,151,098
Tomasz P Stys, *Physician*	2,106,918
Scott Pham, *Physician*	2,096,690
Adam T Stys, *Physician*	1,953,062
Corey L Teigen, *Physician*	1,798,327
Rebecca Nelson, *Senior Vice Presi*	1,111,539
Craig Lambrecht, *President - Sanfo*	873,647
David Link, *Executive Vice Presider*	994,432
Bill Marlette, *Treasurer*	802,947

2013	
Name/Title	Compensation
Rebecca Nelson, *Senior VP & COO - HSD (Thru Nov 13)*	4,842,070
Rebecca Nelson Deferred Comp, *Senior VP & COO - HSD (t*	3,782,496
Tomasz P Stys, *Physician*	2,634,732
Scott Pham, *Physician*	2,438,552
Corey L Teigen	2,297,555
William C Brunner	2,249,392
Bruce Pitts MD, *Chief Medical Officer (thru July 13)*	2,102,001
Kelby K Krabbenhoft, *Sanford Health President & CEO*	1,951,933
Lisa Carlson, *Former Chief Financial Officer Corp*	1,636,216
Craig Lambrecht, *President - Sanford Bismarck*	893,909

2014	
Name/Title	Compensation
Scott Pham, *Phys*	3,420,899
Kelby K Krabbenh	2,500,619
Tomasz P Stys, P	2,496,113
Adam T Stys, Phy	2,307,590
William C Brunne	2,248,099
Corey L Teigen, P	2,106,758
Dennis Millirons, I	1,367,918
Michael LeBeau M	1,187,335
Mark Lundeen MD	1,085,290
David Link, *Execu*	1,019,822

2015	
Name/Title	Compensation
Kelby K Krabbenhoft, *Sanford Presi*	4,635,839
Scott Pham, *Physician*	2,919,505
Tomasz P Stys, *Physician*	2,689,915
Adam T Stys, *Physician*	2,496,823
William C Brunner, *Physician*	2,438,328
Wilson T Asfora, *Physician*	2,196,880
Michael LeBeau MD, *Trustee/Sanfo*	1,318,677
David Link, *Chief Strategy Officer (t*	1,187,684
Nate White, *Chief Operating Officer*	1,157,021
Bill Marlette, *Treasurer*	1,011,854

2016	
Name/Title	Compensation
David Link, *Frmr Chief Strategy Officer (thru 116)*	4,174,052
Kelby K Krabbenhoft, *Sanford President & CEO*	3,032,936
Scott Pham, *Physician*	2,934,430
William C Brunner, *Physician*	2,680,132
Tomasz P Stys, *Physician*	2,581,062
Adam T Stys, *Physician*	2,409,860
Timothy Lindley, *Physician*	2,362,351
Michael LeBeau MD, *Trustee/Sanford Physician*	1,438,533
Nate White, *Chief Operating Officer*	1,179,300
Bill Marlette, *Treasurer*	1,076,713

2017	
Name/Title	Compensation
Kelby K Krabbenhoft, *Sanford Preside*	3,166,316
Scott Pham, *Physician*	2,926,448
William Brunner, *Physician*	2,698,037
Tomasz P Stys, *Physician*	2,686,642
Adam T Stys, *Physician*	2,504,453
Larry Burris, *Physician*	2,298,310
Nate White, *COO/President Fargo*	1,484,074
Michael LeBeau MD, *Trustee/Senior V*	1,443,682
Randy Bury, *Chief Administrative Offic*	1,101,011
JoAnn L Krunkel, *CFO*	1,063,529

Source: Sanford Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Assets										
Current Assets					$ 800,903	$ 793,101	$ 721,821	$ 594,718		
Limited Use Assets					1,157,698	887,848	898,289	857,901		
Property, Plant & Equipment					1,513,739	1,369,400	1,319,718	1,141,047		
Other Assets					218,415	213,206	211,116	171,800		
Total Assets	-	-	-	-	**3,690,755**	**3,263,555**	**3,150,944**	**2,765,466**	-	-
Liabilities and Net Assets										
Current Liabilities					496,863	413,989	396,808	345,759		
Long-term Liabilities										
Total Liabilities					1,525,927	1,256,705	1,267,821	1,077,743		
Net Assets					2,164,828	2,006,850	1,883,123	1,687,723		
Total Liabilities & Net Assets	$ -	$ -	$ -	$ -	$ 3,690,755	$ 3,263,555	$ 3,150,944	$ 2,765,466	$ -	$ -

Income Statement

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Operating Revenue										
Patient Service Revenue					$ 3,086,517	$ 2,943,498	$ 2,799,279	$ 2,300,714		
Provision for Bad Debts					(145,574)	(165,461)	(130,467)	(99,782)		
Net patient revenue less provison for bad	-	-	-	-	2,940,943	2,778,037	2,668,812	2,200,932	-	-
Premium Revenue					425,830	192,427	144,308	136,702		
Other Operating Revenue				-	342,557	303,855	268,113	163,970		
Net assets released from restrictions for operations					11,780	16,353	24,669	15,141		
Total Operating Revenue	-	-	-	-	3,721,110	3,290,672	3,105,902	2,516,745	-	-
Unrestricted Operating Expenses										
Salaries, wages and related benefits					2,016,238	1,919,987	1,861,635	1,463,129		
Supplies					617,902	544,166	534,315	394,905		
Purchased services and other					453,092	431,012	428,010	362,166		
Medical claims					251,533	97,803	64,908	69,542		
Depreciation and amortization					157,420	157,555	154,722	119,431		
Interest					29,765	30,128	31,466	28,258		
Total Operating Expense	-	-	-	-	3,525,950	3,180,651	3,075,056	2,437,431	-	-
Net Income from Operations	-	-	-	-	**195,160**	**110,021**	**30,846**	**79,314**	-	-
Investment return					(8,495)	22,005	(5,379)	27,914		
Change in interest rate swap valuation					916	1,154	1,680	(677)	-	-
Loss on extinguishment of debt					-	-	-	(2,934)		
Other expenses and losses				-	(18,539)	(15,194)	(13,637)	(18,237)	-	-
Total nonoperating gains, net	-	-	-	-	(26,118)	7,965	(17,336)	6,066	-	-
Excess Revnue over Expense, before co	-	-	-	-	**169,042**	**117,986**	**13,510**	**85,380**	-	-
Contributions received in connection with	-	-	-	-	-		120,059	5,976		
Excess Revnue over Expense	-	-	-	-	**169,042**	**117,986**	**133,569**	**91,356**	-	-
Net assets released from restrictions for acquisitions of property and equipment					3,576	2,160	5,326	5,010		
Pension plan related changes other than net periodic plan expense					(15,347)	1,304	33,632	(22,499)		
Increase in Net Assets	$ -	$ -	$ -	$ -	$ 157,271	$ 121,450	$ 172,527	$ 73,867	$ -	$ -

Source: Sanford Audited Financial Statements

St Alexius

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Eric Belanger, *Neurosurgeon*	1,503,989
Steven Karljic, *Neurosurgeon*	1,442,692
John Windsor, *Interventional*	915,614
Leslie Rainwater, *Urologist*	796,803
Brent Herbel, *Interventional R*	761,060
Andrew Wilson, *President/CE*	615,921
Dr Syed Hyder, *VP Medical A*	485,097
Gary Miller, *President/CEO*	298,066
Rosanne Schmidt, *VP/CNO*	253,345
Duwayne Schlittenhard, *VP F*	234,250

2011	
Name/Title	Compensation
Steven Kraljic, *Neurosurgeon*	1,671,358
Eric Belanger, *Neurosurgeon*	1,652,421
Robert Oatfield, *Interventional Cardi*	805,029
Leslie Rainwater, *Urologist*	792,864
Brent Herbel, *Interventional Radiolo*	784,645
Gary Miller, *President/CEO*	508,519
Dr Syed Hyder, *VP Medical Affairs*	506,795
Rosanne Schmidt, *VP/CNO*	281,419
Wanda Pfaff, *VP Human Resources*	252,625
Duwayne Schlittenhard, *VP Profess*	247,713

2012	
Name/Title	Compensation
Eric Belanger, *Neurosurgeon*	1,984,929
Steven Kraljic, *Neurosurgeon*	1,600,858
Leslie Rainwater, *Urologist*	1,001,259
Brent Herbel, *Interventional Radiolo*	910,278
Robert Oatfield, *Interventional Cardi*	783,096
Gary Miller, *President/CEO*	709,115
Shiraz Hyder, *VP Medical Affairs*	559,831
Rosanne Schmidt, *VP & Chief Nursi*	305,775
Wanda Pfaff, *VP Human Resources*	275,265
Duwayne Schlittenhard, *VP Profess*	270,680

2013	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurge*	1,959,608
Dr Steven Kraljic, *Neurosurge*	1,564,530
Dr Brent Herbel, *Interventiona*	768,762
Dr Christopher Fukuda, *Urolo*	766,238
Dr Allen Booth, *Cardiovascul*	718,728
Dr Michael Brown, *Director/C*	714,441
Gary Miller, *President/CEO*	561,699
Syed Hyder, *VP Medical Affa*	438,589
Rosanne Schmidt, *VP Chief I*	235,347
Duwayne Schlittenhard, *VP H*	205,501

2014	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurgeon*	2,300,947
Dr Steven Kraljic, *Neurosurgeon*	2,144,056
Dr Christopher Fukuda, *Urologist*	1,040,711
Gary Miller, *President/CEO (Partial*	795,367
Brent Herbel, *Interventional Radiolo*	770,454
Dr Allen Booth, *Cardiovascular & Th*	762,161
Dr Michael Brown, *Director/Cardiova*	760,996
Shiraz Hyder, *VP Medical Affairs*	668,155
Joseph Messmer, *Interim President/*	377,986
Rosanne Schmidt, *VP & Chief Nursi*	321,102

2015	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurgeon*	2,001,922
Dr Steven Kraljic, *Neurosurgeon*	1,984,671
Jeffrey Drop, *Director*	1,243,310
Dr Allen Booth, *Cardiovascular & Th*	775,057
Dr Michael Brown, *Cardiovascular S*	772,687
Boyd Marts, *Cardiovascular Surgeo*	769,954
Gary Miller, *Former President/CEO*	764,326
Shiraz Hyder, *VP Medical Affairs*	653,908
Kurt Schley, *CEO*	527,762
Joseph Messmer, *Interim President/*	392,534

2016	
Name/Title	Compensation
Dr Steven Kraljic, *Neurosurgeon*	2,094,642
Jeffrey Drop, *Director*	1,343,536
Dr Eric Belanger, *Neurosurgeon*	991,661
Dr Allen Booth, *Cardiovascular & Thoracic Surg*	805,075
Boyd Marts, *Cardiovascular Surgeon*	802,013
Dr Michael Brown, *Cardiovascular Surgeon*	794,165
Kurt Schley, *President/Market CEO*	606,189
Shiraz Hyder, *VP Medical Affairs*	574,250
Kevin Dahmen MD, *Director*	491,856
Todd Preszler MD, *Director*	481,091

2017	
Name/Title	Compensation
Dr Steven Kraljic, *Neurosurgeon*	1,741,860
Jeffrey Drop, *Director*	1,463,693
Kym Chandler, *Neurosurgeon*	1,048,960
Boyd Marts, *Cardiovascular Surgeo*	856,182
Dr Allen Booth, *Cardiovascular & Th*	855,352
Dr Michael Brown, *Cardiovascular S*	844,900
Kevin Dahmen MD, *Director*	628,352
Kurt Schley, *Director & CEO*	624,964
Shiraz Hyder, *VP Medical Affairs*	557,521
Todd Preszler MD, *Director*	519,177

Source: St. Alexius Form 990

TRINITY HEALTH & AFFILIATES

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**245,993,420**	**299,355,451**	**289,016,536**	**354,555,120**	**304,581,894**	**320,274,641**	**326,909,495**	**343,256,289**
Contributions and grants	2,237,788	2,311,018	973,398	581,169	882,485	455,678	1,000,420	989,846
Program service revenue	242,014,918	289,982,315	285,352,213	288,652,040	303,832,376	319,236,043	324,534,819	339,392,091
Investment income	1,356,665	1,021,896	2,149,764	335,936	1,279,673	2,053,216	2,891,532	4,086,064
Other revenue	384,049	6,040,222	541,161	64,985,975	(1,412,640)	(1,470,296)	(1,517,276)	(1,211,712)
Expenses	**238,491,890**	**273,369,815**	**271,294,965**	**281,695,301**	**266,631,873**	**284,490,233**	**285,766,508**	**289,483,280**
Grants	417,699	574,274	109,150	265,140	65,700	42,695	305,181	328,506
Salaries/Emp. Benefits	112,977,763	119,323,020	121,387,830	118,973,490	117,749,092	128,847,856	130,308,766	130,124,828
Other expenses	125,096,428	153,472,521	149,797,985	162,456,671	148,817,081	155,599,682	155,152,561	159,029,946
Revenue less expenses	7,501,530	25,985,636	17,721,571	72,859,819	37,950,021	35,784,408	41,142,987	53,773,009
Total Assets	508,339,689	569,541,785	655,440,720	204,703,659	240,116,969	256,607,242	253,406,674	669,932,345
Total Liabilities	274,590,263	309,204,107	376,839,020	47,296,519	54,627,826	51,921,017	41,939,113	481,837,654
Net assets or fund balances	233,749,426	260,337,678	278,601,700	157,407,140	185,489,143	204,686,225	211,467,561	188,094,691
Bad Debt Expense				37,235,009	10,907,414	11,668,252	12,030,387	16,862,202
Medicare								
Revenue Received (incl. DSH & IME)				80,810,183	86,247,019	95,802,446	81,446,956	83,191,546
Allowable Cost of Care re: payments				88,001,604	96,552,067	113,625,298	11,180,140	98,825,791
Surplus (Shortfall)	0	0	0	(7,191,421)	(10,305,048)	(17,822,852)	70,266,816	(15,634,245)

Source: Trinity Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Trinity Health & Affiliates	-	142,286,571	122,979,923	268,161,318	282,919,529	298,898,528	303,428,741	318,371,603
Trinity Homes	20,488,003	17,825,049	18,443,698	20,490,722	20,912,847	20,337,515	21,106,078	21,020,488
Trinity Hospital Pharmacies	66,171,734	74,682,853	86,379,487	-	-	-	-	-
Trinity Hospital Laboratories	66,171,734	55,187,842	57,549,105	-	-	-	-	-
Other program services	49,685,576	-	-	-	-	-	-	-
Total	**202,517,047**	**289,982,315**	**285,352,213**	**288,652,040**	**303,832,376**	**319,236,043**	**324,534,819**	**339,392,091**
Expenses								
Trinity Health & Affiliates	-	145,199,097	182,724,467	227,345,207	198,714,242	217,077,460	219,738,142	226,221,316
Trinity Homes	21,613,913	20,229,749	19,992,813	23,715,544	20,467,431	21,568,696	20,965,868	20,593,824
Trinity Hospital Pharmacies	22,002,960	24,387,501	27,389,266	-	-	-	-	-
Trinity Hospital Laboratories	10,182,506	10,617,572	10,067,171	-	-	-	-	-
Other program services	143,774,071	-	-	-	-	-	-	-
Total	**197,573,450**	**200,433,919**	**240,173,717**	**251,060,751**	**219,181,673**	**238,646,156**	**240,704,010**	**246,815,140**

Source: Trinity Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				2.85%	0.85%	3.51%	0.49%	0.46%
Financial Assistance at cost				4,230,543	1,673,863	2,037,882	1,190,007	1,251,775
Medicaid				3,796,991	519,678	7,537,919	204,019	0
Costs of other				0	0	0	0	0
Total	0	0	0	8,027,534	2,193,541	9,575,801	1,394,026	1,251,775
Other Benefits, net				0.00%	0.00%	0.00%	0.08%	0.13%
Community health improvement services and community benefit operations				0	0	0	147,278	314,850
Health professions education				0	0	0	74,484	16,130
Subsidized health services				0	0	0	0	0
Research				0	0	0	0	0
Cash and in-kind contributions for community benefit				0	0	0	2,660	200
Total, Other benefits	0	0	0	0	0	0	224,422	331,180
Total, Overall	0	0	0	8,027,534	2,193,541	9,575,801	1,618,448	1,582,955
%, Total Expense	0.00%	0.00%	0.00%	2.85%	0.85%	3.51%	0.57%	0.59%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bonds

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount	Issue Price	Description of Purpose
Ward County North Dakota		9/27/2017				56,875,000	Refund Series 2006 Bonds; Hospital Construction
Ward County North Dakota	394023EW8	12/28/2017				382,748,522	Hospital Construction

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Martin Rothberg MD	992,473
Kevin Collins	707,661
Jeffrey Verhey	582,970
Jeffrey Sather	575,824
John Nelson	528,980
Scott Knudson	486,275
Danial R Padgett	467,427
John M Hutch	411,928
Asitha Dias	410,996
Kevin Seehafer	291,296

2011	
Name/Title	Compensation
Kevin Collins MD, *Director*	1,011,875
Martin Rothberg MD, *Director*	837,438
Jeffrey Verhey MD, *Former Director*	562,953
John Kutch, *President/CEO*	436,126
Paul Simonson, *VP*	255,570
Kevin Seehafer, *CFO*	242,845
Dave Kohlman, *VP*	186,877
Randy Schwan, *VP*	184,835
Thomas Warsocki, *VP*	177,846
John Sheenan MD, *Former Director*	174,545

2012	
Name/Title	Compensation
Kevin Collins MD, *Director*	823,845
Jeffrey Verhey, *Former Director*	547,422
John Kutch, *President/CEO*	488,981
Paul Simonson, *VP - HR*	255,950
Barbara Brown, *VP - CNO*	216,028
Dave Kohlman, *VP - Facilities*	196,065
Randy Schwan, *VP - Marketing*	186,889
Thomas Warsocki, *VP - Physician R*	173,635
Martin Rothberg MD, *Director*	125,531
Alison Fyre, *Assistant Secretary*	45,426

2013	
Name/Title	Compensation
Martin Rothberg MD, *Director*	1,086,385
Kevin Collins MD, *Director*	753,348
John Kutch, *President/CEO*	556,930
Paul Simonson, *VP - HR*	254,359
Barbara Brown, *VP - CNO*	209,394
Dave Kohlman, *VP - Facilities*	182,166
Randy Schwan, *VP - Marketing*	178,662
Thomas Warsocki, *VP - Physician Rela*	166,391
Dennis Empey, *VP & CFO*	80,537
Alison Fyre, *Assistant Secretary*	51,838

2014	
Name/Title	Compensation
John Kutch, *President/CEO*	681,937
Scott Knutson MD, *Director*	617,979
Dennis Empey, *VP & CFO*	302,755
Paul Simonson, *VP* - HR	251,366
Dave Wanner - *VP - CIO*	229,448
Randy Schwan, *VP - Marketing*	223,337
Thomas Warsocki, *VP - Physician R*	213,937
Barbara Brown, *VP - CNO*	208,905
Dave Kohlman, *VP - Facilities*	184,438
Rhonda Walter, *VP - Trinity Homes*	164,836

2015	
Name/Title	Compensation
John Kutch, *President/CEO*	832,465
Scott Knutson MD, *Director*	547,025
Dennis Empey, *VP & CFO*	352,983
Paul Simonson, *VP - HR*	280,279
Thomas Warsocki, *VP - Physician C*	208,423
Randy Schwan, *VP - Mission Integra*	208,226
Dave Kohlman, *VP - Facilities Mana*	208,012
Martin Rothberg MD, *Director*	204,753
Rhonda Walter, *VP - Trinity Homes*	186,169
Karen Zimmerman, *VP & CNO*	185,930

2016	
Name/Title	Compensation
Martin Rothberg MD, *Director*	850,441
John Kutch, *President & CEO*	761,112
Scott Knutson MD, *Director*	581,669
Dennis Empey, *VP & CFO*	370,898
Paul Simonson, *VP - HR*	278,138
Glen Taylor Wilson, *VP - Clinical Integration*	246,372
Randy Schwan, *VP - Mission Integration*	216,056
Thomas Warsocki, *VP - Physician Operations*	212,056
Dave Kohlman, *VP - Facilities Management*	207,437
Rhonda Walter, *VP - Trinity Homes Administrator*	187,200

2017	
Name/Title	Compensation
John Kutch, *President & CEO*	835,542
Martin Rothberg MD, *Director*	780,654
Scott Knutson MD, *Director*	603,937
Dennis Empey, *VP & CFO*	379,505
Paul Simonson, *VP - HR*	291,845
Glen Taylor Wilson, *VP - Clinical Int*	278,073
Philip Patterson, *VP & CAO*	263,048
Thomas Warsocki, *VP - Physician C*	228,846
Randy Schwan, *VP - Mission Integra*	222,187
Dave Kohlman, *VP - Facilities Mana*	216,179

Source: Trinity Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted
Assets									
Current Assets	8,623,539	$ 8,141,733	$ 8,197,917	$ 7,826,812	$ 7,076,798	$ 4,417,936	$ 4,290,549	$ 3,700,454	$ 3,432,281
Limited Use Assets	5,252,706	5,000,824	4,154,117	4,137,245	3,925,260	3,006,064	2,754,001	2,623,633	2,293,700
Property, Plant & Equipment	8,025,580	7,853,456	7,676,734	6,773,283	6,566,958	4,548,908	4,221,827	3,374,103	3,349,524
Other Assets	4,293,875	3,743,070	3,350,103	3,037,979	2,864,173	476,585	409,538	331,467	246,075
Total Assets	**26,195,700**	**24,739,083**	**23,378,871**	**21,775,319**	**20,433,189**	**12,449,493**	**11,675,915**	**10,029,657**	**9,321,580**
Liabilities and Net Assets									
Current Liabilities	4,475,583	4,491,239	4,502,282	4,138,177	4,045,002	2,748,146	2,492,833	2,366,829	2,360,351
Long-Term Liabilities									
Total Liabilities	12,851,684	12,753,656	13,131,658	10,979,413	9,889,727	6,646,459	6,806,905	4,815,345	5,011,642
Net Assets	13,344,016	11,985,427	10,247,213	10,795,906	10,543,462	5,803,034	4,869,010	5,214,312	4,309,938
Total Liabilities & Net Assets	$ 26,195,700	$ 24,739,083	$ 23,378,871	$ 21,775,319	$ 20,433,189	$ 12,449,493	$ 11,675,915	$ 10,029,657	$ 9,321,580

Income Statement

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted
Operating Revenue									
Patient Service Revenue	$ 16,406,252	$ 15,747,094	$ 14,718,528	$ 12,843,346	$ 12,206,460	$ 8,288,991	$ 7,849,161	$ 6,495,919	$ 5,966,053
Provision for Bad Debts	(574,954)	(548,965)	(489,558)	(358,820)	(605,596)	(480,302)	(431,457)	(323,275)	(306,079)
Net patient revenue less provision for	15,831,298	15,198,129	14,228,970	12,484,526	11,600,864	7,808,689	7,417,704	6,172,644	5,659,974
Premium and capitation revenue	1,067,582	1,039,749	869,030	790,948	687,581	467,093	422,493	378,568	359,441
Net assets releaed information	50,510	39,826	36,352	24,476	27,984	13,566	12,120	12,357	20,513
Other Operating Revenue	1,396,015	1,350,141	1,204,695	1,038,200	1,083,416	689,037	617,136	464,505	434,021
Total Operating Revenue	18,345,405	17,627,845	16,339,047	14,338,150	13,399,845	8,978,385	8,469,453	7,028,074	6,473,949
Unrestricted Operating Expenses									
Salaries, wages and related benefits	7,949,446	7,594,863	7,056,453	6,093,539	5,792,799	3,793,347	3,549,999	2,850,939	2,612,189
Employee benefits	1,525,511	1,510,144	1,457,253	1,211,902	1,182,036	841,318	831,816	729,746	657,147
Contract labor	296,611	242,018	205,916	117,471	101,384	86,365	82,903	56,471	43,937
Total labor expense	9,771,568	9,347,025	8,719,622	7,422,912	7,076,219	4,721,030	4,464,718	3,637,156	3,313,273
Supplies	2,983,635	2,880,802	2,676,637	2,293,317	2,124,452	1,468,953	1,430,933	1,190,255	1,127,789
Purchased services and professional fe	2,083,761	2,059,267	1,889,460	1,601,894	1,449,833	857,177	775,408	683,560	613,443
Depreciation and amortization	857,154	870,289	835,213	740,321	697,808	479,882	464,750	405,631	407,340
Occupancy	748,346	744,444	698,198	592,182	571,577	370,404	348,864	307,722	290,580
Medical Claims	406,330	417,054	414,648	362,848	284,449	238,209	210,245	198,355	191,531
Interest	224,882	207,152	195,829	163,060	156,985	110,533	102,781	84,071	70,651
Other	868,437	835,673	758,103	691,576	638,249	410,448	401,745	296,565	256,032
Total Operating Expense	17,944,113	17,361,706	16,187,710	13,868,110	12,999,572	8,656,636	8,199,444	6,803,315	6,270,639
Operating Income Before Other Item	**401,292**	**266,139**	**151,337**	**470,040**	**400,273**	**321,749**	**270,009**	**224,759**	**203,310**
Consolidation Costs	-	-	-	-	(42,857)	(16,950)	-	-	-
Pension curtailment gain	-	-	-	11,054	149,734	-	-	-	-
Pensions settlement loss	-	-	-	-	(195,987)	-	-	-	(48,986)
Litigation accrual	-	-	-	-	(36,448)	-	-	-	-
Asset impairment charges	(264,366)	(248,070)	(39,623)	(23,402)	(56,293)	-	-	-	-
Restructuring costs	-	(36,184)	-	-	(45,166)	-	-	-	-
Premium revenue adjustment	-	-	(65,335)	-	-	-	-	-	-
Net Income from Operations	**136,926**	**(18,115)**	**46,379**	**457,692**	**173,256**	**304,799**	**270,009**	**224,759**	**154,324**
Investment earnings (losses)	488,715	859,934	(199,326)	106,553	606,309	325,646	(19,159)	483,550	328,038
Equity in earnings of unconsolidated af	328,353	376,642	162,075	182,907	265,703	-	-	-	-
Change in market value and cash payn	25,671	52,955	(94,783)	(10,223)	(25,351)	45,818	(114,468)	13,554	(39,928)
(Loss) Gains from early extinguishment	(39,857)	792	(43,056)	(96,924)	(1,623)	-	(13,458)	(10,185)	(949)
Gain on controlling interest related to a	-	-	-	40,317	-			-	-
Inherent contributions related to acquis	1,903	65,103	133,355	-	-	-	216,796	-	-
Inherent contributions related to acquis	-	-	87,170	-	-	-	-	-	-
Other, including income taxes	7,419	(488)	(2,011)	(8,692)	(15,865)	(9,824)	27,333	(28,765)	(10,856)
Total nonoperating items	812,204	1,354,938	43,424	213,938	829,173	361,640	97,044	458,154	276,305
Excess Revenue over Expense	**949,130**	**1,336,823**	**89,803**	**671,630**	**1,002,429**	**666,439**	**367,053**	**682,913**	**430,629**
Excess Revenue over Expenses Attributable To Noncontrolling Interest	(47,619)	(45,599)	(48,460)	(34,836)	(14,032)	(10,566)	(8,312)	(6,580)	(4,133)
Increase in Net Assets	$ 901,511	$ 1,291,224	$ 41,343	$ 636,794	$ 988,397	$ 655,873	$ 358,741	$ 676,333	$ 426,496

Source: Trinity Health & Affiliates Audited Financial Statements

Appendix C – Financial Assistance, Raw HCRIS Detail, All North Dakota Hospitals

Column: 708
Concept: Cost of initial obligation of insured patients approved for charity care (charges * cost-to-charge ratio) (2552-10 only) [costs_insured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	15	23	12	23	18	9	12	15	15
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	56,390	266,142	240,204	44,283	127,852	51,261	199,929	222,994	246,247
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	1,992,069	317,074	0	0	1,190,751	615,280
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	363,251	375,616	1,196,630	7,051,228	10,038,768	4,125,739	5,177,296	4,736,772	7,682,396
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	10,639,080	20,511,691	9,443,562	11,337,504	5,083,112	1,813,717	1,762,297	2,355,158	1,715,206
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	1,694,004	
350070	INNOVIS HEALTH	FARGO	Short Term	0	1,188,806	394,744	314,457	553,855	1,734,644	1,111,062	2,191,436	2,569,392	2,041,894
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	198	4,438	12,714	245	59,644	13,784	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	46	41	0	0	0	13,839	6,191	33,245	36,595
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	2,804	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	2,846	2,537	2,613	6,204	17,065	0	27,479	18	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	0	0	25,764	2,647	464	134	2,225	13	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	55,121	0	0	5,000	1,838
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	15,300	2,508	6,182	24,817	13,639	6,294	4,694	11,485	29,417
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	61,814	31,157	126,798	167,707	47,239	400,078	728,985
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	90,960	185,174	147,834	9,166	139,519	3,276	18,771	41,160
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	36,154	27,298	43,687	36,726
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	102,878	35,581	27,182	129,599	43,499	18,518	12,797
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	2,796	14,010	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	7,029	19,475	46,855	26,006
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	41,334	0	0	133,725	34,479	61,916	42,640	52,287
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	4,623	985	3,257	12,227	20,879	34,671	31,974	46,220	16,151
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	17,285	13,145	13,521	17,398	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	57,291	32,628	80,301	62,499	130,346	36,312	7,775	5,207
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	2,291	2,483	3,258	0	0	3,456	255	2,395
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	0	0	0	130,293	41,390	99,844	0	0	23,771
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	40,024	8,223	0	0	0	10,121	149,042	28,521	14,201
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	909	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	12,151	15,514	23,757	8,570	22,271	28,998	44,311	50,845	76,346
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	114,608	21,530	15,574	3,217	4,447	2,686	1,935	1,168	1,408
351328	LINTON HOSPITAL	LINTON	Critical Access	0	114,608	27,196	0	0	4,447	0	0	24,893	7,479
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	21,468	33,161	18,913	33,077	96,402	54,819	175,081	411,403	382,985
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	21,468	164,668	119,308	306,320	96,402	231,946	279,118	54,216	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	15,892	14,785	7,966	6,753	17,423	909	23,897	18,716	7,544
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	15,892	16,373	94,463	96,677	17,423	168,849	623,006	0	104,322
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	203,576	0	0	0	23,219	36,154	106,149	203,913	138,982
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	2,305,656	588,545	198,544	505,695	35,364	149,396	168,987	332,240	496,166
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	95,706	110,737	92,971	100,600
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	97,844	20,051	153,790	187,696	233,542	447,332

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 722
Concept: Cost of initial obligation of uninsured patients approved for charity care (charges * cost-to-charge ratio) (2552-10 only) [costs_uninsured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	11	13	18	20	19	25	27	26	25
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	805,940	1,466,367	1,410,810	612,633	3,300,568	3,990,361	3,384,882	1,694,721	2,035,621
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	802,437	871,688	5,214,596	5,757,152	582,777	1,027,742
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	3,257,232	5,130,742	8,204,332	10,632,040	7,341,888	8,224,134	8,527,808	11,005,264	10,751,936
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	1,012,363	728,409	544,423	2,218,930	2,897,774	3,272,744	3,048,692	3,270,166	2,648,273
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	1,589,557	1,295,960	1,908,805	1,739,464	1,434,792	1,396,594	1,177,534	2,154,704	
350070	INNOVIS HEALTH	FARGO	Short Term	0	1,435,573	933,461	1,737,491	1,029,306	1,722,150	1,386,405	2,002,493	3,986,536	3,698,852
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	5,528	5,226	2,958	7,166	37,561	6,177	4,372	41,779	6,010
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	46	41	2,639	20	20,969	14,971	5,794	15,058	18,690
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	22,954	10,767	7,287	7,198	513	7,050	40,138	73,349	117,457
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	18,548	12,882	3,346	35,122	4,352	12,081	0	38	38,527
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	16,162	8,452	19,341	18,516	4,890	0	0	24	14,276
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	10,329	18,146	39,296	26,182	32,382	23,094
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	3,691	7,584	663	50,568	14,507	0	0	371	3,472
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	68,053	40,620	85,012	78,312	1,126	21,514	150,318	1,969	6,511
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	51,801	0	0	0	612	4,248	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	365	950	48,751	43,721	57,591	36,936	46,705	89,521	123,100
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	196,997	89,903	133,507	44,895	20,433	10,746	4,266	28,761	38,286
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	71,458	129,409	40,342	36,632	57,237	61,975	31,884	63,311	71,637
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	11,440	34,709	12,773	24,764	28,803	52,059	43,027	43,109	53,119
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	64,913	34,830	40,737	66,899	24,577	47,936	70,314	38,378	44,541
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	10,147	18,941	3,110	34,376	12,902	3,835	3,646	28,703	12,998
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	194,791	129,594	72,917	135,039	93,402	3,847	57,457	130,019	131,703
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	114,049	108,480	158,407	33,894	69,078	89,695	92,811	88,845	94,784
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	162,880	134,011	574,577	358,420	14,771	14,358	54,048	92,218	129,658
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	65,833	30,267	6,574	0	0	0	19,497	22,239	9,437
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	33,569	14,011	20,706	14,706	0	0	0	13,412	16,372
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	34,048	21,664	18,896	5,960	14,680	3,036	16,921	44,285
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	9,105	27,848	30,173	1,974	10,946	1,425	1,815	8,857	187
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	122,819	142,620	36,966	0	0	16,800	13,053	0	408
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	40,024	119,075	0	154,725	42,898	14,926	22,588	117,206	181,765
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	120,375	0	0	0	0	0	6,095	156	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	46,991	48,891	37,655	51,399	38,971	21,805	2,938	31,053	1,306
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	33,342	33,035	34,070	3,547	3,268	0	1,896	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	33,342	27,340	35,610	35,865	3,268	173	15,888	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	12,037	0	0	0	39,980	21,920	53,116	96,523	174,678
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	12,037	67,731	102,200	48,908	39,980	67,769	103,720	100,629	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	11,111	18,414	34,571	16,701	9,033	3,645	10,935	4,232	5,378
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	11,111	189,891	154,124	157,735	9,033	63,813	153,625	0	20,900
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	376,437	358,232	538,099	390,888	38,992	42,510	282,942	424,350	607,994
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	494,993	943,326	750,919	631,848	326,042	476,220	679,002	1,006,651	1,207,031
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	237,764	442,261	431,594	313,816	165,819	42,324	47,048	65,293	115,140
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	425,941	502,176	423,414	319,674	48,793	340,336	782,022	1,068,159	1,555,706

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 747

Concept: Partial payment by uninsured patients approved for charity care (2552-10 only) [pymt_uninsured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	1	1	1	1	1	0	1	1	1
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	240,884	426,079	307,044	192,952	574,457	43,934	459,647	0	3,856
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	0	83,854	0	0	114,885	1,165
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	0	0	220,552	183,334	60,581	63,744	174,220	99,134	100,174
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	587,692	523,443	381,163	718,056	44,030	19,552	24,565	14,582	24,210
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	48,314	
350070	INNOVIS HEALTH	FARGO	Short Term	0	234,151	158,060	262,701	85,245	176,657	102,804	136,165	622,202	581,079
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	100	502	1,364	400	0	1,532	4,793
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	2	2	0	0	0	11,827	1,029	1,032	581
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	274	600	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	7,909	1,987	0	184	200	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	4,462	0	1,021	0	487	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	0	4,712	10,134	19,252	295	346	1,817	0	714
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	2,248	0	0	0	30	1,263	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	3,019	161	374	204	25	2,395	4,840
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	1,783	7,655	5,282	123	830	2,079	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	694	100	175	214
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	1,136	0	4,052	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	1,768	1,203	1,271	453	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	1,636	2,937	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	0	550	7,753	168
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	0	0	0	0	0	758	913	950
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	4,718	5,408	3,944	0	0	0	3,715	12,542	4,981
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	12,003	3,951	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	1,210	2,216	946	370	795	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	550	550	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	30,012	0	0	0	0	8,234	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	0	0	0	0	0	0	20	25	12,537
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	0	0	5,710	8,963	0	0	0	36,557	1,804
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	948	2,184	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	948	2,076	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	0	0	0	0	361	48	205	1,527	2,409
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	0	3,545	2,110	3,171	361	13,834	13,335	17,680	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	725	171	0	85	675	1,515	100	20	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	725	230,095	27,915	27,915	675	14,377	21,229	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	0	0	0	0	0	694	155	945	1,070
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	0	0	0	0	0	775	2,398	7,395	9,819
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	1,501	3,253	16,862	31,784
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	0	0	7,189	6,603	15,122	13,272

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 746

Concept: Partial payment by insured patients approved for charity care (2552-10 only) [pymt_insured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	7	8	3	1	1	1	1	1	1
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	30,199	6,894	13,742	11,173	9,666	19,495	12,569	0	0
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	0	30,597	0	0	53,841	5,979
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	31,054	53,004	152,951	395,936	205,742	83,931	306,615	214,345	307,750
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	6,430,284	7,434,056	2,937,796	263,606	87,541	120,682	104,482	88,000	50,668
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	121,481	
350070	INNOVIS HEALTH	FARGO	Short Term	0	58,898	11,017	87,481	52,231	172,353	163,113	221,004	169,835	118,101
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	94	600	387	0	167	206	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	2	2	0	0	0	2,322	343	557	1
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	1,582	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	1,685	0	0	1,313	106	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	0	0	229	1,921	178	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	3,474	309	1,069	723	973	340	0	0	736
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	40,426	825	1,015	1,352	781	6,526	13,253
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	3,952	7,240	183,459	2,640	137,081	2,318	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	1,502	941	271	1,070
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	49,111	32,009	13,228	57,708	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	585	1,293	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	0	1,371	772	2,320
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	0	0	0	0	0	1,150	903	106
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	496	1,988	1,591	2,691	5,735	4,284	3,434	16,463	6,932
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	0	16,085	200	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	471	1,325	332	2,244	80,729	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	2,039	2,039	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	0	0	0	3,655	1,413	104,114	0	0	17,385
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	474	474	0	0	0	0	251	53	1,446
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	0	0	22,172	28,712	0	0	0	41,413	9,112
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	2,406	4,623	5,248	0	135	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	2,406	1,279	0	0	135	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	18,438	21,201	488	0	53	213	1,436	5,437	3,381
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	18,438	11,528	63,871	347,593	53	258,992	17,756	3,493	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	145	94	141	0	373	0	152	354	243
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	145	19,617	101,812	96,580	373	115,124	257,923	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	0	0	0	0	0	1,502	3,677	400	1,945
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	0	0	0	0	0	8,007	3,862	4,890	3,396
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	5,647	9,860	8,072	13,080
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	0	0	5,441	8,458	1,330	2,714

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Insured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	9	15	9	21	18	8	11	14	15
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		0	0	0	0	0	0	0	0	0
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	2	0	0	0	1	1
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		0	0	1	7	10	4	5	5	7
350015	SANFORD BISMARCK	BISMARCK	Short Term		4	13	7	11	5	2	2	2	2
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		0	0	0	0	0	0	0	2	
350070	INNOVIS HEALTH	FARGO	Short Term		1	0	0	1	2	1	2	2	2
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	1
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		2	1	0	1	0	0	0	0	0
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Uninsured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	10	12	16	19	18	25	26	25	24
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		1	1	1	0	3	4	3	2	2
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	1	1	5	6	0	1
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		3	5	8	10	7	8	8	11	11
350015	SANFORD BISMARCK	BISMARCK	Short Term		0	0	0	2	3	3	3	3	3
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		2	1	2	2	1	1	1	2	
350070	INNOVIS HEALTH	FARGO	Short Term		1	1	1	1	2	1	2	3	3
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	1	0	0	0	0	0	0	0
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		0	0	1	0	0	0	0	0	1
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		0	1	1	1	0	0	1	1	1
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	1	0	0	0	0	1	1	2

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Insured and Uninsured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Sum
	(millions)			0	19	27	25	40	36	32	36	40	39	
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		1	1	1	0	3	4	3	2	2	
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	3	1	5	6	2	2	
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		4	5	9	17	17	12	13	15	18	
350015	SANFORD BISMARCK	BISMARCK	Short Term		5	13	7	13	8	5	5	6	4	
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		2	1	2	2	1	1	1	4	0	
350070	INNOVIS HEALTH	FARGO	Short Term		2	1	2	1	3	2	4	6	5	
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	1	
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	0	1	0	0	0	0	0	0	
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	1	1	
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		1	0	1	0	0	0	0	1	1	
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		3	2	1	1	0	1	1	1	2	
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	1	0	0	0	0	1	1	2	

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Appendix D – Insurer Data Request

Table Mockup for North Dakota Insurance Data DRAFT

Please replace the NAIC statewide numbers 2010-2018 with data for your company's results in North Dakota. The statewide data are simply shown as an example -- please replace.
Please estimate 2019 and project data for 2020-2022 using current policy and your most likely scenario for regulation. Assume the HIT is repealed as per Dec. 2019 federal law.
We know 2019 claims won't be fully complete and 2019 full-year expenses may not be fully tabulated by Feb 6, 2020 due date -- please estimate full year best possible.
Please note there are three additional data fields that are not on the NAIC supplemental: Average deductible, total allowed claims, Medicaid managed care.
Please try to estimate total allowed claims and average deductibles using a consistent method across time. Zero deductibles count towa Estimated Projected ==>

For your Company Only (not statewide)

Calendar Years	2010	2014	2015	2016	2017	2018	2019	2020	2021	2022
Health premiums earned (from Part 2, Line 1.11)		<========== ========== Most Important Years ==========>								
Individual	121,119,359	194,006,259	242,299,636	243,932,210	240,147,155	255,459,103				
Small Group Employer	289,890,522	291,271,574	303,224,993	294,678,443	300,037,906	319,110,613				
Large Group Employer	453,338,202	701,787,635	721,605,268	734,705,676	753,273,099	805,814,251				
Federal taxes and federal assessments										
Individual	389,693	4,419,871	14,008,439	7,754,117	4,829,644	4,976,710				
Small Group Employer	1,408,217	12,284,760	15,051,751	8,069,877	3,914,141	-2,338,904				
Large Group Employer	1,698,933	11,924,313	25,122,400	16,886,108	4,812,790	9,848,940				
State insurance, premium and other taxes										
Individual	1,784,177	3,410,588	4,263,017	4,211,239	4,096,250	4,307,029				
Small Group Employer	4,556,127	5,540,011	5,066,016	5,001,534	5,176,372	5,270,938				
Large Group Employer	2,519,902	5,592,193	6,035,708	5,688,432	6,072,118	6,300,227				
Net adjusted premiums earned after reinsurance (Lines 1.8+1.9+1.10+1.11)										
Individual	118,625,599	180,483,381	221,689,989	231,173,900	230,843,035	245,687,789				
Small Group Employer	283,529,085	268,618,302	282,474,587	280,867,290	290,533,736	315,608,626				
Large Group Employer	448,834,886	674,549,412	688,157,488	708,315,961	740,360,398	787,423,764				
Incurred claims excluding prescription drugs										
Individual	106,829,243	148,487,708	180,601,977	187,516,702	183,319,287	179,148,457				
Small Group Employer	222,125,579	209,399,147	211,589,042	216,002,439	207,384,054	238,357,221				
Large Group Employer	361,153,065	539,720,187	562,990,899	576,913,215	582,096,592	619,754,609				
Prescription drugs										
Individual	14,799,301	28,252,329	36,731,947	44,968,681	46,886,855	49,554,675				
Small Group Employer	33,376,507	30,850,258	39,815,104	41,773,320	42,910,875	46,739,430				
Large Group Employer	57,027,284	103,592,545	118,550,388	122,169,657	124,125,168	141,151,385				
Pharmaceutical rebates										
Individual	862,247	1,457,034	4,581,467	5,145,096	7,374,522	10,278,371				
Small Group Employer	1,748,208	1,578,952	5,911,494	6,362,406	7,258,729	9,958,422				
Large Group Employer	2,277,829	8,002,831	14,961,549	19,506,627	21,649,256	28,113,316				
Total incurred claims (Lines 2.1 + 2.2 - 2.3 - 2.4 + 3)										
Individual	120,766,298	175,309,995	212,802,990	227,353,507	226,139,001	223,374,636				
Small Group Employer	253,753,879	238,671,904	245,498,561	251,414,938	247,358,646	281,437,285				
Large Group Employer	415,902,519	635,310,074	666,583,912	679,577,490	688,743,106	738,866,156				
Net incurred claims after reinsurance (Lines 5.0+5.1+5.2+5.3-5.4+5.5-5.6)										
Individual	116,150,025	161,187,942	196,510,373	224,505,848	219,375,754	220,711,866				
Small Group Employer	256,331,485	238,829,187	243,602,439	248,971,517	246,224,789	281,126,478				
Large Group Employer	417,695,774	624,532,999	693,269,522	652,580,183	676,031,753	729,453,112				
Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1+6.2)										
Individual	620,331	816,538	1,027,285	1,137,634	780,430	749,911				
Small Group Employer	1,472,768	1,235,448	1,448,215	1,474,215	1,256,493	1,444,231				
Large Group Employer	2,117,631	2,570,204	5,828,574	6,526,118	4,696,741	4,990,356				
Total claims adjustment expenses (Lines 8.1 + 8.2)										
Individual	4,313,423	4,941,940	6,050,280	5,345,482	6,567,381	12,350,924				
Small Group Employer	7,296,616	8,180,548	8,842,148	9,016,706	11,604,647	24,602,808				
Large Group Employer	9,072,345	16,437,821	17,734,051	15,497,859	17,629,054	30,306,251				
Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)										
Individual	9,881,216	9,524,911	12,937,241	15,470,295	13,404,881	12,933,467				
Small Group Employer	11,713,853	13,234,470	12,535,625	15,451,840	15,517,868	17,263,210				
Large Group Employer	10,676,805	23,223,697	24,333,194	26,170,451	25,344,505	27,169,830				
Underwriting Gain/(Loss)										
Individual	-12,339,396	4,012,050	5,164,810	-15,285,359	-9,285,411	-1,058,379				
Small Group Employer	6,714,363	7,138,649	16,046,160	5,953,012	15,929,939	-8,828,101				
Large Group Employer	9,272,331	7,784,691	-53,007,853	7,541,350	16,658,345	-4,495,785				
Number of Certificates/Policies										
Individual	33,896	26,776	29,811	28,121	26,612	24,539				
Small Group Employer	42,281	33,493	33,183	31,798	30,825	31,409				
Large Group Employer	57,198	76,340	71,191	71,033	70,733	73,404				
Number of Covered Lives										
Individual	47,687	49,075	54,151	49,718	47,192	43,333				
Small Group Employer	79,378	64,497	64,424	62,179	60,381	60,028				
Large Group Employer	120,348	160,820	149,872	151,322	149,111	154,872				
Number of Groups										
Individual	xxx	xxx	xxx	xxx	xxx	xxx				
Small Group Employer	5,193	4,805	4,841	4,883	4,845	3,144				
Large Group Employer	204	578	772	883	856	590				
Member Months										
Individual	535,780	582,131	667,548	620,560	594,515	549,367				
Small Group Employer	995,164	788,308	757,106	741,852	710,767	713,623				
Large Group Employer	1,437,007	1,913,878	1,857,512	1,828,600	1,795,950	1,832,387				
Health premiums earned (from Part 2, Line 1.11) per Covered Life										
Individual	2,540	3,953	4,475	4,906	5,089	5,895				
Small Group Employer	3,652	4,516	4,707	4,739	4,969	5,316				
Large Group Employer	3,767	4,364	4,815	4,855	5,052	5,203				
Total incurred claims (Lines 2.1 + 2.2 - 2.3 - 2.4 + 3) per Covered Life										
Individual	2,532	3,572	3,930	4,573	4,792	5,155				
Small Group Employer	3,197	3,701	3,811	4,043	4,097	4,688				
Large Group Employer	3,456	3,950	4,448	4,491	4,619	4,771				

Individual Market							
Improve Health Outcomes	130,184	280,351	395,947	488,305	329,900	275,357	
Activities to Prevent Hospital Re	22,318	28,352	68,270	72,321	27,138	11,023	
Improve Patient Safety and Red	50,205	137,675	221,653	182,619	123,300	135,446	
Wellness & Health Promotion A	152,741	322,717	276,989	251,939	176,367	190,033	
HIT Expenses	264,881	47,445	64,425	142,452	123,727	138,046	
Total (1 to 5)	620,329	816,539	1,027,285	1,137,636	780,431	749,908	
Cost Containment Expenses	1,548,748	1,659,859	1,824,261	1,293,399	1,423,895	1,501,258	
Other Claims Adjustment Expen	2,888,679	3,336,031	4,174,668	3,996,665	5,118,105	10,849,667	
General Administrative Expense	8,706,618	8,521,577	11,568,309	14,821,524	13,397,508	13,842,831	
Total Expenses (6 to 9)	13,877,140	14,334,005	18,594,521	21,249,225	20,709,941	26,943,666	
Small Group Market							
Improve Health Outcomes	284,394	493,294	539,060	485,596	428,845	513,804	
Activities to Prevent Hospital Re	64,811	29,618	19,536	15,099	23,016	31,954	
Improve Patient Safety and Red	200,030	216,234	251,067	212,574	200,093	289,906	
Wellness & Health Promotion A	445,068	430,599	529,634	599,730	452,417	443,251	
HIT Expenses	478,465	65,706	108,916	161,221	152,122	168,315	
Total (1 to 5)	1,472,767	1,235,450	1,448,215	1,474,218	1,256,493	1,444,230	
Cost Containment Expenses	1,978,326	2,702,661	2,025,084	2,042,356	2,202,695	2,557,631	
Other Claims Adjustment Expen	4,990,523	5,743,521	6,670,095	6,889,744	9,314,651	22,045,176	
General Administrative Expense	10,032,384	11,139,136	10,552,409	13,235,556	14,269,879	16,326,151	
Total Expenses (6 to 9)	18,507,076	20,820,767	20,695,800	23,641,874	27,043,715	42,373,188	
Large Group Market							
Improve Health Outcomes	200,539	893,366	3,123,724	2,428,962	1,334,717	1,266,505	
Activities to Prevent Hospital Re	59,915	18,487	22,446	16,430	30,912	38,326	
Improve Patient Safety and Red	170,310	397,754	417,673	261,935	256,213	337,946	
Wellness & Health Promotion A	762,588	1,065,796	1,515,413	2,424,792	1,611,511	1,973,663	
HIT Expenses	924,276	194,804	749,318	1,394,003	1,463,390	1,369,675	
Total (1 to 5)	2,117,628	2,570,206	5,828,574	6,526,121	4,696,742	4,990,359	
Cost Containment Expenses	2,098,748	4,871,907	3,771,893	4,092,641	5,243,523	6,082,937	
Other Claims Adjustment Expen	6,844,012	11,673,241	13,820,938	11,249,679	12,240,075	24,223,303	
General Administrative Expense	10,049,656	22,890,512	23,372,724	24,039,932	23,008,138	31,899,471	
Total Expenses (6 to 9)	21,138,872	42,005,866	46,794,131	45,908,373	45,188,480	67,196,067	

Questions not on the NAIC form:

Estimated Average Deductible ($ per policy)

Individual Market	
Small Group Market	
Large Group Market	

Total Allowed Claims ($)

Individual Market	
Small Group Market	
Large Group Market	

Medicaid Results (primary insured -- not including Medicare wraparound, duals, LTC for aged etc.)

Reimbursements	
Incurred Claims	
Non-Claim Benefit Expense (clinic overhead, member care management etc. not reflected in claims)	
Member Months	

Appendix E – Aon Private Reinsurance Proposal

Public Sector Partnership:

State Governments:

Financial solutions that transfer volatility away from the individual health market allowing for rate stability and taxpayer healthcare savings

Q4 2020

Opportunity Overview:

The Governor signed HB 1106 enabling North Dakota's Reinsurance Association of North Dakota (RAND) to implement a non-private reinsurance program to reduce healthcare costs for individual taxpayers participating in the State's healthcare marketplace. To supplement the cost-saving efforts of the 1332 waiver program, the State should evaluate purchasing private reinsurance to further reduce costs for individual taxpayers participating in the State's healthcare marketplace. Private reinsurance can assist driving down/stabilizing rates and preventing spikes providing consistency for taxpayers/users.

Using reinsurance to transfer the budgetary/program volatility, creates immediate opportunities for the State of North Dakota including:

- Transferring volatility away from the existing RAND program into the private market
- Reduces the future "known, unknowns", thereby allowing greater funding flexibility with the safety and security of knowing that protection is in place in the event of a higher than normal claims year
- Provides stability in rates from payers as a pre-arranged amount of funding is known
- Predictable cash flows for insurers and the state as there is no need, once coverage is purchased, to adjust the reimbursement levels to carriers based on higher than expected claim numbers and amounts
- Adjudication and claims processing is handled by the reinsurer, removing some of the operations of running the program in house

In addition, given the current Covid-19 health crisis there is likely to be further pressure on the individual health market. According to a recent Kaiser Family Foundation report, "…enrollment in the individual market was fairly steady from March to September 2020. In normal years, there is typically more attrition during these months as more people leave the market than come in during special enrollment periods (SEP). However, SEP enrollment was higher this year in healthcare.gov and state based exchanges." These solutions can help mitigate impacts stemming from the global pandemic.

The analysis that follows is based on 2017 RAND claims data provided by the State of North Dakota. The analysis can be updated based on more recent data, however the key points remain the same.

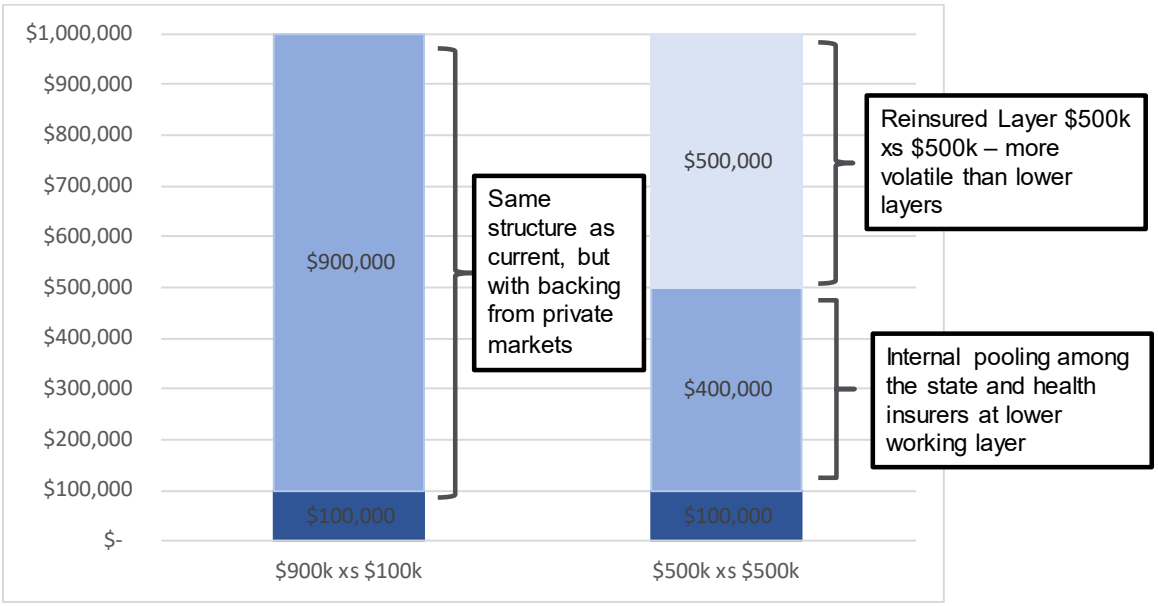
How would a private reinsurance program work?

The State of North Dakota in conjunction with RAND would purchase a transparent, reliable, and easily understood reinsurance policy that provides immediate recoveries based on predetermined attachment and exhaustion points.

When considering the existing Reinsurance Association of North Dakota (RAND) program, there are two main structural options to consider.

Excess of Loss

- Provides recoveries after a pre-determined amount of loss
- Smooths results in excess of pre-determined attachment point



Aggregate Stop Loss

- Provides recoveries after a pre-determined amount of loss in a defined/determined time period
- Coverage ensures the aggregation of numerous claims do not drain the financial reserves of the risk-bearer/entity



How much would this cost?

Aon modeled various scenarios using stochastic and deterministic models, we also used market data to derive pricing.

Aon used available data collected for the initial 1332 Waiver Process to illustrate a few structural and pricing options that would make sense given the current RAND structure. In evaluating solutions for North Dakota our overarching motivation is to maximize coverage, deliver fast payment, and provide clear benefit to the users of the RAND program.

Projected claims costs were derived from North Dakota's 2017 year. In order to secure pricing from the reinsurance markets, typically 3-5 years of data in required, however we believe this 12-month snapshot provides enough information to draw preliminary conclusions.

Pricing is provided on a 100% experience basis, and blended with national market data to provide more credibility to the block of business. It is illustrated on a per member per month basis.

Aon's analysis is based on following general market underwriting methodologies used across the reinsurance industry to develop a likely premium. Since North Dakota would be transferring the volatility to the market, the amount of money allocated to reinsurance claims in one particular year does not have to be as conservative as what may be traditionally allocated to a self-funded plan. Because RAND is a newly formed self-insured reinsurance program, it is not surprising that additional conservatism was included in the preliminary (NovaRest) actuarial analysis.

Claims Projections:

	75% Coinsurance	
Source	$900k xs $100k	$500k xs $500k
Nova Rest	$106.68	
Market	$67.27	$8.18
Aon - Deterministic	$58.53	$4.38
Aon - Stochastic	$58.82	$4.65

Pricing Options:

*XOL Pricing by layer	Premium
1. $900k xs $100k	$70.58
2. $500k xs $500k	$5.58
*Agg Pricing	
1. 110% of expected	$27.64
2. 120% of expected	$20.61
3. 130% of expected	$14.58

Key Takeaways:

- Based on the 2017 claims year costs there are indications that meaningful cost savings can be achieved by a private reinsurance purchase
- Claims costs can be shifted to the private market for less dollars than they are being funded for in the existing program, leaving additional funding to further stabilize rates and pay for the private purchase
- We can transfer claims to the private market for .65-.85 cents on the dollar (this is based on only one claims year and we would need 3-5 years to fully validate this with third party capital)
- The structures presented would provide more program certainty to payers allowing for greater flexibility in rate pricing
- While the premium payments for the State of North Dakota may be higher than the claims cost in some years, high claims years will counter balance the years where the state ends in a negative net position
- As an example, 1 in 20 years the reinsurer is projected to lose $20.57 per member per month, paying $1.30 to the state for every $1 the state pays in premium

Return Period (1 in X years)	**Losses (PMPM)**	**Reinsurer Position (PMPM)**
Average	$58.82	$11.76
5	$72.34	-$1.76
20	$91.14	-$20.57
40	$99.22	-$28.64

Considerations for Next Steps:

In order to procure formal pricing from the market, additional information is needed.

Reinsurance Parameters	Key Considerations
Data Required (last 3-5 years)	- Membership Data - Claims Triangles - Large Claim Loss Data - Plan Design Changes (Historical and Proposed)
Attachment Point	- Attachment points can allow for any corridor, both overlapping what is being offered or just covering a piece - To reduce total cost coinsurance can be included which will reduce the reimbursement by a percentage for each claim
How Much "Limit" to Purchase	- Often relatively small incremental premium to purchase higher limit - Markets will cap the limit they offer based on their risk tolerance
Contractual Considerations	- If the State of North Dakota does not cede the entire $900k xs $100k layer to the reinsurance market, arrangements will be needed to administer the pooling layer - Additional analysis will be required to confidently opine on the contractual structure between the State of North Dakota reinsurance program and the reinsurers

Who would provide this backstop?

Reinsurance companies are the providers of this protection and have been active participants in the health market for several years.

There is a significant market appetite for health exposure. There are several highly rated counterparties that will be interested in an excess of loss or aggregate structure as these are the main vehicles used to transfer volatility in the space.

All counterparties would be highly rated ("A" or better AM Best and/or S&P) entities with significant capital and strong track records of paying claims as agreed.

To learn more about potential structures, pricing and capacity please contact the team on the following page.

For Additional Information:

Knowing that our fiduciary commitment is always to our clients and prospects, Aon's Public Sector Partnership team focuses on developing innovative solutions to help governments and other public institutions reduce volatility and increase the resiliency of their mission. The PSP is a global team of talented colleagues that have deep experience serving in government, insurance, reinsurance, and the capital markets.

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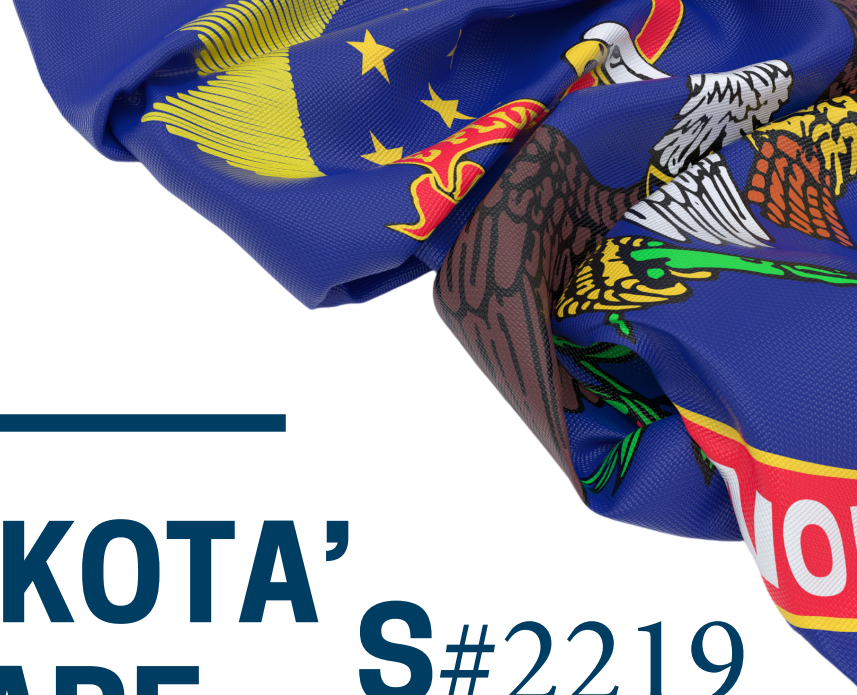
North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER



NORTH DAKOTA'S#2219 HEALTH CARE TRANSFORMATION

A 3-STEP APPROACH TO LEADING THE NATION IN QUALITY HEALTH CARE, **NOT COST** OF HEALTH CARE.



WHERE WE ARE

NORTH DAKOTA INSURANCE DEPARTMENT

WHERE WE ARE

On a per-capita basis, hospital expenses in North Dakota were highest in the nation in 2017, and their growth rate of about 8% per year since 2010 was among the fastest in the U.S.

HOSPITAL UTILIZATION

North Dakota has seen a dramatic increase in hospital usage. North Dakota Hospitals are seeing longer hospital stays than the national average, and utilization is growing faster in North Dakota than most of the rest of the country.

HOSPITAL EXPENSES

Hospital Expenses are ranking in the top 5 nationally and continuing to grow at higher than national average rates (also top 5 rankings), creating a revenue drives cost scenario.

HOSPITAL REIMBURSEMENT

In the last decade, private hospital reimbursement based on Medicare rates grew from 170 percent of Medicare in 2010 to over 200 percent of Medicare in 2018

HOSPITAL QUALITY

North Dakota hospitals have the worst two-year state level performance in the Midwest, with poor clinical outcomes

.



3 REMEDIAL SOLUTIONS

NORTH DAKOTA INSURANCE DEPARTMENT

SOLUTION 1:

Strengthening Employer Coverage: Both nationally and in North Dakota small employers have dropped coverage over the last several decades as the cost of coverage has continued to rise. There is no federal requirement for small employers to provide this coverage. We are proposing to provide help to small employers – in the long run it will lead to more affordable premiums, a healthier North Dakota, and help our small businesses grow.

- Keep all options open for employer coverage by crafting state rules for association health plans, and allowing small employers to self-fund their insurance through level funded plans authorized by state legislation.
- Study combining the individual and small group markets, or allow employers to subsidize employee premiums purchased through the exchange.
- Maintain and reduce insurance premiums by utilizing private capital backed reinsurance.

SOLUTION 2:

Medication Optimization: Study after study supports medication optimization as a successful tool to reduce costs and improve patient health. Medication optimization crosses across all health sectors, and to succeed requires payers, hospitals, and all medical providers to be involved.

- Mandate the development of specific curriculum at both the University of North Dakota Medical School and the North Dakota State University Pharmacy School on medication optimization.
- Require that medical providers achieve minimum medication optimization CE credits.
- Require insurers provide medication optimization review, within 72 hours of discharge, and at least annually for any patient with 3 or more prescriptions, and more than one chronic medical condition.

3 REMEDIAL SOLUTIONS

NORTH DAKOTA INSURANCE DEPARTMENT

SOLUTION 3:

Better Care for North Dakotans: North Dakota spends more on Medicaid than any other state, but success isn't measured by that metric. We need to keep as many people in private coverage as possible, and we shouldn't be replacing private coverage with public coverage. We also should not support commercial reimbursement rates for only a portion of the Medicaid population, driving diversity in the quality of treatment, misaligned with treating the most needy North Dakotan's fairly. We will push the legislature to consider new approaches including:

- Increase the size of the Medicaid beneficiary risk pool by realigning and implementing rates in parity with both the traditional and expansion Medicaid populations, that creates market competition, deviates away from revenue driving health care costs and encourages fairness among all Medicaid populations, while also re-basing CAHs.
- Implement integrated health homes to provide community and value based care to North Dakotans, modeled after current commercial primary care models, delivering significant federal funds to Medicaid beneficiaries.
- Providing access to a new North Dakota account which allow Medicaid recipients to pay for their share of premiums or to cover cost-sharing like deductibles.



NDHA
North Dakota Hospital Association Est. 1934

2021 HB 1012
House Appropriations Committee Human Resources Division
Jon Nelson, Chairman
January 21, 2021

Chairman Nelson and members of the House Appropriations Committee Human Resources Division, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to offer comments in support of HB 1012 and specifically in response to the interim health care study performed by the Insurance Commissioner.

First, I want to stress that North Dakota hospitals strongly support reforms to promote health care access and affordability, including efforts to reform health markets, increase telehealth, improve health care price transparency, promote value-based care, and strengthen patient adherence to medications. We take responsibility for driving cost containment and improving quality. Hospitals stand ready to discuss ways in which we can all work together to help patients better manage their care, drive quality, and reduce costs. But we all need to operate from the same set of facts in order to move those initiatives forward.

We believe that all North Dakotans should have access to high quality, affordable health insurance. We are lucky to have some of the lowest premiums in the country. Premiums are a reflection of not only health care cost, but also of market circumstances and the amount of health care used by patients. As you are probably aware, North Dakota does not have a competitive health insurance market. Approximately 92% of payments to hospitals is fixed – meaning hospitals have no ability to negotiate a different rate. Government payers such as Medicare, Medicaid, and military programs do not negotiate rates. And, because we do not have a competitive commercial health insurance market, the dominant payer - which has about 85% market share - dictates rates paid to hospitals with no negotiation. I recently confirmed with our larger hospitals that they are not able to negotiate rates with the dominant payer. In any case, if hospitals do not manage their costs well, payers do not pay them more. The bottom line is that

hospital expenses do not drive prices; prices in North Dakota are set by Medicare, Medicaid, and the dominant commercial insurer.

It is important to point out some concerns we have with some of the data and how it is presumed to apply to North Dakota. For example, the study draws conclusions regarding the rates paid by private health plans as compared to Medicare rates. The study asserts that private insurers in North Dakota went from paying 170% to 200% of Medicare rates during the nine years covered by the study. This has been pointed out as evidence that hospitals do negotiate rates with payers. First, I do not know how the consultants calculated these figures. I spoke with the two major commercial insurers in the state yesterday and they both confirmed that their rates are between 175 and 180% of Medicare. Had the consultants wanted to provide useful data on which to base policy decisions, North Dakota specific data would have been more helpful.

In addition to the concern we have with the data and assumptions, we are unsure how relevant the study is given the current Coronavirus pandemic. Hospitals have stepped up in unprecedented ways to meet the challenges of COVID-19. They ramped up testing efforts, bought additional personal protective equipment (PPE), added ICU bed capacity, paid for expensive temporary staff to care for additional patients, and created COVID-19 isolation units. In the midst of incurring these additional expenses, revenue plummeted. Hospitals cancelled non-emergency procedures to save scarce PPE and bed space, and many patients postponed care due to fear of the virus. While federal assistance, such as CARES Act funding helped, it is nowhere close to replacing the enormous revenue lost due to the pandemic.

Despite what the study authors assert, hospitals are not "back to normal". North Dakota hospital revenue crashed in March, April, and May 2020. Some of the rebound that happened after that was due to pent up demand from patients who were delaying care but could no longer. Hospitals took care of sicker, more fragile patients because care had been postponed. Hospitals meanwhile also took care of a record number of COVID patients. Hospitals came perilously close to being overwhelmed just eight weeks ago when they had a record 334 COVID patients. Please keep in mind that is an additional 300 patients on top of the other patients they cared for. As a comparison, in our first spike last May, there were 40 COVID patients hospitalized. We do not know if we will see additional spikes or if this represents a return to normal. No one will know what "normal" health care is going to look like for some time. And, as the study notes,

hospital margins are small - roughly 2%. With such thin margins, there is no cushion to absorb such losses.

We are also concerned with the report's conclusion that there was a large jump in hospital cost without an analysis of the reasons why it may appear that way. The study's inclusion of hospital expense data from 2010 in the growth calculations grossly skews the results. We requested adjustment, or at least an annotation, to data skewed by hospitals switching to provider-based billing between 2010 and 2019. Including this data causes what looks like a jump in expenses when, in reality, it is the product of a different methodology of reflecting costs. We also asked if the consultants considered that three of the six PPS hospitals have major patient populations from Minnesota, which means hospital costs are not all born by North Dakotans. They did not take this into consideration. They also did not analyze how increasing wages due to oil activity factored in. Wages constitute 60% of hospitals' cost. These are examples of how cost is driven by market forces that hospitals do not control.

The study also implies that increased hospital costs result in increased reimbursement or more expensive insurance premiums. As already noted, hospitals do not get more reimbursement just because their costs increase. They must operate within a budget of 90% of payments that are fixed and over which they have no control. Also contradicting this point is that North Dakota health insurance premiums are among the lowest in the country. Consumers are evidently not being charged for what the study asserts is a high-cost hospital environment. These two study findings do not square.

We are also concerned that the policy recommendations do not correlate with the data. I would like to comment specifically on a few that are of most concern to us: suggested cuts to the Medicaid Expansion program and government setting of rates.

Medicaid Expansion cuts.

In North Dakota, approximately 24,000 low-income adults have gained coverage under expanded Medicaid. Without any discussion of how it would reduce hospital costs or health insurance premiums, the study suggests that Medicaid Expansion be cut in several ways.

First, they suggest cutting the number of people who qualify by reducing the eligibility limit from 138% to 100% of federal poverty level. As a preliminary matter, this is not even an option. CMS

has not approved it when requested by states. And, even if it were allowed, it is not a wise policy decision. It would likely result in higher uninsured rates and worse access to care for many near-poor adults. And it is unclear why this would even be suggested given that, as the authors acknowledge, "…the savings to North Dakota is limited." The expansion population is covered at a 90 percent federal matching rate, which means $1 million savings to North Dakota requires $10 million in cuts.

The study also suggests cutting Medicaid Expansion reimbursement to providers. We think it is important to point out that Medicaid does not pay for the cost of care. Hospitals lose money when they provide care to a patient covered under any government program – whether that be Medicare or Medicaid. Even when current expansion rates are blended with traditional Medicaid payments, hospitals still lose money. Despite this, Medicaid Expansion has been able to greatly help patients, North Dakota communities, and health care providers. Hospitals have seen a significant decrease in the amount of uncompensated care since the program started. Bad debt and charity care in North Dakota rose from $102 million in 2008 to $274 million in 2014—a nearly threefold increase. Thanks to Medicaid Expansion, bad debt dropped nearly in half to $150 million in 2016.

While cutting Medicaid Expansion payments to health care providers may save five to eight million dollars in general funds as the study points out, it fails to acknowledge the loss to the North Dakota health care system of $200 million in federal funds. Medicaid Expansion represents a huge impact on North Dakota's economy - the budgeted amount for the 2019-2021 biennium alone was $633 million. Taking that much money out of the system cannot be sustained. It is merely a cut to providers and is not cost containment. This would surely result in a cost shift to private payers. If Medicaid rates do not provide fair reimbursement, the cost must be paid by the remaining users of the system. As some pay less, others must pay more. Consequently, private payments go up, taking health insurance premiums along with them. This seems counterproductive if the aim is to reduce premiums.

This policy suggestion also fails to acknowledge that the health care sector is the largest employer in North Dakota. You cannot affect health care without affecting the entire economy of the state. Medicaid Expansion brings in $90 in federal matching funds for every $10 of state general funds invested, which flows directly into local economies supporting employment, wages, and state tax revenue. Again, it is budgeted at $633 million for this biennium. Its impact keeps the cost of health insurance low for the businesses that drive our economy. It is critical to

covering operating costs at our hospitals, the loss of which will result in staff cuts and closed facilities. Medicaid Expansion pays salaries of employees who work at those hospitals, which in turn results in income and sales tax collections in the state. The state's investment of one dollar to secure nine is a fantastic return on investment not only for the health of patients but of our entire economy. This is of such importance now as we are in the middle of a pandemic that has caused so much upheaval in our economy – especially in the health care sector. We simply cannot sustain further instability now.

Government setting of rates

The study recommends that the state government *s*et maximum hospitals rates in the private insurance market and in the state employee plan (NDPERS) by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates. Such policies cap the total amount that hospitals and physicians can be paid when they are not in network. These rate caps are viewed by the authors as an alternative to more rigid price setting regulations when competitive outcomes are difficult to achieve. They assert that setting maximum hospital rates provides a benchmark for negotiations with insurers. What this fails to understand is that, in North Dakota, hospitals and physicians largely participate in all networks. We do not have an out of network, surprise billing problem, as in other states. The authors state that this will also put downward pressure on in-network rates. This also fails to recognize the unique market in North Dakota in which hospitals do not have negotiating power with the dominant insurer. Rate caps would simply allow the dominant insurer to further lower its rates.

In summary, we hope that we can work together to come up with solutions that work for our state. There are many suggestions in the study we have supported in the past and will continue to do so, such as reforms to promote health care access and affordability, increase telehealth, and promote value-based care. We cannot support approaches that merely cut payment to providers and do nothing to contain costs, fail to balance patient access, and do not focus on improving quality.

I would be happy to respond to any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

House Bill No. 1012 #2215

House Appropriations Human Resources Division

January 21, 2021

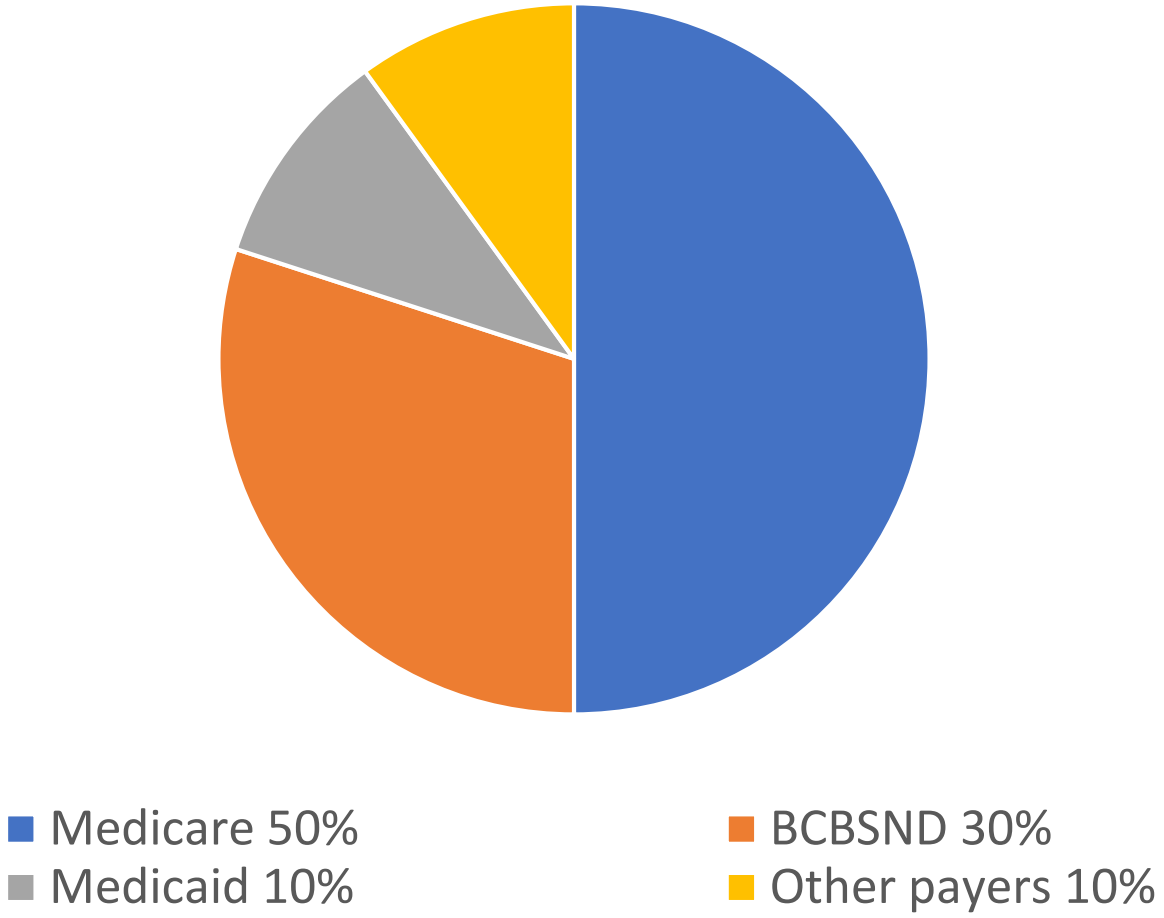
Tim Blasl |President

NDHA
North Dakota Hospital Association
Est. 1934

ND hospitals strongly support health care access and affordability

- Policy options we support
  - Reform health markets
  - Increase telehealth
  - Improve health care price transparency
  - Promote value-based care
  - Strength patient adherence to medications

ND Payer Mix – 90% Fixed



ND specific focus is needed

- The study claims private insurers in ND went from paying 170% to 200% of Medicare rates.
- The study claims this is evidence that hospitals do negotiate rates with payers.
- The two major commercial insurers both confirmed that their rates are between 175 and 180% of Medicare.

What Drives Cost

- Study claims ND expenses highest in nation
- Half of our PPS hospitals have major patient populations from MN, which means the calculation assumed costs are all born by North Dakotans.
- Wages in ND increased at a high rate. Ex. oil activity, nursing shortage, recruitment challenges for professional services.
- The amount of health care used by patients (utilization) is the main driver of health care costs.

ND health insurance premiums are low

Hospitals operate within a budget of fixed payments.

Hospital margins are small - roughly 2%.

Hospitals do not get more reimbursement just because costs increase.



ND has among the lowest premiums in the country…



Which leads to low commercial provider rates

Medicaid Expansion Cut

- The report suggests reducing Medicaid Expansion rates - which would cut about $400 million out of the healthcare system in the next four years.
- It fails to acknowledge that the expansion population is covered at a 90 percent federal matching rate.
- Traditional Medicaid rates don’t cover the cost of providing health care services.
- Medicaid Expansion helps subsidize traditional Medicaid rates - even with the higher rates, providers overall still lose money when treating Medicaid patients.

NDHA
North Dakota Hospital Association
Est. 1934

QUESTIONS?

Tim Blasl | President
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tblasl@ndha.org

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/22/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson called the meeting to order at 8:31 a.m.

Discussion Topics:

- Child Nutrition and food services
- Behavioral Health
- Covid-19 impact
- Early childhood education
- DOJ Settlement
-

Kirsten Baesler, State Superintendent (8:33 am) testified about the ND Department of Public Instruction #2254

Nancy Nikolas Maier, Director of Aging Services (9:40 am) testified about the DOJ Settlement agreement summary #2230

Chair Nelson closed the meeting at 11:11 a.m.

Cole Fleck, Committee Clerk

Kirsten Baesler
State Superintendent
Donna Fishbeck
Chief of Staff
Laurie Matzke
Assistant Superintendent

NORTH DAKOTA DEPARTMENT OF
PUBLIC INSTRUCTION #2254

600 E Boulevard Ave., Dept. 201
Bismarck, ND 58505-0440
Phone (701) 328-2260
Fax (701) 328-2461
www.nd.gov/dpi

NDDPI and NDDHS Collaboration

- Child Nutrition Food Services
  - Direct Certification
- Behavioral Health
  - Residential Placements of Students with Special Needs
  - School based Mental Health
- Covid 19 related work
  - Educational Neglect Guidance
  - Healthy Return to Learning Team
  - Pandemic EBT (P-EBT)
- Early Childhood Education
  - North Dakota continues to be committed to building a high-quality B-5 early care and education system that enables vulnerable children to have a strong foundation for kindergarten.
  - DPI and DHS have long partnered on Birth to Five related programs
  - Early Childhood Education Council
  - Hunt Institute Legislative Retreat



DOJ SETTLEMENT #2230
AGREEMENT SUMMARY
HOUSE APPROPRIATIONS – HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

January 22, 2021

NORTH Dakota
Be Legendary.™

SETTLEMENT AGREEMENT BETWEEN U.S. DOJ & STATE OF ND

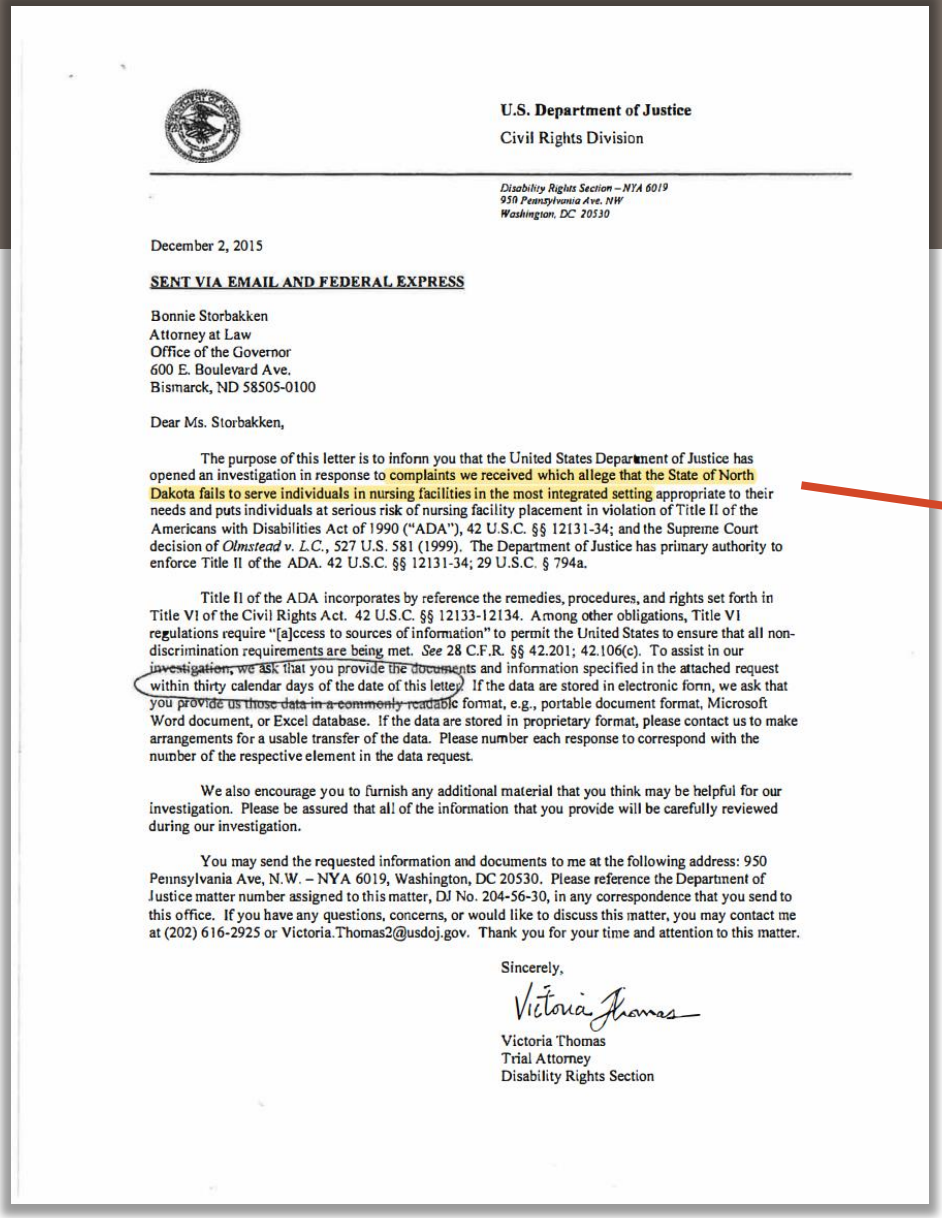
Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective December 14, 2020

Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.



NOTIFICATION FROM DOJ



U.S. Department of Justice
Civil Rights Division

Disability Rights Section – NYA 6019
950 Pennsylvania Ave. NW
Washington, DC 20530

December 2, 2015

SENT VIA EMAIL AND FEDERAL EXPRESS

Bonnie Storbakken
Attorney at Law
Office of the Governor
600 E. Boulevard Ave.
Bismarck, ND 58505-0100

Dear Ms. Storbakken,

The purpose of this letter is to inform you that the United States Department of Justice has opened an investigation in response to complaints we received which allege that the State of North Dakota fails to serve individuals in nursing facilities in the most integrated setting appropriate to their needs and puts individuals at serious risk of nursing facility placement in violation of Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12131-34; and the Supreme Court decision of *Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has primary authority to enforce Title II of the ADA. 42 U.S.C. §§ 12131-34; 29 U.S.C. § 794a.

Title II of the ADA incorporates by reference the remedies, procedures, and rights set forth in Title VI of the Civil Rights Act. 42 U.S.C. §§ 12133-12134. Among other obligations, Title VI regulations require "[a]ccess to sources of information" to permit the United States to ensure that all non-discrimination requirements are being met. *See* 28 C.F.R. §§ 42.201; 42.106(c). To assist in our investigation, we ask that you provide the documents and information specified in the attached request within thirty calendar days of the date of this letter. If the data are stored in electronic form, we ask that you provide us those data in a commonly readable format, e.g., portable document format, Microsoft Word document, or Excel database. If the data are stored in proprietary format, please contact us to make arrangements for a usable transfer of the data. Please number each response to correspond with the number of the respective element in the data request.

We also encourage you to furnish any additional material that you think may be helpful for our investigation. Please be assured that all of the information that you provide will be carefully reviewed during our investigation.

You may send the requested information and documents to me at the following address: 950 Pennsylvania Ave, N.W. – NYA 6019, Washington, DC 20530. Please reference the Department of Justice matter number assigned to this matter, DJ No. 204-56-30, in any correspondence that you send to this office. If you have any questions, concerns, or would like to discuss this matter, you may contact me at (202) 616-2925 or Victoria.Thomas2@usdoj.gov. Thank you for your time and attention to this matter.

Sincerely,

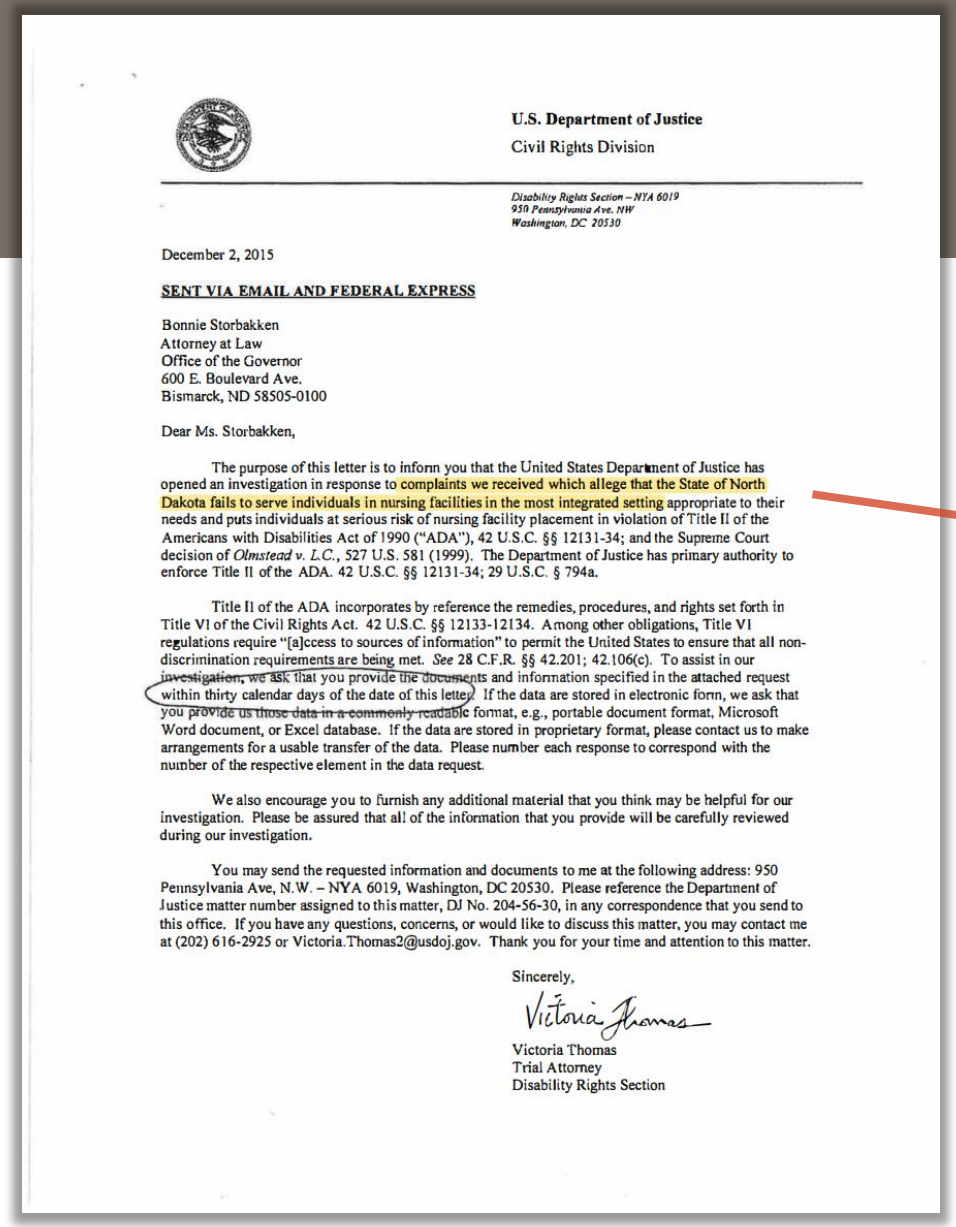
Victoria Thomas

Victoria Thomas
Trial Attorney
Disability Rights Section

DECEMBER 2015

> "...complaints we received which allege that the State of North Dakota fails to serve individuals in nursing facilities in the most integrated setting...

NOTIFICATION FROM DOJ



U.S. Department of Justice
Civil Rights Division

Disability Rights Section – NYA 6019
950 Pennsylvania Ave. NW
Washington, DC 20530

December 2, 2015

SENT VIA EMAIL AND FEDERAL EXPRESS

Bonnie Storbakken
Attorney at Law
Office of the Governor
600 E. Boulevard Ave.
Bismarck, ND 58505-0100

Dear Ms. Storbakken,

The purpose of this letter is to inform you that the United States Department of Justice has opened an investigation in response to complaints we received which allege that the State of North Dakota fails to serve individuals in nursing facilities in the most integrated setting appropriate to their needs and puts individuals at serious risk of nursing facility placement in violation of Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12131-34; and the Supreme Court decision of *Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has primary authority to enforce Title II of the ADA. 42 U.S.C. §§ 12131-34; 29 U.S.C. § 794a.

Title II of the ADA incorporates by reference the remedies, procedures, and rights set forth in Title VI of the Civil Rights Act. 42 U.S.C. §§ 12133-12134. Among other obligations, Title VI regulations require "[a]ccess to sources of information" to permit the United States to ensure that all non-discrimination requirements are being met. *See* 28 C.F.R. §§ 42.201; 42.106(c). To assist in our investigation, we ask that you provide the documents and information specified in the attached request within thirty calendar days of the date of this letter. If the data are stored in electronic form, we ask that you provide us those data in a commonly readable format, e.g., portable document format, Microsoft Word document, or Excel database. If the data are stored in proprietary format, please contact us to make arrangements for a usable transfer of the data. Please number each response to correspond with the number of the respective element in the data request.

We also encourage you to furnish any additional material that you think may be helpful for our investigation. Please be assured that all of the information that you provide will be carefully reviewed during our investigation.

You may send the requested information and documents to me at the following address: 950 Pennsylvania Ave, N.W. – NYA 6019, Washington, DC 20530. Please reference the Department of Justice matter number assigned to this matter, DJ No. 204-56-30, in any correspondence that you send to this office. If you have any questions, concerns, or would like to discuss this matter, you may contact me at (202) 616-2925 or Victoria.Thomas2@usdoj.gov. Thank you for your time and attention to this matter.

Sincerely,

Victoria Thomas
Trial Attorney
Disability Rights Section

DECEMBER 2015

> "...complaints we received which allege that the **State of North Dakota fails to serve** individuals in nursing facilities in the most integrated setting..."

49
PER 1000

PEOPLE OVER 65 IN CERTIFIED NURSING FACILITIES

HIGHEST RATE IN THE U.S.

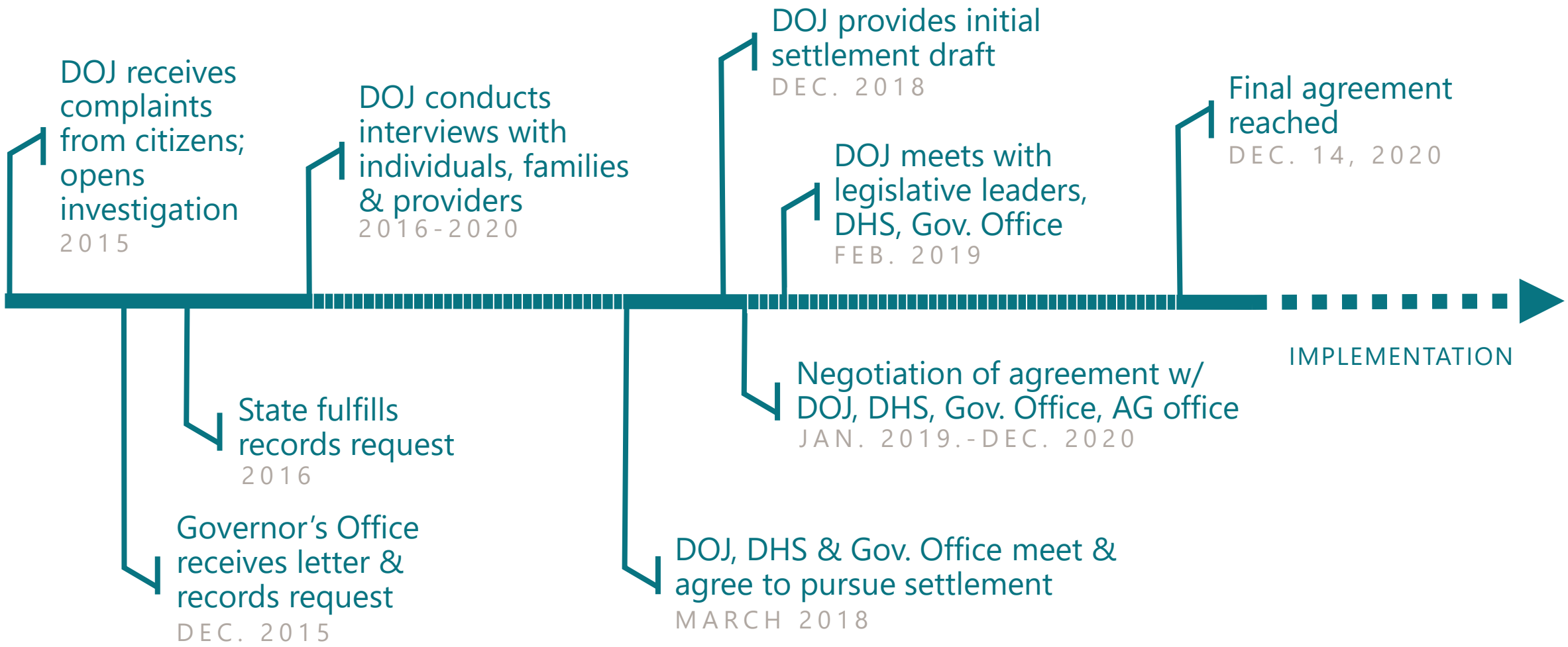
Sources: Henry J Kaiser Foundation, US Census Bureau (2016)

VARIETY OF CONCERNS

EXAMPLES PROVIDED BY DOJ

- **Unnecessary segregation** of disabled individuals in skilled nursing facilities
- Adults in skilled nursing facilities who would **rather be in their community**
- **Imbalance of funds** to skilled nursing facilities and community-based services
- **Lack of awareness** about existing transition services and available tools

TIMELINE


DOJ receives complaints from citizens; opens investigation
2015
DOJ conducts interviews with individuals, families & providers
2016-2020
DOJ provides initial settlement draft
DEC. 2018
DOJ meets with legislative leaders, DHS, Gov. Office
FEB. 2019
Final agreement reached
DEC. 14, 2020
IMPLEMENTATION
State fulfills records request
2016
Governor's Office receives letter & records request
DEC. 2015
DOJ, DHS & Gov. Office meet & agree to pursue settlement
MARCH 2018
Negotiation of agreement w/ DOJ, DHS, Gov. Office, AG office
JAN. 2019.-DEC. 2020

KEY TERMS | DOJ SETTLEMENT
Americans with Disabilities Act

The Americans with Disabilities Act (ADA) requires public agencies to **eliminate unnecessary segregation** of persons with disabilities and provide services in the **most integrated setting appropriate** to the needs of the individual.

In **1999** the Federal Supreme Court **Olmstead** decision **affirmed** the **ADA** requirements.



KEY TERMS | DOJ SETTLEMENT
Most Integrated Setting

A *living environment* that allows individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

For Example

Single Family Home
Apartment
Townhome
Condominium
Farm or Ranch
Adult Foster Care
Living with family

KEY TERMS | DOJ SETTLEMENT
Community Integration Mandate

Public entities are required to provide **community-based services** when:

- Community-based services are **appropriate** for the individual; and
- The individual **does not oppose** community-based treatment; and
- Community-based treatment can be **reasonably accommodated**, taking into account:
  - Resources available to the entity and
  - Needs of others receiving disability services.



BENEFITS OF DOJ AGREEMENT

1. **Expands and raises awareness** about community-based care options available to adults with physical disabilities

2. Allows individuals to make **informed choices**, including the option to receive care while enjoying the benefits of community living in the least restrictive setting

3. Builds upon the investments made by the 2019 Legislature and our **shared goal** of improving services to citizens

KEY TERMS | DOJ SETTLEMENT
Informed Choice

The process by which the State ensures that Target Population members have an opportunity to make an informed decision about where to receive services.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

For Example

- Person-centered planning
- Info about benefits of integrated settings
- Facilitated visits or other experiences in integrated settings
- Opportunity to meet with peers (other individuals with disabilities who are living, working and receiving services in integrated settings)
- Reasonable efforts to identify and address concerns

What do we need to do to help someone make an informed choice about how they may want to access services in the most integrated setting that is right for them?



AGREEMENT VISION

- Long-term care system & supports reform
- Increase access to community-based services
- Increase awareness about service options
- Increase provider capacity & training

Builds upon **shared goal** of improving services to citizens providing care closer to home

AGREEMENT COMPONENTS

I. Introduction
II. Jurisdiction
III. Definitions
IV. Target Population
V. Subject Matter Expert
VI. Implementation Plan
VII. Case Management
VIII. Person Centered Plans
IX. Access to Community Based Svc
X. Information, Screening & Diversion
XI. Transition Services
XII. Housing Services
XIII. Community Provider Capacity & Training
XIV. In-reach, Outreach, Education & Natural Supports
XV. Data Collection & Reporting
XVI. Quality Assurance & Risk Management
XVII. Enforcement
XVIII. General Provisions

IV. TARGET POPULATION MEMBERS (TPM)

COMMUNITY MEMBERS

- Adults with disabilities living in an integrated community setting, but at risk of Medicaid-funded nursing facility care.
- Adults with disabilities in need of additional community-based services to continue living in an integrated community setting.

NURSING FACILITY MEMBERS

- Adults with disabilities who reside in a nursing facility and receive Medicaid-funded long-term care services.
- Adults with disabilities who reside in a nursing facility who are at risk of becoming eligible for Medicaid-funded services.

Who are we trying to reach?

Target population

Basic Eligibility

- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.



IF in skilled nursing setting

- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

IF in hospital or home setting

- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL

KEY TERMS | DOJ SETTLEMENT
Physical Disability

"Physical Disability" – means an impairment that substantially limits major life activity, including one or more major bodily functions, see 42U.S.C 12102: 28 C.F.R 33.108 such that the individuals meets ND's Nursing Facility Level of Care (LOC) by requiring for example, assistance with activities of daily living such as toileting, eating, or mobility.

ND Admin code 75-02-09, as may be amended.

WHO IS NOT A MEMBER OF THE "TARGET POPULATION"

Individuals under age 21

Individuals who are not Medicaid eligible

Individuals who are not expected to need services for at least 90 days

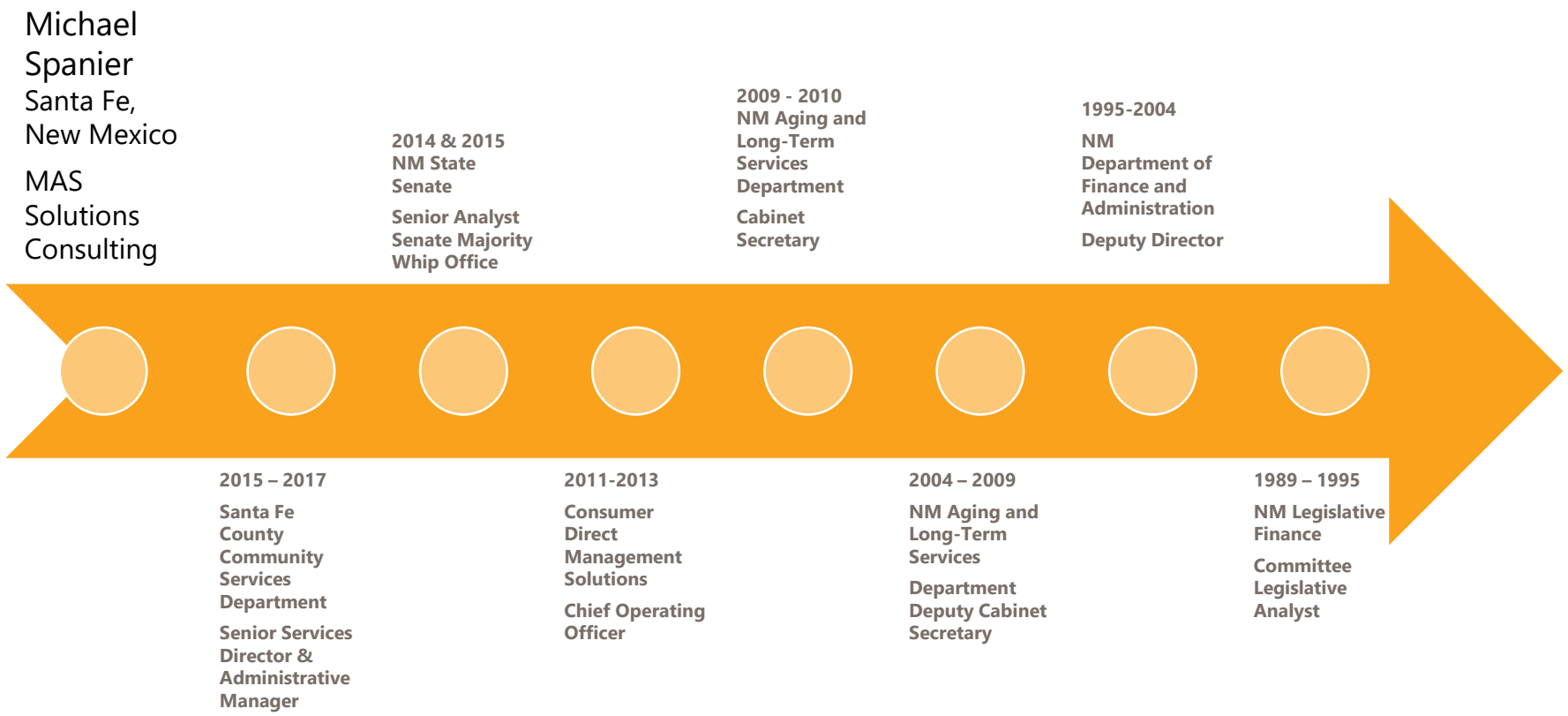
Individuals with an intellectual disability or mental illness who do not screen at a nursing facility level of care



V. SUBJECT MATTER EXPERT

Individual chosen by the parties with expertise in management, administration and finance of HCBS

Provide technical assistance and compliance reviews

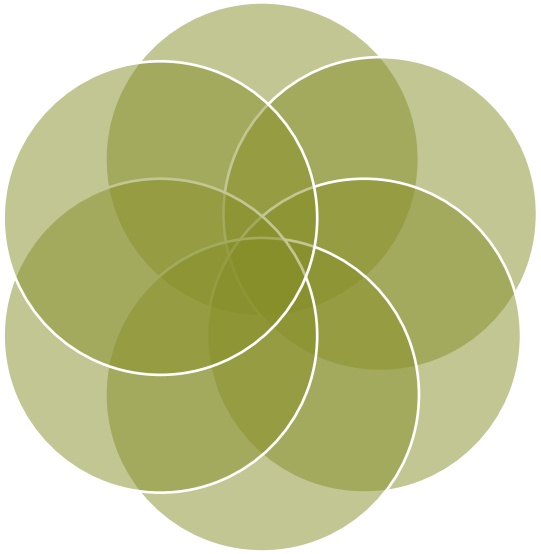


VI. IMPLEMENTATION PLAN

Within 120 days of effective date produce draft plan

Establish a method to address challenges to implementation

Review relevant services, capacity and barriers

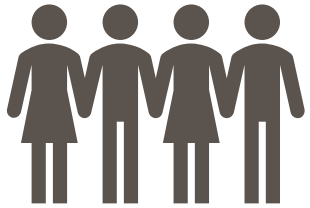


Assign agency and division responsibility for achieving benchmarks

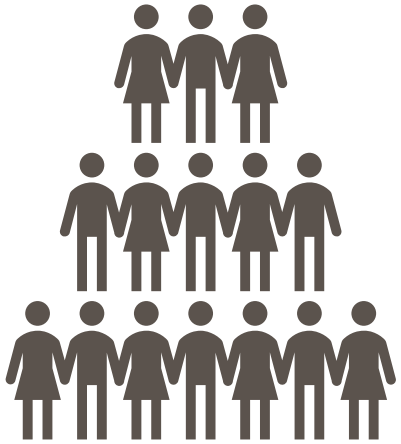
Engage Stakeholders

Identify benchmarks and timelines for meeting Agreement's requirements

VII. CASE MANAGEMENT



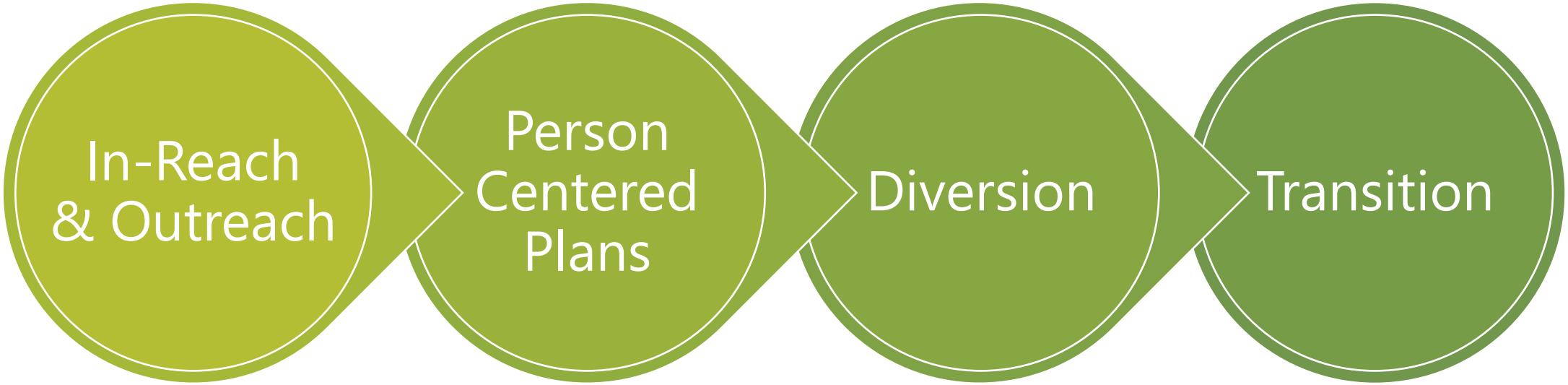
64 HCBS Case Managers



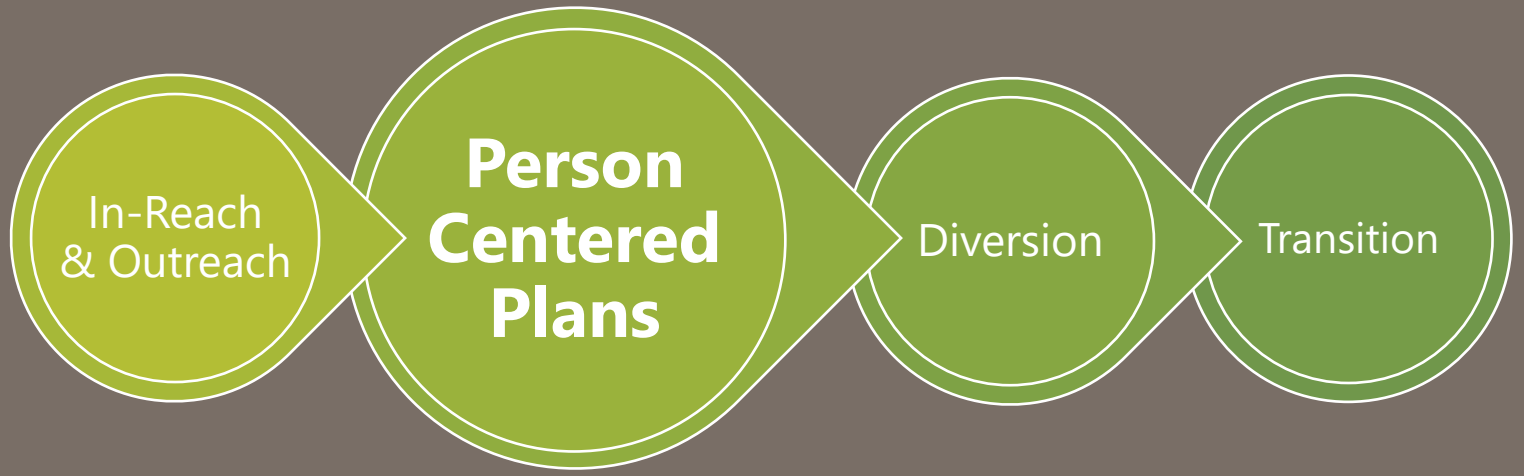
Served 2300 individuals
(Nov 2020)

- Provide case management for older adults & individuals with physical disabilities receiving:
  - Service Payments for the Elderly and Disabled (SPED)
  - Expanded SPED (Ex-SPED)
  - Medicaid 1915-(c) Waivers
    - Aged and Disabled
    - Tech Dependent
  - Medicaid State Plan Personal Care (MSP-PC) in community
- Conduct informed choice referral visits

ND / DOJ AGREEMENT STRATEGY



VIII. STRATEGY



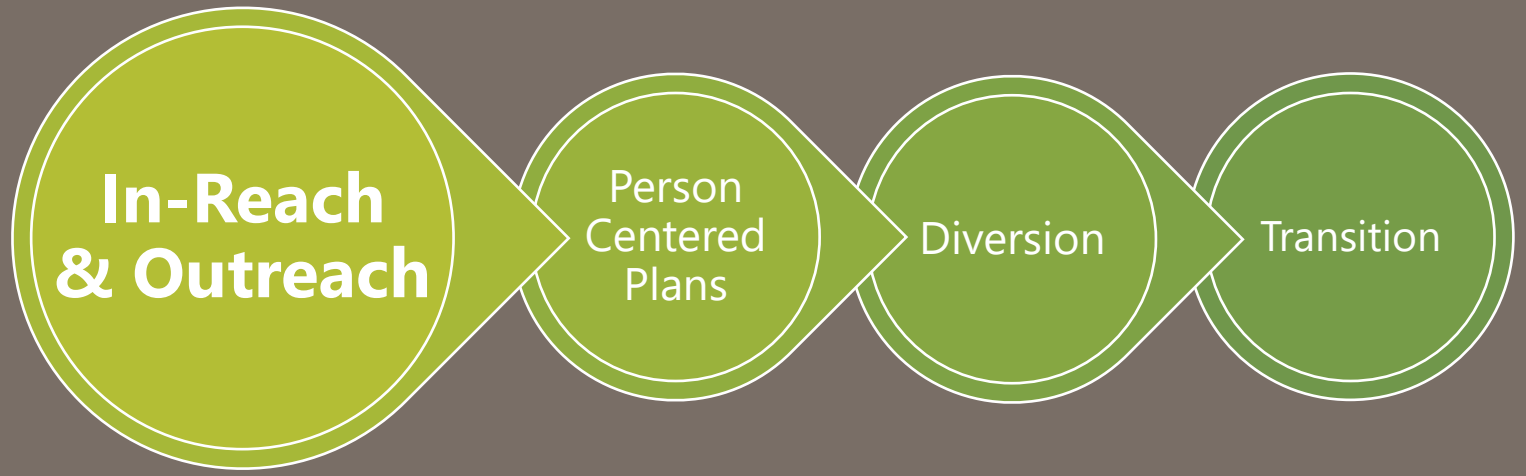
PERSON CENTERED PLANNING

Medicaid mandated process, developed by individual and case manager to identify supports and services that are necessary to meet the individual's needs in the most integrated setting

GOALS

Year 1	Year 2	Year 4	Year 6	Year 8
•290 Target Population Members (TPM)	•Additional 290 TPM	•Additional 650 TPM	•Additional 670 TPM	•Additional 670 TPM

XIV. STRATEGY



IN-REACH

Informing individuals in skilled nursing facilities and hospitals of their care options

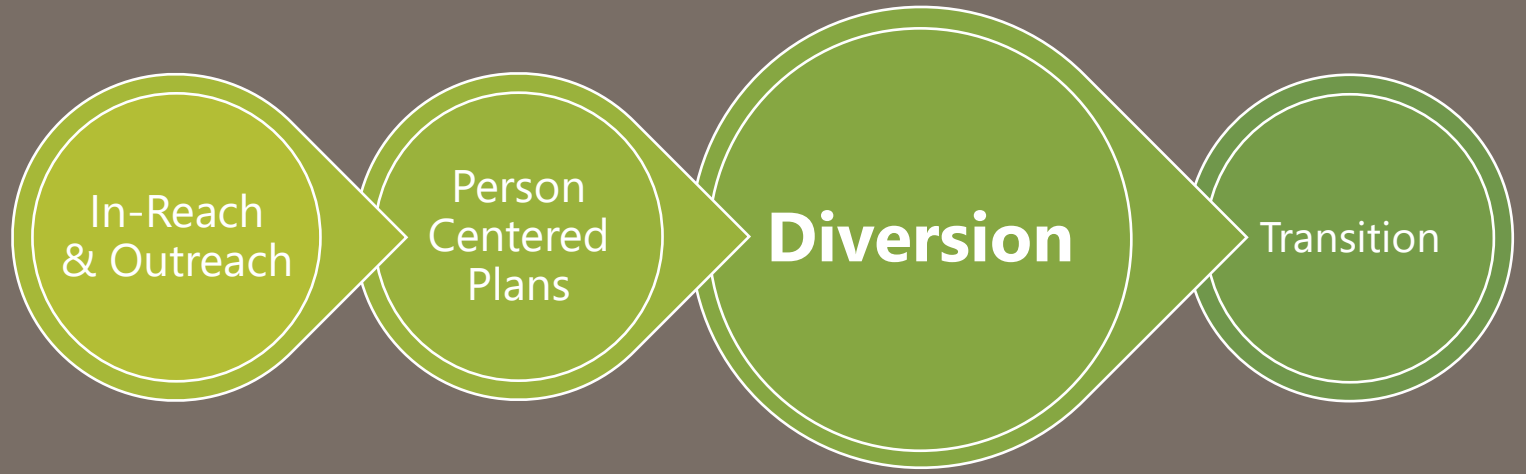
OUTREACH

Informing individuals and stakeholders in the community about their care options

GOALS

Within 9 months	Year 2	Year 4	Year 5 and after
•Individual or group in-reach to all skilled nursing facilities	•Develop peer support system	•Individual in-reach to at least 1,000 Skilled Nursing Facility target population members	• In-reach to all newly admitted or identified Skilled Nursing Facility target population members

X. STRATEGY



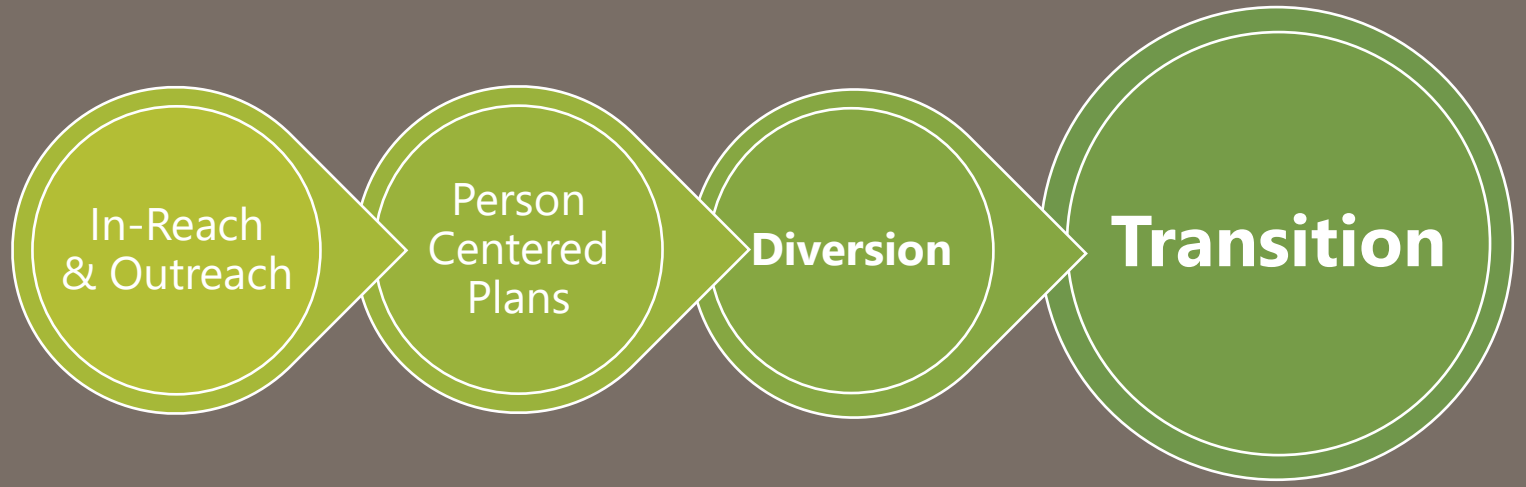
DIVERSION: COMMUNITY LIVING

Set of activities that allow a target population member to avoid placement in a skilled nursing facility and remain living in their home and community

GOALS

Year 2	Year 4	Year 6	
•100 Target Population Members (TPM)	•150 additional TPM	•150 additional TPM	Total 400 diverted

XI. STRATEGY



TRANSITION TO COMMUNITY

Services to prepare an individual currently residing in a skilled nursing facility to return to an integrated community setting

GOALS

Year 2	Year 4	Year 6	Year 8
•Transition 100	•Transition 60% identified through person centered planning (PCP)	•Transition 70% identified through PCP	•Transition all remaining individuals identified PCP

XII. HOUSING SUPPORTS

INTEGRATED HOUSING

Federal, state, or local assistance to TPM who need help accessing available integrated housing and support for TPM where lack of housing has been identified as a barrier to community-based services

GOALS			
Year 1	**Year 2**	**Year 3**	**Year 4-8**
•Assist 20 Target Population Members (TPM)	•Assist additional 30 TPM	•Assist additional 60 TPM	•Assist additional number of TPM based on aggregate need

KEY TERMS | DOJ SETTLEMENT
Permanent Supported Housing

Affordable, permanent housing coupled with housing supports and other community-based services. Individual lives in a private home alone, with family, significant other, or roommates of their choosing.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

Notes

- Tenants must have access to community provider for intermittent on-call, planned and back up community-based services
- Must be scattered site housing

KEY TERMS | DOJ SETTLEMENT
Integrated Housing

Housing **cannot be provided in** group homes, nursing facilities, boarding homes, residential care facilities or assisted living residences; or any building where more than 25% of the occupants are TPM.

Requires state to **provide** funding for **rental assistance** including reasonable expansion of existing capacity by funding and providing rental assistance to support permanent housing for TPM.

Requires state to **provide** for **assistance** with **identifying** housing, **coordinating** housing modifications, applying for subsidized housing, as well as help **preserving** tenancy if temporarily admitted to a Nursing Home.

XIII. PROVIDER CAPACITY AND TRAINING



State will ensure an adequate supply of qualified trained community providers to enable target population members to transition and live in most integrated setting



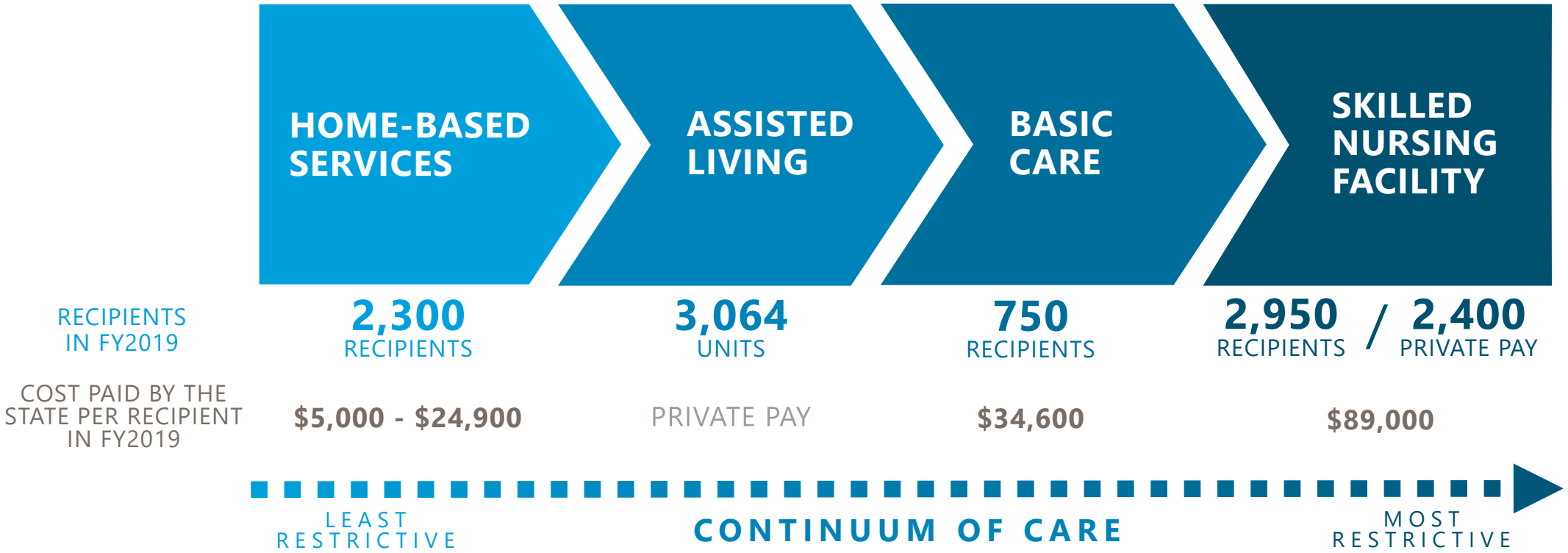
Provide guidance and training to nursing homes and other community providers who make a commitment to provide community-based services



Draft plan to addresses provider capacity, reimbursement rates, incentives to serve individuals with significant medical/supervision needs, those living on Native American reservations and in rural areas

CONTINUUM OF CARE

LONG-TERM CARE SERVICES & SUPPORTS

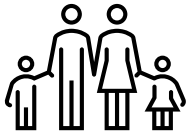


OPPORTUNITIES FOR COLLABORATION

Internal and external partners

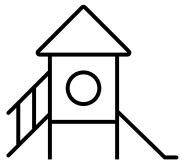


DHS Key Priorities



Build Stronger Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Enhance Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



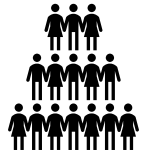
Provide Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Innovate and Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



Inspire a High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

Meet Margo



Margo is 53

She lives alone in her home

Margo has disability-related physical impairments. She is Medicaid eligible and meets a nursing home level of care.

Her monthly income is from Social Security Income, $783 per month

Margo needs support in the morning and the evening, and some home-making assistance to live independently and some occasional help with non-medical transportation. She can manage the rest of her day with the help of several assistive devices.

Margo is a good candidate for **Medicaid State Plan-funded Personal Care and the Medicaid waiver**

What will help Margo to choose to live at home?

AGING & ADULT SERVICES
Types of *Support Services* available via HCBS

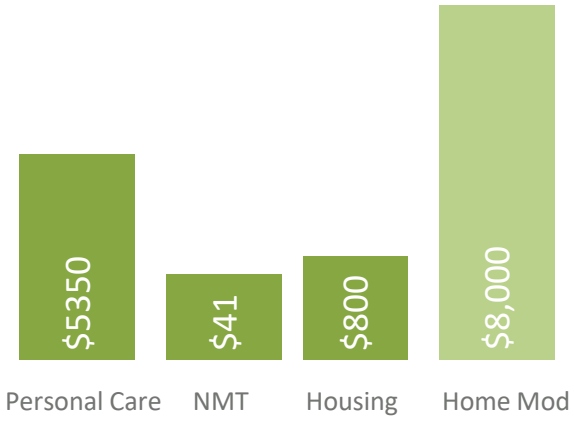
- Adult Day Care
- Adult Foster Care
- Adult Residential Care
- Attendant Care
- Case Management
- Chore Service
- Community Support Services / Residential Habilitation
- Community Transition Services
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care
- Emergency Response System
- Environmental Modification
- Family Home Care & Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Care Services
- Respite Care
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Care

At home no services | At home with family no Services | At home with family with services | At home visiting services | At home - Live-in Caregiver | Assisted Living | Basic Care | Skilled Nursing Facility

Wants to stay in her home and it has been determined that her care needs can be met there safely

$5391/mo

+ $8,000 (one time)





?

Chose an agency provider

Needs help with rent

Needs some modifications to bathroom and kitchen

Meet Barb



Barb is 67 years old

Barb lives alone in her home.

Her monthly income of $1,193 comes from Social Security. Barb is Medicaid eligible.

She meets a Nursing Facility Level of Care because of her dementia and related impairments. She needs supervision and help with her personal cares.

Barb is a good candidate for the **HCBS Medicaid Waiver and Medicaid State Plan Personal Care.**

What will help Barb to choose to live at home?

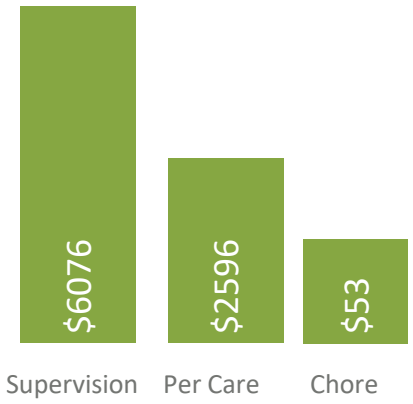
AGING & ADULT SERVICES
Types of *Support Services* available via HCBS

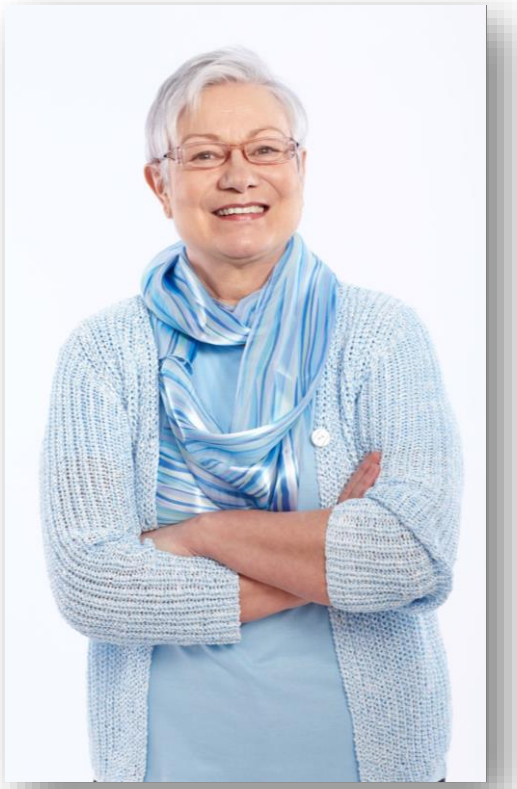
- Adult Day Care
- Adult Foster Care
- Adult Residential Care
- Attendant Care
- Case Management
- Chore Service
- Community Support Services / Residential Habilitation
- Community Transition Services
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care
- Emergency Response System
- Environmental Modification
- Family Home Care & Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Care Services
- Respite Care
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Care

At home no services | At home with family no Services | At home with family with services | At home visiting services | At home - Live-in Caregiver | Assisted Living | Basic Care | Skilled Nursing Facility

Wants to stay in her apartment and it has been determined that her care needs can be met there safely

$8725/mo





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Family enrolled to provide the care

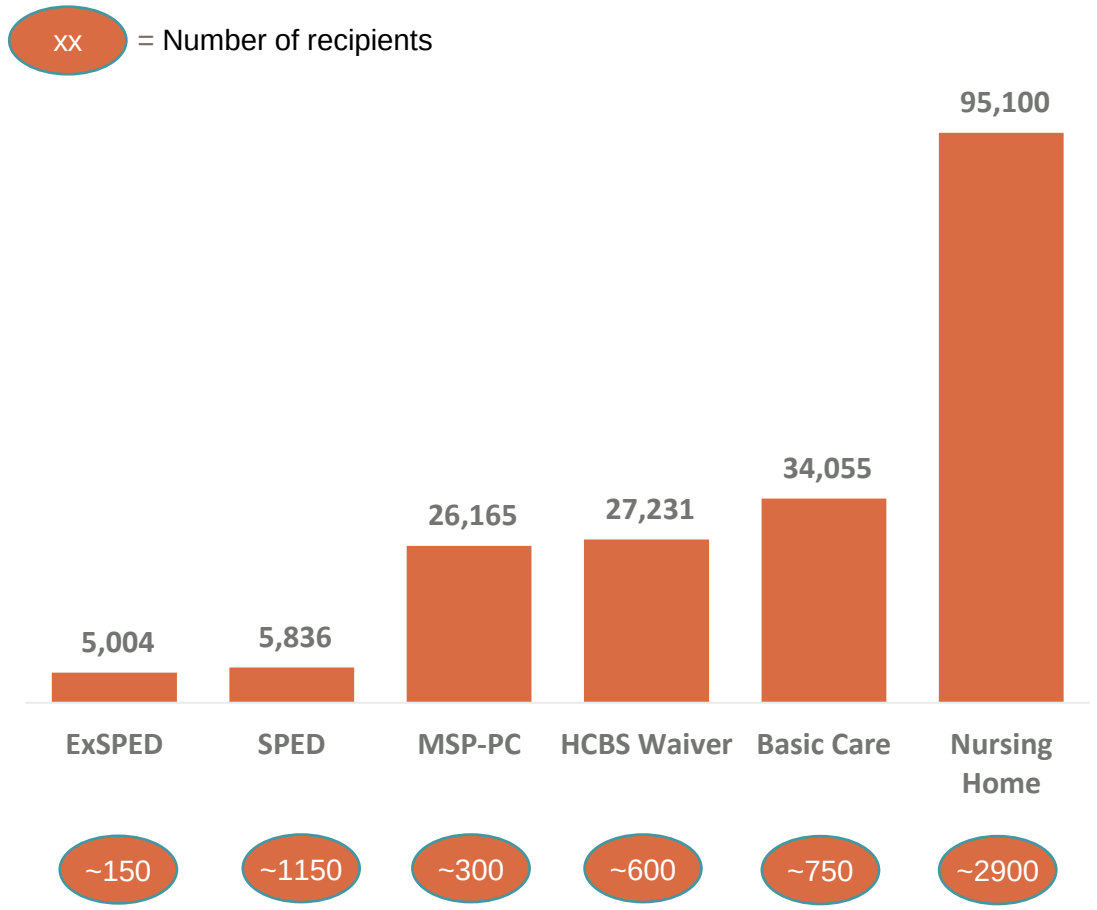
History wandering, often up at night

DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

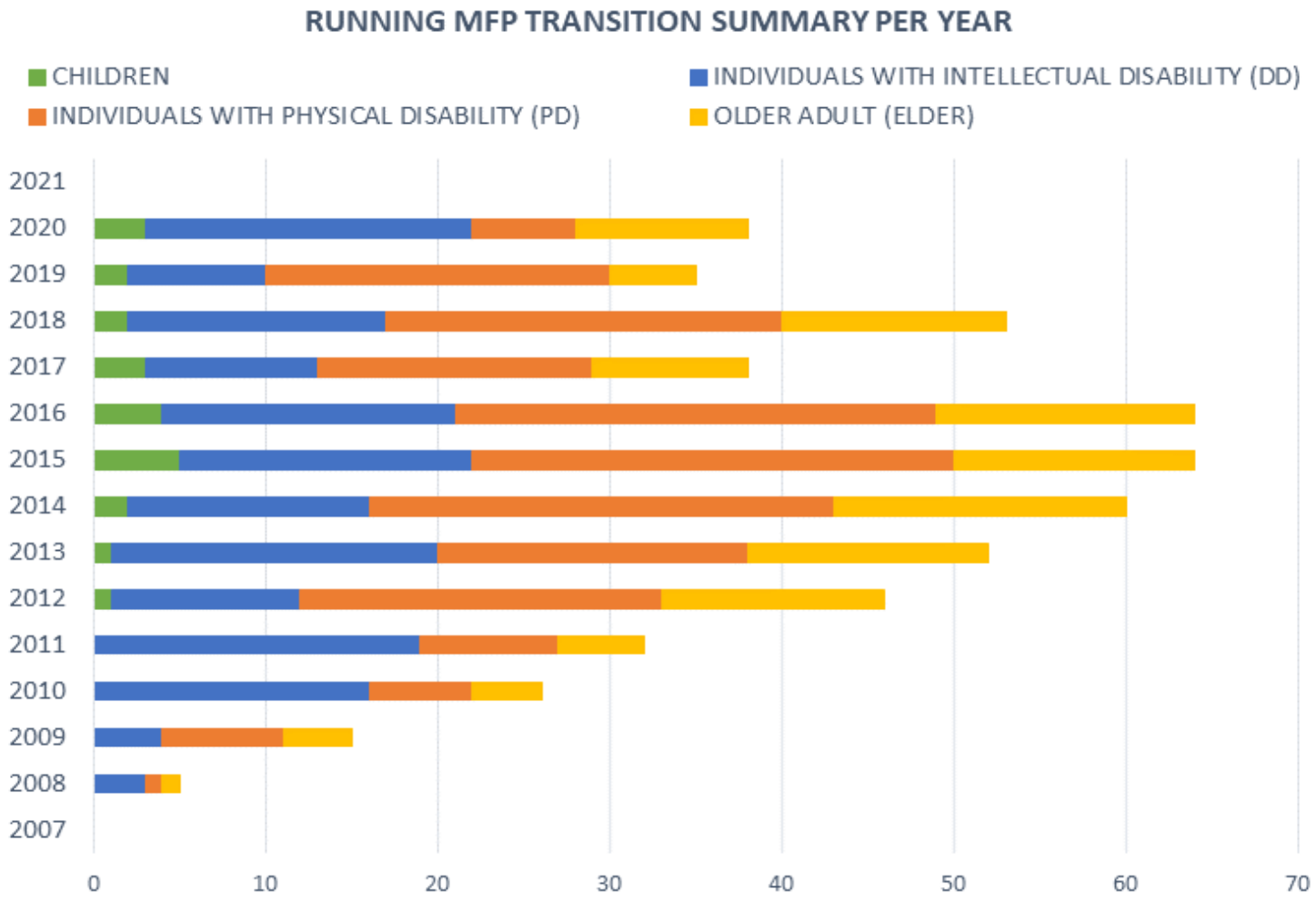
- Service Payments for the Elderly and Disabled (SPED): Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- Expanded SPED (Ex-SPED): Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- Home and community-based services (HCBS) waiver: This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- Medicaid State Plan personal care (MSP-PC): Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- Basic Care: Room and board and personal care services for persons eligible for Medicaid.

AGING & ADULT SERVICES
Money Follows the Person

Federal Grant designed to assist states to increase the use of home and community-based services (LTSS System Rebalancing)

- Eliminate barriers that prevent individuals from receiving LTSS in the settings of their choice

- Original award - $8.9 million (2007)
- Award through 2020 - $29 million (fed) and $1.7 million (state)
- Transitioned 528 individuals from institutional settings back to the community





Contact Information

Nancy Nikolas Maier
DOJ Agreement Coordinator

Director, Aging and Adult Services
Division, Department of Human Services

1237 W Divide Ave, Suite 6
Bismarck, North Dakota 58501-1208
Phone: 701-328-4601
Toll-Free Aging & Disability Resource LINK: 1-855-462-5465
E-mail: carechoice@nd.gov



2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/25/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson Opened the meeting at 9:00 a.m.

Discussion Topics:

- AARP
- Designer Genes
- Providing meals for seniors
- NDACP
- Grand Forks Growth and Support Centers

Janell Moos, AARP Associate Director, (9:08 am) testified about Economic Assistance #2525

Scott Bur, Executive Dir of Independence Incorporated (9:12 am) testified about the center for independent living, oral testimony

Damian Schlinger (9:23 am) testified about Vocational Rehab, oral testimony

Roxanne Romanick (9:26 am) testified about Designer Genes of ND #2534

Brian Arett, Executive Director of Valley Senior Services (9:33 am) testified about providing meals for seniors #2278 #2279

Nikki Wegner, Program Manager for the Alzheimer's Association (9:47 am) testified about the Alzheimer's Association #2314 #2315 #2316

Bruce Murry, Executive Dir. of ND Assoc. of Community Providers (9:59 am) testified about NDACP #2498

Julie Erickson, Exec. Dir. (10:06 am) testified about the Grand Forks Growth and Support Center #3055

Scott Anderson, Program Service Dir. for Development Homes Inc. (10:25 am) testified about DHI #2415

Lorena Poppe, Owner and Exec. Dir. of Poppy's Promise (10:44 am) testified about Poppy's Promise #2499

Scott Burtsfield, Exec. Dir of Vocational Training Center (11:06 am) testified about the NDACP #2460

Tom Newberger, Chief Exec, Officer for Red River Human Services Foundation (11:21 am) testified about the Red River Human Services Foundation #2419

Donna Byzeweski, Program Director of the corporate guardianship program at Catholic Charities North Dakota (11:28 am) testified about the corporate guardianship program at Catholic Charities North Dakota #2281

Jon Larson, Executive Director of Enable Inc. (11:35 am) testified about the NDACP #2423

Josh Askvig, State Director at AARP (11:46 am) testified about AARP of ND #2402 #2403

Pamela Mack, Director of Advocacy Services for the Protection & Advocacy Project (11:54 am) testified about the Protection & Advocacy Project #2290

Sarah Carlson (11:59 am) testified about Family Voices of North Dakota #2679

Chair Nelson closed the meeting at 12:09 p.m.

Cole Fleck, Committee Clerk

House Appropriations Committee #2525
IN SUPPORT – HB 1012 – DHS Budget – Economic Assistance
January 25, 2021
Janelle Moos, AARP North Dakota
jmoos@aarp.org – (701) 355-3641

Chairman Nelson and members of the House Appropriations Human Resources Division, I am Janelle Moos, Associate State Director of Advocacy at AARP North Dakota.

AARP is a non-profit, non-partisan membership organization with more than 84,000 members in North Dakota. Our mission is to empower people to choose how they live as they age.

We wanted to take a moment to weigh in on a couple of important economic assistance issues.

First, SNAP is an important program that ensures older adults and families get the nutrition needed. We have closely monitored the food crisis more Americans and North Dakotans faced during the pandemic. SNAP benefits are an important tool that addresses this crucial problem. It is an especially important program for Americans over 50 because many face challenges to employment, live on fixed incomes, live alone, and have limited financial resources to pay for necessities like food, housing, and essential medicine. To people struggling to put food on the table, hunger is not a political issue, it is a daily reality. SNAP is a vital lifeline that feeds 23,840 North Dakota households. 35% of those recipients are either elderly or disabled. Also remember, participants generally spend their SNAP dollars locally, soon after receiving them, boosting local economies. An important benefit in this time.

Also, LIHEAP has served as a lifeline for low-income families. As you may know, AARP believe utility issues and rates are a key pocketbook issue. We have intervened in various cases in front of the North Dakota Public Service Commission on behalf of older adults and consumers and know the struggle of families to afford their utility payments. Having a safety net for families especially in our climate is not only the right thing it is the moral thing to do.

We encourage you to continue to support these programs to ensure no North Dakotan goes hungry or without heating or cooling assistance when they need it.

Again, we appreciate the time to raise issues important to North Dakotans 50+ and would be happy to answer any questions. Thank you.

HB 1012 #2534
House Appropriations – Human Resources Division
Monday, January 25, 2021
Rep. Jon Nelson - Chairman

Chairman Nelson and Members of the House Appropriations – Human Resources Division:

My name is Roxane Romanick and I'm representing Designer Genes of ND, Inc., as their Executive Director. Designer Genes' membership represents 260 individuals with Down syndrome that either live in our state or are represented by family members in North Dakota. Designer Genes' mission is to strengthen opportunities for individuals with Down syndrome and those who support them to earn, learn, and belong.

Individuals with Down syndrome have made many strides in living in their homes, schools, and communities because of educational and medical advances, public policy, and advocacy efforts. Public investments in early intervention, family support, public schools and special education, post-secondary school options, and home and community-based services do make a real difference for people with Down syndrome. The vast majority of our membership are living in home and community-based settings. Thank you for your important part in opening up these opportunities.

My daughter, Elizabeth, and our family are an example of the positive outcomes of this investment. Elizabeth has been a consumer of services from the first day of her life when her Early Intervention staff visited her in the hospital until the present with support from Vocational Rehabilitation and the Minot State Access Disability Services and the ASTEP program. Her education was supported by special education and general education from 2002 to 2018. A number of her job experiences have been supported by Vocational Rehabilitation. As a family, we have been supported by Family Voices of ND as well as the connections we've made through Designer Genes and the rest of the Down syndrome community across a wide arena of areas. All of these services and supports poured into a reservoir that she is depending on as she works on an Early Childhood Paraprofessional Associates from Dakota College of Bottineau. Who would have thought?

Our organization has interest in a number of areas of HB 1012 and this single piece of testimony is presented to draw your attention to those areas:

1. **Developmental Disabilities Division**
    a. **Payments for providers** – We stand in support with other advocacy efforts and the recommendation to award providers within the Developmental Disabilities system up to a 3%/3% increase. Our individuals across the life span from infants and toddlers in

our Early Intervention (Infant Development) to our oldest individuals with Down syndrome rely on this system.

b. **Eliminate the $11 million in state cost savings to the adult services providers -** This cut to our providers is devastating. The provider system has been stressed due to COVID, recruiting and maintaining staff, and assuring health and safety for everyone that they serve. These challenges put individuals at risk of institutionalization and instead of helping more individuals to move out of the Life Skills Transition Center, we will see the reverse happening.

c. **Restore and reallocate $100,000 Experienced Parent Funding –** In the 65th session, a number of advocates worked with legislators to secure an amendment on HB 1012 for $100,000 in state general funds and $160,000 in designated funds from the federal Part C grant to support the Experienced Parent program within the ND Part C Early Intervention system. In her January 20, 2021 budget detail testimony, Tina Bay, Director of the Developmental Disabilities Division, reported that this funding (both state and federal grant) would be cut as part of the state's cost saving plan.

Family-to-family support, parent support, peer support – call it what you want - is a critical element in sustaining the confidence and competence for families who have children with special health care needs. Our organization for one is designed expressly with that purpose in mind. In a 2005 research study of postnatal support of mothers of children with Down syndrome (mere_43_304.196_212.tp (brianskotko.com), the vast majority of mothers reported a desire to be connected to their local down syndrome organization "which can provide practical knowledge in addition to establishing the beginnings of a long term support relationship."

Our families who are raising children with special health care needs need other families to connect with who have lived experience either through their own experiences or through helping other families. We need structured approaches to matching families with other families like Family Voices of North Dakota does through their Parent-to-Parent program. I am requesting that upon restoring the $100,000 cut from the DD budget that it is reallocated to the Children and Family budget and passed on to Family Voices of North Dakota. (See below). Family Voices will put this money to work from Day 1 for the citizens of North Dakota and has the resources to do so.

2. Children and Family Services

a. Restore $100,000 to Family Voices and Reallocate $100,000 from DD

I am requesting that $200,000 be restored and given to Family Voices of North Dakota. They currently have $175,00 in the 2019-2021 biennium and have been told that $100,000 is being eliminated due to the cost savings plan. With your restoration and reallocation, they would have $275,000 to continue, plus expand the work they do to help families navigate and access a variety of service delivery systems. Believe your

money will go to work. Without an amendment from your committee, our North Dakota families will have lost $200,000 in critical supports.

3. **Vocational Rehabilitation**
    a. **Restore state general funds for the Centers for Independent Living –** If anyone should be testifying on this section, it's my daughter, Elizabeth. Through Dakota Center for Independent Living (DCIL), she was able to get her driver's permit. DCIL's active engagement on the Bismarck-Mandan Mayor's Committee on People with Disabilities helped her to know about their scholarship program, of which she's been awarded funding the last 3 years. Probably what she would tell you about the most though is their Youth Empowering Social Status (YESS) movement and the opportunities that she's had to develop leadership, speak publicly, and connect to other youth and young adults with disabilities and without. Sustaining our four Centers for Independent Living is another piece if assuring individuals with disabilities in our state live quality lives.

Thank you for your time and I will take any questions that you may have.

Roxane Romanick
Executive Director
Designer Genes of ND, Inc.
701-391-7421 info@designergenesnd.com

Testimony #2278
House Bill 1012 – Department of Human Services
Aging Services Budget
House Appropriations - Human Resources Division
January 25, 2021

Chairman Nelson and members of the committee, my name is Brian Arett. I am the executive director of Valley Senior Services providing services for senior citizens in the six counties of southeastern North Dakota. I am also a member of the North Dakota Senior Service Providers, an association of agencies that provide Older Americans Act Services to the senior population of this state.

Attached to my testimony is a copy of a booklet entitled Feeding Grandma 2021. This is the fifth booklet in a series that we have provided during the legislative session. Each session we have updated it to provide the most current and in-depth data on senior hunger, how our programs help prevent this from happening in North Dakota and why it is one of the most cost-effective methods for keeping seniors in their homes.

The basic premise behind this booklet is that providing a stable source of healthy, nutrient dense meals is a key factor in successful aging. And because this service is very cost effective - the cost of providing senior

meals for a year equals two days in the hospital or five days in a nursing home - it makes good fiscal sense for our state and for the people we serve.

But, the Senior Nutrition Program is so much more than just a meal. At senior centers, it is a chance for our seniors to engage and socialize with other seniors. And our “Meals on Wheels” programs provide meals to our most vulnerable seniors, those that are unable to leave their homes. Home delivered meals also provide our homebound senior with a daily well-ness check. Many times, this might be the only human contact our seniors have throughout their day. This happens every day in our most rural communities and in our largest cities.

In the state of North Dakota 49% of our seniors live alone, 67% live in rural areas, 61% are women and 20% live in poverty. Inadequate nutrition and /or limited social contact has direct health consequences that affect the healthcare system and the economy.

The agency I work for – Valley Senior Services – provides about 1,400 Meals a day to the seniors of southeastern North Dakota. The average age of the people we serve is just over 82. For many of the people that we

deliver meals to, their only contact with another person during the day is the volunteer making that delivery. We feel that this connection combined with an incredibly healthy meal provides invaluable support that allows many of these people to continue living independently much later in life than they otherwise would. And the partnership that we have with the state of North Dakota through funding provided by the Department of Human Services Aging Services Division is critical in making this happen.

Over the past few sessions, our senior meal programs have had great support from legislators in adding state dollars to the Aging Services budget to work toward our Associations' goal - to have enough combined Federal Title III and State Funds so that ALL senior meals provided by Title III agencies receive the unit rate reimbursement. The $4.60 unit rate reimbursement is NOT intended to cover the full cost of the meal. The total cost, estimated to be $11.02/meal, are covered with participants' program income contributions, required local match, NSIP dollars and additional funds raised locally.

In the testimony provided las week by Nancy Nikolas-Maier, Division Director for the Aging Services Division, she presented a proposed budget

for the biennium for Senior Nutrition Services of $12,036,132. A portion of these funds, the NSIP dollars of $1,693,820, are distributed to providers separate from the $4.60/meal reimbursement we receive for the meals we provide to seniors. This leaves a balance of $10,342,312 in funds designed for reimbursement to providers. Her testimony also noted that meal counts increased dramatically during the pandemic and that we served 103,672 meals in the month of November 2020. If we continue to serve that number of meals it would require funding of $11,445,389 to provide reimbursement for every meal served – an increase of $1,103,079 over the budgeted amount. Our first request of this committee is to add this amount to the budget to reimburse providers for every meal served through this program.

It is also important to point out that the unit reimbursement rate of $4.60/meal has not been increased since July of 2015 – a period of six years at the conclusion of the current biennium. At the same time, costs connected to providing this service have grown by 28.3% (from $8.59/meal to $11.02/meal). With that in mind, our second request of this committee is to increase the per meal unit rate to $5.60/meal. This request would recognize the impact that inflation has on the cost of maintaining this service and would add an additional $2,448,128 for the 2021-23 biennium.

These additional funds will help us to continue to keep up with the growth in demand for our services brought on by the ever-growing aging population. It will also assist us to keep up with rising food costs, and the costs associated with attracting, and retaining the employees required for providing our services.

North Dakota Senior Service Provider agencies are dedicated to making our state the best place possible to grow old. We feel that the State of North Dakota is a natural partner in helping us to accomplish this goal and ask that you add $3,551,207 in state funds to the 2023-25 biennium budget.

Thank you for your time in consideration of this testimony. I would be happy to answer any questions you might have.

Feeding Grandma 2021



A 2021 Legislative Document#2279 #2279

Provided by North Dakota Senior Service Providers (NDSSP)
www.ndseniorservices.org

We Feed Seniors So They Can Remain Healthy and Independent

North Dakota Senior Service Providers (NDSSP) is a group of agencies that provides services to older adults across the entire state of North Dakota. Older Americans Act Title III Nutrition Programs are some of the services we provide. Funding for this program flows to the state from the federal Administration for Community Living and consists of two primary components:

- **Congregate Nutrition Services** - providing nutritious meals for seniors in a social, group setting
- **Home Delivered Nutrition Services** - providing meals for homebound seniors, also known as Home Delivered Meals and Meals on Wheels

This document provides the highlights and updated usage and cost information for Federal Fiscal Year 2019. Research citations for this "Feeding Grandma 2021" document can be found in the "2015 Feeding Grandpa" document available at www.ndseniorservices.org.

Congregate & Home Delivered Meals Are Cost Effective

Many of the chronic health conditions that result in frailty and disability, loss of independence, and reduced quality of life in older adults are preventable through low-cost lifestyle interventions, incorporating proper nutrition and physical activity. Clearly these meals save valuable health and long-term care dollars.



Source: Meals on Wheels America, 2019.

Congregate & Home Delivered Meals Promote Good Health

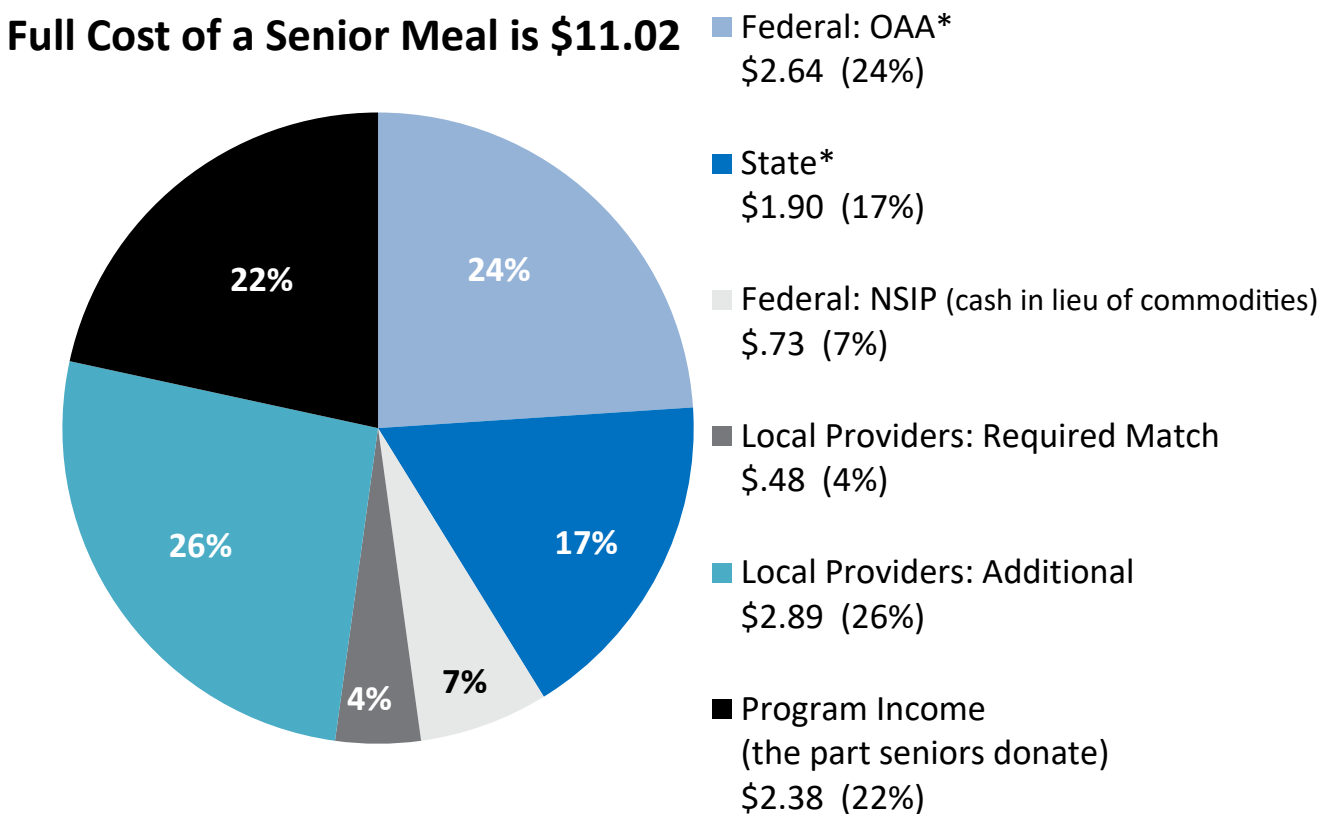
Nutritional status is closely associated with an older person's ability to function and remain independent. Hospitalized older adults suffer from many adverse effects when malnourished. Nutritious meals, tailored to older adults, reduce the risk of chronic diseases and related disabilities, prevent nutritional deficiency, and improve health over the long term.

Congregate & Home Delivered Meals Save the State Medicaid Money

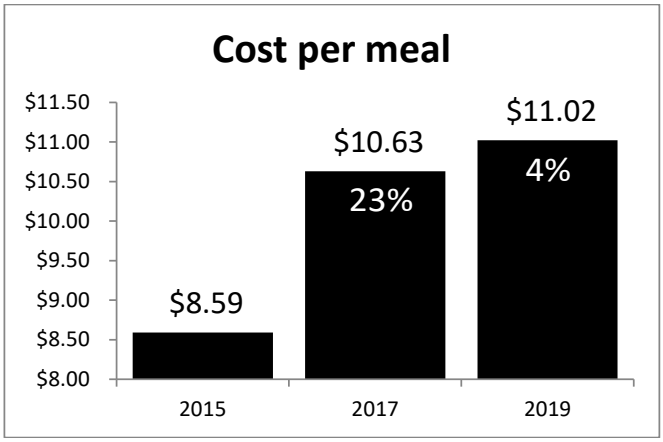
These older adults who participate in our nutrition programs have many of the characteristics that make them nursing home-eligible. In federal fiscal year 2019, 172 of the 4,801 home-delivered meal clients scored with 3+ ADL (Activities of Daily Living) limitations AND were Medicaid eligible. This is a conservative estimate of the nursing home-eligible clients receiving home delivered meals. According to the 2019 Genworth Financial cost of care survey, the average annual cost in a North Dakota nursing home is $132,324. **This means the Medicaid cost to the state for nursing home care for these 172 people would have been over $22.76 million in 2019 alone.**

Congregate & Home Delivered Meals Funding is Lagging Behind Ever-increasing Costs and the Long-term Aging of the Population

In federal fiscal year 2019, the average full cost to provide a senior meal was $11.02. Below is a chart identifying where the money came from in FFY 2019 for these senior meals.



IMPORTANT NOTE: The Federal OAA and State monies are the funds that reimburse agencies the unit rate for the meal. **These two categories sum to only $4.54 a meal and not the unit rate of $4.60 per meal because there was not enough funding for all of the meals to be reimbursed** at the unit rate in 2019. If 100% of the meals were reimbursed at the unit rate, these two figures would add up to $4.60.*



The average cost of a senior meal continues to increase. While the state has provided additional funding in past sessions, it has not been enough to keep up with inflation. In federal fiscal year 2019, a total of 1,087,541 meals (546,066 congregate and 541,475 home-delivered meals) were provided across the state.

COVID-19 Response

Mid-March 2020, the COVID-19 pandemic shut down ALL congregate meal sites in North Dakota, per ND Aging Services mandate. Providers were deemed "essential" and stepped up to provide grab-n-go meals, take-out meals, and drive-thru meals, as well as adding many people to the Home Delivered Meals programs. Meals during the COVID-19 pandemic have increased over 40% over pre-pandemic times in some areas. While federal COVID-19 stimulus funds were allocated to help pay for these meals, the funding did not cover the full cost of the meal and will be spent out by 12/31/2020. Until there is an effective vaccine and all have been vaccinated, many of the state's older adults will continue to utilize these safe methods of getting food. **The average cost of a senior meal continues to increase. 2020 has seen food shortages, increased costs for both food and supplies, and the need for Personal Protective Equipment for staff and meal volunteers. All of these things have caused a spike in meal costs across the state; however these costs are not reflected in the graphs, which only show data through June 30, 2019.**

The basic unit rate of $4.60/meal has not changed since 2015. We are asking to be included with other Department of Human Services programs, which receive annual cost of living increases. Additionally, agencies are only allocated federal and state funding for a portion of the meals they provide. NDSSP is asking to be treated the same as other Department of Human Services providers. We request that we be paid a basic unit rate, with annual cost of living increases, for ALL of the Title III meals provided across the state - not just a portion of them.

Meal providers need to be able to depend on stable, basic rate funding for food, supply, and staffing costs. We try to utilize volunteers as best as we can for our meal programs, but we still have staffing costs. As our senior population continues to grow, we need to work collaboratively in a proactive way so essential services, such as senior meals, will not suffer as the state budget fluctuates. **These meals help seniors remain in their homes and out of costly nursing homes.**

Take action to save Medicaid dollars and support an increased basic unit rate for ALL Title III senior meals. Thank you!

Written by Colette Iseminger, MS, RD, LRD of the Grand Forks Senior Center for North Dakota Senior Service Providers, 620 4th Ave South, Grand Forks, ND 58201 c/o Brian Barrett, APT Solutions brian@aptnd.com Cell: 701-471-5104



NORTH DAKOTA
ALZHEIMER'S STATISTICS

65+ NUMBER OF PEOPLE AGED 65 AND OLDER WITH ALZHEIMER'S BY AGE*

Year	65-74	75-84	85+	TOTAL
2020	1,900	5,500	7,200	15,000
2025	2,300	6,700	7,400	16,000

** Totals may not add due to rounding*

Estimated percentage change



OF DEATHS FROM ALZHEIMER'S DISEASE (2018)

356

10th *highest Alzheimer's death rate in America*

4th *leading cause of death*

GERIATRICIANS

of geriatricians in 2019 **15**

127% increase needed to meet Alzheimer's population needs in 2050

CAREGIVING (2019)

30,000
Number of Caregivers

35,000,000
Total Hours of Unpaid Care

$454,000,000
Total Value of Unpaid Care

HOSPITALS (2017)

1,193
# of emergency department visits per 1,000 people with dementia

33.7%
increase in emergency department visits since 2007

19.2%
dementia patient hospital readmission rate

HOSPICE (2017)

468
# of people in hospice with a primary diagnosis of dementia

18%
of people in hospice have a primary diagnosis of dementia

MEDICAID

$190 MILLION
Medicaid costs of caring for people with Alzheimer's (2020)

13.2%
change in costs from 2020 to 2025

MEDICARE

$17,572
per capita Medicare spending on people with dementia (in 2019 dollars)

AIM
ALZHEIMER'S IMPACT MOVEMENT™
alzheimer's association®

*More than **5 million Americans** are living with Alzheimer's. The cost of caring for those with Alzheimer's and other dementias is estimated to total **$305 billion** in 2020, increasing to more than **$1.1 trillion** (in today's dollars) by mid-century. Nearly **one in every three seniors** who dies each year has Alzheimer's or another dementia.*

For more information, view the ***2020 Alzheimer's Disease Facts and Figures*** report at **alz.org/facts.**

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alzheimer's association®

#2315

North Dakota Dementia Care Services Program

Our state's residents affected by Alzheimer's and other dementia can receive support through the North Dakota Dementia Care Services Program (DCSP), a contract program through the Department of Human Services, Aging Services Division. For many families, the DCSP services are a lifeline when they need it most.





Since 2015, Lisa Millsap of Minot has been living with Alzheimer's disease. Her husband, Mel, has been caring for her in their home. Before the pandemic, Lisa was able to go to adult day care while Mel worked. Now, Mel is a 24/7 caregiver. Lisa and Mel have benefited from the support of the Alzheimer's Association through the DCSP, including care consultations with an on-staff dementia care expert. "Lisa was not properly diagnosed when she first developed early-onset," Mel says. "I'm grateful for the programs and support Lisa and I have received from the Alzheimer's Association and their staff through the state-funded Dementia Care Services Program.

Mel is one of the estimated 30,000 unpaid Alzheimer's caregivers in North Dakota. He wants people to understand that his wife Lisa "is still Lisa."

Alzheimer's Association Minnesota-North Dakota Chapter
2631 12th Ave. S, Ste. A, Fargo, ND 58103
24/7 Helpline 800.272.3900 | **alz.org/mnnd**

North Dakota Dementia Care Services Program

The Alzheimer's Association has served North Dakota residents through the Dementia Care Services Program (DCSP) since 2010 to improve disease management and increase family support to people living with dementia and their caregivers. Services include:







Care Consultation

Individuals with memory loss, family members, or concerned professionals meet with Alzheimer's Association Care Consultants. Consultants provide a customized road map including information about the diseases, care plans, resources for housing, financial and legal planning, referrals to community resources and support for caregivers. Meetings generally take place via phone, at the individual's home or at their preferred location.

Physician Outreach

Health care setting outreach informs medical staff in clinics, hospitals and public health agencies about the importance of Alzheimer's early detection and diagnosis, as well as how to make referrals for family education and support.

Education - General Public & Professional Development

Community outreach offers education on dementia-related topics, such as understanding memory loss, brain health, partnering with one's doctor, and understanding communication. Classes are available for the general public, professionals, care partners, medical professionals, and law enforcement.

COVID-19 Update

Fortunately, COVID-19 has not disrupted the services provided by the DCSP. Without any delay and with the support of staff across the country, the Association has found innovative and creative ways to continue to reach constituents virtually. Depending on the client's preference, care consultations have been conducted via video conference or phone.

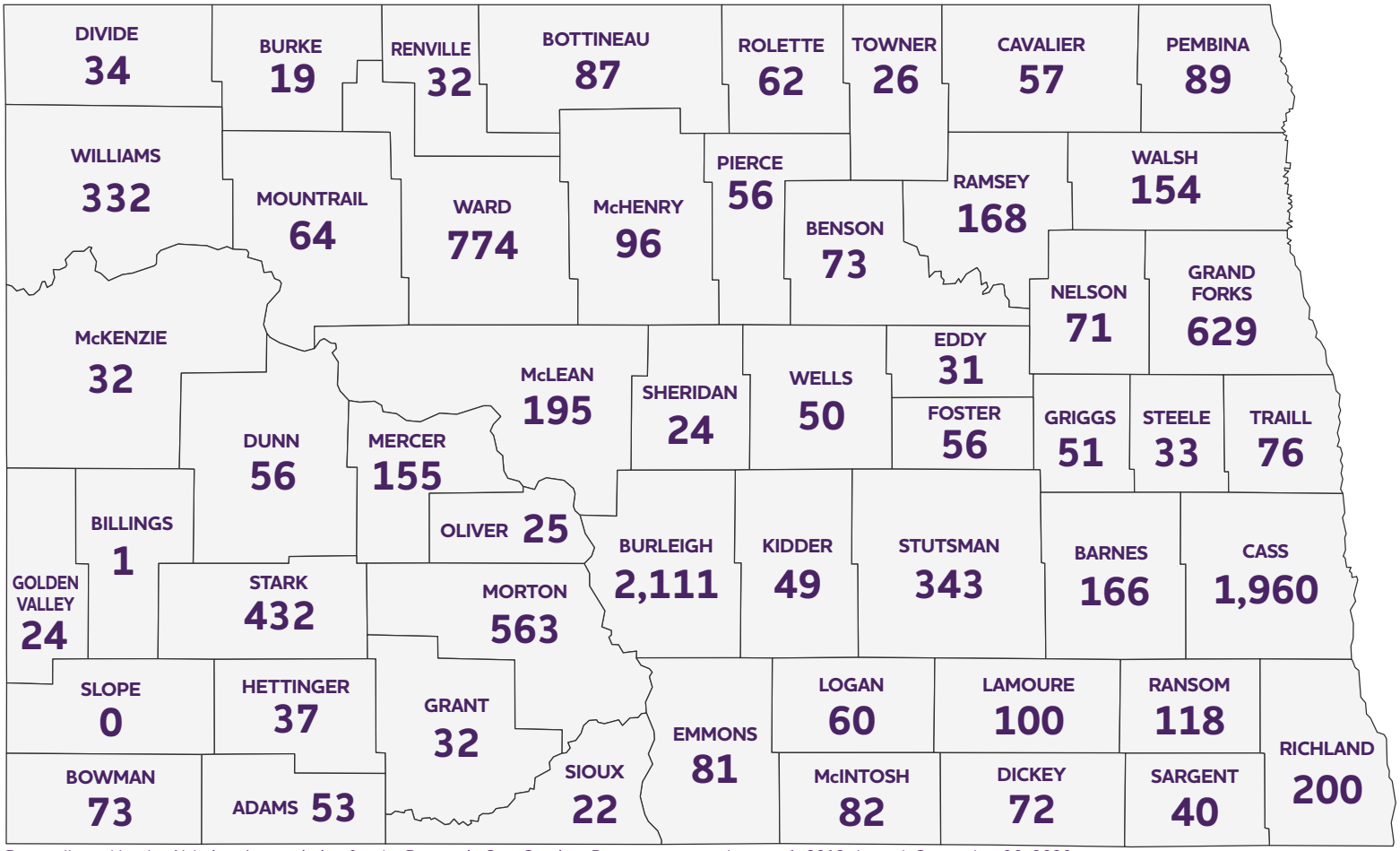
We have seen an increase in interest for professional dementia training, both from organizations as well as individuals. Our North Dakota long-term care and community-based providers that previously have not participated are now joining. Also, individual direct care workers, who previously would travel to receive training are now able to participate from their workplace or home. Although we still believe in-person training is the most effective way to improve quality care, interactive training from virtual locations has proven useful during the pandemic.

alzheimer's association®

North Dakota Dementia Care Services Program

The Alzheimer's Association has supported the families of 3,328 people living with dementia, including providing 11,896 care consultations for 6,898 caregivers.

Individuals Served by County[1] January 1, 2010 - September 30, 2020



Data collected by the Alzheimer's association for the Dementia Care Services Program contrat January 1, 2010 through September 30, 2020.

We have also educated **44,018** people across the state, to increase awareness of community resources, to understand the disease process, and to improve the quality of care of people living with dementia in North Dakota.

Alzheimer's Association Minnesota-North Dakota Chapter

2631 12th Ave. S, Ste. A, Fargo, ND 58103

24/7 Helpline 800.272.3900 | **alz.org/mnnd**

alzheimer's association®

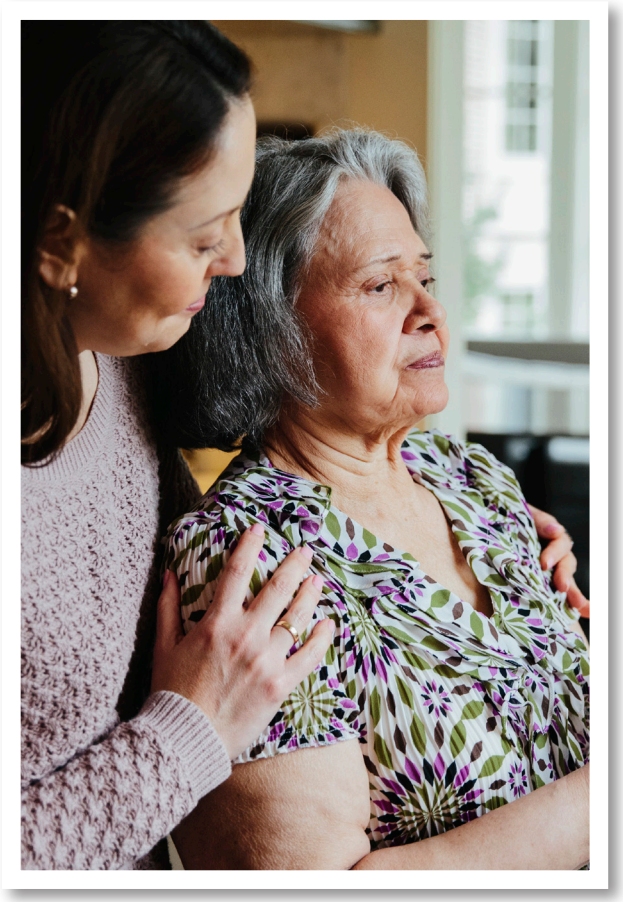
North Dakota Dementia Care Services Program

What is the value of the Dementia Care Services Program?

Recent research has demonstrated that two types of programs have potential for reducing avoidable health care and premature nursing home placement. One is the DCSP's caregiver support programs, and the other focuses on the care delivery team. Studies indicate that resources assisting caregivers have promise for reducing unnecessary emergency department visits and hospitalizations, and reducing transitions to residential care for individuals with Alzheimer's disease and other dementias.

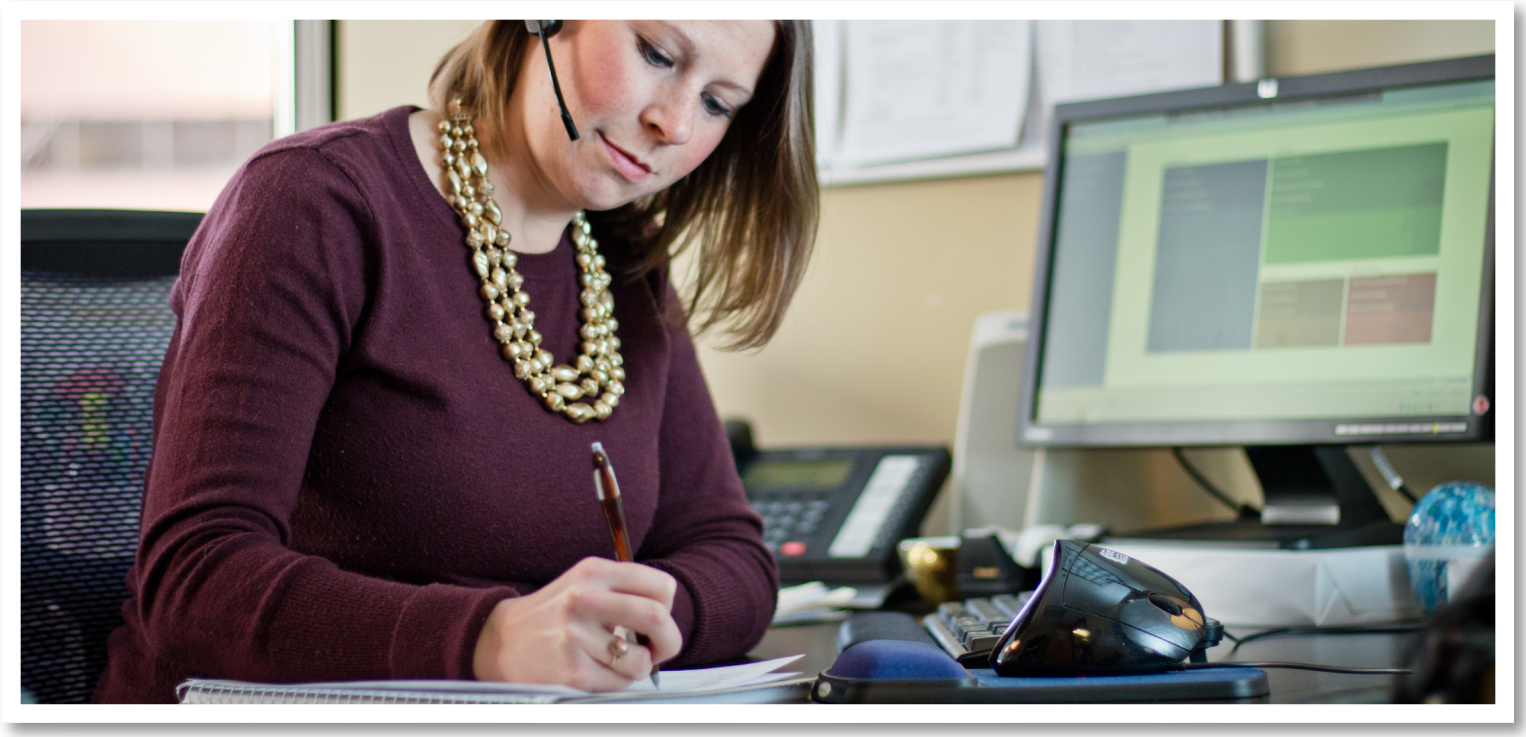


An evaluation from the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences found:



- Over a 42-month program period, the legislature appropriated an investment of $2.2 million for the contract and has estimated results of long-term care cost saving of $39.2 million, such as those incurred through hospital or emergency related services and delays in placing a person with dementia in long-term care facilities.
- Caregivers who were more engaged in DCSP activities had greater hospital and rural ambulance cost savings compared to caregivers who were not.
- Caregivers who participated were more likely to complete important dementia care-related tasks like establishing a power of attorney and instituting health care directives.
- Caregivers who received DCSP services were twice as likely to either delay nursing home placement or decrease their likelihood of placement. The total cost avoided was $3,007,147 (based on 46 people who indicated an increase in the amount of time to place a person with the disease in an institution).

Additional Services Provided Outside of the North Dakota Care Services Program



24/7 Helpline (800.272.3900)

Staffed in 200 languages, this resource serves people with memory loss, their caregivers, healthcare professionals and the public by providing information and referrals to local community programs and services; dementia-related education; crisis assistance; and emotional support.

Support Groups

More than thirty support groups are held each month in various North Dakota locations and are led by trained volunteer facilitators to provide support, assistance, and encouragement to individuals and their care partners impacted by dementia.

facebook.com/alzmnnd

twitter.com/alzmnnd

youtube.com/user/alzmnnd

instagram.com/alzmnnd

linkedin.com/company/alzheimer's-association-minnesota-north-dakota

Testimony
House Bill 1012 – Nikki Wegner, Alzheimer's Association, ND/MN Chapter
Human Resources Subsection of House Appropriations Committee
Representative Jon Nelson, Chairman
January 25, 2021

Chairman Nelson and members of the committee, my name is Nikki Wegner and I am the Western North Dakota Program Manager for the Alzheimer's Association. I am one of six staff who provide programs and supports to North Dakota residents impacted by Alzheimer's and other dementia.

Thank you for the opportunity to speak with you today in support of House Bill 1012.

We appreciate the continued funding included in this bill for the Dementia Care Services Program (DCSP). This longstanding partnership between the State and the Alzheimer's Association has provided a life-line for thousands of North Dakota families when they need it most, when they are faced with a dementia diagnosis and growing care needs for their family member. This program has also provided dementia education for tens of thousands of community members and professionals across the state.

While the Department of Human Services, Aging Services Division presented a recommended budget cut of $168,000 for this program in the next biennium, we are asking the committee to consider an increase of $132,000. I will explain why we believe this funding increase is necessary to meet the growing needs of North Dakota residents.

With the recent Olmstead Settlement Agreement, we understand that the legislature and the administration are looking carefully at how North Dakota can transform its long-term care system, so that people can remain at home with access to the care that they need. The DCSP supports and encourages access to available home and community-based services.

In fact, the UND Center for Rural Health studied the first few years of the DCSP at the request of the legislature. **Over a 42-month period, with an investment of $2 million, the state saved an estimated $39 million in long-term care costs from reduced hospital and emergency related services and delays in placing a person with dementia in long-term care facilities.**[1] You can see more details on that study in the document submitted with my written testimony. This document also includes a full overview of the DCSP, has a more in-depth explanation of our

[1] Center for Rural Health Assessment of North Dakota Dementia Care Services Program July 2013, p. 6

services, the total numbers of people-served, as well as a map of North Dakota showing our service numbers by county.

The goals of the DCSP are 1) to improve care, quality of life, and health outcomes, and 2) to reduce total cost of care associated with the disease for individuals, families and ultimately the state budget.

In testimony to this committee, DHS mentioned that in response to public health recommendations during the pandemic, that we have transitioned to providing training in a virtual format. They also further indicated that with virtual training, they expect to see a significant reduction in costs because of reduced travel and administrative costs.

While virtual training has been useful during the pandemic and well-received by professionals, we caution against moving to a fully virtual model. We still believe in-person education is the most effective way to improve quality care. Additionally, community members have not been as accepting of video technology, with some experiencing technical difficulties in connecting, and many indicating a preference for in-person services as soon as it is safe to do so. Given professional training is only a small component of the DCSP services, and there are community members who cannot or will not participate virtually, we recommend a hybrid model post-pandemic.

In the current contract for the DCSP[2], the Alzheimer's Association has:

- Delivered 1,744 Care Consultations – for 1,229 caregivers on behalf of 640 people living with dementia.
- Educated 2,054 community members across the state.
- Trained 135 law enforcement and 1,198 health care professionals.
- Referred 120 people to Family Care Services Program.

While professional training across the state is a valuable asset, it does not represent the largest impact of this program.

The greatest value of the DCSP remains supporting people directly impacted by dementia. We educate, support and provide resources to individuals living with dementia, their caregivers and families. The innovative services provided promote early detection and diagnosis, care coordination, effective caregiver training, support groups, and planning for the future.

[2] Data collected by the Alzheimer's Association for the Dementia Care Services Program contract July 1, 2019 through November 30, 2020

It is important to note that the services provided through the DCSP are available to all residents regardless of income, and differ from case management services provided through Medicaid-waivers. Case management is a valuable tool for those who qualify for those programs, but does not provide the same expert consultation provided by the Alzheimer's Association for those impacted by dementia.

Dementia that is unmanaged negatively impacts the individual diagnosed, their caregivers and ultimately creates a costly toll for communities and on the economy. Consider a few facts from our research:

State Costs
North Dakota's 2020 Medicaid costs for people living with dementia were $190 million – and that cost is expected to rise 13.2% by 2025.[3]

The average annual per person Medicaid cost for someone without dementia is $374, versus $8,779 for someone with dementia – that means that a person with dementia costs Medicaid ***23 times more*** than a person without dementia.[4]

Family Costs
Out of pocket costs for an individual with dementia are 3.5 times greater than for those without. [5]

We estimate that the value of care provided by North Dakota's 30,000 unpaid dementia caregivers is $454 million.[6]

Why are these costs so high?

1. Dementia complicates the management of other conditions,
2. People with dementia have more hospitalizations, in fact, twice as many as other older adults,[7]
3. And people with dementia have more emergency room visits.

The DCSP can help reduce these high costs. For example, studies have consistently shown that active management of dementia can improve the quality of life of affected individuals and their

[3] 2020 North Dakota Alzheimer's Statistics
[4] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 46
[5] *Ibid, p. 47*
[6] 2020 North Dakota Alzheimer's Statistics
[7] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 48

caregivers.[8] And that is where the Dementia Care Services Program enters the equation for North Dakota.

Growing Need

The need for care and support across North Dakota is growing. One in 10 people age 65 and older are living with Alzheimer's.[9] In 2017, we estimated there were 14,000 North Dakotans living with Alzheimer's. Today, we estimate that number to be 15,000. We expect those numbers to rise to 16,000 by 2025, an increase of 14% in just 8 years.[10]

Additionally, the Department of Human Services has indicated a need for a self-paced, online professional dementia education program to train Qualified Service Providers (QSPs). We support this because we know that staff training is an important determinant of quality dementia care across the long-term care spectrum.[11] The Alzheimer's Association has developed a program to deliver evidence-based online dementia training based on our nationally recognized Dementia Care Practice Recommendations.

Request for Funding Increase

To respond to this growing need, we are seeking an 11% increase in funding from $1,200,000 to $1,332,000. Please note that this program has never received a funding increase since it began in 2010.

Without these dollars, we will be unable to meet the increased demand for care consultation, professional training and community education, leaving residents with less access to these vital services that help to keep those living with dementia at home in the community.

We look forward to the continued partnership with the State to better support North Dakota residents and reduce long-term costs to the State. With the State's continued support, the Alzheimer's Association aims to ensure that everyone in North Dakota has access to the services proven to improve disease management and increase family support. We ask this committee to support the funding necessary to continue these vital services and expand our ability to serve the growing need.

Thank you for your consideration. I would be happy to answer any questions you may have.

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[8] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 12
[9] *ibid*, p. 18
[10] 2020 North Dakota Alzheimer's Statistics
[11] *The Gerontologist*, Volume 58, Issue suppl_1, February 2018, p. S103–S113

HB 1012 #2498
NDACP Testimony
House Appropriations Committee
Human Resources Division
Hon. Jon Nelson, Chairman
January 25, 2021

Chairman Nelson and members of the Human Resources Division of the House Appropriations Committee, good morning, and thank you for this opportunity. I am Bruce Murry, Executive Director of the North Dakota Association of Community Providers (NDACP.org). NDACP is the membership organization of 30 licensed providers of services to North Dakotans with developmental disabilities (DD). We serve about 90% of people with DD in North Dakota.

As a registered lobbyist for NDACP, I would like to introduce several board members who will give in-person or video testimony from their respective areas of expertise:

Julie Erickson, CEO of Grand Forks Growth and Support Center, Grand Forks;
Scott Anderson, Program Service Director for Development Homes, Inc., Grand Forks;
Lorena Poppe, CEO of Poppy's Promise, Bismarck, NDACP Vice President;
Scott Burtsfield, CEO of Vocational Training Centers (VTC), Fargo;
Tom Newberger, CEO of Red River Human Services Foundation, Fargo; and
Jon Larson, CEO of Enable, Inc., Bismarck, our NDACP President.

I'd also like to introduce another NDACP member, Brooke Austin, CEO of Community Living Services, Fargo, who submitted written testimony about Section 11 services.

NDACP has a relatively simple legislative platform for the 2021-2023 biennium, in recognition that uncertain times face the energy and agricultural sectors in our state.

- Restoration of approximately eleven million dollars ($11,000,000) to provider rates for residential habilitation and intermediate care facilities for people with intellectual and developmental disabilities (ICFID);
  - Maintenance of the Governor's proposed two million, four hundred thousand dollar ($2,400,000) to day support services such as individual employment, group employment, and prevocational services, with a matching reduction to ICFID and residential habilitation;
- Inflationary increases to DD providers of 3% each year of the 2022 - 2023 biennium;
- Emergency appropriation of up to $250,000 to NDDHS to financially stabilize DD providers disproportionately affected by the COVID-19 emergency — especially In Home Support and Day Service providers who specialize in those needed services;
- Restoration of all cuts to Section 11 State General Fund services to people with DD who don't qualify for the DD Medicaid Waiver;

- Fully fund the 1915(i) Medicaid Amendment with special attention paid to ensure it remains accessible to people with DD/ID, as currently planned;
- Fully fund reforms and behavioral health initiatives of the Life Skill and Transition Center;
- Retention of a substantial state tax credit to employers who hire North Dakotans with developmental disabilities and mental illness, in HB 1405 (2021).

We also support restoration of funding for recreation and leisure centers with consideration of serving additional communities; a close review of the infant development and Part C budgets to ensure timely services can be brought to bear to minimize developmental delays; and strengthening of rates in related home and community based services to North Dakotans with other kinds of disabilities — QSP services under Aging Services and for brain injury, as well as 1915(i) Medicaid Amendment behavioral health services. NDACP is persuaded that building a new State Hospital as proposed in HB 1012 makes sense to move more mental health services to the community. It is difficult to move beyond brick and mortar legacies built by generations past, but it is probably time.

Many of you know we have welcomed Angela Dinius as Workforce Development Director for NDACP. She and I are both happy to answer any questions that may arise about NDACP, its members' services to people, and our priorities. Our contact information is below.

Thank you for your kind attention.

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North Dakota Association of Community Providers

HB 1012 #3055
Testimony
House Appropriations Committee
Human Resources Division
Hon. Jon Nelson, Chairman
January 25, 2021

Good morning Chairman Nelson and members of the Human Resources Division of the House Appropriations Committee. My name is Julie Erickson and I want to thank you all for this tremendous opportunity to stand in front of you today and share a part of my journey and thoughts with all of you.

My experience with the developmental disability field over the past 15 years has been unique, challenging at times, and very passion filled. For you to best understand my perspective, I will share the trifold areas of different roles in my life that have shaped this view. First, I am the executive director for a Day Support program in Grand Forks called Grand Forks Growth and Support Center. Secondly, I had the privilege of teaching at the University of North Dakota in the rehabilitation and human services Undergraduate program. Lastly, and what I believe to be my most important role, I have the honor of being the mother to an amazing 14-year-old boy named Ryan.

Ryan is my third child and I knew he was a little bit different from my other children almost immediately after he was born. He did not meet his milestones at the same rate as my other two children and would often learn a skill and then lose that skill such a smiling or sitting up. We started Ryan in the infant development program to start tracking his progress and laying the foundation for services to help him thrive. At seven months old, Ryan began having severe seizures that ranged from 2 to 10 minutes long. There were periods of time where all Ryan did was seizure or sleep. He tried and failed seven different seizure medications before we were sent to Saint Paul Children's Hospital for further help. Ryan underwent a left functional hemispherectomy at the age of 11 months old. As his parents, we were very aware that the removal of the left hemisphere of Ryan's brain would have many impacts on his functioning and skills throughout his whole life. We also knew the other option is that he would probably die from his seizures if we did not choose this surgery. Ryan had two major brain surgeries within a week of each other to remove the tissue that was causing the seizure activity. The surgery was successful but left him with many major deficits.

His right peripheral vision field is cut and will never be repaired, he can use his right arm but his hand is not functional to do skills with. He walks and gallops with a limp and an uneven gait

pattern. And lastly, since they removed his speech center, Ryan has many challenges with communicating. Intellectually, he functions at about a three or four-year-old level. He can understand anything and everything that people say to him and is able to talk in small phrases that are sometimes hard to understand.

He is the most loving, sensitive, caring, and exceptional boy I have ever met. He values the small things in life like his family teachers and those around him and just really likes to be with people. He is in eighth grade at Schroeder Middle School in Grand Forks and is surrounded by a wonderful staff and also has a wonderful medical team. Ryan has received services through North Dakota Medicaid since he was nine months old. He has been through five brain surgeries, three orthopedic surgeries, months and months of hospital stays filled with uncomfortable tests and procedures. He has been through more hours of therapy than I can count. He is a fighter! He is my why! I tell you about my son Ryan not to gain your pity or for you to admire me just for surviving the tough times that I have been through. But I want to show you my testimony comes from multiple perspectives, not only as a developmental disabilities provider, but as the mother of a child with very severe disabilities.

The skills I gained navigating through the years of raising a special needs child actually were the greatest experience I could have had to become the director of Grand Forks Growth and Support, which was formally known as Agassiz Enterprises. Agassiz Enterprises was a developmental disability provider that started in the late 1970s. When I took over as their director in 2017, I most definitely had my hands full and many challenges against me. In a nutshell, I took a place that was basically functioning as outdated institution-type center. A place that needed tremendous updates to be accessible, ethical, and most of all a place that I would even feel comfortable bringing my son for care someday. This set the bar very high for all employees that worked at our center. After seven weeks as the executive director, we rebranded and changed our business name to begin a new start. I couldn't be more proud of the team that I have and how far we have come in 3 1/2 years. This experience gave me the perspective to know that the disability field still needs so much work and it needs to come from multiple entities who come together to work for the greater good of this community.

I will speak now to what I have seen in the last 3 1/2 years of being a provider of developmental disabilities services. As a standalone day support program our agency relies solely on the funds of Medicaid. We do not get paid for the services any time the individuals that we support do not attend day program. During the COVID pandemic, We have faced major financial challenges from the decrease in attendance of those who attend our day program due

to obstacles that were outside of our control. We were fortunate to apply and receive the PPP loan funding in April which eventually turned into a grant. This funding however was not enough. Myself and a few other smaller providers gathered And asked for more financial assistance from the state. We were able to apply and received four separate retainer payments which have helped us maintain our staff and stay open. We have 36 people who attend our day program close to 40 hours a week and there were days in November when we only had nine of these people present for services due to many COVID related reasons. Somehow, we survived 2020 and have started to return back to more of a normal attendance rate in the new year. Although we survived this challenging time, we do not have much left in our reserve fund going forward and any cuts to developmental disability providers would severely impact us. The funds the DD Division provided through Appendix K to stabilize us have been exhausted, and more.

I fully believe that people should have options for their services in their life. Without smaller providers these options would be taken away. I think it is important to look at a smaller providers as the small town businesses. We have heart, integrity and passion for our work and those we support at our agencies. We are the directors and staff who go above and beyond to make sure that people are receiving the best services that they can. Throughout the COVID pandemic, we had multiple testing events at our agency to decrease COVID risk on our staff and those supported. You could find me, dressed in full PPE climbing in and out of the vehicles to assist, calm, and hold the hands of the individuals we support while they were getting their COVID test.This is just one example of the small provider flavor I was speaking of. North Dakota needs providers with these qualities and if we face more financial strain there may be many of these providers who can no longer keep their doors open.

I would like to talk briefly about the effect the proposed $11 million cuts in the area of developmental disabilities would have on the agencies that provide services and those that receive services in the state of North Dakota. As a whole, developmental disability providers struggle to find a workforce that will bring high-quality care to the people that we support. Direct support professional's are the biggest group of staff that we struggle to hire and maintain. Although it is a rewarding job at times, it is also a very physical and stressful job. Cuts in our budget would present us with many more challenges when hiring, training and maintaining these employees. With low paid or not enough direct support professional staff, agencies are unable to provide high-quality care! High quality care is the most important thing. I can tell you right now, I struggle as Ryan's mother to think about it would be like to put him in a residential facility. My husband and I hope to keep him at home with us as long as we can,

and we also hope and pray that the quality of services continues to grow and increase in the years to come.

People with intellectual and developmental disabilities need the highest care possible. They have already experienced so much hardship and struggle in their life — even those who don't remember exactly whathard times and struggle they faced. Their resilience and real-quality of life is shown by the love, smiles and happiness that many of the people who receive DD services display every day of their lives. Plain and simple, they deserve the very best from the developmental disabilities industry.

Thank you again for the opportunity to stand before you and give my testimony. I welcome any questions that you may have.

Testimony #2415
House Bill 1012 – Development Homes, Inc.
House Appropriations – Human Resources Division
Hon. Jon Nelson, Chairman
January 25, 2021

Good morning Chairman Nelson and other distinguished Committee members;

My name is Scott Anderson, Program Service Director for Development Homes, Inc. (DHI) from Grand Forks, ND. I am honored and grateful to have his opportunity to speak with you on behalf of DHI, other ND Community Providers, and all the people we serve and support. The focus of my testimony will be to speak to the importance of the quality support and services we as Community Providers do each and every day, seven days a week and 365 days a year. We are fortunate to have the opportunity to serve and support others in the great state of ND.

Development Homes, Inc.(DHI) was established in 1974 supporting children and 46 years later we continue to serve children, along with adults and families as well. Our mission: "Development Homes, Inc. is committed to the provision of quality community based support services to person with disabilities, enabling them to maximize their individual potential, and fulfill their personal dreams." DHI provides a variety of services to about 170 unique individuals and we employ about 500 staff. DHI is currently the 8th largest employer in our Grand Forks community. The people we support, our organization and our staff, have a significant financial impact on our community. With the continued support from this legislature, DHI and every other provider will continue to provide opportunities for people to have the quality lives that we all aspire to have.

In March of 2020, the impact COVID-19 In ND reached a level that impacted each and every community across the state. Our schools were closed to all in-school education and the all too familiar term of "distance learning" was established and implemented. For all parents and those providers who support children, of which DHI is one, the impact was immediate and without precedent. The announcement was made on March 15, 2020 that kids would not be going to their school building for education starting the very next day, March 16, 2020. The determination and dedication of parents and providers to forge ahead with providing immediate educational support to our children was remarkable. At DHI, we were supporting 12 kids in placements living outside the family home. Most of the kids we support in that environment are in need of significant staff support, with most receiving a staff designated to support each child individually. The needed support, just within DHI, would be 10-12 staff working an additional eight (8) hours per day, five (5) days per week for the next 11 weeks. This totals approximately 4,000 to 5000 hours of unscheduled staffing time and the task of providing that support started the very next day. Several other providers across the state were also thrust into "stepping up" immediately to support many children during daytime, school hours. With the very common and prevalent "can-do" attitude, providers across the state were able to meet this challenge and provide the needed support for our kids. This event truly exemplifies the caring and quality of the organizations ND has providing services to people with disabilities. And one more lingering issue, not one provider has been given a dime of reimbursement for providing this support to our kids over these 11 weeks from March 16, 2020 through May 28, 2020. For providers in the state of ND, it is about the quality of services and being there

when we are needed, no matter the circumstances. We believe that efficiency is important but quality is essential. We need to be good stewards of the resources we have, but above all else, when needed, we need to be prepared to the best we can be, and deliver each and every time. But now that we have spent our hard won reserves to provide these services, our providers are less able to face the next crisis.

In November 2019, DHI opened a new Children's ICF-IDD in Grand Forks. This was a special project in collaboration with the DD Division, Life Skills and Training Center (LSTC) and DHI for the purpose of residential services for four children that were currently at LSTC. This ICF-IDD (5509) became fully operational on 2/24/2020 when the fourth of four boys moved in. This endeavor was certainly going to be challenging enough without COVID-19 but COVID-19 and school closings happened just three weeks later. Each of the four boys DHI was serving at 5509 had behavioral and mental health concerns. As was stated earlier, DHI has been around 46 years and has always served children. The difficulties we encountered and still encounter today are the lack of community resources to help support people, especially children, with higher behavioral needs when they present these difficulties. Sue Forester and the LSTC staff have been excellent to work with and been extremely supportive. The most significant issue with LSTC is logistics. Grafton is an hour away from Grand Forks. When behavioral issues arise, they can escalate very quickly, and any support LSTC can offer will not be timely enough to assist with resolving the event.

DHI has its' own "crisis team", made up of mostly administrative professionals with years of experience and all are Therapeutic Response trainers. DHI has this team so that we can respond with in-person support quickly during our most difficult behavioral events. Even with this timely support, sometimes events reach the intensity that mental health professionals are needed to assess the person having difficulty, for safety for themselves and others. When these calls are made, the first responders are the Grand Forks Police officers. Most times, the police officers arrive and just their presence will de-escalate the event, but not always. We have had events involving both children and adults we serve that have involved the need for physical, chemical, as well as mechanical(handcuffs) restraints with police officers and our staff intervening to try and keep everyone safe. In cases such as these, the paramedics arrive and we ask that the person be transported to the hospital for a psychiatric evaluation. The Grand Forks Police Department has been very professional, responsive and supportive during each of these intense events. The police are sometimes unsure of what their role is at times, as we are not looking for criminal charges against those struggling. Because of this, they can be frustrated with us and ask why did we call them. To be clear, when we make a call for emergency services, we are really looking for a safe transport to the hospital so that person struggling can be assessed.

Once at the hospital, it may take 30 minutes to several hours for psychiatric services to get involved and the assessment completed. Often there is lab work to insure medication levels are within therapeutic range. To be clear, the individuals having difficult have most times presented physical aggression toward others, including staff, others we support and even police officers. Property damage such as making holes in walls, throwing objects, slamming doors with enough force to dislodge the door or the door frame, and breaking windows are common during these intense events. The people are also most times, self-injurious and elopement risks as well. The hospital in Grand Forks has been very unwilling to admit people presenting these types of difficulties. In my conversations with the on-call psychiatrists assessing, especially when assessing children, they will not admit. I have been told that "We (the

hospital) cannot admit this person as we are not equipped to handle them as they are just too violent." In an ironic twist, soon after they say that, they discharge the person and say that they are calm enough to return to their home. This is not just a DHI or Grand Forks issue. Providers across our state can tell you very similar stories about the frustration of taking on people with significant challenges, without adequate community support from others to assist the person in being successful in their community. As you are all well aware the behavioral and mental health support systems in ND, as well as in our country, are overwhelmed and under-staffed. There are more people in need of this type of support than there is support available. If providers are going to be successful with reducing the number of people at LSTC, we are going to need to be fully-funded to provide the support needed, creative with our approaches (like our own response teams), collaborative with LSTC and our home regions, and have adequate and responsive community support and services that will be of assistance when that assistance is needed most. The net result of not having the supports and resources needed, is a failed placement. When we are working to help those who pose the greatest need, efficient is important but quality is essential. Success means allowing people to thrive in an environment where we learn and grow every day. When people are able to maximize their full potential and live the life they dream of, that is definitely success!

I want to thank each of you for your time and attention today. It has been an honor and privilege to have this opportunity to share on behalf of Development Homes, Inc. as well as the many wonderful and dedicated providers in the great state of North Dakota.

Respectfully,

Scott Anderson, Program Services Director
Development Homes, Inc.

Testimony #2499
House Bill 1012 – Department of Human Services Budget
House Appropriations – Human Resources Division
Representative Jon Nelson, Chairman

January 25, 2021

Chairman Nelson and Members of the House Appropriations Committee – Human Resources Division:

My name is Lorena Poppe. I am the owner and executive director of Poppy's Promise, a Bismarck-based provider of In-Home Support services through the Developmental Disabilities traditional Home and Community Based Waiver. I am testifying today in support of the Department of Human Services budget, particularly that of the Developmental Disabilities Division, with amendments.

I started Poppy's Promise in the Fall of 2017 in response to families of kids with disabilities expressing there was a shortage of providers to be available to meet the needs of their children and families. My goals were to 1) be another option as families seek out services that will best meet the needs of their children, and 2) meet kids and families where they are at on their unique journeys to full inclusion and participation in home and community life. We believe strongly in designing supports that will help to keep kids in their family homes and communities and minimize the need for institutionalization in a place that is unfamiliar to the child. In our short existence, we have seen the difference a small provider organization can make and are proud that we have been part of keeping families together in their home communities.

I am the sole owner of Poppy's Promise. I started my business by getting a Small Business Administration loan and taking a leap of faith. I knew there was a need, but understand now more than ever, 3 ½ years later, how critical it is that DD providers be supported to do the important work of helping people with disabilities achieve maximum health, happiness and freedom of choice across their lifetimes. At Poppy's Promise, we operate on a month-to-month basis without having a large financial reserve to fall back on. Since opening the doors at Poppy's Promise, I have been excited to see other new provider organizations popping up across the state. This is an exciting thing for North Dakota and I believe there is definitely a place for new organizations that can work together with longstanding providers to assure gaps in services are filled and people can receive supports and services in the least restrictive setting.

In listening to the budget detail of the DD Division of the Department of Human Services, I am concerned that new providers and those that are smaller and more specialized are not being fully considered. Specifically regarding the In-Home Supports program, you heard testimony from the Department indicating that program had the largest drop in utilization over the course of the Covid-19 pandemic (27%). And yet, In-Home Supports was left out of the Appendix K option to receive retainer payments to help providers stay in business during the pandemic. For providers of services that were eligible to receive retainer payments, those payments were an important part of keeping the doors of those businesses open. With the current extension of the Appendix K, there is an opportunity for the Department to extend the retainer payment option to those providers most in need and help to assure the services families rely upon don't disappear.

Another area of concern for all providers of DD services, but especially small providers, is the intention of the Department of Human Services to require providers to absorb the cost of accreditation necessary to maintain DD licensure. Because DHS contracts with one organization for accreditation, the Council on Quality and Leadership (CQL), providers would be forced to pay several thousands of dollars toward the accreditation process. This includes travel and lodging expenses of CQL reviewers coming to North Dakota from across the country. There is no reimbursement for accreditation built into the DHS budget. Poppy's Promise does not have the ability to cover that cost. I believe strongly in review processes being in place to assure quality of services, but also know the reality of trying to maintain a business that does not have the ability to set aside thousands of dollars for unreimbursed licensure requirements.

I come before you today to ask that you consider the current state of services for people with disabilities during an ongoing pandemic, the financial vulnerability of new and small providers, and the addition or preservation of funds to assure all providers who are relied on heavily by the citizens of North Dakota are able to survive and stand strong in continuing to provide supports and services.

Thank you for your time today, and I would be happy to answer any questions you may have.

Testimony Regarding House Bill 1012 #2460
House Appropriations Committee
Human Resources Division
Representative Jon Nelson, Chair
January 25, 2021

Good Morning Chairman Nelson, members of the House Appropriations Committee, my name is Scott Burtsfield, and I am a member of the North Dakota Association of Community Providers and the Executive Director for the Vocational Training Center, a licensed service provider for people with intellectual and developmental disabilities, located in Fargo, North Dakota. I want to first thank you for the opportunity to speak to you about House Bill 1012.

As most of you are aware, in 2018 a new payment system was implemented that forever changed the landscape regarding how North Dakota pays for services to those providing care and support for individuals with Intellectual and Developmental Disabilities. The implementation of this new system denoted a culmination of research, design and collaboration that intended to impartially, efficiently, and soundly allocate resources for the state's most vulnerable citizens.

Now, a couple of years into the new system, we realize our task is not quite completed. We still have work to do. We understand that there remain issues to be resolved and changes to be made. And we're doing it.

For instance, community providers, working diligently and collaboratively with Developmental Disabilities Division leadership, have recently been addressing deficiencies pertaining to inadequate reimbursement rates for services such as Day Habilitation, Prevocational Training and Small Group Employment Supports.

However, other matters will need further scrutiny as we move forward. For example, in addition to inadequate rates, organizations delivering solely Day Support services experience even greater challenges regarding provider liability and the under-utilization of expected and contracted services.

These challenges become especially evident in matters of contracted attendance for supported individuals versus actual attendance. Basically, this means that whether supported individuals attend their Day programs or not, for whatever reason, providers of Day Services remain responsible for providing 100 percent of the staffing, resources, etc. without compensation for the services and expenses they incur based on the expected attendance.

Though the issue was evident at the onset of our payment system over two years ago, this flaw became especially palpable throughout the COVID-19 pandemic where smaller

providers and specialized providers of Day and Family Supportive Services were disproportionally impacted for many of the above-mentioned reasons.

Another concerning COVID casualty that will need further examination, by all vested parties, pertains to matters of choices and restrictions for individuals with Intellectual/Developmental Disabilities in our state.

Throughout this pandemic there were too many instances in which supported individuals were confined to their residence for extended periods of time – against their will, choice, or volition. While certain situations warranted quarantining for obvious health and safety reasons, there were also many instances in which the "lockdowns" were unwarranted and became harmful. Harmful to an individual's mental health, harmful to their employment placement, and harmful to their sense of being and self-worth. It is now all too easy to cite the many situations in which we found the cure to be worse than the disease.

We will see these types of negative effects grow for many of the supported individuals served throughout North Dakota. However, this time it will not come in the form of COVID-19. It will be due to the federal elimination of Section 14(c) of the Fair Labor Standards Act (FLSA) which allows employers to pay wages below the federal minimum to employees who have significant disabilities.

While this is a highly controversial topic, with very valid points on both sides of the issue, there are many instances in which the utilization of subminimum wages creates meaningful employment opportunities for people with very significant disabilities. It is widely accepted that work is a valued activity in our society that promotes independence and enables individuals to participate in the whole community experience.

However, many with significant disabilities experience limited productivity which too often translates to limited job opportunities. Many deadline-driven or task-driven employers cannot look past the limited productivity or nature of the disability in their hiring decisions to realize they are passing by individuals that are tremendous assets to any work environment and desire to use their skills and abilities to the greatest extent possible.

Unfortunately, this may all become a moot point if employers will be required to pay the new proposed federal minimum wage. For one, such actions will not only destroy smaller organizations such as our beloved Vocational Training Center, but also create a very real scenario in which individuals with the most significant disabilities would likely never be offered the opportunity to work at all.

As you can see, in our industry, there is no shortage of trials, tribulations, transformations and reforms. However, through it all, there has been one fundamental element to the success of the individuals we support. This has always been our Direct Support Professionals (DSPs).

The incredible Direct Support Professionals in our state literally give their blood, sweat and tears to provide support and care for the state's most vulnerable population. They are increasingly held to much higher standards in terms of what is expected of them in their day-to-day work. In the last nearly three years there have been increased standards, training requirements, data collection and entry…the list goes on. These expectations have been imposed upon them with implementation of many of the new rules, policies, and mandates that accompanied the implementation of the payment system.

As a show of appreciation for DSPs increasing roles, responsibilities, expectations, and hazardous job duties, the Governor is recommending our DSPs and our services for individuals with disabilities be treated as "less than." "Less than" his recommendations for increases in other industries, "less than" his support for other professionals, and "less than" state employees who do not face being hit, bit, kicked, covered in human excrement daily.

Therefore, I am asking you to please cast aside the Governor's recommendation and support NDACP's request to leave provider services rates unscathed and support a 3% increase for each year of the biennium for service providers and the Direct Support Professionals we employ.

Again, I wish to thank Chairman Nelson and fellow members of the House Appropriations Committee for the opportunity to speak to you about House Bill 1012. I would be happy to answer any questions.

Scott Burtsfield, Executive Director
The Vocational Training Center

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Testimony #2419
House Bill 1012 – Funding DD Recreational & Social Centers
House Appropriations – Human Resources Division
Rep. Jon Nelson, Chairman
January 25, 2021

Chairman Nelson and members of the House Appropriations Human Resources Division, for the record, my name is Tom Newberger. I am the Chief Executive Officer for Red River Human Services Foundation. We provide services to people with Intellectual and Developmental Disabilities (IDD) in Fargo, West Fargo and Wahpeton, North Dakota. I am here today to ask you to restore the $150,000 that was removed from the Governor's budget in the "Budget Account Code 712000" for the 2021-2023 budget. These funds are for Recreational and Social activities for people with IDD in Fargo and Grand Forks.

I will now explain why these funds are so critical and needed. First, our agency is a licensed and accredited provider for services. One of our programs is the Activity Center that has existed since 1972 and has 425 members. During this time period, the Activity Center has provided Recreational and Social services to people not only from our agency, but from the community and other IDD service providers. We provide services in the afternoons, evenings and on week-ends so people with disabilities can live better lives. Examples of what our Activity Center offers for people with disabilities is hosting dances, playing pool, darts and air hockey, ceramics, safety training classes, such as how to stay safe while walking or riding bikes, providing food for those who cannot afford it, going to people's homes or apartments if they are sick and buying them medications if they cannot afford it. We also support camping during the summer which they really enjoy. These are just a few examples of what we do to give people with disabilities better lives.

A question I received during the 2017-2019 legislative session from the Appropriations Committee was "Do other licensed residential providers do these services too?" This was a great question and really helped all the legislators at that hearing understand our critical services. My response to the question was yes, the residential providers do their best to give people in their programs options, but it is generally very difficult to do based on the limited number of FTEs they

have. For example, if everyone on this committee lived in the same group home and I am the only staff working with you in the late afternoon and evening, and one of you wants to stay home and watch television, another one of you wants to go out and get an ice cream cone, another one of you wants to go the park and another one of you wants to go bowling while someone else wants to play pool and the last one of you wants to do ceramics. The question is how can I as your only staff keep you all happy when everyone wants to do something different? The way to keep you all happy is to bring you to the Activity Center which our non-profit operates and our staff will meet your dreams and desires. The Activity Center promotes social connections and helps prevent mental health issues and reduces anxiety and possible physical aggression. So briefly, this is what our services do.

From a financial perspective, our annual budget for the Activity Center is $221,000 and the State has supported our services with $37,500 per year or seventeen percent (17%) of our budget. From an Activity Center member's perspective, the $37,500 from the State equates to just below twenty-five cents per member per day. This is a very low cost. We previously implemented membership dues of $8.00 per month and then reduced it to $6.00 per month to make it more affordable. Most of the members could not afford it, so now have no membership dues.

I kindly and strongly recommend that this committee re-instate the funding for the two Recreational and Social Centers in our State and consider increasing it to fifty-cents per day per member or a total of $300,000 per Biennium as a good portion of our other funding has been lost.

Thank you and I will be happy to answer any questions you may have.

House Appropriations – Human Resources Committee #2281

Testimony on House Bill 1012

Representative Jon O. Nelson – Chairman

January 25, 2021

Chairman Nelson and members of the House Appropriations – Human Resources Division Committee, my name is Donna Byzewski and I am the Program Director of the corporate guardianship program at Catholic Charities North Dakota. I am respectfully asking your committee to approve funding as detailed in the Developmental Disabilities Division budget for corporate guardianship services for people with intellectual disabilities. To continue providing quality services to meet the needs of current and future clients, we respectfully ask for a cost of living increase of 3% for the first year of the biennium and 3% for the second year.

The court appoints a guardian when a person's capacity to make decisions is compromised and he or she is at risk of neglect, abuse and exploitation. It is important to note that many adults with intellectual disabilities are their own decision maker. However, there are critical times when the person may need the services of a guardian, and if no one else is available or appropriate, a corporate guardianship is a necessity. Corporate guardianship is the guardian of last resort. Our contract specifies that Catholic Charities ND can only accept referrals from Developmental Disabilities Program Managers from the regional human service centers in North Dakota.

In the past 18 months, we have admitted 61 individuals to our program. We have made great strides reducing our waiting list for services. One year ago, our waiting list was at an all-time high of 126 people and our current list has the names of 92 persons. The reduction is primarily due to the additional legislative funding we received for 20 new slots/openings on 7/1/19. This has had a tremendous impact on the lives of people who were on the waiting list and I sincerely thank you for making this happen!

Our request for the next biennium is as follows:

7/1/21 to 6/30/22	489 wards x $8.37 x 365 days = $1,493,919 489 wards x $0.25 (3% COL) x 365 days = $44,621	$1,538,540
7/1/22 to 6/30/23	489 wards x $8.62 x 365 days = $1,538,540 489 wards x $0.26 (3% COL) x 365 days = $46,406	$1,584,946
7/1/21 to 6/30/23	Petitioning costs	$89,555
	Total for FY 2021 & FY 2022	**$3,213,041**

The request that we are submitting is bare bones, allowing us the capacity to meet the needs of 489 wards during the next biennium. We realize that the Department of Human Services' budget is tight but the requested funding will help assure that we have the staff and resources to meet the critical health and safety needs of the individuals we serve. Thank you for the opportunity to stand before you today and I would be happy to answer any questions you may have.

Testimony on HB 1012 #2423
Hon. Jon Nelson, Chairman
Human Resources Division
House Appropriations Committee
January 25, 2021

Chairman Nelson and members of the committee, my name is Jon Larson and I am the executive director of Enable Inc., a licensed developmental disabilities provider here in Bismarck. I also currently serve as the president of our provider association, NDACP.

On April 01, 2018 North Dakota implemented a long-awaited new payment system for developmental disability providers. This new payment system was developed by consultants who worked in close consultation with a steering committee that consisted of personnel from the Department of Human Services and DD providers. That steering committee began in the Spring of 2011 and continues to work on issues that arise with this still new system. I have been a member of this steering committee since its implementation.

Although not perfect the new payment system has done a good job of achieving its objective of fairly allocating resources based on individual needs as measured by a nationally recognized assessment tool and utilizing the existing allocation of resources. This new process involves the use of scores from the Supports Intensity Scale (SIS), a mathematical multiplier to connect the scores to authorized support hours, and a unit rate matrix with standardized rates for defined services, which result in a unique annual Individual Budget Allocation for every client.

This new system took years to develop and prior to implementation there were fears expressed by some providers, advocates, and consumers about the viability of continued provision of the same quality services that everyone has come to expect. Upon implementation on April 01, 2018 services continued as expected without drastic alterations to service delivery and providers have adapted to the changes created by

the new system. The steering committee continues to meet on a regular basis to address issues that have arisen since the implementation of this new system.

A central component of the new system is the Supports Intensity Scale or SIS. The SIS is a nationally normed tool that is used to identify the unique needs of the individual we support in our programs. North Dakota contracts with an independent organization, The Rushmore Group, to administer these assessments. Each individual supported is to have a new assessment every three years unless there is a significant life changing event that would require a new assessment. The Department hired a consultant in the fall of 2019 who found a trend of rising SIS scores from the assessments that occurred three years previously. A rise in the SIS score results in a higher payment to the provider. There are many reasons a SIS score would change including a deteriorating health or behavioral condition or an inaccurate score in the initial assessment or subsequent one. The information Optimus used in that conclusion is now nearly one and a half years old. They also noted at the time that they were seeing a leveling off of the increasing scores and it may indicate a stabilization of scores or even a U-shaped curve in the data that would result in a return to scores more closely related to the original.

NDACP has collected data from our members that compares the SIS score resulting from an assessment done in 2020 to the previous score and this data indicates that in aggregate the new scores are slightly lower than the previous scores resulting in lower payments to providers. The executive budget proposes a reduction in rates to residential providers based on the trends they saw prior to 2020. This new payment system is still very new and 2020 interrupted everything making data analysis difficult. The position of our association is to request that the rates in this new system not be reduced at this time to allow for the system to have time to stabilize. Adjustments to rates may be necessary but should be done in consultation with the steering committee and should be done in a manner that is cost neutral to the appropriation.

Accreditation by the Council on Quality and Leadership, CQL, has been required for licensure since the days we were operating under a lawsuit. This cost has been paid by the Department either through rate setting and cost settlement prior to the new system or directly after the new payment system. This cost is proposed to go back to providers in the executive budget. CQL accreditation is quite expensive, especially for smaller providers. This was not a cost recognized when developing rates in the new payment system and we feel that this required cost should continue to be paid by the Department.

The last area I want to address is the loss of funding for service under section 11. You have written testimony from Brooke Austin, from Community Living Services in Fargo that explains it in more detail than I will at this time. Section 11 uses state dollars at a very reasonable cost to provide a much-needed service to people who otherwise fall through the cracks. Providers receive a payment of $7.00 a day for people in this program, far less than it actually costs to provide the service. Without this service, the people in this program will likely struggle and require more urgent services that will cost more and be less appropriate to meet their needs.

In summary, I am requesting that the rates in the new payment system not be reduced as proposed in the executive budget, that accreditation costs continue to be paid by the Department and that section 11 funding be restored. In addition I recommend inflationary increases of 3% and 3% for state fiscal years 2022 and 2023. Thank-you for your consideration and I would be happy to answer any questions you may have.

Jon Larson
Executive Director, Enable, Inc.
President, NDACP
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701-220-1892

North Dakota: 2020 Long-Term Services and Supports (LTSS) State Scorecard #2402

The fourth edition of the *LTSS State Scorecard*, released in fall 2020, takes a multi-dimensional approach to measure state-level performance of LTSS systems that assist older adults, people with physical disabilities, and family caregivers. Unlike many other rankings that focus on a particular aspect of LTSS system performance, the *Scorecard* compares state LTSS systems across multiple dimensions, reflecting the importance and interconnectedness each has on the overall LTSS system. The full report is available at www.longtermscorecard.org

Data used for this *Scorecard* was analyzed in 2019, prior to the COVID-19 outbreak. Therefore, performance on this *Scorecard* does not include the impact of the pandemic on the LTSS system, which is considerable. Nevertheless, the *Scorecard* indicators continue to be highly relevant, both in the current environment and in a future post-COVID world.

Purpose: The *Scorecard* aims to empower state and federal policy makers and consumers with information they need to effectively assess their state's performance across multiple dimensions and indicators, learn from other states, and improve the lives of older adults, people with physical disabilities, and their families.

Results: The *Scorecard* examines state performance, both overall and along five key dimensions. Each dimension comprises 4 to 7 data indicators, for a total of 26 indicators. The *Scorecard* also measures changes in performance over the previous three years wherever possible (reference data available for 21 of the 26 indicators). The table below summarizes current performance and change in performance at the dimension level. Indicator data appear on the next page.

Dimension	Rank	Number of indicators with trend*	Number of indicators showing:		
			Substantial improvement	Little or no change	Substantial decline
OVERALL	**28**	**21**	**7**	**13**	**1**
Affordability & Access	**30**	6	1	4	1
Choice of Setting & Provider	**25**	6	2	4	0
Quality of Life & Quality of Care	**20**	2	1	1	0
Support for Family Caregivers**	**34**	4	2	2	0
Effective Transitions	**22**	3	1	2	0

* Trend cannot be shown if data are missing for either the current or baseline data year.
** The support for family caregivers dimension comprises 12 policy areas, organized into four broad categories. Change is shown at the category level in the table above. Policy data are shown on the next page.

North Dakota: 2020 Long-Term Services and Supports State Scorecard Data

Dimension and Indicator (Current Data Year)	Current Rate	Baseline Rate	Rank	Change	National Average	Top State Rate
OVERALL RANK			**28**			
Affordability and Access			**30**			
Nursing Home Cost (2018-19)	**328%**	333%	**48**	▬	245%	168%
Home Care Cost (2018-19)	**99%**	97%	**46**	▬	80%	51%
Long-Term Care Insurance (2018)	**106**	119	**4**	✗	43	138
Low-Income PWD with Medicaid (2016-18)	**59.1%**	51.8%	**12**	✓	56.7%	79.2%
PWD with Medicaid LTSS (2017)	**41**	43	**24**	▬	46	100
ADRC/NWD Functions (2019)	**54%**	52%	**37**	▬	66%	96%
Choice of Setting and Provider			**25**			
Medicaid LTSS Balance: Spending (2016)	**17.3%**	17.1%	**48**	▬	45.1%	73.5%
Medicaid LTSS Balance: Users (2017)	**27.7%**	29.1%	**51**	▬	64.2%	83.9%
Self-Direction (2019)	**5.6**	*	**35**	*	30.4	149.1
Home Health Aide Supply (2016-18)	**25**	16	**12**	✓	22	47
Assisted Living Supply (2016)	**102**	105	**1**	▬	49	102
Adult Day Services Supply (2016)	**48**	10	**17**	✓	61	171
Subsidized Housing Opportunities (2017-18)	**6.1%**	6.2%	**21**	▬	6.2%	18.6%
Quality of Life and Quality of Care			**20**			
PWD Rate of Employment (2016-18)	**38.1%**	25.3%	**1**	✓	21.4%	38.1%
Nursing Home Residents with Pressure Sores (2018)	**4.8%**	*	**1**	*	7.3%	4.8%
Nursing Home Antipsychotic Use (2018)	**17.8%**	18.5%	**44**	▬	14.6%	7.8%
HCBS Quality Benchmarking (2015-19)	**0**	*	**38**	*	1.30	3.60
Support for Family Caregivers			**34**			
Supporting Working Family Caregivers (6 policies)	**0**	0	**38**	▬	3.17	13.50
Family Responsibility Protected Classification (2019)	**0**	0			0.29	2.00
Exceeds Federal FMLA (2019)	**0**	0			0.29	3.00
Paid Family Leave (2019)	**0**	0			0.50	3.50
Mandatory Paid Sick Days (2019)	**0**	0			0.85	3.00
Flexible Sick Days (2019)	**0**	0			0.75	3.00
Unemployment Insurance for Family Caregivers (2019)	**0**	0			0.49	1.00
Person- and Family-Centered Care (3 policies)	**3.00**	1.28	**28**	✓	3.04	5.50
Spousal Impoverishment Protections (2019)	**1.00**	0.28			0.90	2.00
Having Caregiver Assessment (2019)	**1.00**	1.00			1.34	2.50
CARE Act Legislation (2019)	**1.00**	0			0.80	1.00
Nurse Delegation and Scope of Practice (2 policies)	**4.50**	4.00	**13**	✓	3.30	5.00
Nursing Tasks Able to be Delegated (2019)	**3.50**	3.50			2.69	4.00
Nurse Practitioner Scope of Practice (2019)	**1.00**	0.50			0.61	1.00
Transportation Policies (1 policy)	**0**	0	**8**	▬	0.14	1.00
Volunteer Driver Protection (2019)	**0**	0			0.14	1.00
Effective Transitions			**22**			
Nursing Home Residents with Low Care Needs (2017)	**13.1%**	*	**41**	*	8.9%	2.1%
Home Health Hospital Admissions (2017)	**14.7%**	17.6%	**7**	✓	15.8%	13.8%
Nursing Home Hospital Admissions (2016)	**14.4%**	13.8%	**22**	▬	16.8%	4.7%
Burdensome Transitions (2016)	**20.1%**	19.2%	**5**	▬	28.6%	16.2%
Successful Discharge to Community (2017-18)	**49.9%**	*	**48**	*	53.9%	68.5%

* Comparable data not available for baseline and/or current year. Rank cannot be calculated without current data. Change in performance cannot be calculated without both baseline and current data.
ADRC/NWD = Aging and Disability Resource Center/No Wrong Door
CARE Act = Caregiver Advise, Record, Enable Act
FMLA = Family and Medical Leave Act
HCBS = Home- and Community-Based Services
LTSS = Long-Term Services and Supports
PWD = People with Disabilities

Key for Change:

✓	Performance improvement
▬	Little or no change in performance
✗	Performance decline
*	No trend available

House Appropriations Committee #2403
IN SUPPORT – HB 1012 – DHS Budget – Aging Services
January 25, 2021
Josh Askvig, AARP North Dakota
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(701) 355-3642

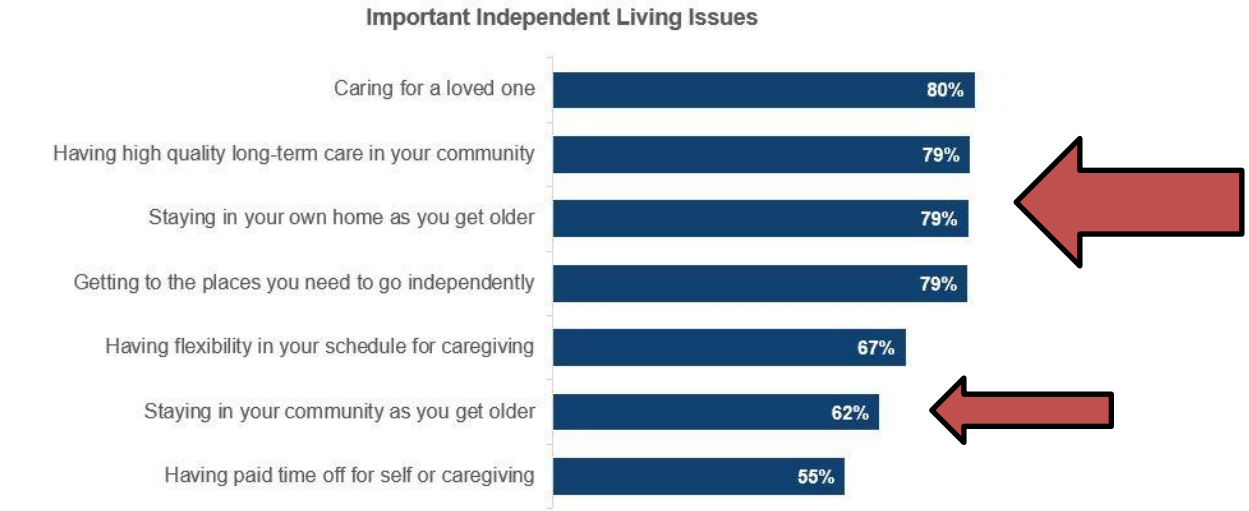
Chairman Nelson and members of the House Appropriations Human Resources Division, I am Josh Askvig, State Director at AARP North Dakota.

AARP is a non-profit, non-partisan membership organization with more than 84,000 members in North Dakota. Our mission is to empower people to choose how they live as they age.

Our story began when our founder, Dr. Ethel Percy Andrus discovered a former colleague of hers living in a chicken coop. She had run out of money and couldn't find anywhere to get the help she needed. Dr. Andrus decided she would make it her life's work to ensure older adults were given the opportunity to have dignity and purpose and founded what today is AARP.

We appreciate this committee's work to dig into issue important to older North Dakotans and this need will continue to grow. Today our population age 50+ is almost 256,000 and 50% of those households are age 65 or older. Today in North Dakota over 9 counties have a mean age of over 50 and a number of others are right on their heels.

AARP North Dakota supports the intent that DHS Director Chris Jones stated in his budget overview that the Department's effort is to provide services and care as close to home as possible. Below is a chart from our 2020 North Dakota Vital Voices Survey, a state specific survey of issues that impact North Dakotan's 45+ conducted every three years. In our survey last year, 79% indicated that staying in their own home as they got older, getting to the places they need to go and having access to quality long term care in their community was extremely or very important. Also, 62% said staying in their community as they got older was extremely or very important. It was no surprise to us and I am sure it doesn't surprise you.



I1. For the following list of issues, please indicate how important each is to you personally. (Percent 'extremely important' or 'very important') (n=722)

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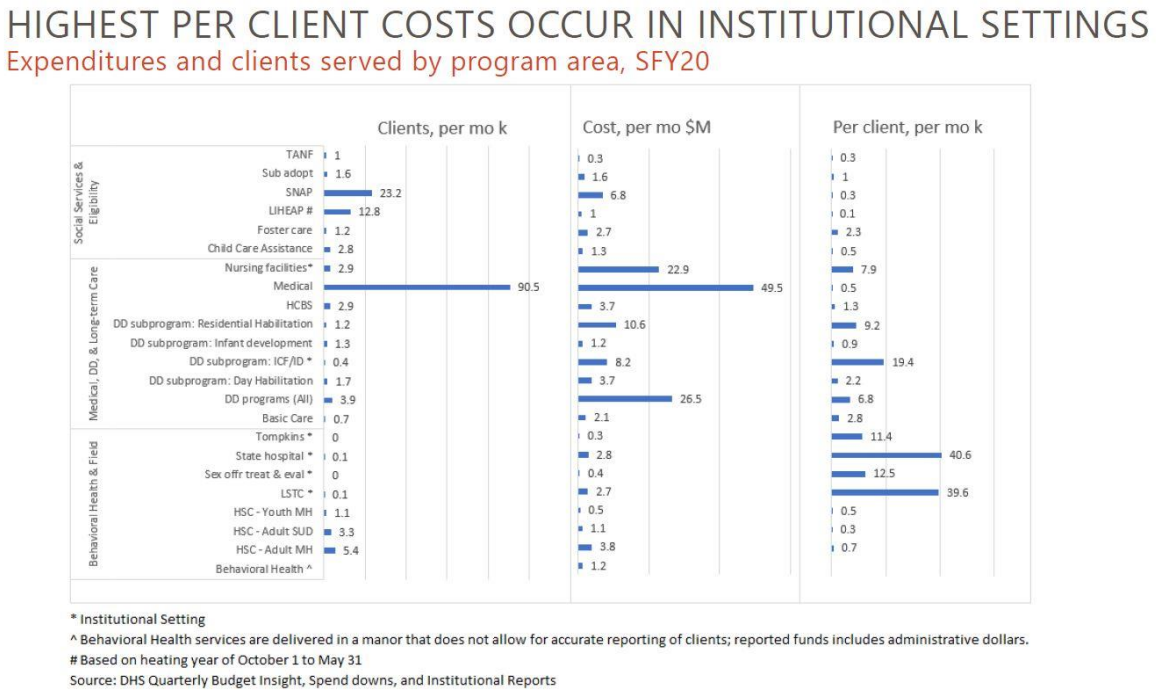
Knowing this the work to continue to move resources, supports and efforts into delivering services through an HCBS model is commonsense. It also makes dollars and cents. If you look at the chart that was shared during the overview it is very clear that serving individuals in home and community based settings is not only preferred it is cost effective. The chart appears to show about 1/7th of the cost ($7.9k per client per month for Nursing facilities vs $1.3k per client per month for HCBS).



* Institutional Setting
^ Behavioral Health services are delivered in a manor that does not allow for accurate reporting of clients; reported funds includes administrative dollars.
# Based on heating year of October 1 to May 31
Source: DHS Quarterly Budget Insight, Spend downs, and Institutional Reports

Additionally, in line with the efforts to intervene early to stave off long term costs, the changes made last session to access the state funded Service Payments for the Elderly and Disabled (SPED), adding Expanded SPED and centralizing ADRL intake are already paying dividends.

Attached you will find the *North Dakota: 2020 Long-Term Services and Supports (LTSS) State Scorecard*. This is the 4th time the Commonwealth Fund, The Scan Foundation and AARP have teamed up to provide a state LTSS assessment with apples to apples comparisons. If you look at the card you will see North Dakota made substantial improvement in 7 of the 21 indicators. And two of those were in the area of Choice of Setting and Provider dimension. In fact, North Dakota was recognized nationally during the roll out of the 2020 Scorecard for the work it has done to make improvements.

But let's be clear, while we have done good work, we still have plenty of work to do. Specifically, look at the indicators on the back related to Nursing Home Cost, Medicaid LTSS Balance: Spending and Medicaid LTSS Balance: Users, and Successful Discharge to Community where we continue to rank low. Investments in HCBS like those in the Aging and Adults Services area only aid in moving those measures. Again, for AARP and the thousands of North Dakotans we represent, it's about choice. Older North Dakotans deserve to know they have options for care as they age. Overwhelmingly they prefer to stay in their homes and communities and the budget should continue the state moving in a direction that prioritizes Home and Community Based care.

A couple of other notes related to the Aging and Adults Services portion of the DHS budget. The importance of the Long Term Care Ombudsman should be highlighted. During the pandemic, Karla Backman and her team were a critical component to ensuring that the rights of residents and their families were respected and honored. The Ombudsman program was an often needed referral for our team at AARP as the pandemic unfolded.

Finally, we would be remiss not to mention Senior Nutrition funding. The meals programs funded through the Aging and Adults services budget are a critical life line for older adults. They promote good health and as evidenced during the pandemic a critical component to keeping individuals at home and in their communities. The North Dakota Senior Service Providers put together a document every legislative session about their meals funding. I was reading through the 2021 document and understand that it is estimated that 1 year of meals funding is equal to 5 days in a nursing home. And in too many instances malnourishment leads to hospitalization and increased LTC needs. It should also be noted that meals programs also help to combat isolation and loneliness.

Combine these factors with the idea that it appears many of these senior providers will be losing some additional federal supports they received during the pandemic and knowing they

have seen a significant shift in their costs as they have moved to almost exclusively pick up or to go meals, and there is a need for a funding increase. We would encourage you to increase the meals funding to ensure that this critical service can meet the needs.

Again, we appreciate the time to raise issues important to North Dakotans 50+ and would be happy to answer any questions. Thank you.

House Appropriations – Human Resources Division #2290

Sixty-seventh Legislative Assembly of North Dakota

House Bill No. 1012

January 25, 2021

Good afternoon, Chairman Nelson, and Members of the House Appropriations – Human Resources Division. I am Pam Mack, Director of Advocacy Services for the Protection & Advocacy Project (P&A).

P&A is an independent state agency. Its mission is to advocate for the human, civil, and legal rights of individuals with disabilities. P&A strives to ensure that every individual with a disability is treated with the same dignity and respect as all other ND citizens.

P&A is here today to support HB 1012 and the funding for services for individuals with developmental disabilities. The Department of Human Services has identified a long-range goal to purposefully focus on the need for crisis services at the Life Skills & Transition Center (LSTC). At the same time, it is working on transitioning for many of the current residents to the community, ultimately operating with a lower census. This is consistent with the Transition to the Community Task Force goals that have been established and the state's requirement to ensure that individuals with disabilities are able to live and work in the least restrictive environment.

P&A has been involved in the steering committee to collaboratively implement the reimbursement system for DD providers. The current

budget, as presented by the DD Division, includes a decrease in reimbursement rates for providers relative to the array of residential services. P&A recommends that the DD Division further determine whether the recommended residential reimbursement rates in the DD budget are adequate to provide for the level of acuity and support needs of the individuals who are transitioning out of the LSTC. This may require a need to compare the daily rate at the LSTC with current rates within community providers, the outlier process, and perhaps the establishment of tiers of service. For example, the per diem at LSTC is $1,200. The average daily reimbursement for community ICF's/IDD is just over half that amount. We cannot set up the community providers to fail by not giving them sufficient resources to serve the same client.

The current budget proposal eliminates the Section 11 grant funds from the DHS budget. These monies provide program management services for individuals with developmental disabilities who are not eligible for other DD services. This is concerning as this helps to ensure all individuals with developmental disabilities receive appropriate treatment, services, and habilitation consistent with NDCC 25-01.2-02[1].

P&A is aware that the proposed budget for the DD Division shifts the cost for Accreditation with The Council on Quality Leadership, which is required for all DD providers, to the providers. This is a valuable mechanism to ensure that quality services are provided. The cost associated with this

[1] **https://www.legis.nd.gov/cencode/t25c01-2.pdf**

may be difficult for providers that are smaller and do not have the array of revenue options to cover this cost with CQL Accreditation.

Thank you for your consideration. I'm happy to answer questions. You are also welcome to contact me at **pmack@nd.gov** or by phone at (701) 328-3975.

Testimony on House Bill HB1012
2021 Legislative Session
January 24, 2021
Rep. Nelson, Chairman; House Appropriations-Human Resources
Division #2679

Good morning, Chairman Nelson and members of the committee. My name is Sarah Carlson. I live in Dickinson, ND and I am writing this, representing my own thoughts and not on behalf of my employers.

Family Voices of North Dakota is statewide health information and education center who serves families of children with special health care needs in ND. Family Voices provides emotional and informational support to many families across North Dakota who have a child who has an ongoing medical diagnosis such as asthma, heart conditions, physical disabilities, and emotional/behavioral issues. The staff provides assistance and care coordination to families by helping them access and navigate services, understand what these services mean, how systems work, where does the funding come from and by providing emotional, informational and educational support information to assist with their unique and individual needs.

This support intersected with my life before my child left the hospital after birth. And again, and again, support and resources were provided because I had a lot of questions and my child's health was very complex. By the time my child was 1, I found myself attending a weekend leadership institute, at no cost to me, to learn more about the structure of funding and services in North Dakota. Shortly after that, I became a staff for Family Voices. Shortly after that, I gained another employer to provide family support focusing on children birth to age 3 for Early Intervention as an Experienced Parent. I then was recruited for the Family Advisory Council for the Department of Health's Special Health Services. And then appointed by the governor for family representation on the Interagency Coordinating Council, where I later held a chair position. I was doing this all while juggling family, raising a baby with complex healthcare needs, and a managing a full time leadership position, at ABLE, Inc., supporting adults with disabilities. I continue to do all of these things, and have served on National committees and speaking at National conferences.

This year, there are some vital funding decisions that are dependent upon your support.

1. **DD Division: Payments for Providers.**
    - Please offer your support for a 3%/3% increase. Providers across the state struggle with recruitment and retention of staff. Providers rely heavily upon these increases to both retain existing employees and attract new staff. The majority of the workforce is entry-level direct support staff, who have risked so much in the last year to keep people with very serious health conditions safe from COVID while maintaining quality of life. This increase is critical to continue to provide safe, consistent supports to some of our state's most vulnerable people.

2. **Children and Family Services: Restore $100,000 to Family Voices.**
   DD Divison: Restore Experienced Parent Funding of $100,000 and reallocate to Family Voices.
   - In 2017, I provided testimony along with many others to secure funding for parent/peer support with the Experienced Parent program. This support to families is critical while they are just starting their journey in services. I recommend restoring the $100,000 cut from the DD budget and reallocating it to Family Voices of North Dakota. Family Voices is a natural fit to provide these supports to families as they manage Project Carson, a program designed to support mothers who have a prenatal diagnosis or at birth diagnosis for their baby. Connecting this program with existing resources and connections to Early Intervention makes logical sense and does not put pressure on the DD division, to reinvent the wheel on parent support. In addition to the $100,000 for Experienced Parents (work specifically for families with children birth to age 3), please support a restoration of the $100,000 that was cut from Children and Family Services. Without this $200,000 total in the budget to support families, families will suffer and lack the critical support that is needed to provide emotional support and navigate complex systems. I am a reminder that the supports offered by Family Voices. That support has produced a domino effect, by helping mold a leader for this state, and also by continuing to offer that support to other families in the Southwest area of the state. I have personally supported hundreds of families in different capacities navigating birthing support, healthcare, infant development, educational, and employment services for people with special healthcare needs and their families. I receive referrals from all avenues, most often from professionals, silo-ed in one of those services mentioned. I do not believe that I would have been able to provide supports to other families if Family Voices did not first reach out to offer support to me and my family. Let my story be an example of the tremendous benefit these services have provided, and need to be continued for families across ND.

Thank you for your time and consideration. Please support these necessary changes.

Sarah Carlson
Cell: 515.450.7378
skunkriverstudio@gmail.com

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/25/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 2:15 p.m.

Discussion Topics:

- Arc of ND
- Mental Health Advocacy Network
- SUD Voucher
- Behavioral health care
- Homelessness in ND
- Cooper House

Kirsten Dvorak, Exec. Dir. Arc of ND (2:13 pm) testified about the Arc of ND #2436

Carlotta McCleary, Exec. Dir. (2:24 pm) testified about the Mental Health Advocacy Network #3355

Ty Hegland, Chair, North Dakota Addiction Treatment Providers Coalition (2:34 pm) testified about the North Dakota Addiction Treatment Providers Coalition #2502

Jeff Herman, CEO of Prairie St. John's of Fargo (2:44 pm) testified about Prairie St. John's #3352

Kurt Snyder, Exec. Dir. (2:49 pm) testified about the Heartview Foundation #3349

Brenda Owen (2:55 pm) testified about Summit Counseling Services, oral testimony

Denise Harvey, Director of Program Services with the North Dakota Protection and Advocacy Project (3:10 pm) testified about the ND P&A #2677

Jessica Lynn Bauers, Consumer (3:16 pm) testified about Jerry D's, oral testimony

Dan Maddler, CEO (3:21 pm) testified about Beyond Shelter #2445 #2446 #2447 #2448 #2449

Jesse Jahner, Sheriff (3:38 pm) testified about the Cass County Jail #3079

Dareen Knightly, COO (3:50 pm) testified about the Dakota Foundation, oral testimony

Trina Gress, Vice President of Community Options (4:03 pm) testified about Community Options #2465

Marissa Mahanna, Program Supervisor of Cooper House (4:13 pm) testified about the Cooper House #2457

Kandia Qual, Program Director for the Dacotah Foundation in Fargo (4:26 pm) testified about the Dacotah Foundation #2372

Taylor Restad, Director at LaGrave on First (4:35 pm) testified about the Northeast Human Service Center's budget #2466

Donene Feist, Director for Family Voices of North Dakota (4:43 pm) testified about Family Voices of North Dakota #2367 #2368 #2369 #2370

Roxanne Romanick, Executive Director (5:10 pm) testified about Designer Genes #2534

Vicki Peterson, Family Consultant (5:17 pm) testified for Family Voices of ND #2375

Chair Nelson closed the meeting at 5:28 p.m.

Cole Fleck, Committee Clerk

The Arc
North Dakota

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Testimony House Bill 1012 #2436
House Appropriations-Human Resources
January 25, 2021

Chairman Nelson and members of the Committee, my name is Kirsten Dvorak. I am the executive director of The Arc of North Dakota, which includes all six Arc chapters in North Dakota: Bismarck, Bowman, Dickinson, Fargo, Grand Forks, and Valley City. Our mission is to improve people's quality of life with intellectual and developmental disabilities and actively support their full inclusion and community participation.

According to the Developmental Disabilities Assistance and Bill of Rights Act (DD Act) and other federal legislation, "disability is a natural part of the human experience…". Prevention activities do not diminish the value of individuals with intellectual and/or other developmental disabilities (I/DD) but instead strive to maximize independence and enhance people's quality of life with I/DD.

Individuals with intellectual and/or other developmental disabilities deserve the opportunity for a full life in their community where they can live, learn, work, and socialize. To achieve this goal, they need a comprehensive, person-centered and directed, system of appropriate high-quality long-term supports and services (LTSS), a well-trained, fairly compensated workforce of providers, and direct support professionals.

The quality and effectiveness of LTSS for people with I/DD depends upon qualified providers of supports and services with adequate skills and training. Inadequate compensation hampers both recruitment and retention of direct support professionals (DSP). Insufficient funding would negatively impact the quality of support available to people with I/DD and the success that individuals have in living the life they choose in the community.

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It has been over 40 years since The Arc of North Dakota began the task of eliminating the state institution at Grafton. In 1980, The Arc was called the ARC, and the Life Skills and Transition Center (LSTC) was named the Grafton State School. When the lawsuit to close San Haven and the Grafton State School was dismissed in 1995, it was with the understanding that the state would continue to work to keep our citizens in their homes and communities. The Arc of North Dakotas' vision of closing LSTC has not changed. However, The Arc of North Dakota supports the census reduction and being a provider that specializes in crisis and stabilization services.

However, we have concerns about the decrease in the disability services budget. The reduction would jeopardize the promise of keeping our citizens in the programs to participate fully in their communities, where they experience quality of life and personal independence. We ask that you reinstate the 11 million dollars of funding. Funding that is used for person-centered home and community supports that are delivered in natural community environments.

I urge you to help us look for answers to a problem that has troubled us well over the 40 years.

House Appropriations-Human Resources Division Committee
Sixty-seventh Legislative Assembly of North Dakota #3355
House Bill 1012
January 25, 2021
Senator Jon Nelson, Chair

Good afternoon Chairman Nelson and Members of the House Appropriations-Human Resources Division. I am Carlotta McCleary, Executive Director of Mental Health America North Dakota and Executive Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer /family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

MHAN has provided testimony since the 64th interim human service committee meetings (2015-2016) regarding our priorities for mental health services. We argue that peer to peer and parent to parent support, consumer choice, diversion from corrections, a core services zero-reject model, and conflict free grievance and appeals processes, and the access to a full and functional continuum of care serve as the backbone to correcting the crisis in North Dakota's behavioral health system.

MHAN is speaking in support of HB 1012. During the Sixty sixth legislative session, MHAN stressed that North Dakota needed to put the HSRI Report of 2018 into action. That report, much like the Schulte Report of 2014 said that North Dakota needed to drastically reduce its reliance on institutionalization and make sure that it had a fully functional community-based mental health system for children, their families, and adults that is as near their home as possible. Among the accomplishments of the last legislative session were the commitment to apply for the 1915(i) State Plan Amendment, peer support certification and training, prevention and early intervention pilot program in schools, the behavioral health pilot program, and the behavioral health resource coordinator in our schools.

MHAN's vision for this current legislative session was to ensure that the HSRI report would continue to be an active "road map" to ending the decade-long behavioral health crisis. MHAN commends the Department of Human Services for its continued emphasis on improving behavioral health services. The Department of Human Services' efforts in diverting people from corrections with Free Through Recovery and Community Connect should be applauded. MHAN also supports the building of a new State Hospital at Jamestown with reduced number of beds, along with development of six to ten beds in the western part of the state.

However, MHAN is deeply concerned about the current state of North Dakota's children's mental health system of care. Roughly 10% of all children in North Dakota have a serious emotional disorder (SED). As of 2019, this translates to roughly 18,000 children. We are currently serving only 1 out of every 18 children who have a serious emotional disorder. As a result of not having access to care, many children are being sent into the juvenile justice system. From 2011 to 2017, the number of children in juvenile corrections who had a serious emotional disorder rose from 49% to 79%. Although there have been improvements, children with serious emotional disorders still represent the majority of children in the corrections system despite only accounting for 10% of all children in North Dakota. The *Olmstead* decision of 1999 and subsequent litigation made clear that people with disabilities (including mental illness) must be given access to community-based services before requiring that they seek only institutional care. Let me be clear: *Olmstead* applies to children too.

It comes as no surprise that the COVID-19 pandemic has led to an increase in behavioral health challenges and has forced our society to rethink how it conducts business and serves the community. Our national Mental Health America released a report this year finding that there was a 93% increase from 2019 in the number of people who took their anxiety screen, and a 62% increase in the number of people who took their depression screen. They found that children and youth ages 11-17 had been "more likely than any other age group to score for moderate to severe symptoms of anxiety and depression." In addition, they found that "since the end of May 2020, nearly every racial/ethnic group has been experiencing consistently higher rates of suicidal ideation than the 2019 average." The Centers for Disease Control found that the COVID-19 pandemic has considerably

increased the symptoms of anxiety disorder and depressive disorder compared to 2019. In their study, 40.9% of American adults reported at least one adverse mental or behavioral health condition, with 10.7% of respondents reporting to have seriously considered suicide in the previous 30 days. Suicidal ideation was especially pronounced among racial and ethnic minorities, young adults, unpaid caregivers for adults, and essential workers.

As the Executive Director of the North Dakota Federation of Families for Children's Mental Health I can attest that we have seen an increase in our children and youth who have displayed more significant mental health symptoms and suicidal ideation. In addition, COVID-19 has made it more difficult for children, families, and young adults to get access to the services and supports that they need and it has become much more difficult for teams to coordinate care. Families in the Bismarck area are reporting a concern for dealing with children's mental health crisis. Families have reported that when calling crisis response, the service is done over the phone instead of in-person. In order to deescalate someone, you really need to have an in-person, human connection to develop rapport with the individual. Once they are deescalated, in-person debriefing is essential to prevent future crises. In addition to crisis response, families in the Bismarck area are also without safe beds as an option for children's mental health crisis. Safe beds are a safe place for a child to deescalate as an alternative to costly hospitalization. As a result, the only options many families have are: a) do nothing, b) hospitalize their child, c) call law enforcement.

MHAN has other concerns with the Governor's proposed budget regarding reductions in children's mental health. The Governor's proposed budget cuts the voluntary treatment program from its previous budget of $533,440 to a proposed 2021-2023 budget of $453,424. Prior to this program, many parents were forced to relinquish custody of their children in order to receive mental health services (and those services were in a residential treatment facility). With the creation of the voluntary treatment program, those parents were no longer required to relinquish custody of their children in order to receive treatment that would be provided in that residential treatment facility. During the last legislative session, the voluntary treatment program was given the flexibility to provide services to children in order to prevent an out-of-home placement. The voluntary

treatment program is essential in families being able to maintain custody of their children and provide linkages to community-based services. Cuts to this program would be detrimental.

MHAN supports parent peer support and the organizations that provide this valuable service. Family Voices of North Dakota, who provides support to children with special healthcare needs and their families, and North Dakota Federation of Families for Children's Mental Health, who provides support to children with mental health needs and their families, are both facing reductions as proposed in the Governor's budget. Family peer support organizations provide support, provide education for families, assist families in system navigation, give education for providers, and advocate with families so that they receive the services and supports that their child needs. MHAN supports fully funding family peer support organizations.

As you can see there is still a lot of work left to do in mental health. Now is not the time to reduce our efforts to improve the mental health system of care for children, adults, and their families.

Thank you for your time and I would be happy to answer any questions you may have.

Carlotta McCleary
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Please Support the SUD Voucher #2502

Chairman Nelson & Members of the House Appropriations Human Resources Committee,

The past year has been a challenging one for the Substance Use Disorder (SUD) providers of North Dakota. With the ongoing COVID-19 Pandemic and suspension of acceptance of new patients into the SUD Voucher Program, providers have had to balance an increase in demand for services with a sudden lack of resources.

North Dakota's SUD providers represent one of the most important parts of the overall healthcare and behavioral health systems in North Dakota. With a high prevalence of alcoholism and binge drinking in our state, combined with an Opioid Crisis and Methamphetamine resurgence, these providers work tirelessly to serve those in need. Despite being underfunded and in high demand, these providers save lives while simultaneously saving millions in healthcare, social service, legal, and correctional costs.

The North Dakota SUD Voucher is one of the most important tools in serving North Dakotans who have a Substance Use Disorder. The voucher provides not only the ability of patients to obtain critical services in a timely manner, but it provides provider choice so patients can stay close to home and their families. Additionally, the voucher serves as a tool to keep patients out of emergency rooms, hospital beds, jails, courts, and morgues.

With the suspension of accepting new patients into the program on July 1, 2020, many providers were left with no options for their patients. With countless patients in the process of accessing services, the pipeline to serve those in need was cut off with a twelve hour notice. Though some may look at this as an unfortunate outcome of an expended appropriation, providers have often asked our association what they should tell those patients. Additionally some have wondered if those patients will survive long-term? When we ask providers to take a year off from serving patients, we run the risk of significant damage to patients, communities, and our state.

Continued On Back...

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With an ongoing pandemic, high alcoholism rates, Opioid Crisis, and Meth resurgence, we respectfully ask you support the $17 million dollar request for the voucher by Governor Burgum. Though some may see a significant budget increase, those of us who serve patients know this represents increased savings to our communities and state, as well as the ability to save more lives.

Sincerely,

Ty Hegland
Chair, North Dakota Addiction Treatment Providers Coalition

Main Points:

- 98% of Licensed Addiction Counselors in North Dakota believe the SUD Voucher saves lives.
- SUD patients are not revenue neutral. Supporting the SUD Voucher saves millions in countless areas. According to the National Institute of Health, one dollar spent in SUD services saves $6 in correctional costs and/or $13 in primary healthcare costs.
- There are nearly 100 entities and thousands of individuals working to provide SUD services in North Dakota. 70% of providers believe their patients and practices were negatively affected when we stopped accepting new patients into the voucher program on July 1, 2020.
- Patients need a fully funded two year voucher. Passing the $17 million dollar re quest by Governor Burgum will help the industry get back on track and stop the underfunding of these critical services.
- The SUD Voucher should support all levels of care across the state of North Dakota and ASAM CUA assessments/treatment plans by licensed clinicians should always lead determinations of level of care. A full continuum of care is vital to our state.
- Due to limited funding, the SUD Voucher should not be extended to providers operating outside the borders of North Dakota unless they reside in an underserved area and complete a Certificate of Need style process.
- According to the American Medical Association, nearly 50% of individuals with a Substance Use Disorder have a co-occurring Mental Health Diagnosis. As a result, many of the SUD providers in the state provide comorbidity/dual diagnosis clinical services in order to serve both issues.

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The Key Components of Supporting North Dakota SUD Patients & Providers

* The citizens and patients of North Dakota need a fully-funded SUD Voucher for the full two years of a biennium.

* Patients need the support of a full continuum of care. Due to the severity of illness and additional factors clinical assessments, commitments, jail diversion programs, etc., we cannot eliminate support for any levels of care, as it will cause serious harm to thousands of patients across North Dakota. This includes Residential, Outpatient, Medication Assisted Therapy, and Community Based Supports.

* SUD Providers across the state support the efforts of the ND Dept. of Human Services with community based services and social supports. However it is imperative that due to the severity of illness and ASAM clinical standards, Residential and Outpatient Clinical Services continue to be prioritized and supported due to being the core services of SUD treatment for patients.

* The costs of not treating SUD patients is not revenue neutral. NDATPC encourages the state to continue pursuing Medicaid Waivers to offset general funding costs, including pursuit of an IMD Waiver. The 1915i Waiver is a great start in this process, however we cannot continue to deny Residential/High Intensity Care for low-income individuals in North Dakota, as it causes more harm to patients, families, and communities. As a result of not having an IMD waiver, hospitals, jails, and many additional entities experience higher operating costs and patients receive services that are not effective in dealing with Behavioral Health/SUD disorders.

* According to the National Institute of Health, for every dollar spend on SUD services, $6 are saved in correctional costs and $13 are saved in primary healthcare costs.

* Due to recent budget issues, North Dakota should not enroll providers who are not licensed in the State of North Dakota, unless it is an underserved area and they complete a Certificate of Need process. Given the volume of providers within five miles of the border, the depletion of a SUD Voucher fund will only accelerate if this occurs and we will run into the same issue of the 2020-2021 biennium.

* The State of North Dakota should be in be in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) at all times. This includes sufficient access for patients and payments to providers.

* ASAM Assessments carried out by licensed clinicians need to determine levels of care for patients. Other entities should not be involved in influencing service provision and levels of care through policy, as it causes patients to be cared for in inappropriate clinical settings and compounds the Behavioral Health/SUD disorders of a patient.

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Support the SUD Voucher

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CASS COUNTY GOVERNMENT
www.casscountynd.gov

Office of the Sheriff
Jesse Jahner, Sheriff

January 13, 2021

North Dakota House Appropriations Committee
ND State Capitol Building
Via electronic submission

I am writing today to express support for the ND SUD Voucher program, and to urge approval of the requested increase in funding for the 2021-2022 biennium.

As the administrator of one of the largest jails in North Dakota, in the county with the greatest population and highest per capita need for services, I can attest to the fact that the SUD program has been one of the most beneficial programs we have ever participated in, and has contributed more significantly to improved outcomes for recipients than any other single program for which I have been a stakeholder.

You may not be aware that persons who are incarcerated are ineligible for Medicaid reimbursements. If a person is enrolled in Medicaid at the time they are arrested, their coverage lapses during the period that they are physically incarcerated. If they have never enrolled, they must wait until after they are released to start the process, as there is no existing support for enrollment navigators, no access to internet, and often persons in jail do not have access to the necessary information needed to enroll for coverage even though they may be eligible.

The SUD Voucher has filled the gaps in our needs continuum in multiple ways. It was instrumental in allowing us to connect defendants afflicted with addiction to immediate treatment for opioids, providing necessary funding to bridge the gap until Medicaid enrollments could be completed by the clinic. The SUD Voucher was also a critical resource for helping to ensure a seamless transition from inmate to patient for dozens of people who entered residential treatment programs. It was devastating to us when the funding ran out, resulting in the elimination of a primary route for immediate access to needed care.

The funding for this program is needed now more than ever, and we all recognize that the amount allocated last time significantly underestimated the actual need. This is a program that pays real dividends for those it serves, and I wholeheartedly support the proposed budget request. The various government units are going to spend this money either way – I believe we should spend it in support of treatment rather than in response to the medical and behavioral consequences of ongoing and un-addressed addiction.

Sincerely,

Capt. Andrew Frobig
Jail Administrator
Cass County Sheriff's Office

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Funds Run Dry for North Dakota Addiction Treatment Program — Counselors Say Lives are at Stake

Written By: Patrick Springer | Aug 29th 2020

Dale Lein couldn't shake the hold alcohol had on him. His addiction started in high school and followed him like a shadow throughout life. He found it difficult to hold down a job. He occasionally got into car accidents while driving drunk. He became estranged from his family. Finally, last year, a health crisis forced Lein to reckon with the fact that alcohol was destroying his life. A brain tumor, shoulder surgery and complications from decades of hard drinking put him in the hospital for four weeks. Alcohol, his doctors said, was killing him.

Lein desperately wanted to get sober. But he faced what seemed like an insurmountable problem. He was disabled and couldn't afford treatment. Then Lein got a break. He qualified for a state program that pays for addiction treatment for those who lack health insurance or other means to pay. After failed efforts in the past, Lein has achieved sobriety, thanks to help from counselors at Heartview Foundation and the state payment program.
"I've been sober now a year and five months," Lein said. "That's the longest I've ever been sober." Before getting treatment, "That's all I did my whole adult life was drink and drink and drink."

The payment program, called the substance use disorder voucher program, has provided treatment for 4,200 people struggling to recover from addictions since it started in September 2016. But money for the program is unexpectedly running out, so the North Dakota Department of Human Services was forced to freeze the program, barring new clients from enrolling — cutting off access to a program that addiction treatment advocates say is a lifeline for people who otherwise end up, untreated, cycling through hospital emergency rooms and jails, at much greater cost.

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“They’re going to end up in our jails and emergency rooms — or they’re going to die,” Tonya Sorenson, a licensed addiction counselor and clinical supervisor at First Step Recovery in Fargo said of those who will lack treatment because the program is closed to new clients. “That’s the reality of what we’re dealing with. We see our clients in the paper, in the obituaries.”

Pamela Sagness, director of behavioral health for the state Department of Human Services, said officials have worked to maintain services for those currently in the voucher program. “The continuity of services is just vital,” she said, noting the risk of relapse for anyone battling addiction. Officials have struggled to budget for a new program and, for the current budget, had to make their best estimates of demand for services in December 2018.
“We’re really for the first time getting our arms around the scale of the need,” she said. The program currently is paying to help 1,348 clients.

The state's regional human service centers are aware of the suspension of new voucher clients and can once again serve as the “safety net for addiction service needs” and have expanded access to 24/7 crisis services in all regions, Sagness said. “No services were discontinued or stopped,” she said. “The notification was specific to stopping growth of the program.” Heartview Foundation, First Step Recovery and 20 other addiction treatment centers around the state were abruptly told on June 30 that money was running out, giving them just hours to prepare and try to finish pending applications.

Before the voucher program, those who couldn’t afford addiction treatment from private counselors had to seek treatment at eight regional human service centers around the state, where they often faced long waiting times, addiction treatment advocates said. “They were required to stand in long lines in human service centers around the state,” said Kurt Snyder, executive director of Heartview Foundation. “The beauty of the voucher system is it allows the private providers to open their doors to all comers. It made a real difference for a lot of people.”

Lein started his treatment with an 18-day regimen, with three days of residential service followed by 15 days of outpatient counseling and therapy. He continues to meet with his counselor once weekly, has weekly group therapy and regularly attends Alcoholics Anonymous meetings. “It does wonders,” he said. “It does absolute wonders for people who are in a crisis right now.” Under the voucher program, clients whose treatment is deemed medically necessary can qualify for evidence-based treatment from approved addiction treatment centers located close to home. The funding freeze on new clients — which addiction treatment advocates say could deny services to thousands of people struggling with addictions around the state — comes despite Gov. Doug Burgum’s outspoken support for addiction recovery, which he has made a priority issue since taking office in December 2016.

Yet addiction counseling center executives, including those at Prairie St. John's, ShareHouse and First Step Recovery, said they are unaware of efforts by Burgum to try to come up with money to provide services to new clients. “Under Gov. Burgum’s leadership, DHS is working diligently to pursue federal funding and identify possible rollup dollars in its existing budget to provide additional funding for the SUD voucher program, after attempts to find other sources including CARES Act funding were exhausted,” Burgum spokesman Mike Nowatzki said in a statement.

Human services officials have “consistently asked to increase funding to meet demand” for the voucher program, increases that were incorporated in Burgum’s budget requests last session, and approved by lawmakers, he said. Funding for the program, which enjoys strong bipartisan support in the Legislature, has risen dramatically since the program’s start four years ago.
“Behavioral health and recovery remains a priority of this administration, and to suggest otherwise because of a funding situation related to further expanding a program that has already been significantly expanded under this administration is disingenuous,” Nowatzki said.
'A race against the clock'

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Spending in 2015, the voucher progam's first year, totaled $252,294, which mushroomed to almost $8.3 million during the 2017-19 budget. During the current budget for 2019-21, vouchers are budgeted for $7.9 million — but more than $7.1 million had been spent by early August, with almost a year remaining in the biennium. Spending for 2017-19 exceeded the current biennium because the current two-year budget was planned before all of the receipts from the last biennium were in hand, Sagness said. "We want to get services to people in need," she said. "That's our mission. But there are limits to the funding."

To serve clients caught by the voucher funding squeeze, Prairie St. John's and ShareHouse are absorbing some of the costs. "It became a race against the clock to help people," said Ty Hegland, executive director of ShareHouse, adding that the vouchers are a "gap filler for patients who have no other means." ShareHouse will spend $50,000 to $60,000 per month to help fill the void, while Prairie St. John's bad debt and charity care spiked by $100,000 this month, said Jeff Herman, Prairie St. John's chief executive. "It's deplorable," Herman said, referring to the emergency created by the state's abrupt cutoff. "That's embarrassing for the state."

Extending charity care is difficult because treatment centers operate on thin margins, so it can't be sustained indefinitely, Hegland said. Meanwhile, costs elsewhere will spike as people with untreated addictions end up in jails and emergency rooms, he said. "This isn't just going to go away," Hegland said. "It's not going to be revenue neutral, and it's going to be very expensive."

A family member of a client who couldn't be accepted for treatment because voucher funding has been exhausted scolded staff at Summit Counseling Services, which serves western North Dakota, where treatment is scarce. "How can you sleep at night?" an angry family member asked staff, Executive Director Brenda Owen recalled. "It's heartbreaking."

Despite the freeze on adding new voucher clients, funding will be available for new patients receiving methadone treatments for opioid addictions, because federal money can pay for that, Sagness said. But the state general fund is the sole funder of the voucher program.
The rise in funding has been possible because of strong legislative support for the voucher program, said Sen. Judy Lee, R-West Fargo, chairwoman of the Senate Human Services Committee. "This was a legislative-established program," she said, which she views as an investment rather than an expense. "It's been remarkable," she said, adding that budgeting for the new program was an "absolute dartboard deal trying to figure out."

When the Legislature convenes in January, replenishing funds for the substance use disorder voucher program will be a priority, Lee said. But the state's economy has been hammered by the pandemic, which has caused oil revenues to plunge. "We know it's going to be a really challenging budget year," she said. She agrees with addiction counseling advocates that it's better to help people before their lives spiral into crisis. Legislators are convinced that the program pays dividends by helping people lead productive lives.

"Catch people before they fall to the bottom again and get them on track again," she said. Recovering from addiction is a constant struggle, Lein said. He feels grateful that his voucher approval recently was extended. "I'm still fighting alcohol," he said. "There's no doubt about it. I can't imagine what I'd do if I didn't get in. I don't know where I'd be. I don't even know if I'd be alive." As for the lack of funds to accept new clients, he added, "I'm hoping and praying that this will change."

https://www.inforum.com/news/4107496-north-dakota-launches-state-funded-voucher-program-addiction-treatment

NORTH DAKOTA
NDATPC
ADDICTION TREATMENT PROVIDERS COALITION

Minot Daily News

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Drug Overdoses On the Increase

Overdose deaths have quadrupled in the Minot area since last year

By Andrea Johnson
September 30, 2020

Overdose deaths in the Minot area have increased dramatically over the past year but police say it is not clear whether the stress of the ongoing coronavirus pandemic is one of the reasons why. "The pandemic's effect on the opioid use is unclear," said Minot Police Department Capt. Dale Plessas, investigations and records commander, in an email interview. "We saw an increase in overdoses prior to the pandemic."

According to the Minot Police Department, police had responded to 67 overdose incidents between Jan. 1 and Sept. 15, with 11 of those incidents resulting in overdose deaths. In all, there have been 13 overdose deaths in Minot through Sept. 15. In 2019 police responded to 31 overdose incidents in Minot, with three official overdose deaths.

Even those numbers may be out of date. On Monday Minot police said they were investigating the apparent overdose deaths of two 24-year-old men and sought help from the public in identifying what type of drugs the men might have taken and from where they might have gotten those drugs. Police said they fear that more people might overdose and die. During an unrelated court hearing on Tuesday, Ward County Deputy State's Attorney Todd Schwarz remarked to Judge Gary Lee that, by Schwarz's count, the area is now up to 14 fentanyl overdose deaths this year and Ward County now has more fentanyl overdose deaths than it does due to COVID-19. He said two more were lost over the weekend.

A woman who has been charged with dealing drugs wrote a letter to Lee this week from the jail and begged to be released to go to a drug treatment program. She told the judge that someone she loved died in her arms of a drug overdose last week. The woman, sober now after spending a few days in jail, wrote that she realizes that she has been battling drug addiction for years, knows that she is very ill, and wants to take the opportunity to get better. The woman is one of many people in the community who has lost a family member or a friend to the tragedy of a drug overdose or have found themselves facing criminal charges that are connected to their own addiction battle.

"Many overdoses and deaths that have occurred in the Minot area are linked directly to fentanyl," wrote Plessas in the emailed interview. "Often, opiate users purchase the drugs under the false pretense that they are receiving heroin or Oxycodone. The only way for drug users to protect themselves is to stop using." Police have said that fentanyl is particularly dangerous, not only to users but also to police officers and other first responders who might be exposed at the scene of an overdose.
"Fentanyl is reportedly up to 50 times more potent than heroin," said Plessas in the email. "As a result, we are concerned about the potential danger to first responders. Our officers are supplied with personal protective equipment to include gloves, N95 masks, and Tyvek ensembles. To date, our officers have not reported any exposures to fentanyl that required treatment."

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Officers have also saved the lives of some of the people who have overdosed. “Our officers are equipped with Narcan to protect them from accidental exposure and to administer to victims of opioid overdoses,” said Plessas. Narcan, which is also known as naloxone, is a medication that can temporarily reverse the results of an opioid overdose and restore normal breathing, according to the National Institute on Drug Abuse. It usually works in two to five minutes, but the effects wear off and the person will still always require medical attention after the overdose. Naloxone can be administered via auto injection or nasal spray. Friends, family or others who administer naloxone to reverse an opioid overdose are protected from civil liability under state law.

Plessas said that officers have seen various drugs in overdose cases, but fentanyl is commonly part of the equation.

Plessas said officers want people to know that help is available.

https://www.minotdailynews.com/news/local-news/2020/09/drug-overdoses-on-the-increase/

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Drug Overdoses, Fatalities on the Rise in Fargo

By Bailey Hurley
January 22, 2021

FARGO, N.D. (Valley News Live)

Drug overdoses are on the rise in Fargo, up over 300 percent compared to this time last year.

Fargo Police say just within the first few weeks of 2021 the department has responded to nine overdoses, two of which were fatal. By this time last year, FPD had responded to two overdoses, one of which was fatal. “And those are just calls that we got sent out to! There’s a lot of people that overdosed and by virtue of Narcan or family members or friends, they’re being revived and the police would never know about that,” Fargo Police Chief David Zibolski said.

Our goal and our mission as a narcotics unit is to identify the people that are supplying the drugs that lead to overdoses. Basically, they’re taking advantage of people suffering from addiction and we’re holding those people accountable,” Narcotics Sergeant Matt Christensen said.

Christensen says most overdose cases in the metro involve mixtures of fentanyl, heroin and meth. He says some of the cases the department is currently investigating have ties to California. Christensen also says more often than not, the ones supplying the deadly drugs in the metro are not local.

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https://www.valleynewslive.com/2021/01/23/drug-overdoses-fatalities-on-the-rise-in-fargo/

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January 25, 2021 #3352

North Dakota House Appropriations Human Resources Sub Committee

Chairman Nelson and Committee Members,

My name is Jeff Herman. I serve as the CEO of Prairie St. John's of Fargo. I am also the Chairman of the Board of Directors for the ND Hospital Association and a past member of the State Mental Health Planning Council.

Prairie St. John's offers a continuum of behavioral health care including acute inpatient hospital care, residential treatment and day hospitalization. Our patients come from throughout North Dakota and Minnesota. We are a part of a network of private and public providers.

I am here to support the $9 million Substance Use Disorder Voucher increased allocation to the Department of Human Services in HB1012.

Through my 25+ years in behavioral health, I have come to conclude that for persons who suffer from addiction and mental illness, the best outcomes are correlated with; 1. Immediate attention when there is an openness to care on the part of the patient, 2. Care is provided at the level determined by appropriately trained professionals, and 3. A reliable method of payment for services that exist so patients are not further destabilized and that providers stay viable. No person enters our facility without all these considerations being reviewed. The level of care ranges from individual assessment to acute hospital care (as an aside we provided over $5.5 million dollars of charity care last year).

As you know the allocation that you made last legislative session served our citizens for only about one year of the biennium. The additional $9 million will serve to provide evidence as to what is needed and what tweaks we need to make to stabilize the programs in future biennia.

I also understand that in addition to the appropriation, NDDHS needs resources of staff to implement the increased voucher funding. The investment will prevent pain and suffering and is prudent to prevent clogging up our emergency rooms, courts, and prisons systems.

Thank you. Jeffrey A. Herman, MBA, RN

January 25, 2021 #3349

House Appropriations Human Resources Division

Chairman Nelson and members of the House Appropriations Human Services Division

My name is Kurt Snyder and I am the Executive Director of the Heartview Foundation. Heartview is a drug and alcohol treatment program established in 1964. We have over one hundred employees with an Opioid Treatment Program, outpatient programming and a 16-bed residential program in both Bismarck and Cando, ND. Last year we served individuals from 38 of the 53 counties of ND.

I am here today to voice our support for House Bill 1012 and specifically, the full funding of the SUD Voucher.

Since the inception of the SUD Voucher, it has been invaluable to providing access and care to so many citizens of North Dakota. And today, the need for substance use services is greater than ever as the opioid epidemic and COVID-19 devastate our communities.

Up until October of 2020, ND Medicaid did not cover the medication in the Opioid Treatment Programs and the SUD Voucher has been the only source of funding to cover these costs. We are grateful. However, the need for the SUD Voucher to support OTPs continues to be necessary. If an individual is Medicaid or Medicaid Expansion eligible, they still need to move through the approval process. In Burleigh County, we are experiencing a 3 to 4 month process for approval. Our patients rely on the SUD Voucher to have access to these lifesaving services in the interim.

I understand that the SUD Voucher is for filling gaps in coverage and is the payer of last resort. When other payment coverage is secured, Heartview has made repayments to the SUD Voucher Program. Please consider that Heartview's patient population, is over 65% Medicaid and/or Medicaid Expansion. (20% Medicaid and 47% ME). Much of our use of the SUD Voucher are for Medicaid or ME eligible individuals. If the approval process was addressed, our reliance on the SUD Voucher would be greatly reduced.

One solution for this issue is for ND Medicaid to identify Heartview Foundation and other Opioid Treatment Programs as "qualified Entities" to do Presumptive Eligibility. Presumptive eligibility is a Medicaid policy option that permits states to authorize specific types of "qualified entities," to screen eligibility based on gross income and temporarily enroll eligible individuals in Medicaid. Presumptive eligibility serves a dual purpose of providing immediate access to needed health care services while putting people on a path to ongoing coverage.

This concludes my testimony, and I would be open to answer any questions of the committee.

Kurt Snyder, Executive Director

Office: 701-751-5708 Cell: 701-426-8677

Email: kurt@heartview.org

HB 1012 #2677
House Appropriations
Human Resources Division
Representative Jon Nelson, Chairman
January 25, 2021

Representative Nelson and other members of the Committee, I am Denise Harvey, Director of Program Services with the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency that protects people with disabilities from abuse, neglect, and exploitation, and advocates for the civil and legal rights of people with disabilities.

P&A supports the 1915(i) state plan amendment, and the tremendous efforts made to put this into place. P&A appreciates the extensive work done by DHS to expand behavioral health services to meet the needs of people with the right service, at the right time, nearest their home.

P&A supports the building of a new State Hospital with reduced beds, in conjunction with the establishment of 6 to 10 beds in the western part of the state. As per the 2020 update to the HSRI report, “There is little evidence to support investment in high-cost residential treatment when resources could be allocated elsewhere.” Our office has worked collaboratively with the State Hospital regarding discharge planning for individuals with longer stays. It is anticipated that with the current availability of Residential Habilitation Services, and the availability of additional Home and Community-Based Services through the 1915(i), that more individuals will be able to successfully reside in integrated community settings. It is expected that as the state of ND works toward having a full continuum of services in place for those with behavioral

health needs that there will be more beds available to appropriately meet the needs of individuals requiring acute care, for and not longer than, the length of stay needed for treatment. It is hoped that this will alleviate the pressure on law enforcement officials and other entities from varying parts of the state who are faced with emergent placement needs.

P&A supports peer support, along with certification and professional supervision for this program. We look forward to hearing of the positive results from consumers using this program. This has been a top priority for the consumers of mental health services for years, and we are very grateful for the support provided for this program and encourage on-going full financial support for this program.

P&A supports full funding for advocacy groups to include the Federation of Families and Family Voices. It is our understanding that these programs are marked for significant cuts for the next biennium. The support provided for families through these programs is invaluable. Families that use these programs often face ongoing challenges and need navigation through systems and support to meet the most critical needs of their families. Reductions in funding for these programs would be very detrimental to families with the highest level of needs.

P&A supports full funding for the North Dakota Brain Injury Network. The proposed significant cut in this program, which already has a limited staff of 3 persons, would drastically reduce services provided across the state of North Dakota. Services provided through the North Dakota Brain Injury Network that involve outreach, education and collaboration are not individual specific services and would not be reimbursable through the 1915(i). While the efforts to increase services for individuals

with brain injury through the 1915(i) are greatly appreciated, there remains much work to be done beyond this. The knowledge base and services provided by the North Dakota Brain Injury Network are essential for individuals with Brain Injuries and family members throughout our state.

In addition, P&A supports full funding for the facilitation of the ND Brain Injury Advisory Council by the Consensus Council. The work of the Advisory Council is vast and complex. The particularly skilled facilitation provided for meetings with members across the state, along with sub-committees, has been important in assisting the Council to meet targeted goals to best serve individuals with Brain Injuries and family members.

I am glad to answer any questions.

Denise Harvey, Director of Program Services
Protection & Advocacy
701-328-2950



Experience the Eide Bailly Difference

Cooper House Impact Report #2445

A Study of the Impact of Housing
North Dakota's Chronically Homeless Population

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Cooper House Impact Report & Cost Study

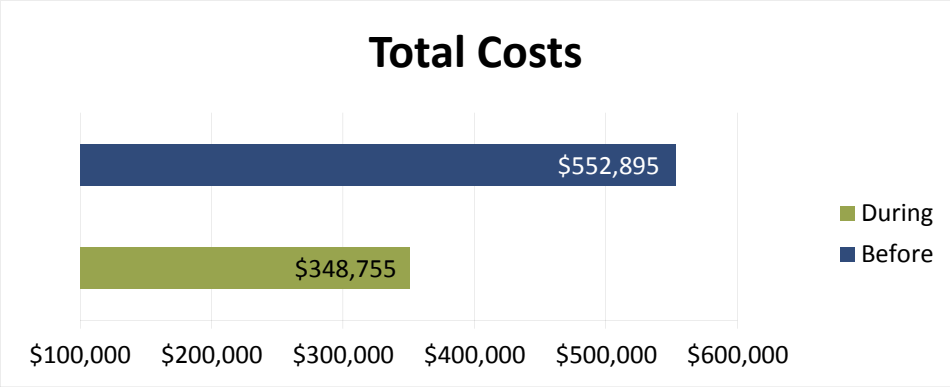
Eide Bailly was engaged by the Fargo Housing & Redevelopment Authority (FHRA) to compile cost data for a group of residents of Cooper House, a supportive housing for the homeless project managed by FHRA. We have compiled data showing the costs to society prior to when these people secured housing at Cooper House and then 12 months during their time housed at Cooper House. Because people move in and out not all dates line up over the same time frame. We have attempted to collect data showing 12 months prior to being housed at Cooper House and during their stay at Cooper House. We have not audited, reviewed or tested this information beyond simple due diligence while collecting it.

Background:

Cooper House opened in Fargo, ND in May of 2010. The Cooper House apartment's provide permanent supportive housing for homeless persons and is a stabilizing next step in the lives of people coming out of shelters or transitional housing programs. It consists of 42 apartments, 32 of which are efficiencies and 10 are one bedroom units. The apartments are rented exclusively to individuals who are documented as homeless. Preferences are given to those experiencing chronic or long-term homelessness, veterans, and people with disabilities. Homeless is defined as an individual or family who lacks a fixed, regular, and adequate nighttime residence. Chronic or long-term homelessness is considered to be anyone being homeless for 12 consecutive months or 4 times in the past 3 years.

Mental Health Technicians are on staff 24 hours, seven days a week at Cooper House, and a part time Licensed Addiction Counselor and a full time Case Manager are in the building daily, working with the clients and offering needed services. Family Health Care Center provides a part time nurse on site who provides medication management, infection control, health assessment, and referrals and follow up.

Cooper House employs a "Housing First" hybrid model, where people are provided a home first and then are offered a variety of services to help improve their lives and keep them in housing.



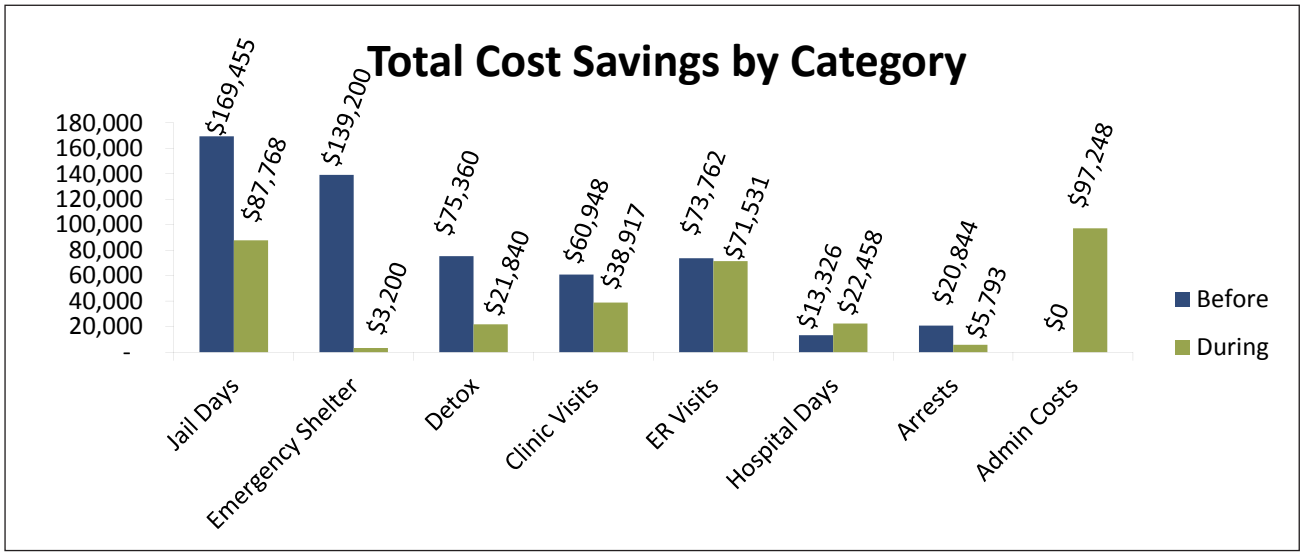
Conclusion:

Based on the results from the cost study, it is evident that housing the chronically homeless is "the smart way to do the right thing." There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that this study was conducted, through October 31, 2011. Being proactive in helping the homeless population is shown to help save the tax payers money and to make the community a better place to live.

The Study:

This study is meant to be a snapshot of the impact of housing North Dakota's chronically homeless population. The data of this study was collected with the consent of 66 tenants (the Study Group) who have lived at Cooper House at various times since it opened. Area service providers, shelters, law enforcement, the court system, and healthcare providers have all cooperated in providing the information gathered throughout this study. Once the information was consolidated then an average per person per month cost was calculated and this was used to calculate the group average.

Below is an overview of the costs comparisons for a one year period prior to being housed and a one year period ending October 31, 2011.



Note: There are two significant public cost drivers not captured by this study. Those of the judicial system which includes all costs related to court processing, arrests, and those costs related to state hospital days attributed to court ordered rehab. For some individuals this was up to dozens of times prior to living at Cooper House.

Healthcare & Medical Costs:

Based on the information received from Sanford Hospital, the Cost Study Group, costs went from $148,036 to $132,906 for a 10% decrease in costs or a savings of $15,130. The healthcare and medical cost data was compiled through October of 2011.

Law Enforcement & Legal costs:

Based on the information received from the Fargo Police Department, the cost associated with arrests declined from $21,000 to $6,000, which resulted in a decrease of $15,000, or 72%. The jail day costs were reduced from $170,000 to $87,800 for an $81,687 or 48% decrease.

Overall, legal and law enforcement saw a cost savings of $96,738 for those living at Cooper House, with some individuals having 100 less jail days than before they were homeless. The law enforcement and legal cost data was compiled through October of 2011.

Detox Costs:

Based on the information received from the Fargo Police Department, the average cost per detox visit is $120, not accounting for police officers time to collect and transport individuals to the facility. The total cost for detox visits decreased from $75,360 to $21,840. For the Cost Study Group, this is a cost savings of 71% or $53,520. In addition, this particular Study Group has seen 446 fewer visits. The detox cost data was compiled through October of 2011.

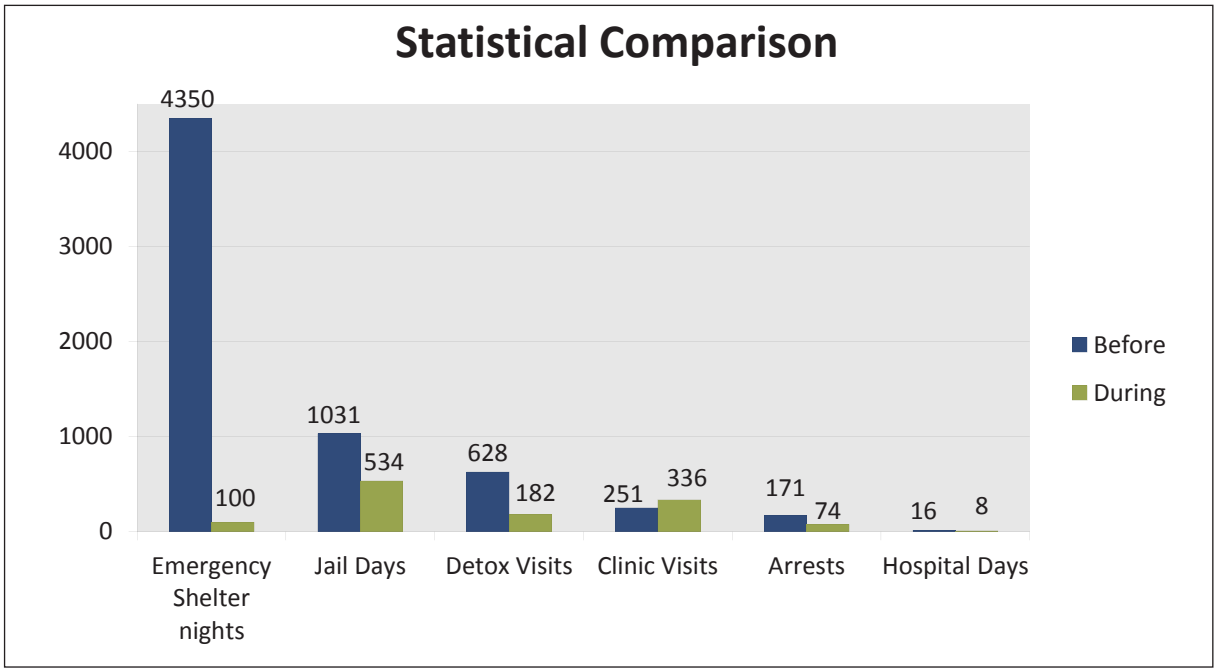
Administration Costs:

The capital outlay of the administration costs is $97,248. This service is provided by Dacotah Foundation through a contract with Southeast Human Services. The front desk is staffed 24/7 and these individuals are considered key to the success and integration back into the community. They staff check tenants and guests in and out of the building, monitor the security system, help with wellness checks, and work to link tenants to appropriate services.

Emergency Shelter:

Based on the information provided by only one of several homeless shelters in Fargo, the Study Group costs were reduced from $139,200 to $3,200, for a total cost savings of $136,000 or 98%. The number of emergency shelter nights was reduced from 4,350 to 100. The emergency shelter cost data was taken from averaging the costs for 2010 and 2011 to determine the average cost per year. The number of times accessed was taken compiled through October 2011.

Below is a statistical comparison of the number of times a service was accessed for the Cost Study Group before and during their residency at the Cooper House:



Places of Birth:

Many of the participants in the cost study call North Dakota their home and have lived here their entire life. Below, the red stars indicate where a portion of the Cost Study Group individuals are originally from.



Please note that not all costs were captured during the study. Some services accessed are not accounted for here and the cost of working with these individuals on the street is understated. For example, only one of several homeless shelters and one of the two hospitals were contacted for this study. Meals from community based organizations are also not accounted for here. In addition, costs accumulated here are only based on the individuals costs accumulated while living in Fargo and do not account for costs incurred in other locations.

Testimony in Opposition of HB 1012 #2446
Appropriations – Human Resources Division
Chairman: Representative Jon O. Nelson
January 25, 2021

Submitted by: Dan Madler, Chief Executive Officer - Beyond Shelter Inc. (BSI), 701-730-2734, dmadler@beyondshelterinc.com, Lobbyist #30

Chairman Olson and members of the Committee, my name is Dan Madler, I live in ND District 27 and I am the CEO of Beyond Shelter, Inc. (BSI), a mission driven North Dakota nonprofit developer of affordable housing. I would like to express my opposition to House Bill 1012 because of the recommended cuts to the proposed supportive service funding for two (2) Housing First Projects, Cooper House, located in Fargo, ND and LaGrave On First, located in Grand Forks, ND and further, I oppose HB 1012 because it provides no supportive service funding for another Housing First Project, Edwinton Place, located in Bismarck, ND.

Who is Beyond Shelter Inc.:

- Mission Driven ND nonprofit developer of affordable housing
- To-date BSI has closed on the financing of 43 affordable housing projects producing 1,270 affordable homes
- BSI in partnership with several stakeholders/partners has developed three (3) Housing First Projects in ND (Cooper House, LaGrave On First, and Edwinton Place) producing 124 permanent supportive housing homes for households suffering from **chronic homelessness** - defined as individuals and families residing in a place not meant for human habitation, in an emergency shelter, and who have been homeless and residing in such a place for a least one year or on at least four separate occasions in the last three years

Invest in things that work and Housing First works:

- Housing First is a proven model of ending homelessness
- It offers immediate access to housing with supportive services to follow
- Housing First is a cost-savings solution. The data and evidence is clear, Housing First saves North Dakota, ND Communities, and ND taxpayer's money. Chronic homeless households create the biggest financial burden on local medical, law enforcement, and service providers (see pages 11, 12, 39, and 40 of Housing the Homeless North Dakota's 10-year plan to End Long-Term Homelessness, Cooper House Impact Report, and Cooper House Financial Community Impact handout)

<u>The need for Supportive Service Funding is absolute</u>:

- If service providers are not able to staff the facility and provide onsite, person-centered treatment, individuals living at Housing First facilities would not be successful in their recovery, stabilization, and integration back into the community
- Supportive Service funding also provides for 24/7 staffing with a supervised entrance. This is necessary because without it, the Housing First Projects would experience unauthorized overnight guests, large parties, unlimited consumption of alcohol, weapons, and potentially an increase in violence, all of which impact a tenant's ability to remain housed

<u>Investments made to-date and continuing investment request:</u>

- $22.6 Million in total development costs have been invested to provide the 124 Housing First homes (Cooper House – 42 homes, LaGrave On First – 42 homes, and Edwinton Place – 40 homes)
- For the 2019-2021 biennium, Cooper House received a $550,000 general fund grant to provide services to individuals expiring chronic homelessness. I respectively request Cooper House to be funded at **$570,000 for the 2021-2023 biennium**
- For the 2019-2021 biennium, LaGrave On First received a $375,000 general fund grant to provide services to individuals expiring chronic homelessness. I respectively request LaGrave On First be funded at **$515,000 for the 2021-2023 biennium**
- For the 2019-2021 biennium, Edwinton Place received $0.00 from the general fund to provide services to individuals expiring chronic homelessness. I respectively request Edwinton Place be funded at **$640,000 for the 2021-2023 biennium**
- Total investment request = **$1,725,000** which is an increase of **$800,000** from the 2019-2021 base level funding

In closing, I would like to note that all three (3) Housing First Projects, Cooper House in Fargo, LaGrave On First in Grand Forks, and Edwinton Place in Bismarck, serve homeless households that come from all across North Dakota and I respectively request your support for to fully fund supportive services for all three (3) Housing First Projects for the 2021-2023 biennium.

Thank you for your time and consideration.

#2447

FM COALITION TO END HOMELESSNESS

United Way of Cass-Clay



THE 2020 STATE OF HOMELESSNESS

IN THE FARGO–MOORHEAD METRO AREA

A REPORT OF THE FM COALITION TO END HOMELESSNESS IN COLLABORATION WITH UNITED WAY OF CASS-CLAY

ABOUT THE FM COALITION TO END HOMELESSNESS

For 30 years, the FM Coalition to End Homelessness (the Coalition) has been working to address the concerns surrounding homelessness in the Fargo-Moorhead Metro. In response to a growing concern to a local rise in homelessness, four local emergency shelters came together in 1989 to form the Fargo-Moorhead Coalition for Homeless Persons to improve service delivery. As the Coalition became a forum for discussion about the particular circumstances related to working with those experiencing poverty and homelessness, the Coalition grew to include other organizations serving homeless and low-income populations. The Coalition's purpose was to coordinate and improve service delivery in the most humane and efficient manner possible, and it grew to become an active force to provide, expand, and obtain new services. In 2007, the Coalition became a 501(c)(3) nonprofit corporation, hired its first director, and became the key leader in implementation of the City of Fargo's Ten-Year Plan to End Homelessness.

Today, more than 70 partners from service areas related to housing, physical and behavioral health, recovery, law enforcement, community action, disability, and veterans' issues, as well as faith-based groups and individual community members concerned about homelessness, come together with a unified mission: working in partnership to find permanent solutions to prevent and end homelessness in Fargo, Dilworth, Moorhead, and West Fargo. Through unified advocacy, partner education and trainings, and community and regional collaboration, the Coalition strives to fulfill its mission and live up to its recently refreshed name and make homelessness rare, brief, and one-time for individuals and families in this community.

MAIN CONTRIBUTORS

Sarah Hasbargen, Southeastern North Dakota Community Action Agency (SENDCAA), Self-Sufficiency Coordinator

Megan Jenson, United Way of Cass-Clay, Senior Community Impact Manager

Sarah Kennedy, Presentation Partners in Housing (PPiH), Homeless Prevention and Diversion Program Director

Kyle Sample, Churches United, Shelter Supervisor at Micah's Mission

Emma Schmit, CAPLP (Lakes & Prairies Community Action Partnership, Inc.), Housing Director

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Dara Lee, Clay County HRA, Executive Director

Prepared by:
Megan Jenson, United Way of Cass-Clay, Senior Community Impact Manager

Graphic Design by:
Brett Lysne, Sandwich Club Design Co.

For the purpose of this report, we will refer to our geographic location as Fargo-Moorhead Metro (FM Metro). In 2018, the most recent data available, the US Census Bureau's American Community Survey (ACS) estimates the population for the Fargo-Moorhead Metropolitan Statistical Area at 245,471 individuals (source.)

This includes the population in Cass County, North Dakota, and Clay County, Minnesota, who are primarily located in the cities of:

- Dilworth, MN
- Fargo, ND
- Moorhead, MN
- West Fargo, ND

Throughout this report we will use FM Metro as our general location, or specifically Cass County, ND, and Clay County, MN, if there is a difference based on the state boundaries.

Additionally, some of the data and processes included in this report are by established Continuums of Care (CoCs). A CoC is a regional planning body of stakeholders designed to promote a shared commitment to the goal of ending homelessness.

CoC planning includes:

- Gathering and analyzing information to understand homelessness in the region;
- Understanding and supporting compliance with HUD and other funders;
- Implementing strategic plans to end homelessness based on data;
- Operating a regional Coordinated Entry System;
- Measuring results of regional planning and performance; and
- Prioritizing limited resources.

The West Central Minnesota CoC includes the following counties: Becker, Clay, Douglas, Grant, Pope, Otter Tail, Stevens, Traverse, Wadena, and Wilkin, along with the White Earth Reservation. It is one of ten CoCs in the state of Minnesota.

North Dakota operates as one CoC for the entire state.

PLANNING AND ADVOCACY ORGANIZATIONS

The FM Coalition to End Homelessness (the Coaltion) is a principle leader for ending homelessness in the FM Metro and serves as the official North Dakota Region 5 Coalition, the six-county southeastern part of the state. The Coalition is in close partnership with the West Central Minnesota CoC and North Dakota CoC as a platform for cross border collaboration between our two cities, two counties, and two states.
www.fmhomeless.org

The Minnesota Coalition for the Homeless (MCH) is a public policy and advocacy organization working to ensure statewide housing stability and economic security. Working with partners across the housing continuum in direct service to state agencies, MCH generates policies, community support, and local resources for housing and services to end homelessness in Minnesota.
www.mnhomelesscoalition.org

The West Central Minnesota CoC is tasked with developing, implementing, aligning, and monitoring regional planning related to preventing and ending homelessness. Through broad collaboration and planning, the CoC utilizes data, training, information sharing, and planning meetings to move towards making homelessness in West Central MN rare, brief, and one-time.
www.homelesstohoused.com

The North Dakota Coalition for Homeless People (NDCHP) brings together partners across the state to lead the effort in ending homelessness in the state through coordination, education, and advocacy. NDCHP's vision is for ND to have safe, decent, and affordable housing that is available to all. www.ndhomelesscoalition.org

The North Dakota CoC is tasked with developing, implementing, aligning and monitoring regional planning related to ending homelessness. The CoC is composed of representatives of relevant public and private organizations that come together to plan for and provide a homeless response system that is dedicated to preventing and ending homelessness in the state of North Dakota. North Dakota Housing Finance Agency is the collaborative applicant for the North Dakota CoC.
www.ndhomelesscoalition.org/who-we-are-2

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MESSAGE FROM THE EXECUTIVE DIRECTOR

June 23, 2020

As this report is released to our community, we are living through a global pandemic and our nation is facing the most significant conversation about race since the Civil Rights movement. It would be an understatement to say that 2020 is shaping up to be a year few could have imagined. Over the past months, homeless services have had to make a major pivot in response to COVID-19. Providing emergency shelter, moving people into housing, and providing key stabilization services without spreading a dangerous virus has tested our homeless response system and our providers on a personal level. But, the partners of the Fargo-Moorhead Coalition to End Homelessness have demonstrated the creativity, perseverance, and resilience they have shown time and time again. Our partners keep moving forward getting the day to day work done while not losing the vision that homelessness can be ended in our community.

That vision is rooted in social justice and human rights. Our mission to end homelessness relies on vital collaboration as we work together to strategically respond to systems of oppression and injustice that hinder people from thriving so that everyone has a safe place to call home. People of color experience homelessness disproportionate to the population. This calls upon us as a coalition to step up to address racial injustice. Healthcare remains out of reach to many who find themselves in a housing crisis. Therefore we need to get health care providers to see housing as a prescription. Affordable housing is out of reach for many in our community. So, we must step up to address costs and income inequality. This is why this State of Homelessness report is so important: to identify issues, celebrate successes, and use data as a key for finding solutions. This report is more than numbers and charts, this document tells a story and provides a map we can use to chart a new course.

In partnership,

Cody J. Schuler
Executive Director

FM COALITION TO END HOMELESSNESS

The purpose of this document is to provide our community with a comprehensive report of available data related to homelessness in the FM Metro. The writers have made the decision to lay out this report in four sections:

Who are our neighbors experiencing homelessness in our community?

What are the needs of those experiencing homelessness in our community?

What are we doing as a community to address homelessness?

What is next for our community?

In each section, you as the reader should have a better understanding of the answer for each question posed. Additional information can be found in the Appendixes related to the data sources and references used in the creation of this report, as well as definitions for some of the terms used throughout the report and additional resources available.

WHO ARE OUR NEIGHBORS EXPERIENCING HOMELESSNESS IN OUR COMMUNITY?

ESTIMATE OF THE NUMBER OF INDIVIDUALS EXPERIENCING HOMELESSNESS

To estimate the number of individuals experiencing homelessness in our community on any given night, we need to look at the estimates of those:

- sheltered in emergency shelter and transitional housing programs
- staying in a place that is not a regular or permanent place to stay, such as outdoors, in a car, vacant building, or a place of business, and
- doubled up with a friend or family member on a temporary basis because they have nowhere else to go.

Below is an overview of the housing inventory count, which provides a snapshot of the number of individuals homeless service programs can serve at any given time. For more on available programs and services, see the section entitled "What are we doing as a community to address homelessness?".

Project Type	Cass County	Clay County	Both
Emergency Shelter	210	74	284
Transitional Housing	36	73	109
Rapid Re-Housing	36	79	115
Permanent Supportive Housing	168	457	625
Other Permanent Housing	0	0	0
Total	450	683	1,133

With this current inventory we see on any given night there are 246 individuals in Cass County, ND, and 147 individuals in Clay County, MN, who are experiencing homeless in a sheltered location (either in emergency shelter or in a transitional housing program).

We can estimate, through the Emergency Shelter Bed Prioritization list which is managed by all Emergency Shelters in partnership, as of the beginning of April 2020, there are a total of 113 individuals staying in a place that is not a regular or permanent place to stay and actively looking for access to a shelter bed. This could include places such as outdoors, in a car or vacant building, or in a place of business. These 113 individuals include 98 adults, 6 school aged children (ages 5 to 18), and 9 children under the age of 5.

Those currently doubled up continues to be much more difficult number to gather, as those individuals are often the most unseen. As of April 2020, 555 students were identified as homeless in our metro school districts. At this same point, there were 33 school aged children were staying at the two emergency shelters that serve families and 6 school aged children were actively seeking shelter with their parents. The remaining 516 students identified as homeless are most likely to be doubled up. However, we believe that is a significant under-representation of those who are currently doubled up in our community.

Pulling this all together, on any given night, there are 1,022 individuals estimated to be experiencing homelessness in the FM Metro.

Sheltered	393
Unsheltered	113
Doubled Up	516
Total	1,022

This is consistent with last year's estimate of 1,075 individuals estimated to be experiencing homelessness in the FM Metro. While we must rely on an estimate for this number, the rest of this report includes more details and data collected on those in our community that received services to overcome their housing crisis and resolve their homelessness.

DEMOGRAPHICS OF INDIVIDUALS AND HOUSEHOLDS EXPERIENCING HOMELESSNESS

According to data available in the Homeless Management Information System (HMIS), in 2019, 3,322 individuals received homeless services either in Cass County, ND, or Clay County, MN. We need to acknowledge there is a level of duplication in these numbers as Minnesota and North Dakota do operate in separate information systems; for example, if an individual received services in both Fargo and Moorhead, they would be counted twice in the data below.

A majority of individuals experiencing homelessness are working age adults, with 61% of those who received services being between the ages of 18 and 54. Additionally, of those served, 23% were children under the age of 18 and 15% were older adults ages 55 and older.

Ages	Clay	Cass	Total	
Under 5	179	96	275	8%
5 to 12	218	114	332	10%
13 to 17	74	87	161	5%
18 to 24	118	186	304	9%
25 to 34	287	389	676	20%
35 to 44	239	317	556	17%
45 to 54	203	283	486	15%
55 to 61	112	221	333	10%
62+	47	117	164	5%
Don't know or refused	1	3	4	0%
Did not collect	29	2	31	1%
Total	1,507	1,815	3,322	

When looking at gender along with age, adult males make up the majority of the homeless population at 49%. Overall, 61.5% of the total homeless population identify as male and 37.5% as female. Additionally, 13 individuals identify as trans female (male to female), 5 individuals identify as trans male (female to male), and 6 individuals identify as gender non-conforming.

Gender by Age	Male	Female	Trans Female (Male to Female)	Trans Male (Female to Male)	Gender Non-Conforming	Client Doesn't Know/Client Refused	Data Not Collected
Adults	1,639	854	13	4	5	0	4
Percent of Total	49%	26%	0%	0%	0%	0%	0%
Children	382	383	0	1	1	0	1
Percent of Total	11%	12%	0%	0%	0%	0%	0%
Unknown Age	21	10	0	0	0	0	4
Total	2,042	1,247	13	5	6	0	9
Percent	61.5%	37.5%	0.4%	0.2%	0.2%	0%	0.3%

In total, this is an increase of only 39 individuals compared to the number of individuals who received homeless services either in Cass County, ND, or Clay County, MN in 2018. There is no major difference in age distribution or gender. Although, there was an increase in the number of individuals identifying as transgender or gender non-conforming. In 2019, a total of 24 individuals (roughly 1% of all individuals served) identified as transgender or gender non-conforming compared to only 15 in 2018.

In 2019, just under half of individuals who received homeless services identified their race as White, showing a significant racial disparity which exists among the homeless population compared to the general population in the FM Metro. As of 2018, US Census Bureau's American Community Survey (ACS) estimates show 87.1% of the total population in the FM Metro identify as White alone. With 19% of the homeless population identifying as Black or African American and 20% identifying as American Indian, we see significant racial disparities as these populations are overrepresented compared to the general population. The US Census estimates show only 6.1% of the general population identify as Black or African American alone and 1.4% as American Indian and Alaska Native alone (Census Estimates).

Race	Total	Percent of Total
White	1,620	49%
Black or African American	627	19%
Asian	9	0%
American Indian or Alaska Native	669	20%
Native Hawaiian or Other Pacific Islander	25	1%
Multiple races	277	8%
Client Doesn't Know/ Client Refused	26	1%
Data Not Collected	69	2%
Total Persons	3,322	

This is a slight increase in the rate of individuals of color who are experiencing homelessness. In 2018, 50% of individuals experiencing homelessness identified as White alone.

Additionally, 10% of individuals experiencing homelessness identify their ethnicity as Hispanic/Latino. Again, this is an overrepresentation compared to the general population, which is currently estimated at only 3.2% (Census Estimates).

Ethnicity	Total	Percent of Total
Non-Hispanic/Non-Latino	2,918	88%
Hispanic/Latino	324	10%
Client Doesn't Know/Client Refused	10	0%
Data Not Collected	70	2%
Total Persons	3,322	

The 3,322 individuals served throughout 2019 make up a total of 2,325 separate households. A vast majority (84%) of the households do not include children.

Household Type	Total	Percent of Total
Singles: Adults without children	1,943	84%
Families: Adults with children	313	13%
Youth: Youth only, no adults, with or without their own children	43	2%
Unknown Household Type	26	1%
Total Households	2,325	

This is a very consistent breakdown of households, from 2018, although there was an increase of 44 households served from last year.

Chronically Homeless

Individuals who are considered chronically homeless are typically more vulnerable and have significantly higher barriers, meaning they require more supportive services and longer-term support to be successful in ending their continued homelessness episode or episodes.

To be classified as chronically homeless, individuals must meet all the following:

- Currently experiencing homelessness,

- Been homeless for at least one year during the current episode OR homeless for less than one year in the current episode, but homeless at least four times in the previous three years, and
- Disabled (those who have a physical, mental, or other health condition that limits the kind of work they can do OR those who have a physical, mental, or other health condition that makes it hard for them to bathe, eat, get dressed, get in and out of bed or chair, or get around by themselves).

In HMIS, 22% (720) of individuals served in 2019 were considered chronically homeless. They make up 25% of all the households served. We must acknowledge that 10% of individuals served throughout 2019 did not have data collected on this classification, and thus results may differ if we had access to this information. Although, this does show improvement in data collection from last year, as in 2018, 30% of individuals served did not have data collected on this classification.

Like the overall homeless population, a majority of the chronically homeless individuals are working age adults. Of the individuals who are considered chronically homeless, 68% are between the ages of 18 and 54, with only 14% under 18. Aging adults are classified as chronically homeless at a higher rate compared to the general homeless population, with 18% of the chronically homeless population age 55 and older (compared to 15% of the general homeless population).

Age	Total	Percent of Total
Age 0-17	102	14%
Age 18-24	42	6%
Age 25-34	146	20%
Age 35-44	141	20%
Age 45-54	161	22%
Age 55-61	91	13%
Age 62 and above	37	5%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	720	

Like the general homeless population, a majority (65.8%) of the chronically homeless identify as male, followed by 33.5% identifying as female. Three individuals who are considered chronically homeless identify as trans female (male to female) and one individual identifies as gender non-conforming.

Gender	Total	Percent of Total
Male	474	65.80%
Female	241	33.50%
Trans Female (Male to Female)	3	0.40%
Trans Male (Female to Male)	0	0.00%
Gender Non-conforming	1	0.10%
Client Doesn't Know/ Client Refused	0	0.00%
Data Not Collected	1	0.10%
Total Persons	720	

Overall, compared to last year's data, the chronically homeless population is slightly younger with a 3% increase in those under the age of 18 and a 3% decrease in those over the age of 55. This may be due to better data regarding this sub-population.

In 2019, the 720 individuals considered chronically homeless made up a total of 591 separate households. A vast majority (93%) of the households do not include children.

Household Type	Total	Percent of Total
Singles: Adults without children	547	93%
Families: Adults with children	44	7%
Youth: Youth only, no adults, with or without their own children	0	0%
Unknown Household Type	0	0%
Total Households	591	

Youth

Youth homelessness is often harder to track. According to data available in HMIS, in 2019, 324 youth received homeless services either in Cass County, ND, or Clay County, MN. These are young adults 24 years old or younger, living without parents or guardians and may be parenting themselves.

Age	Total	Percent of Total
Age 12-17	60	19%
Age 18-24	264	81%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	324	

Unlike the general homeless population, youth are more diverse in their gender identity, with only 46% identifying as male. In addition to 48% identifying as female, 2% identifying as trans female (male to female), 2% as trans male (female to male), and 2% as gender non-conforming.

Gender	Total	Percent of Total
Male	150	46%
Female	157	48%
Trans Female (Male to Female)	6	2%
Trans Male (Female to Male)	5	2%
Gender Non-conforming	6	2%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	324	

LGBTQ+ youth experience homelessness at a high rate than their peers. As part of the 2021 State of Homelessness Report, we hope to include more data on this and the unique experiences of youth homelessness in our community.

Of the 324 youth served in 2019, 31 youth are parents themselves and between the ages of 18 and 24 years old. They have a combined total of 49 children in their care.

Youth are assessed for housing services utilizing a specialized tool geared towards those under 24 years of age. Within this assessment, 56% of youth answered that their lack of housing was because of an unhealthy relationship, either at home or elsewhere (emotional, physical, psychological, or sexual).

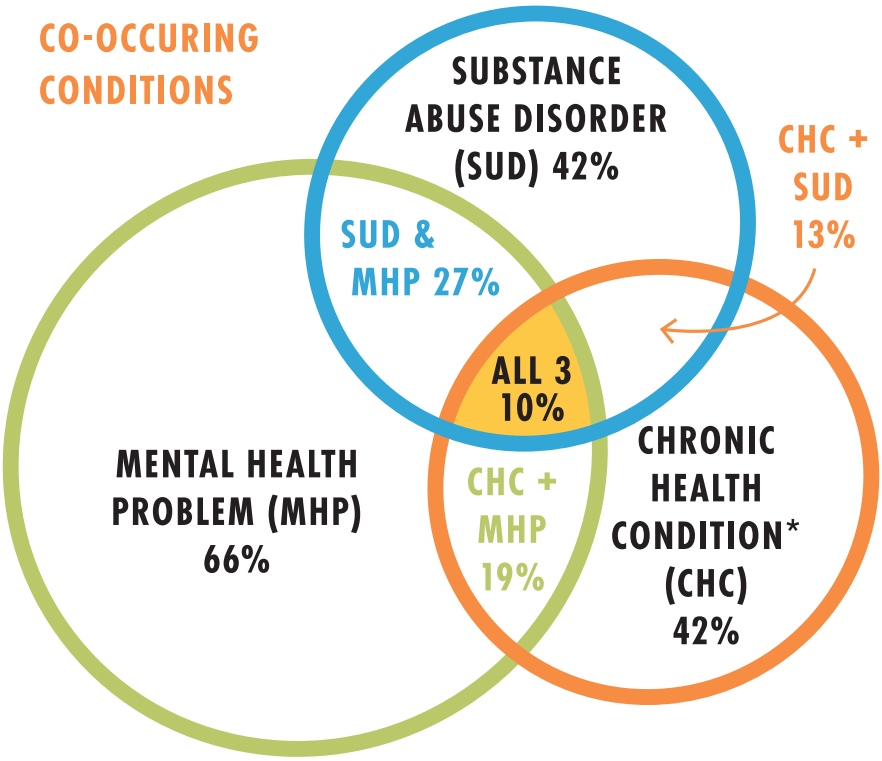
Health Conditions & Co-occurring Conditions

Physical health, mental health, and substance abuse are significant concerns and barriers among the people experiencing homelessness in our community. According to data available in HMIS, 44% of the individuals served in 2019 have a disability of long duration. This includes any disability that is ongoing, continued, or for an indefinite duration.

Of individuals diagnosed with a disability:

- 42% have been diagnosed with a chronic health condition, physical disability, or developmental disability.
- Two thirds (66%) have been diagnosed with a mental health problem.
- 42% have a substance abuse disorder (to either drugs, alcohol, or both).

Often individuals experiencing homelessness also experience co-occurring conditions. When looking at those who reported being diagnosed with a chronic health condition, serious mental health problem, and/or substance abuse disorder, 41% of respondents have been diagnosed with more than one of these conditions and 10% report all three.



These results differ from the numbers published last year because last year's data was based on self-responses as part of the Everyone Counts survey administered in October 2018 by homeless

service providers. Due to the different data sources from this year to last, we are unable to compare the annual results.

Overall, most individuals with a chronic health condition, substance abuse disorder, mental health problems, or a combination of these conditions in our community are housed. Individuals experiencing homelessness are not experiencing their housing crisis because of these conditions alone – rather it is due to a unique combination of experiences, traumas, lack of support networks, and access to services or supports. This section is included to highlight the fact that many individuals in our homelessness response system need access to additional services, in addition to housing support. Moving from homeless to housed looks different for each individual and each household; and often includes many other aspects of our community social services network.

Prior Living Arrangements

In HMIS, shelter and supportive housing programs in the FM Metro collect information regarding prior living arrangements for individuals who entered services. In 2019, almost half (46%) of individuals stated they were homeless, meaning they were staying at a shelter, transitional housing, or place not meant for human habitation.

Another 11% of individuals came from an institutional setting, including psychiatric hospital/facility, substance abuse facility, hospital, jail, prison, long-term care facility, or halfway house. 14% identified they were living in their own apartment or home with or without subsidies or support, and 21% were staying with a friend or family member.

Prior Living Arrangements - All Clients	Total	Percentage
Homeless	1,196	46%
Institutional Settings	288	11%
Permanent Housing/Own/ Rental	365	14%
Doubled Up (Staying with Friends or Family)	532	21%
Hotel or Motel without Voucher	77	3%
Client Doesn't Know/Refused	19	1%
Data Not Collected	114	4%
Total	2,591	

As a community, we are very concerned with the percentage of individuals and families entering homelessness from permanent housing. This intensifies when we look at families with children and youth experiencing homelessness.

With families entering services, 31% are coming from permanent housing, previously living in their own apartment or home with or without subsidies or support. This is a significant increase compared to the overall population.

Prior Living Arrangements - Families	Total	Percentage
Homeless	162	39%
Institutional Settings	7	2%
Permanent Housing/ Own/Rental	130	31%
Doubled Up (Staying with Friends or Family)	93	22%
Hotel or Motel without Voucher	18	4%
Client Doesn't Know/Refused	1	0%
Data Not Collected	3	1%
Total	414	

With youth experiencing homelessness, we see a significant increase in the percentage of individuals previously doubled up or staying with friends or family prior to entering homelessness, 37% compared to 21% with the general homeless population.

Prior Living Arrangements - Youth	Total	Percentage
Homeless	96	30%
Institutional Settings	22	7%
Permanent Housing/ Own/Rental	37	11%
Doubled Up (Staying with Friends or Family)	121	37%
Hotel or Motel without Voucher	9	3%
Client Doesn't Know/Refused	8	2%
Data Not Collected	31	10%
Total	324	

Prior Experiences

According to data collected in HMIS, of the 3,322 individuals served, 2,591 individuals entered programming or began receiving services in 2019. Almost a fourth (24%) of these new entries had a history of Domestic Violence. We must acknowledge 21% of individuals who entered services throughout 2019 did not have data collected on their domestic violence history, and thus results may differ if we had access to this information.

Of those with a history of Domestic Violence, 34% identified fleeing domestic violence as the reason for their current homeless situation.

Domestic Violence History	Total	Percent of Total
Fleeing Domestic Violence	207	34%
Not Fleeing Domestic Violence	361	59.30%
Client Doesn't Know/ Client Refused	3	0.50%
Data Not Collected	38	6.20%
Total Households	609	

This data does not capture the full impact and history of violence for many individuals experiencing homelessness. Violence may often be the primary reason why someone is experiencing homelessness but may not reported as the immediate cause. Additionally, research shows for many chronically homeless individuals, one of their first times experiencing homelessness was as a victim of violence. However, this is not captured in this data as it only reflects their current episode of homelessness.

According to agency specific data, 80% of the individuals who stay with YWCA of Cass Clay (YWCA), are seeking services due to violence. This is in line with national research which has shown being a victim of violence is the number one reason that woman become homeless (Source). To get a more accurate number the YWCA has changed how they ask clients about their history of violence. Previously, those seeking shelter were asked, "why are you checking into the shelter". However, many who had initially fled an unsafe situation may have temporarily sought shelter with a family, friend or elsewhere, leading them to select that they were homeless. In recognizing the low response in initial reporting of fleeing violence as women entered the shelter, YWCA staff were coached on how to ask probing questions on what lead to the woman's homelessness.

Of those who had been assessed for housing programs utilizing the VI-SPDAT tool, a staggering 58% of participants responded that their current period of homelessness had been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma they have experienced. In addition, approximately 34% of people experiencing homelessness, who were assessed for housing services, identified that they had been attacked or beaten up since becoming homeless.

As part of the Everyone Counts Survey conducted in October 2018, 243 respondents were asked about adverse childhood experiences and traumatic events in their lives. Among the adverse childhood experiences inquired about in the survey, those experienced the most were:

- Living with a substance user (54%)
- Witnessing abuse of other family member (44%)
- Being physically abused as a child (36%)
- Living with a parent or guardian who struggled with mental health issues (32%)

Additionally, as children, about one-fourth of respondents (28%) lived in a foster home and 18% lived in a group home. About 30% were held for more than a week in a juvenile detention center or other juvenile facility or camp.



WHAT ARE THE NEEDS OF THOSE EXPERIENCING HOMELESSNESS IN OUR COMMUNITY?

INCOME, EMPLOYMENT, AND EDUCATION

Income and employment data were collected for the 2,519 adults served throughout 2019. Income and sources were collected at the start of their services along with when they exited services (Leavers) or at an annual check point if they remained in services (Stayers).

In 2019, only 48% of individuals who started services had a known source of income (one or more). Of those who left services in 2019, only 43% had one or more sources of income.

Number of Adults with Income	Start		Stayers		Leavers	
Total Adults	2,519		830		1,689	
1 or More Source of Income	1,217	48%	77	9%	719	43%

Below is a breakdown of cash income sources.

Cash Income Sources	Start	Stayers	Leavers
Earned Income	423	18	290
Unemployment Insurance	8	0	5
Supplemental Security Income (SSI)	267	32	168
Social Security Disability Insurance (SSDI)	166	16	104

Breakdown of cash income sources, continued:

Cash Income Sources	Start	Stayers	Leavers
VA Service - Connected Disability Compensation	69	1	28
VA Non-Service Connected Disability Pension	25	2	13
Private Disability Insurance	3	0	2
Worker's Compensation	61	9	22
Temporary Assistance for Needy Families (TANF)	68	10	25
General Assistance (GA)	196	9	46
Retirement Income from Social Security	19	0	10
Pension or retirement income from a former job	8	2	6
Child Support	46	6	22
Alimony and other spousal support	1	0	0
Other Source	38	14	21

Below is the breakdown of cash income ranges for all adults on a monthly basis.

Breakdown of Monthly Income Range	Start		Stayers		Leavers	
No Income	1,070	42%	34	4%	739	44%
$1 - 150	158	6%	5	1%	39	2%
$151 - $250	73	3%	5	1%	43	3%
$251 - $500	88	3%	9	1%	49	3%
$501 - $1000	361	14%	30	4%	220	13%
$1001 - $1500	148	6%	10	1%	90	5%
$1501 - $2000	122	5%	7	1%	69	4%
$2001 +	136	5%	8	1%	105	6%
Client Doesn't Know/Refused	3	0%	0	0%	4	0%
Data not collected	360	14%	0	0%	331	20%
Adult stayers not yet required to have an annual assessment			427	51%		
Adult stayers without required annual assessment			295	36%		
Total Adults	2,519		830		1,689	

In 2019, the federal poverty guidelines were set as a single adult making $12,490 annually or about $1,040 per month. Noting most individuals experiencing homelessness are not in family units, you can see that 68% are below that $1,000 per month threshold. Additionally, if we factor in family units, a family of four making $25,750 per year or less is within the 2019 poverty guidelines – this is roughly $2,145 per month (Source).

In addition to employment and cash income, data is collected on non-cash benefits individuals are receiving. A majority of individuals when starting and leaving services had no sources of non-cash benefits.

Non-Cash Benefit Sources	Start		Stayers		Leavers	
No Sources	1,343	53%	18	2%	928	55%
1 + Source(s)	846	34%	86	10%	463	27%
Client Doesn't Know/ Client Refused	3	0%	0	0%	2	0%
Data Not Collected/ Not stayed long enough for Annual Assessment	327	13%	726	87%	296	18%
Total	2,519		830		1,689	

Of those who receive non-cash benefits, most are enrolled in Supplemental Nutrition Assistance Program or SNAP (previously known as Food Stamps).

Type of Non-Cash Benefit Source	Start	Stayers	Leavers
Supplemental Nutrition Assistance Program (SNAP)	812	81	447
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	68	7	37
TANF Child Care Services	9	1	5
TANF Transportation Services	0	0	0
Other TANF-Funded Services	4	0	2
Other Source	145	51	57

For more details on the benefits programs included in this section along with benefit eligibility, please visit:

- Cass County, ND Human Services Website: https://www.casscountynd.gov/our-county/human-services/economic-assistance-division
- Clay County, MN Social Services Website: https://claycountymn.gov/207/Financial-Assistance-Services

As part of the Everyone Counts Survey conducted in October 2018, respondents currently experiencing homelessness were asked about their education and employment. Almost two-thirds (63%) of respondents had at least a high school diploma or some level of college education.

Educational Attainment	Total	Percentage
8th grade or less	10	4%
Some high school but did not finish 12th grade	78	32%
12th grade (high school graduate)	69	28%
Some college but no degree	49	20%
Completed any college degree (2-year Associate or higher)	36	15%
Refused	1	0%
Don't know	0	0%
Total Individuals Surveyed	243	

Additionally, while in grade school, 31% of individuals surveyed had an Individualized Education Plan or required some level of Special Education.

While 48% of adults entering services this past year had some level of income and 34% were enrolled in non-cash benefits, they still experienced a housing crisis that resulted in them becoming homeless. In later sections of this report, there are more details on additional barriers to housing that many individuals experience, along with how our system works to help move these individuals from homelessness to housing regardless of income or employment.

BARRIERS TO SUSTAINABILITY

Individuals experiencing homelessness in our community face many barriers to sustainability or the ability to lead a stable life, specifically when it comes to gaining and maintaining livable-wage employment and safe, stable housing. Poor credit and rental history, access to employment and livable-wages, transportation, and affordable housing are the common themes individuals self-identified as the reasons why they are experiencing homelessness.

According to 5-year estimates by the Census Bureau, as of 2018, in the FM Metro 43% of occupied housing units are rented. Rent prices and low income are causing many renters to be cost burdened. This is when housing costs require more than 30% of a household's income each month. 42% of renters

in our community are considered cost burdened. This is significantly higher than those who own their home at 14%. (Census Estimates)

The rate of cost burdened households changes drastically based on the household's income. Below is a breakdown of those who are housing cost burdened by income level.

Percentage of households who are housing cost burdened by income level	Overall		Owners		Renters	
Less than $20,000	11,991	90%	2,064	81%	9,927	92%
$20,000 to $34,999	7,308	59%	1,782	45%	5,526	66%
$35,000 to $49,999	3,284	27%	1,483	29%	1,801	26%
$50,000 to $74,999	2,113	12%	1,756	17%	357	5%
$75,000 or more	861	2%	689	2%	172	2%
Total Housing Cost Burdened Households	25,557	26%	7,774	14%	17,783	42%

For more information on our region's access to affordable housing, check out:

- The National Low Income Housing Coalition's "Out of Reach" report: https://reports.nlihc.org/oor
- Minnesota Housing Partnership "State of the State's Housing" report for Clay County: https://www.mhponline.org/images/stories/images/research/coprofs/2019/Clay.pdf

The top reasons why people are experiencing homelessness, from respondents of the Everyone Counts Survey conducted in October 2018, included:

- Eviction or did not have leases renewed,
- Not able to afford rent or house payments, and
- Loss of job or work hours cut.

These situations compound when we consider the barriers these individuals face in being able to rent an apartment or getting housing. The top barriers to accessing housing were identified as:

- Credit problems,
- No affordable housing,
- Criminal backgrounds,
- Bad rental history or past evictions, and
- No local rental history or references.

When respondents were asked about supports they felt they needed to access housing, they identified:

- Available affordable housing,
- Deposit assistance,
- Ongoing case management/support services,

- Reliable and affordable transportation,
- Increased income or employment, and
- Ongoing rental subsidies.

When asked about what would help them to maintain stable housing, survey respondents identified employment, affordable housing, and transportation as the top three.

PUBLIC HOUSING ASSISTANCE

Public Housing Agencies (PHA's) are the largest mainstream providers of affordable housing for local communities. In Cass and Clay Counties, three PHA's have made it part of their mission to prioritize families experiencing homelessness and people with disabilities for housing resources. Fargo Housing & Redevelopment Authority (FHRA), Moorhead Public Housing (MPHA), and Clay County HRA (CCHRA) are all active participants in the Coordinated Access, Referral, Entry, and Stabilization (CARES) System and work towards the goals of ending family, youth, veteran, and chronic homelessness in our region. More details about the CARES System can be found in the next section, "What are we doing as a community to address homelessness?".

In 2019, the United States Department of Housing and Urban Development (HUD) allowed PHA's to apply for additional Mainstream Housing Choice Vouchers, commonly called Section 8 vouchers. These vouchers are meant to target adults with disabilities who are experiencing homelessness, initialization, or housing insecurities. Due to their work in showing the great need for additional affordable housing resources in our community, FHRA and CCHRA were able to apply for and were awarded new vouchers for Cass and Clay counties. This was the largest new allotment of vouchers given to CCHRA since its inception. The amount awarded FHRA and CCHRA together was larger than those awarded to other larger metropolitan areas across the nation.

In 2019:

- Moorhead Public Housing reported 83% of new admissions were exiting homelessness.
- Fargo HRA had 480 new admissions listed as previously being homeless throughout their programs.
- Clay County HRA served 360 households in their homeless programs and reported 93% of new admissions to Housing Choice Vouchers had experienced homelessness.

Even with the new vouchers, waiting lists for these programs remain long. The waiting lists for tenant-based Housing Choice Voucher at FHRA and CCHRA are both closed, as the waiting list grew too extreme for new applications. Those on the list can expect to wait two or more years before receiving

vouchers. Other site-based programs such as Public Housing or units for people who are elderly and/or disabled have various waiting lists, with larger units for families having the longest.

NEEDS ASSESSMENT

CAPLP (Lakes & Prairies Community Action Partnership, Inc.) completed a needs assessment for Clay County, MN, in 2018. SENDCAA (Southeastern North Dakota Community Action Agency) completed the same needs assessment in March 2019 for Cass County, ND. There were three parts to this needs assessment:

- A survey for people currently seeking housing services
- A survey for homeless related service providers
- A survey for people previously served by a homeless prevention and assistance program at CAPLP and SENDCAA

Clay County, MN:

Results indicated the top contributor to respondents' housing crisis was not being able to afford their rent. A mental health symptom or chemical use was the second highest contributor to their current housing crisis (50%). Roommate/neighbor issues, and poor credit/poor criminal history were also noted as causes to a current housing crisis.

When asked what would help the most to solve the current housing crisis, the top three responses were case management or other support services (44%), ongoing rent assistance (41%) and credit repair/budgeting (41%). Deposit assistance (35%) and transportation (38%) were also of note (respondents were able to check all that applied).

The provider survey was sent out via an online surveying tool to the Housing Advisory Committee made up of homeless service providers, the FM Coalition to End Homelessness, and various community partners.

- For prevention and homeless assistance, providers felt housing search assistance, landlord/tenant relationships, and financial assistance were most important.
- For families, providers felt the biggest barriers to housing stability were domestic violence, affordable child care, and lack of affordable housing.
- For singles, providers felt criminal history, substance use, and lack of affordable housing were the biggest contributors to housing instability.

- For youth, providers felt youth most often face barriers with little or no rental history, lack of affordable housing options, and employment.

Additionally, a survey was administered via phone for past clients served by Family Homeless Prevention and Assistance Program (FHPAP) at CAPLP in September of 2018. 100% of responding individuals indicated the FHPAP assistance and case management they received from CAPLP helped to stabilize their housing crisis. Rental assistance, utilities, and deposit assistance were stated as being the most helpful to resolving the housing crisis (96%). A third (33%) of people indicated case management was also beneficial (respondents could check all that applied).

Throughout the surveys, multiple themes emerged showing a significant need for affordable housing in our community. Also of note, there is a commonly identified need for supportive services to help find housing, mediate with landlords, and navigate employment and mental health/substance use services.

To gain a deeper understanding of the needs of people who have or are currently experiencing a housing crisis, CAPLP staff conducted two focus groups in January of 2019. The first was with 8 individuals at Micah's Mission, a shelter for families in Moorhead. Respondents were of varying races and ages consistent with shelter population and households served in FHPAP. The top three areas identified as concerns were finding housing, employment, and transportation. Many stated they had barriers on their background that were keeping them from finding housing and employment. They shared that additional case managers to support people with these barriers would be helpful.

An additional focus group was held with clients who are currently housed on CAPLP programs in Clay County, MN. The commonly identified needs by this group included affordable housing options, living-wage jobs, and transportation options to get to important appointments such as apartment viewings or jobs. Respondents felt the services that worked well included Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP), housing search assistance, landlord mediation with their case manager, and general case management services.

Cass County, ND:

Individuals seeking housing services were asked to identify what contributed to their current housing crisis. Of those surveyed, 42% reported the primary cause to their current housing crisis was that they could not afford rent. Other responses included physical health issues (21%), roommate or neighbor issues (18%), and violence or concerns for safety (13%). Less prevalent responses included chemical or substance usage, mental health symptoms, criminal history, and loss of a job or difficulty finding work.

The top three responses for what would help individuals find and keep stable housing included help with past due rent (48%), on-going rental assistance (38%), and deposit assistance (33%). The top non-financial related support is credit repair and budgeting (23%). Other responses which were noted in the respondents' comments were obtaining and maintaining employment, affordable housing, and sufficient income.

All clients who received rent or deposit assistance in March or April of 2019 were called and asked to complete a survey. Out of the 6 clients, 100% reported the assistance they received helped them stabilize their housing and all clients reported they were satisfied with the services they received.

Thirty-nine providers responded to a survey about resources needed to prevent homelessness.

- Providers reported short-term financial assistance, case management, landlord/tenant relationships, housing search assistance, and transportation assistance were the most important in ending and preventing homelessness.
- For families, providers felt the biggest barriers to housing stability were lack of affordable housing options, affordable child care, and poor credit.
- For singles, providers felt mental health, lack of affordable housing options, and criminal history were the biggest contributors to housing instability.
- For youth, providers felt youth most often face barriers with poor or limited rental history, life skills/financial fitness, and lack of affordable housing options.



WHAT ARE WE DOING AS A COMMUNITY TO ADDRESS HOMELESSNESS?

CARES: OUR HOMELESS RESPONSE SYSTEM

The Coordinated Access, Referral, Entry, & Stabilization (CARES) System is our region's approach to the Department of Housing and Urban Development (HUD) mandate that each Continuum of Care (CoC) operate a Coordinated Entry System. HUD defines coordinated entry as a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. CARES follows this mandate but also includes prevention, diversion, and stabilization services. Research shows that to end homelessness, we need to reduce the number of individuals entering our system, and that while housing ends homelessness, some people also need ongoing supports to continue to remain housed.

CARES includes partner agencies interested in assuring a more coordinated, effective, streamlined, and consumer friendly system. Our system operates in partnership between the ND CoC, West Central MN CoC, FM Coalition to End Homelessness, and White Earth Nation.

As a system, CARES strives to manage scarce system resources in a streamlined, transparent, planful, data-driven, and consumer center manner. The CARES System starts when a person seeks crisis services (ACCESS), first attempting to prevent homelessness when possible through connection with mainstream and prevention resources. If homelessness cannot be prevented, persons are prioritized for emergency shelter and supportive housing programs based on vulnerability, client choice, and program openings and eligibility (ASSESSMENT/ASSIGNMENT). The most vulnerable households are assisted with nav-

igation services. Those offered supportive housing are assisted with identifying and working on goals to obtaining and retaining stable housing (STABILIZATION).

A centralized and coordinated system allows us to have current data on the specific needs and characteristics of those experiencing homelessness or at imminent risk of homelessness. This data is valuable for system planning and analysis; including distribution of resources (to agencies and households seeking services), measuring effectiveness of services and programs, equity analysis, and identification of trends and current housing needs by type and population. Recently, both CoCs committed to transitioning how data is entered into Homeless Management Information System (HMIS) to improve data accuracy and usability.

PROGRAMS AVAILABLE

This section includes an inventory of shelter, transitional housing, rapid re-housing, permanent supportive housing, street outreach, and other homeless support services available for individuals experiencing homelessness in the FM Metro along with an estimated breakdown of funding sources for each type of homeless services.

These estimates are based on program self-reporting which was available at the time of publication. This may not be a comprehensive breakdown of all funding sources.

Cass County, Project Type	Federal Funding (ESG, CoC, etc.)	State Funding	Local Funding	Totals	2019 Total Beds
Shelter	$129,833	$185,500	$301,000	$616,333	210
Transitional Housing	$96,396	$0	$40,000	$136,396	36
Rapid Re-Housing	$18,000	$22,000	$286,813	$326,813	36
Permanent Supportive Housing	$677,376	$0	$18,750	$696,126	168
Street Outreach	$0	$0	$25,000	$25,000	NA
Homeless Supportive Services (including Prevention)	$0	$0	$25,000	$25,000	NA
Total	$921,605	$207,500	$696,563	$1,825,668	450

Clay County, Project Type	Federal Funding (ESG, CoC, etc.)	State Funding	Local Funding	Totals	2019 Total Beds
Shelter	$364,578	$82,284	$288,653	$735,515	74
Transitional Housing	$0	$268,700	$0	$268,700	73
Rapid Re-Housing	$0	$574,776	$44,042	$618,818	79
Permanent Supportive Housing	$841,157	$2,103,741	$0	$2,944,898	457
Street Outreach	$0	$568,306	$0	$568,306	NA
Homeless Supportive Services (including Prevention)	$0	$197,702	$72,500	$270,202	NA
Total	$1,205,735	$3,795,509	$405,195	$5,406,439	683

Definitions for each type of program type:

Shelter:

- Offers temporary shelter (lodging) for homeless households.

Transitional Housing (TH):

- Participants must enter into a lease agreement (sublease or occupancy agreement) for at least one month. Leases must automatically renew upon expiration, except with prior notice by either party, up to a max of 24 months.
- Participants receiving rental assistance may be required to live in a specific structure.
- Support services must be available during entire participation in TH.

Rapid Re-Housing (RRH):

- Provides short-term to medium-term assistance (up to 24 months).
- Lease between households and landlord.
- Household's able to select their unit.
- Providers can restrict max length of financial assistance but not length of time in unit.
- Support services must be offered during entire participation in RRH.

Permanent Supportive Housing (PSH):

- Long-term housing.
- Homeless households with a member who has a disability.
- Support services provided that are designed to meet the needs of participants.

Other Permanent Housing (PH):

- Long-term housing not otherwise considered PSH or RRH.
- PH Housing with Services provides long-term housing and supportive services for homeless per-

sons but does not limit eligibility to persons with a disability.

- PH Housing Only projects provide long-term housing for homeless persons but does not make supportive services available as part of the project.

PREVENTION/DIVERSION

For the past three years, the Homeless Prevention Project (HPP) has continued to provide client-centered homeless prevention services. The HPP includes CAPLP, SENDCAA, Presentation Partners in Housing, and The Salvation Army. The goal of the HPP is to ensure low-barrier access for prevention services in line with coordinated entry to prevent and end homelessness.

Households experiencing a housing related crisis apply at one access point. The HPP reviews all applications and prioritizes available resources based on vulnerability of the household. Resources are matched to households to provide the minimum assistance necessary for the shortest time possible in order to stabilize a household. The HPP maximizes community resources in order to assist as many households as possible. In addition to housing focused case management, the HPP can provide rent, utility, and security deposit assistance for households experiencing homelessness or likely to become homeless.

In 2019, the HPP provided $556,751 in financial assistance to prevent 544 households from eviction:

Payment Type	Payments
Rent/Mortgage Payments	443
Security Deposit Payments	324
Utility Bill Payments	177

Looking towards the future, the HPP intends to expand services to include diversion. Diversion is a service that guides households to safe and appropriate alternative housing options without utilizing emergency shelters. This ensures shelter beds are available for those who truly have no other option.

HMIS data shows the number of individuals who entered a shelter and/or housing support program from an institution setting, permanent housing, or a doubled-up situation. This is a target population for diversion and in 2019 this includes 1,185 individuals.

Prior Living Arrangements	Total Individuals
Institutional Setting	288
Permanent Housing/Own/Rental	365
Doubled Up (Staying w/ Friends or Family)	532
Total	1,185

The HPP is working closely with shelters, housing providers, supportive services, and funders to ensure an end to homelessness where it already occurs, prevention of homelessness where it is on the verge, and prioritization of services to the most vulnerable households. See the later section "Process Highlight – Moving towards a Homeless Prevention and Diversion Orientation" for more details.

SHELTER ENTRY

In 2019, 2,057 individuals, 9 adult couples without children, and 485 families inquired about seeking shelter at one of the FM Metro's emergency shelters.

Household Type	Numbers
Single Men	1,346
Single Female	710
Single Other	1
Single Female with Children	403
Single Male with Children	21
Married/Couple with children	61
Married/Couple with no children	9
Total Households	2,551

The 485 families include a combined total of 975 children. Of those children, 44% are ages 0-5. Below is the breakdown of age for the children included in these families.

Total Children	Number	Percentage
Age 0-5	430	44.10%
Age 6-12	369	37.80%
Age 13-17	94	9.60%
Age 18+	37	3.80%
Unknown	45	4.60%
Total Children	975	

In total, this was an increase of 394 households (both singles and family units) compared to 2018.

This data is tracked through the Shelter Entry List, which is a list shared by all the emergency shelters in the FM Metro and was designed to get the most vulnerable people experiencing homelessness a shelter bed when spaces become available. Prior to this coordinated process, those in the community who were searching for a shelter bed would have to check each shelter daily to see if there was any availability. This prevented some of the most vulnerable in our community from getting a shelter bed, while those with more resources were able to access shelter.

Of the 2,551 unique households seeking services, 76% only sought shelter once throughout 2019. The remaining households sought shelter multiple times throughout the year resulting in a total of 3,343 duplicated households who sought shelter throughout 2019.

Number of Times Households Sought Shelter	Number of Households	Percentage
Sought Shelter 1 Time	2,541	76.00%
Sought Shelter 2 Time	547	16.40%
Sought Shelter 3 Times	177	5.30%
Sought Shelter 4 Times	59	1.80%
Sought Shelter 5 Times	14	0.40%
Sought Shelter 6 Times	4	0.10%
Sought Shelter 7 Times	1	0.00%
Total Duplicated Households Who Sought Shelter in 2019	3,343	

Of those seeking shelter, 953 households or 28.5% were able to receive services and a shelter bed. Only 27 households were diverted, or able to find an alternative place to stay rather than entering an emergency shelter. As of the last two weeks in 2019, there were 86 individuals and 21 families still seeking a shelter bed. The remaining households have dropped off the Shelter Bed List either because shelter staff were unable to contact them, or they were no longer in need of a shelter bed.

As part of the coordinated entry process, households seeking shelter are screened for vulnerabilities and needs. Of those households who sought shelter in 2019:

- 41% self-reported criteria that classifies the household as chronically homeless
- 35% self-reported having a disabling condition
- 21% self-reported a history of domestic violence
- Of those with a history of domestic violence, 24% experienced violence within the last 30 days

COORDINATED ASSESSMENT

Households who present as homeless are assessed for appropriate homeless interventions to assist with their current crises. The tool used to assist with assessing those who are homeless is the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). A VI-SPDAT is a survey administered to individuals who meet United States Department of Housing and Urban Development's (HUD) definition of homeless. Under the HUD definition, a person is homeless if they are living in a place not meant for habitation, in an emergency shelter, in transitional housing, or exiting an institution where they currently reside and were homeless before entering. Individuals can also complete a VI-SPDAT if they do not meet these definitions but are fleeing domestic violence, are a veteran, or youth. The VI-SPDAT is used to determine risk and assist with the prioritization of services for individuals who are experiencing homelessness. There are also specific VI-SPDAT tools utilized for families with children and single youth.

Once an assessment is complete and it is identified which housing program is appropriate, individuals and families are placed on the HMIS Priority List to await a housing program opening. The following chart is the breakdown of the Cass County, ND, and Clay County, MN, list as of the end of 2019.

Household Type	Cass County, ND	Clay County, MN	Totals
Singles: Adults without Children	200	437	637
Youth Singles: Age 18-24 without Children	31	41	72
Families: Adults with Children	60	118	178
Youth Families: Youth with Children	7	19	26
Totals	298	615	913

This data was collected in HMIS, and both North Dakota and Minnesota have a coordinated assessment report which collects these assessment referrals. Due to protection regulation, Domestic Violence providers are unable to use HMIS. YWCA of Cass-Clay (YWCA) is the FM Metro's Domestic Violence emergency shelter provider. The data provided by YWCA from a separate report was integrated with these numbers.

From this list we can see there are more families identified and assessed in Clay County, MN. This may be due to Minnesota having additional homeless programs which consider individuals who are doubled up as homeless. Since Minnesota assesses those who are doubled up and because families are more likely to be in these situations, this may explain why there are more families in Clay County, MN. North Dakota does not have any programs for doubled up households; therefore, these individuals are not assessed in North Dakota.

Below is the breakdown of the Priority List at the end of 2019 where housing intervention was recommended for those who were assessed.

- Those who are recommended for PSH (Permanent Supportive Housing programs) would best be assisted with non-time limited, permanent support or a housing first program.
- Households who were assessed as needing TH/RRH (Transitional Housing or Rapid Rehousing programs) would best be assisted with a program that offers more temporary assistance including rental assistance and case management for around 3-6 months, up to maximum of 2 years.
- The housing assessment also determines if a household would be more appropriate for mainstream services to assist with their housing crisis rather than a housing intervention program. These households would be referred to SNAP, MFIP, Section 8, or other programs not designated for individuals experiencing homeless exclusively.

Cass County, ND Breakdown	Adult Head of Household	Youth Head of Household	Total
PSH Single	159	21	180
PSH Family	48	6	54
TH/RRH Single	41	9	50
TH/RRH Family	16	0	16
Total	264	36	300

Clay County, MN Breakdown	Adult Head of Household	Youth Head of Household	Total
PSH Single	234	18	252
PSH Family	81	12	93
TH/RRH Single	180	17	197
TH/RRH Family	31	7	38
Total	526	54	580

COORDINATED ENTRY

When a housing provider has an opening in a program, they will request a referral of a family or individual on the Priority List. The Systems Specialist, who is employed by the FM Coalition to End Homelessness, is responsible for making these referrals and maintaining the Priority List for the FM Metro. The Systems Specialist accepts requests and pulls referrals from the Priority List, guided by the program's eligibility as well as the Prioritization Policies from CARES. The referrals are taken from the list and given to the housing provider. The housing provider then contacts the household and offers them entry into the housing program.

The West Central CoC recently conducted a major data clean-up effort that resulted in a significant decrease in the number of persons on our Priority List. Having accurate data is essential to CoC planning and helps ensure clients are served in a more rapid manner. The North Dakota CoC will conduct a similar process in June 2020.

The West Central MN CoC was recently awarded funding from HUD that will allow for the expansion of Coordinated Entry data management and training. This role will help assure the CoC is able to ensure data remains accurate and current, as well as provide a more accurate understanding of the demand for homeless services at a more detailed level. This position is targeted to start July 1, 2020.

Referrals provided for Cass County Housing Providers:

Household Type	Referrals Reports Processed	Number of Openings
Single	12	50
Single Youth	8	12
Family	16	46
Family Youth	4	5
Total	40	113

Referrals provided for Clay County Housing Providers:

Household Type	Referrals Reports Processed	Number of Openings
Single	18	37
Single Youth	0	0
Family	15	46
Family Youth	1	1
Total	34	84

EQUITY OF OUR SYSTEM

As mentioned in the demographic overview of those receiving services throughout 2019, homelessness disproportionately impacts people of color and those who identify as Hispanic. Equity in our system is something we are beginning to focus on as a community, really looking into the parts of our system that may be causing individuals and families of color barriers to receiving services to help best resolve their housing crisis and current episode of homelessness.

The West Central CoC conducted an Equity Review in August of 2019. For more details on how this study was conducted or key findings, visit:
https://www.homelesstohoused.com/homeless-information-data

Overall, this study found for individuals experiencing homelessness in West Central MN (including Clay County, MN):

- Persons of color had a disproportionately lower number of entries into transitional and permanent housing.
- Race played little role in who got into shelter.
- Overall, the likelihood of a positive or negative leave from a homeless program does not appear to be related to the following variables: race, ethnicity, or gender.
- Persons who have experienced domestic violence are statistically likely to experience a more positive leave.
- Persons over age 50 are statistically more likely to experience a negative leave.
- Native Americans/Alaskans have a slightly higher likelihood of returning to homelessness.

Additionally, the North Dakota CoC conducted an Equity Review as well in early 2020. At the time this report was published, this review was not publicly available. In next year's report we hope to have better equity data specific to the FM Metro, as we see this as an important measure of the success of our system.

PRESSURE ON OUR SYSTEM

This report includes an overview of each part of the CARES System and our community's response to ending homelessness. In order to achieve this ambitious goal, each part of our system and each partner needs to focus on reducing the number of individuals entering our system and effectively serving those in our system to prevent them from returning unnecessarily.

To judge our progress on this, we need to look at our system's flow. In 2019, there were 2,591 individuals who entered into services or entered our system. This is our system's inflow. During the same time, there were 2,166 leavers or individuals who exited from services or our system. This is our system's outflow.

Over the past three years, with access to better data for our community, we have seen the trend of more entries than exits.

Year	Inflow (Entries)	Outflow (Exits)	System Flow
2017	2,249	2,056	+ 193
2018	2,517	2,118	+ 399
2019	2,591	2,166	+ 425

This means while more individuals and families are exiting homelessness, an even greater number are entering homelessness.

EXIT DESTINATION

One vital data point the CoCs and FM Coalition to End Homelessness utilize to monitor project and system performance is exit destination of clients leaving services. The goal is to increase the percentage of individuals who leave homeless programs (street outreach, emergency shelter, transitional housing, rapid re-housing, or permanent housing) and exit to positive destinations versus temporary destinations, institutional settings, or other destinations.

While the CoCs track outcomes by program type (see the next section for more details and more system metrics), listed below are the 2019 cumulative outcomes for all program types operating in Cass and Clay counties, as well as the definitions of each destination category.

This first graph shows all exit destinations for all client populations. We would like to note that outcomes for individuals exiting permanent housing are typically much higher than those exiting shelter or outreach, which lead to the average shown below.

Exit Destination - All Clients	Total	Percentage
Permanent Destinations	716	33%
Temporary Destinations	290	13%
Institutional Settings	72	3%
Other Destinations	63	3%
Client Doesn't Know/Refused	347	16%
Data Not Collected	678	31%
Total Individuals	2,166	

Below are the exit destinations for families who exited from services in 2019. There is a significant increase in the percentage of households who exit to a permanent destination. We attribute this to the larger number of singles in outreach and emergency shelter. In shelter, singles are often more likely to leave without notifying staff of their plans after exit or declining to complete an exit interview, account-

ing for the high percentage of Data Not Collected and Client Doesn't Know/Refused seen in the chart above.

Exit Destination - Families	Total	Percentage
Permanent Destinations	441	72%
Temporary Destinations	83	14%
Institutional Settings	16	3%
Other Destinations	7	1%
Client Doesn't Know/Refused	0	0%
Data Not Collected	64	10%
Total Individuals	611	

With youth exiting services, there is an increase in the percentage of youth exiting into a temporary destination. This is mainly as youth exit services to stay or live with family or friends on a temporary basis. This is not uncommon for youth in general, as this is a very transitional period in most people's lives.

Exit Destination - Youth	Total	Percentage
Permanent Destinations	70	30%
Temporary Destinations	74	32%
Institutional Settings	16	7%
Other Destinations	6	3%
Client Doesn't Know/Refused	24	10%
Data Not Collected	43	18%
Total Individuals	233	

Exit destination definitions:

- **Permanent Destinations** include houses or apartments that are owned or rented by clients with or without any form of subsidy, rental by clients in a public housing unit, permanent supportive housing programs for formerly homeless persons, or living with family or friends on a permanent basis.
- **Temporary Destinations** include emergency shelter, transitional housing programs for homeless persons, hotel or motel, place not meant for habitation (a vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside), or living with family or friends on a temporary basis.
- **Institutional Settings** include foster care homes or group home, psychiatric hospital or other psychiatric facility, substance abuse treatment facility or detox center, hospital or other residential non-psychiatric medical facility, jail, prison, juvenile detention facility, or long-term care facility or nursing home.

- **Other Destinations** include residential project or halfway house with no homeless criteria, deceased, or other.

OUTCOME REPORTS

HUD, with the updated McKinney-Vento Homeless Assistance Act (the Act), views the local homeless response as a coordinated system as opposed to homeless programs and funding sources that operate independently in a community. To facilitate this perspective, the Act now requires communities to measure their performance as a system, in addition to analyzing performance by specific projects or project types.

The intent is for CoCs to regularly measure their progress in meeting the needs of people experiencing homelessness in their community and to report this progress to HUD. Since 2015, CoCs submit their Performance Measures to HUD annually. These include:

1. Length of Time Homeless
2. Number of persons returning to homelessness once housed
3. Number of Total Homeless
4. Change in income (earned and total income)
5. Number of New persons entering homelessness
6. Number of persons retaining permanent housing or exiting to permanent housing

This data is only available for the entire CoC compared to the rest of the report which is specific for the FM Metro. At this point, we are unable to pull these metrics for local communities.

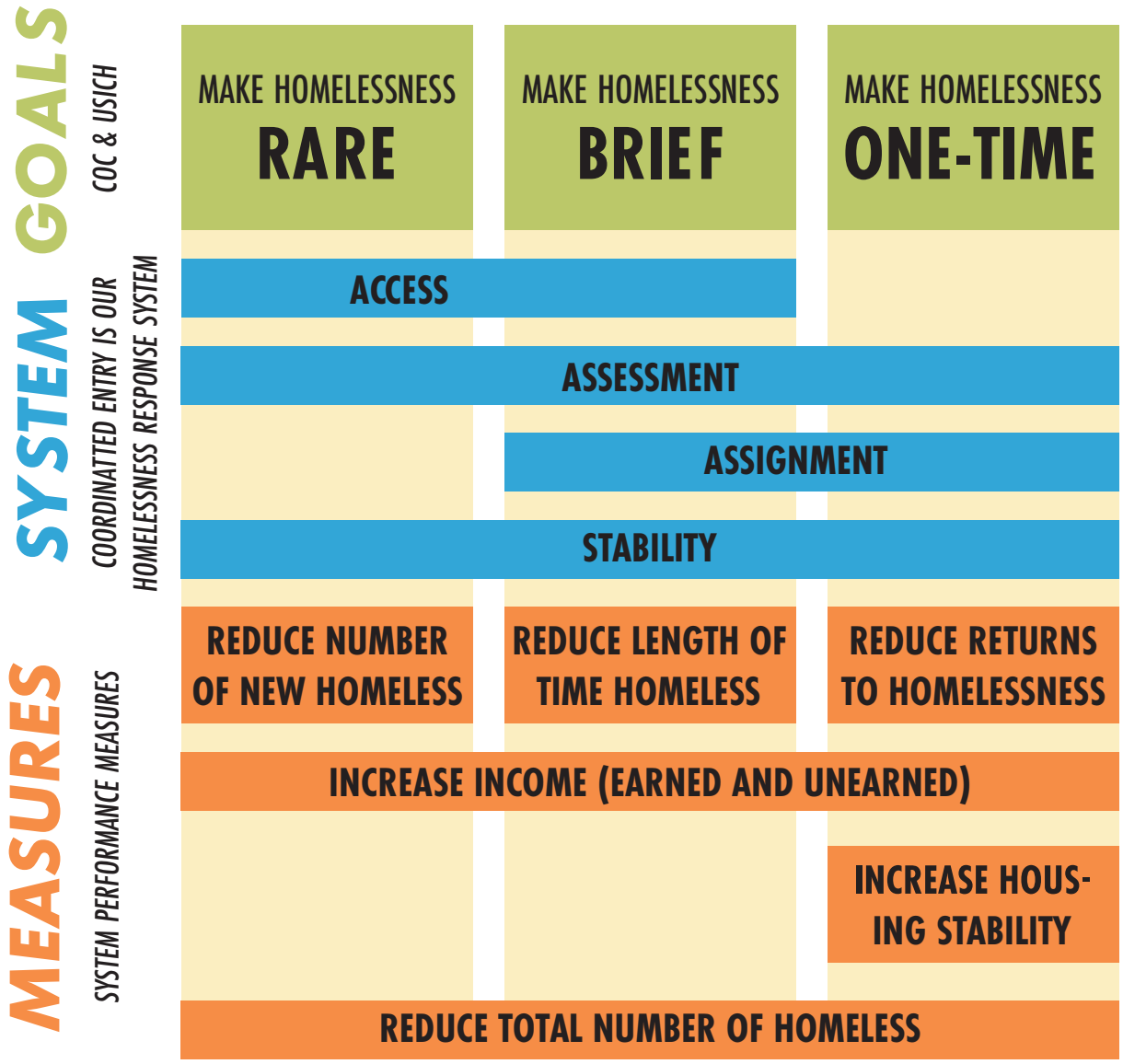


North Dakota CoC

Measures	2015 Baseline Performance	2016 Performance	2017 Performance	2018 Performance	2019 Performance
1. Length of time homeless	205 days ES	**350 days ES**	**405 days ES**	71 days ES	55 days ES
	192 days ES + TH	**360 days ES + TH**	339 days ES + TH	81 days ES + TH	71 days ES + TH
2. Number of persons returning to homelessness once housed	11% in PH in 2 years	**23% in PH in 2 years**	18% in PH in 2 years	14% in PH in 2 years	12% in PH in 2 years
	18% Total in 2 years	18% Total in 2 years	18% in PH in 2 years	**25% Total in 2 years**	20% Total in 2 years
3. Number of total homeless	3,650 HMIS	3,477 HMIS	3,057 HMIS	2,547 HMIS	**3,500 HMIS**
	1,305 PIT	923 PIT	**1,089 PIT**	542 PIT	**557 PIT**
4. Change in income	18% Stayers	20% Stayers	23% Stayers	31% Stayers	42% Stayers
	25% Leavers	25% Leavers	37% Leavers	**26% Leavers**	38% Leavers
5. Number of new persons entering homelessness	2,790	2,184	2,059	**2,066**	1,566
6. Number of persons re-taining permanent housing or exiting to perm. housing	32% All	32% All	**29% All**	34% All	39% All
	87% PH	88% PH	99% PH	**94% PH**	**90% PH**

West Central Minnesota CoC

Measures	2015 Baseline Performance	2016 Performance	2017 Performance	2018 Performance	2019 Performance
1. Length of time homeless	36 days ES	36 days ES	34 days ES	**44 days ES**	37 days ES
	72 days ES + TH	**78 days ES + TH**	**83 days ES + TH**	**112 days ES + TH**	**120 days ES + TH**
2. Number of persons returning to homelessness once housed	8% in PH in 2 years	6% in PH in 2 years	6% in PH in 2 years	5% in PH in 2 years	5% in PH in 2 years
	6% Total in 2 years	6% Total in 2 years	**8% Total in 2 years**	8% Total in 2 years	8% Total in 2 years
3. Number of total homeless	1,220 HMIS	1,215 HMIS	1,047 HMIS	938 HMIS	**978 HMIS**
	242 PIT	211 PIT	**215 PIT**	**246 PIT**	216 PIT
4. Change in income	35% Stayers	41% Stayers	**40% Stayers**	45% Stayers	**40% Stayers**
	50% Leavers	**42% Leavers**	47% Leavers	50% Leavers	64% Leavers
5. Number of new persons entering homelessness	881	**1,081**	927	824	**985**
6. Number of persons re-taining permanent housing or exiting to perm. housing	54% All	**53% All**	**43% All**	**40% All**	**38% All**
	91% PH	91% PH	94% PH	**92% PH**	95% PH



Ultimately, to achieve our community's goals of making homelessness rare, brief, and one-time, we need to monitor our homeless response system through these system performance measures.

Data Highlight: Housing Navigation cost savings from reduced use of costly community services pre- and post-housing

In 2015, United Way of Cass-Clay, in conjunction with members of the FM Coalition to End Homelessness, convened a Design Team of dedicated professionals with a wealth of experience and knowledge spanning nearly 200 years from multiple areas of homeless services. Over the course of three half-day meetings using a consensus model of decision making, the Design Team assessed and developed a Project Summary according to needs based on demographic and geographic populations. Valuing a high level of collaboration and transparency, the Design Team distributed meeting notes and solicited feedback via survey from collaborative stakeholders throughout the process.

This process resulted in a pilot where three new client-centered Housing Navigators would set to work on creating holistic links between existing resources and case management, thus closing gaps and removing barriers in order to achieve housing stability. The goal of this project is to create a new culture of service delivery and enhance collaboration and partnerships among homeless service providers, rooted in the Housing First Philosophy, a proven method of ending all types of homelessness, which offers individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing with a low threshold for entry.

In 2016, Presentation Partners in Housing was selected as the agency to launch this pilot and hired three Housing Navigators. Since the program's inception, Presentation Partners in Housing has hired an additional two Housing Navigators.

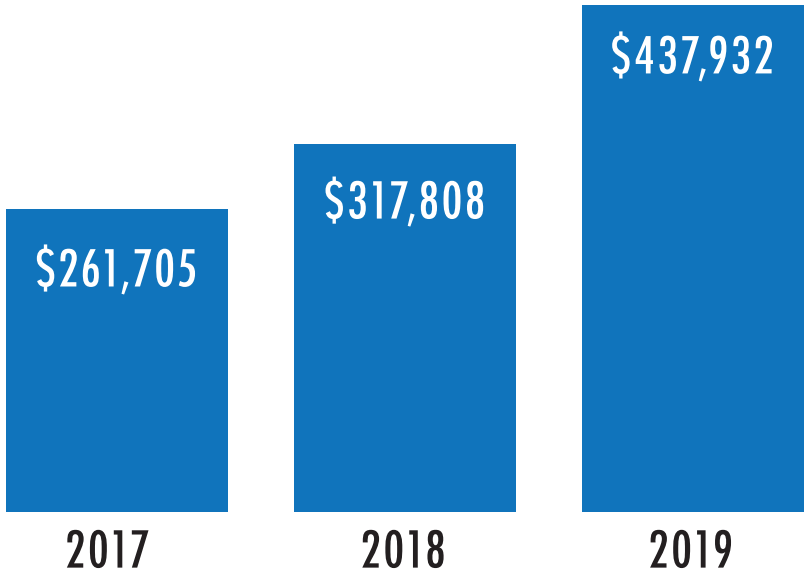
In 2017, after the first complete year of services, 23 active Housing Navigation Program participants were able to attain housing, with 80% stably housed for at least 6 months. Additionally, 20 participants had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services, such as detox admissions, ambulance transports, jail time, emergency room visits, and emergency shelter stays. These 20 participants reduced the usage of these costly services for an estimated cost savings to the community of **$261,705**.

Each of the 20 participants, whose personal data was collected as part of this program, voluntarily agreed to disclose their usage of these community services both while participating in the program and prior to being housed. To calculate the estimated cost savings, actual usage of each community service by each individual participant was collected and compared to the average annual usage of these same services by the same individual participant while homeless in our community.

In 2018, 36 active Housing Navigation Program participants were able to attain housing, with 88% stably housed for at least 6 months. Again, there were 20 participants who had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services. These participants reduced the usage of these costly services for an estimated cost savings to the community of **$317,808**.

In 2019, 47 active Housing Navigation Program participants were able to attain housing, with 100% stably housed for at least 6 months. There were 24 participants who had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services. These participants reduced the usage of these costly services for an estimated cost savings to the community of **$437,932**.

Over the past three years of this program, there has been a combined cost savings estimated at **$1,017,445** for our local community!



THE COST SAVINGS OF HOUSING

Process Highlight:
Moving towards a Homeless Prevention and Diversion Orientation

Historically, community responses to homelessness have focused primarily on addressing the needs of those who have already lost their housing – and our community has been no different. This model has led to communities 'managing' homelessness and, as a result, 'institutionalized' the homeless response system. An effective homeless response will always include providing emergency services and moving people into housing with appropriate supports as rapidly as possible. However, there is a crucial third component to an effective response: homeless prevention and shelter diversion. This third piece has often been under-emphasized and under-resourced in many communities including ours.

Following the lead of exciting new research and evidence-based approaches from communities across the nation, the FM Metro is shifting to a comprehensive, community-based preventative approach to ending homelessness. In designing the local prevention and diversion approach, the FM Metro proactively sought training and guidance from nationally recognized industry experts like OrgCode and the National Alliance to End Homelessness. Additionally, compassionate local providers and incredibly resilient and honest persons with lived experience have continually provided influence and direction on the design of a more robust prevention and diversion system.

No single agency or program can prevent and/or end homelessness. Success of a robust prevention and diversion system requires multi-agency commitment with key collaborations across the local CoCs including social services, public schools, the VA, youth providers, domestic violence providers, mental health and recovery programs, emergency shelters, and many more.

Beginning January 1, 2021, "211" through FirstLink will serve as the primary first point of contact for all households experiencing a housing crisis. Those currently experiencing homelessness and those most at-risk of homelessness will be referred to the Homeless Prevention and Diversion Program at Presentation Partners in Housing (PPiH). Following this referral, a highly trained Homeless Prevention and Diversion Specialist from PPiH will conduct a screening and assessment and work with each household to determine what resources and supports are needed to rapidly resolve their unique housing crisis. The goal is to immediately connect the household to resources as well as develop a housing stability plan that meets their individualized needs. Light touch case management and advocacy are provided along with supports from CAPLP, PPiH, SENDCAA, The Salvation Army, and other important mainstream resources to end homelessness where it occurs and prevent homelessness when it is on the verge. The end outcome is that all households remain housed or have a path to stable housing!

Erin Wixsten from OrgCode spent three days in the FM Metro in February 2020 training local providers and community stakeholders on the framework of successful prevention and diversion programs, in

partnership with FM Coalition to End Homelessness and United Way of Cass-Clay. Erin shared research and examples of communities that have been able to prevent shelter entry for up to 80% of households experiencing a housing crisis, CoCs that were able to close an emergency shelter for good, and high rates of evictions that were prevented as a result of a robust response to homelessness. Erin further stated there is "literally no way" these interventions do not work, and many communities that now embrace these approaches experience guilt that they did not implement prevention and diversion strategies sooner.

The FM Metro is ready to shift to a prevention and diversion orientation and approach to ending homelessness. Support from local city officials, CoCs, FM Coalition to End Homelessness, United Way of Cass-Clay, other local funders, service providers, and consumers have aligned in order to launch this project. We look forward to sharing data and outcomes from the launch of the Homeless Prevention and Diversion Program as part of next year's State of Homelessness Report.



WHAT DOES ENDING HOMELESSNESS LOOK LIKE?

Reasons people find themselves without a home will always exist. But with enough affordable housing in our community, increased employment and income, equity in services and programs, and coordinated service delivery systems, we can make homelessness rare, brief, and one-time for individuals and families in our community—virtually ending long-term homelessness. How do we do that? Our Coalition of service providers, funders, and community members advances our mission through advocacy, education, and collaboration. Our Coalition stands strong that this vision can become a reality.

WHAT IS NEXT FOR OUR COMMUNITY?



Looking to the remainder of 2020 and beyond, the FM Coalition has declared a priority for ending homelessness for youth and families with children. This data based priority was made primarily because it addresses the needs of some of the most vulnerable members of our community while doing the important upstream work needed to prevent future generations of chronic homelessness. We believe it will also work to address other concerns, such as the persistent fact that people of color experience homelessness disproportionate to the rest of the population. Demographic data of individuals experiencing homelessness suggest that early interventions in the lives of children of color will reduce future homelessness in adulthood.

This does not mean we are not working to address all types of homelessness, but making such priorities is how we make the incremental progress to reach audacious goals and accomplish systemic change. 2020–2021 planning and implementation include:

- Leveraging funding support of United Way Cass-Clay, which shares an emphasis on ending homelessness for youth and families with children.
- Create a campaign to increase public awareness about homelessness and efforts being taken to end homelessness.
- Increase awareness of homeless data and issues for local elected leaders as part of a comprehensive policy and funding strategy to advance our work.
- Developing and implementing comprehensive diversion and prevention systems and strategies.
- Developing specific strategies concerning youth and child homelessness.
- Renewed focus on developing strategies to address larger societal and systemic issues such as race, income inequality, and food insecurity.
- Strengthening partnerships with County and State partners in North Dakota and Minnesota.

Our Coalition remains committed to aligning resources and programs to create opportunities for people to thrive so that everyone in Fargo-Dilworth-Moorhead-West Fargo has a safe place to call home.

APPENDIX 1: DATA SOURCES, REFERENCES, AND RESOURCES

Main data sources as they appear:

Homeless Management Information System (HMIS) is the database that many state and federal funders require to be utilized by all homeless service providing agencies and programs.

Fargo-Moorhead Homeless Everyone Counts Survey (Everyone Counts Survey) is based on data provided by the FM Coalition to End Homelessness collected through face-to-face interviews and recorded into an online medium. A total of 243 individuals were surveyed on October 25, 2018, in the FM Metro.

United States Census Bureau Data is the leading source of quality data about the nation's people and economy.

Community Action Needs Assessments were completed by CAPLP and SENDCAA, respectively, in the form of focus groups and interviews. In Clay County, MN, the survey for people currently seeking housing services was administered to anyone that presented to CAPLP offices between the predetermined dates of October 22, 2018, to November 2, 2018. A total of 34 surveys were collected. In Cass County, ND, the survey was conducted for three weeks for anyone who presented at SENDCAA from March 5, 2019, to March 26, 2019. 40 clients applying for deposit or rent assistance completed the needs assessment survey over a three-week time span in March of 2019.

Shelter Entry List the list shared by all the shelters in the FM Metro designed to get the most vulnerable people experiencing homelessness a shelter bed when shelter bed spaces become available.

Coordinated Entry Priority List the active list of households who present as homeless who have been assessed for appropriate homeless interventions utilizing the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SDPAT) to await a housing program opening.

West Central Minnesota CoC Equity Review a summary of three separate equity reviews compiled by the West Central Minnesota CoC.

References as they appear:

United States Census Bureau, ACS Demographics and Housing Estimates, 2018: ACS 1-Year Estimates Data Profiles. Retrieved from https://data.census.gov/cedsci/table?g=310M400US22020&tid=ACSDP1Y2018.DP05&hidePreview=false&vintage=2018&layer=VT_2018_310_M4_PY_D1&cid=DP05_0001E

United States Census Bureau, Financial Characteristics, 2018: ACS 5-Year Estimates Subject Tables. Retrieved from https://data.census.gov/cedsci/table?g=310M400US22020&tid=ACSST5Y2018.S2503&t=Housing&vintage=2018&hidePreview=false&layer=VT_2018_310_M4_PY_D1&cid=DP04_0001E

Safe Housing Partnership, Understanding the Intersections. Retrieved from https://safehousingpartnerships.org/intersection

Office of the Assistant Secretary for Planning and Evaluation, 2019 Poverty Guidelines. Retrieved from https://aspe.hhs.gov/2019-poverty-guidelines

Resources as they appear:

Cass County, ND Human Services Website: https://www.casscountynd.gov/our-county/human-services/economic-assistance-division

Clay County, MN Social Services Website: https://claycountymn.gov/207/Financial-Assistance-Services

The National Low Income Housing Coalition's "Out of Reach" report https://reports.nlihc.org/oor

Minnesota Housing Partnership "State of the State's Housing" report for Clay County: https://www.mhponline.org/images/stories/images/research/coprofs/2019/Clay.pdf

West Central Minnesota CoC Equity Review: https://www.homelesstohoused.com/homeless-information-data

McKinney-Vento Homeless Assistance Act: https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/

APPENDIX 2: KEY TERMS AND DEFINITIONS

For the purpose of this report, **homeless** refers to people who lack a fixed, regular, and adequate night-time residence, including those whose residence is a shelter or transitional housing program, those living in unstable and non-permanent situations, and those forced to stay on a temporary basis with a family member because they have no other place to stay, specifically:

- **Sheltered** includes individuals who are sheltered in emergency shelter and transitional housing programs.
- **Unsheltered** includes individuals who are staying in a place that is not a regular or permanent place to stay, such as outdoors, in a car, vacant building, or a place of business.
- **Doubled up** includes individuals who are staying or living with a friend or family member on a temporary basis because they have nowhere else to go.

Chronically homeless includes individuals who meet all of the following:

- Currently experiencing homelessness,
- Been homeless for at least one year during the current episode OR homeless for less than one year in the current episode, but homeless at least four times in the previous three years, and
- Disabled (those who have a physical, mental, or other health condition that limits the kind of work they can do OR those who have a physical, mental, or other health condition that makes it hard for them to bathe, eat, get dressed, get in and out of bed or chair, or get around by themselves).

Continuum of Care is a regional planning body of stakeholders designed to promote a shared commitment to the goal of ending homelessness.

For the purpose of this report, **exits out of homelessness** are defined by the individuals' destination once they leave services:

- **Permanent Destinations** include houses or apartments that are owned or rented by clients with or without any form of subsidy, rental by clients in a public housing unit, permanent supportive housing programs for formerly homeless persons, or living with family or friends on a permanent basis.
- **Temporary Destinations** include emergency shelter, transitional housing programs for homeless persons, hotel or motel, place not meant for habitation (a vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside), or living with family or friends on a temporary basis.

- **Institutional Settings** include foster care homes or group home, psychiatric hospital or other psychiatric facility, substance abuse treatment facility or detox center, hospital or other residential non-psychiatric medical facility, jail, prison, juvenile detention facility, or long-term care facility or nursing home.
- **Other Destinations** include residential project or halfway house with no homeless criteria, deceased, or other.

Individuals with a disability of long duration are those who have any disability that is ongoing, continued, or for an indefinite duration.

Individuals with a chronic health condition are those who have been diagnosed with a chronic health condition, physical disability, or developmental disability.

Individuals with a mental health problem are those who have been diagnosed with a mental health condition or disorder.

Individuals with a substance abuse disorder are those who have an addiction to alcohol, drugs, or both types of substances.

Youth Homelessness includes young adults 24 years old or younger, living without parents or guardians and may be parenting themselves, who lack a fixed, regular, and adequate night-time residence, including those whose residence is a shelter or transitional housing program, those living in unstable and non-permanent situations, and those forced to stay on a temporary basis with a family member because they have no other place to stay.

Project Type Definitions

Shelter:

- Offers temporary shelter (lodging) for homeless households.

Transitional Housing (TH):

- Participants must enter into a lease agreement (sublease or occupancy agreement) for at least one month. Leases must automatically renew upon expiration, except with prior notice by either party, up to a max of 24 months.
- Participants receiving rental assistance may be required to live in a specific structure
- Support services must be available during entire participation in TH.

Rapid Re-Housing (RRH):

- Provides short-term to medium-term assistance (up to 24 months).
- Lease between household and landlord.
- Household's able to select their unit.
- Providers can restrict max length of financial assistance but not length of time in unit.
- Support services must be offered during entire participation in RRH.

Permanent Supportive Housing (PSH):

- Long-term housing.
- Homeless household with a member who has a disability.
- Support services provided that are designed to meet the needs of participants.

Other Permanent Housing (PH)

- Long-term housing not otherwise considered PSH or RRH.
- PH Housing with Services provides long-term housing and supportive services for homeless persons but does not limit eligibility to persons with a disability.
- PH Housing Only projects provide long-term housing for homeless persons but does not make supportive services available as part of the project.

APPENDIX 3: FM COALITION TO END HOMELESSNESS APPROVED STATEMENT ON ENDING HOMELESSNESS FOR YOUTH AND FAMILIES

To: Members & Partners of the FM Coalition to End Homelessness
From: Cody J. Schuler, Executive Director
Date: August 8, 2019
Re: Approved Statement on Ending Homelessness for Youth and Families

A key component of pursuing strategies to end homelessness in the Fargo-Moorhead Metro area is to identify particular populations where resources can be aligned and timelines established towards a goal of "functional zero" where systemically homelessness is rare, brief, and one-time. At the May 28, 2019 meeting of the general membership of the Coalition, a discussion was held about consideration of a focus population following the successes of previous emphasis on ending Veteran homelessness.

On July 18, 2019 the Board of Directors of the FM Coalition to End Homelessness approved a proposal to create a statement to be distributed to the members of the Coalition to End Homelessness designating a priority on ending homelessness for youth and families with children without distraction from efforts to end homelessness for other populations. The statement and key rational was reviewed (with no action) at the July 23, 2019 meeting of the general membership of the Coalition. **The statement was approved by vote of the membership of the FM Coalition via electronic ballot that closed August 7, 2019.**

Any timelines, strategies, and goals will be identified in the future as the Coalition approves strategies.

Ending Homelessness for Youth and Families with Children Statement

The Fargo-Moorhead Coalition to End Homelessness designates a priority for developing strategies for ending youth homelessness and homelessness among families with children in the Fargo-Moorhead Metro area. This priority includes aligning existing community resources and advocating for new resources. By emphasizing homelessness impacting youth and children, the FM Coalition aims to address root causes, break cycles of poverty, and end future instances of homelessness. While prioritizing youth and families with children, the FM Coalition pledges continued vigilance in seeking strategies and aligning resources for all populations experiencing homelessness, including chronic, veteran, and those fleeing domestic violence.

This designation stands until the FM Coalition states otherwise.

Key rationale for this designation:

- Addressing youth and child homelessness strategically addresses future chronic homelessness.
- Adult homelessness is often rooted in youth/child homelessness and childhood trauma.
- Ending homeless for youth/children is achievable in the near future for our community.
- Placing a priority on this population locally is in line with priorities set by Minnesota's Action
- Plan and the US Interagency Council on Homelessness (USICH).
- Improved services for these populations benefits all populations.
- Public awareness concerning these populations raises awareness about the wider issue of homelessness.
- Prioritizing these populations will not reduce urgency or efforts towards ending homelessness for other populations.

THANK YOU TO:

The State of Homelessness Task Force for expertly preparing this report

United Way of Cass-Clay for partnering in this report and making homelessness part of their bold community goals

Institute for Community Alliances for assisting with data reporting

Sandwich Club Design for layout and design

FM COALITION TO END HOMELESSNESS

United Way of Cass-Clay



#2448

Housing the Homeless

North Dakota's 10 - Year Plan to End Long-Term Homelessness

Prepared by the
North Dakota Interagency Council on Homelessness

October 31, 2018

Office of Governor Doug Burgum
State of North Dakota
600 East Boulevard Avenue
Bismarck, ND 58505

RE: Final Report—North Dakota 10-Year Plan to End Long Term Homelessness

Dear Governor Burgum,

A lot has changed in North Dakota since 2008 when the *North Dakota 10-year Plan to End Long-Term Homelessness* was drafted. The entire state has experienced a catalyst of economic prosperity as people from around the world came to find their fortune, some with nothing more than a few personal belongings and a desire for a better life. As the population and demographics of the state shifted, it remains the North Dakota Interagency Council on Homelessness's belief that every North Dakotan should have the opportunity to succeed in life, and have a safe and stable environment to call home.

The 10-year plan formalized collaborative efforts between seven state agencies, one statewide homeless coalition, and the communities of Bismarck, Fargo and Grand Forks, developing goals and strategies to end chronic homelessness. Creating permanent supportive housing was the primary focus with a secondary focus on providing outreach and prevention services. As improved data provided insight into the multi-faceted challenges vulnerable populations' experience, outreach, prevention and support services became just as critical as housing.

Great strides have been made. However, the efforts to end homelessness continue. Generational poverty must be actively combatted, and youth need stability in order for them to succeed in school and be given the best possibility to grow into self-sufficiency. The chronically homeless need access to more rapid housing projects and customized support services. The safety net also needs to be cast wider for justice-involved individuals, and those facing mental and behavioral health issues. And, we cannot forget about how we can help our senior population age in place and provide resources for families experiencing frequent, short-term homelessness.

The Interagency Council on Homelessness's report highlights the work that was completed over the past decade, it profiles the state most vulnerable populations, and it outlines our recommendations to continue to prevent, reduce and end homelessness.

Respectfully submitted,

Jolene Kline

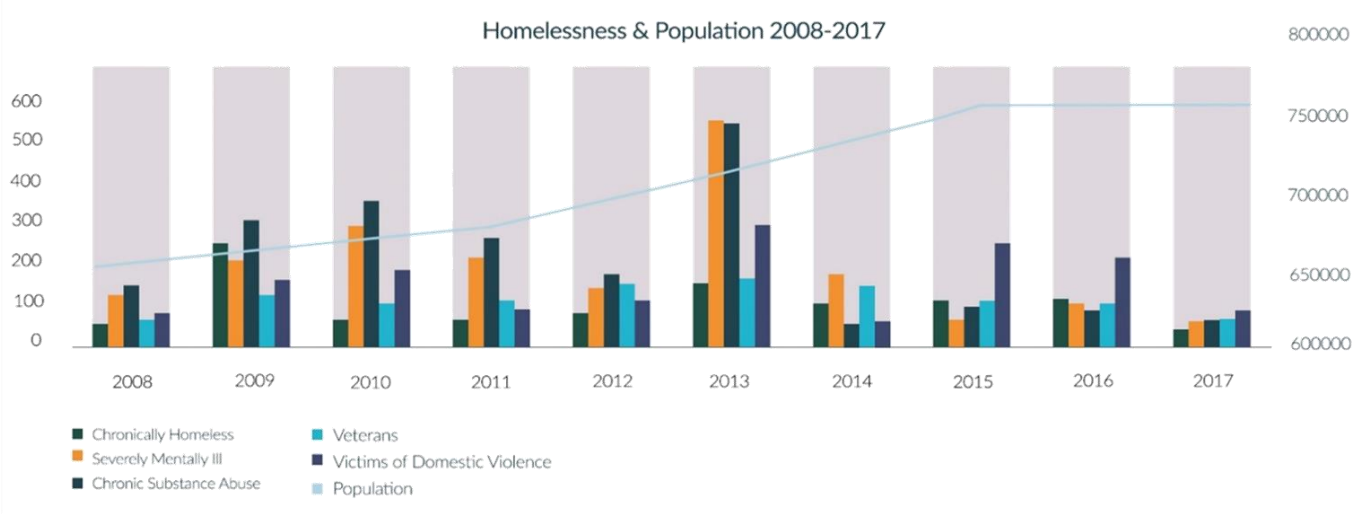
Jolene Kline, Chair
North Dakota Interagency Council on Homelessness

Executive Summary
#2449

Executive Summary

North Dakota's vulnerable populations require person-centered approaches to address their unique needs based on their current living situation, physical and mental health, and financial stability. In 2008, when the *North Dakota 10-Year Plan to End Long Term Homelessness* was implemented, North Dakota's primary focus was on permanent supportive housing for the chronically homeless. Although housing stability is the foundation of ending homelessness, over the past decade supportive services have become just as essential to prevent and reduce both short-term and chronic homelessness.

Counting the state's homeless populations is extremely difficult due to multiple definitions of homelessness, the mobility of the population, rural isolation, and the cyclical nature of homelessness for many individuals and families. In addition, people experiencing homelessness are often reluctant to identify themselves as such, therefore, many do not seek assistance. The U.S. Department of Housing and Urban Development (HUD) requires local service providers to conduct a Point In Time (PIT) Count every January to track sheltered and unsheltered men, women and children. North Dakota's 2017 PIT count totaled 1,089 homeless men, women and children, of which 45 were chronically homeless.



According to the U.S. Interagency Council on Homelessness, chronically homeless persons cost taxpayers as much as $30,000 to $50,000 per year. The cost is calculated based on services utilized such as hospitals, shelters, jail, psychiatric centers, and alcohol and drug treatment. Using the base national average of $30,000, North Dakota taxpayers spent approximately $1,350,000 million in 2017 on the state's chronically homeless population. Permanent supportive housing is estimated to lower that cost by 40 percent. Currently, two 'Housing First' facilities, where chronically homeless individuals are rapidly housed, exist in Fargo and Grand Forks. Although proven highly successful in conserving community resources, these projects are difficult to construct as conventional financing is not an option. Developers must leverage numerous federal, state and local financing programs, and solicit donations and private sector partnerships to structure the zero-debt financing the projects require. Low- and extremely low-income individuals can receive rental assistance which helps ensure rental income, unfortunately, only about one in four people who qualify for housing assistance actually receive it due to limited availability.

The North Dakota Interagency Council on Homelessness (NDICH) studied vulnerable populations based on their current housing situation, mental and physical wellbeing, family disposition, and justice involvement. Each of these populations can have safety nets in place that would effectively prevent or shorten their experience with homelessness if resources are effectively implemented.

- ***Chronically Homeless***—individuals and families residing in a place not meant for human habitation, in an emergency shelter, and who have been homeless and residing in such a place for at least one year or on at least four separate occasions in the last three years. North Dakota averages 138 documented chronically homeless individuals every year. The greatest concentration of community resources is spent on this population with most self-diagnosed as severely mentally ill or having chronic substance abuse problems.
    - State and federal funding is critical for financing permanent supportive housing.
    - Person-centered services are needed to stabilize these individuals and reintegrate them back into the community.

- ***Justice Involved***—persons with mental illness and substance abuse problems are overrepresented in our jails and prisons as compared to the general population. Deinstitutionalization, along with a failure to develop easily accessible and useful outpatient alternatives for treatment, has led to correctional facilities housing the highest concentrations of people with mental health and substance abuse concerns in the country.
    - Incarcerated individuals do not get the depth of mental health and addiction recovery services needed to become stable and sober after their release.
    - Difficulty finding affordable housing and employment, especially for felons such as sex offenders.

- ***Native Americans***—the magnitude of Native Americans experiencing homelessness on and off of the reservations is more than likely higher than the 21 percent currently reported. Reservations have the highest concentrations of extreme poverty in the state, and approximately half of all Native American children living in North Dakota are impoverished, more than five times the rate of other races. Over-crowding and inadequate housing conditions put stress on quality of life, as the majority of Native Americans will not force members in their household out if they do not have another housing option.
    - Approximately 78 percent of Native Americans live off of reservations to pursue educational and financial stability, however, many of these individuals lack support networks.
    - Historical trauma and assimilation of culture impacts the effectiveness of behavioral health treatment.

- ***Youth***—in 2017, according to the PIT count, there were 178 documented homeless children ages 0 to 18 years. School-age children, ages 5 to 18 years old, experiencing homelessness was reported much higher by the North Dakota Department of Public Instruction with 2,166 students documented as either sheltered, doubled-up with other families, living in a hotel/motel, unsheltered, or unaccompanied by an adult during the 2015-2016 school year. A major contributor to the financial stability and well-being of children is secure parental employment, unfortunately, many working families with children struggle to make ends meet. The poverty threshold considered sufficient for a family of four with two children to afford basic necessities was $24,036. In North Dakota, 21,716 children were living in families whose income was below this threshold.

- Support services in rural and urban areas can help stabilize families and youth lessening the need for relocation and out-patient treatment.
- State and federal funding critical for single-parent housing, providing life-skills support, daycare, after-school care, and career or educational advancement.

- ***Foster Youth***—in a survey of youth that aged out of the state's foster care system, 40 percent will experience homelessness by the time they are 21 years old. Of those experiencing homelessness, one out of every three has been incarcerated. North Dakota has the third highest youth incarceration per capita in the nation. Although the majority of foster youth obtain a GED or high school diploma and are employed, they face many challenges transitioning into adulthood without a strong support network.
    - Explore barriers to short- and long-term housing for unaccompanied, emancipated, and youth aging out of the foster care system.
    - Support services that are trauma, age and developmentally appropriate to mitigate emotional and behavioral deterrents.

- ***Frail Elderly and Disabled***— North Dakota ranks seventh in the nation in the highest proportion of individuals age 85 years and older. Based on the aging population, extended life expectancy, and likelihood of having a disability, it is anticipated that one out of two North Dakotans will need long-term care services such as nursing facilities, basic care, assisted living, swing bed or home- and community-based care in their lifetime. Disabilities includes ambulatory, visual, cognitive and hearing loss. Persons with a disability are more than twice as likely to be living in poverty as individuals without a disability.
    - Explore more options for rural and urban community-based alternatives for persons with disabilities and behavioral health issues.
    - Support grant programs for home modifications allowing people to age in place.

These vulnerable populations are the most housing insecure and cost-burdened, where 30 percent or more of their income is allocated to housing. Employed individuals earning minimum wage need to work 70 hours a week on average to afford a one-bedroom, market-rate apartment in North Dakota, and seniors living on the state's average social security payment alone can afford $400 per month in rent.

Moving Forward

The following recommendations are broad-based and will require dedication and investments from numerous state agencies to ensure vulnerable populations are receiving adequate services to accommodate their unique needs and to reintegrate them back into North Dakota's communities. Some of the recommendations are within the 2018 North Dakota Behavioral Health System Study and the State of North Dakota's Information Technology Department's Citizen Experience Initiative.

Breaking the Cycle of Generational Poverty

To end the cycle of generational poverty, children and their parents both need to be housing stable. Screening mechanisms need to be in place for service providers, primary care providers and school counselors to be able to identify problematic family dynamics and refer them to a case manager based on their current situation and complexity of need.

- Create more wrap-around service based housing programs for single parents with children.
- Expand outpatient and community-based services that are flexible such as peer support, community health workers, in-home and school-based clinical services and substance use disorder treatment services to address the behavioral health needs of children, youth and their families.
- Expand targeted, proactive in-home supports for families with children and youth at risk of foster care placement and justice involvement.
- Develop a streamlined process for homeless liaisons located in school districts across the state to be able to refer a case manager to assist families in accessing housing in both urban and rural communities.

Children that are not housing stable, are within the foster care system, do not graduate from high school, or have mental health or substance issues have a much higher probability of needing public assistance as an adult. Early detection and prevention are the best methods to help youth navigate difficult living situations.

- Explore barriers to create emergency shelters, low barrier housing, host homes and other short- and long-term housing options for youth and young adults who are unsheltered, fleeing an unsafe situation, or experiencing a housing crisis.
- Coordinate entry processes and support services that are trauma, age and developmentally appropriate.
- Review state and federal policies and processes impacting unaccompanied youth as well as youth aging out of the foster care system to determine any barriers that can be eliminated.

Lessening the Cost

Some individuals have complex medical and emotional needs, which prohibits their ability to live on their own without a social network assisting them. These individuals are classified as the chronically homeless and create the biggest financial burden on local medical, law enforcement and service providers.

- Finance more Housing First facilities creating more homes to stabilize the chronically homeless and provide funding for support and operations expenses.
- Explore the cost and benefit of funding "harm reduction" shelters, where residents can consume substances or come into a shelter under the influence of drugs and alcohol.
- Create consistent funding for state housing and service programs such as Housing Incentive Fund and the North Dakota Homeless Grant.

Government Efficiencies

The key to enhancing government efficiencies is to establish a systematic approach of clearly defined and repeatable steps where outcomes can be evaluated to generate consistent, optimum results. State agencies and local service providers are well connected and reach out to one another for assistance for the individuals and families they are helping, but most agencies expressed the need for more collaborative efforts to leverage resources and to be more responsive.

- The NDICH should be expanded to represent more stakeholders within government agencies, service providers and individuals and families that have experienced homelessness.
- Identify barriers preventing state agencies from accessing and leveraging HUD’s Homeless Management Information System (HMIS).
- Map the entry points for vulnerable populations and how they transition throughout state agencies and local service providers.
- Identify local, state and federal policies and regulations that hinder vulnerable populations and prioritize actions for change.

Covering the cost of public assistance is challenging for federal and state government and at the local community level. However, there are ways for the state to access additional federal funding through Medicaid to provide direct support to individuals and families.

- Pursue 1915(i) Medicaid state plan amendments to expand community-based services for vulnerable populations.
- Review long-term care facilities placement policies and explore options for community-based alternatives for persons with disabilities and behavioral health issues.

Client-Focused Delivery System

In order to expedite information gathering and to ensure current and accurate information is available, the state needs a consistent, end-to-end experience across all channels and departments where information can be obtained for any service, on any device and at any time. State agencies and local service providers expressed challenges they have noticed in their specific area and feedback from clients. Below are some of the ideas that were recommended:

- Housing Inventory - create an affordable housing inventory for each community/region
- Housing Forms - create a single form used by all regional housing authorities
- Database - create profiles for each client within a centralized database, so individuals or families applying for state or local benefits do not have to re-enter information
- Privacy Laws - review state privacy laws to ensure clients are protected, but at the same time do not hinder state agencies from accessing the information they need to be able to help a client that is transitioning services from one state agency to another.
- Consent Form - create a consent form signed by the client to release information to all state agencies and case managers
- User Profile - create an app or web portal where clients can enter their information that is stored and they can return at any time to complete.
- Online Chat - through an app or web portal, create an online chat function for clients to ask questions and be directed to the correct state agency or local service
- Services Portal - structure website into user categories and group information based on the client scenario, such as homeless or risk of becoming; searching for housing, employment or daycare, needing social services, youth, tribal, etc.

North Dakota's Plan to End Homelessness

North Dakota's Plan to End Homelessness

In 2004, President George W. Bush established a U.S. Interagency Council on Homelessness (USICH) to develop and implement a comprehensive, national approach to end chronic homelessness in America. That same year, President Bush and USICH issued an unprecedented collaborative effort between the U.S. Department of Housing and Urban Development (HUD), U.S. Department of Human and Health Services (HHS) and the U.S. Department of Veteran Affairs (VA) to make both permanent housing and supportive services funding available in a coordinated effort.[1] This was the initial investment towards developing a comprehensive national strategy to end chronic homelessness in 10 years.

At the state level, Gov. John Hoeven created the Governor's Interagency Council on Homelessness (NDICH) which consists of seven state agencies and one statewide homeless coalition, and the communities of Bismarck, Fargo and Grand Forks.[2] The intent of NDICH was to coordinate government policies, identify best practices, analyze individual and family needs, educate stakeholders, and solicit input from the faith and advocacy communities, businesses and the general public to prevent and end homelessness in North Dakota.[3] In 2008, NDICH finalized *North Dakota's 10-Year Plan to End Long Term Homelessness.*[4] A consortium of hundreds of individuals from state agencies, tribal nations, community and state stakeholders, and planning organizations participated in community forums, research studies and planning sessions.

Emphasis was placed on creating permanent housing and supportive services for the men, women, and children who would experience long-term homelessness during the next 10 years. North Dakota's goal was to assist local communities in providing housing, rent subsidies and supportive services, with a benchmark of creating 50 new permanent supportive housing (PSH) units each year to eliminate homelessness across the state. In order to reach this goal, five strategies were developed:

Strategy 1: Develop Permanent Supportive Housing

- Develop non-federal sources of "soft money"
- Create additional permanent supportive housing units
- Create partnerships between developers and service providers

Strategy 2: Improve the Ability to Pay Rent

- Eliminate barriers to employment
- Identify new sources for rent subsidies
- Improve access to mainstream supports (entitlement programs)

Strategy 3: Expand Supportive Services to Wrap Around Housing

- Connect supportive services to housing
- Prevent individuals from transitioning into homelessness or uncertainty

[1] U.S. Interagency Council on Homelessness Historical Overview. Retrieved from www.usich.gov/resources/uploads/asset_library/USICH_History_2016.pdf

[2] North Dakota Interagency Council on Homelessness. Retrieved from https://www.governor.nd.gov/boards/BoardDetails.aspx?boardid=124

[3] Exec. Order No. 2004-09 (2004). Establishing the Governor's Interagency Council on Homelessness.

[4] North Dakota's 10-Year Plan to End Long Term Homelessness. 2008. Retrieved from www.ndhfa.org/Publications/Reports/Partner%20Publications/ndich_finalplan.pdf

Strategy 4: Strengthen Prevention and Outreach Programs

- Emphasize protocols to close front door into homelessness

Strategy 5: Collect and Disseminate Data Relating to Long-Term Homelessness

- Collect information on homeless populations and services provided
- Market and measure progress

NDICH agencies assigned to specific goals within each strategy:

Job Service of North Dakota	JSND
North Dakota Department of Corrections & Rehabilitation	NDDOCR
North Dakota Department of Commerce	NDDOC
North Dakota Department of Human Services	NDDHS
North Dakota Housing Finance Agency	NDHFA
North Dakota Indian Affairs Commission	NDIAC
North Dakota Department of Public Instruction	NDDPI
North Dakota Coalition for Homeless People (private organization)	NDCHP

Progress reports were created in 2010 and 2013 and can be viewed on the NDHFA website.[5] The 2018 report captures the accomplishments over the past decade, lessons learned about the complexities of homelessness, challenges faced by the most vulnerable populations, and recommendations moving forward.

[5] NDICH homelessness reports 2008, 2010 and 2013. Retrieved from www.ndhfa.org/Publications/Resources.html

Accomplishments 2008-2018

Accomplishments 2008-2018

Seven state agencies were assigned to specific goals and strategies in the 10-year plan, but the majority of the accomplishments were achieved through partnerships between the agencies and local service providers consisting of faith-based and non-profit organizations working directly with the homeless and vulnerable individuals and families. The following are highlights of accomplishments achieved through this collaborative initiative.

Strategy 1: Develop Permanent Supportive Housing

Units

In 2008, the original goal was the creation of 50 new permanent supportive housing (PSH) units per year to reach the goal of 461 new PSH units by 2018. Across the state, NDICH members, service providers, and the private sector were involved in the construction or rehabilitation of 1,855 rental units for extremely low-, low-, and moderate-income individuals and families. Twenty-four percent of the units were PSH and 10 percent were allocated specifically for homeless individuals. Table 1 breaks down the type of units constructed or rehabilitated since 2008 by region. Figure 26 on pg. 35 is a map of the eight regions.

Housing Units Constructed or Rehabilitated With State Agency Involvement

	Permanent Supportive Housing Units	Homeless Units	Elderly Units	ADA Units
Region I	37	0	143	15
Region II	52	17	67	34
Region III	12	6	25	9
Region IV	50	42	7	17
Region V	133	60	344	106
Region VI	15	0	130	15
Region VII	96	46	69	36
Region VIII	53	13	211	45
State Total	**448**	**184**	**996**	**277**

Table 1. Housing units constructed or rehabilitated with state agency involvement, 2008-2017. Source: NDHFA

PSH encompasses the 'Housing First' model of rapid placement of homeless individuals into independent and stable housing, and serves as a platform from which they can pursue goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending anything less critical, such as getting a job, budgeting properly, or addressing to mental and behavioral health issues.[6]

Two Housing First, PSH projects were completed and are leased-up. In 2010, the Cooper House in Fargo was the first Housing First complex in the state and was made available exclusively to individuals who were documented as chronically homeless. The 42-unit PSH project was recognized by the National Association of Housing and Redevelopment Officers with a best practices award. The Cooper House become the template

[6] National Alliance to End Homelessness: Housing First. Retrieved from https://endhomelessness.org/resource/housing-first/

for LaGrave on First located in Grand Forks, which also provides 42-units, and opened its doors in 2018. At the time of this report, construction started on the Edwinton Place, a 40-unit complex in Bismarck.

Another proven model deployed is PSH housing for single parents and their children with the intent of transforming families from poverty to prosperity two generations at a time. The Jeremiah Program in Fargo prepares determined single mothers to excel in the workforce, readies their children to succeed in school and reduces generational dependence on public assistance. The Jeremiah Program apartments opened its doors in 2018 to serve 20 low-income families. In West Fargo, ground was broken for Grace Gardens which will provide shelter for 30 women and children seeking refuge from domestic violence. Grace Gardens will assist women to become stable and independent, while providing a safe and nurturing space for the children to attend daycare and after school programs.

Funding PSH

It is virtually impossible for developers to build units that are affordable to low- or extremely low-income individuals with only conventional financing. Lenders loan money for housing development based on the anticipated property income, and when rents are set to affordable levels, there is a huge gap between the money needed to build and the money lenders and investors provide. Most affordable housing financing deals involve a mortgage, tax credits and two or three other sources of money, however, it is not uncommon for developers to rely on upward of 10 financing sources as they try to fill the gap. Low- and extremely low-income individuals can receive rental assistance which helps ensure rental income, unfortunately, only about one in four people who qualify for housing assistance actually receives it.[7]

Funding PSH involves creative financing strategies and invested partners providing federal, state, local and private sector resources. Federal funding administered by NDHFA and NDDOC includes National Housing Trust Fund, Low Income Housing Tax Credits, Neighborhood Stabilization Program, HOME Investment Partnerships Program, Community Development Block Grant, and Emergency Solutions Grants. State funding sources include the North Dakota Homeless Grant and the Housing Incentive Fund (HIF).

HIF is a North Dakota based tax incentive providing critical gap financing for the construction, rehabilitation and preservation of multi-family housing targeted to essential service workers and low- to moderate-income households. HIF has been an instrumental tool in financing housing for individuals with disabilities, who are elderly, and those experiencing homelessness.

In 2011, the North Dakota State Legislature created HIF as a financing tool for taxpayers to receive a state income tax credit and help thousands of people who might otherwise have been priced out of the state's housing market during the peak of energy development. Individuals or corporate contributors received a dollar-for-dollar credit against their state income liability for the year they contributed. Contributions could be targeted to a specific project, community or region when applicable.

Over the course of six years, NDHFA allocated more than $89.6 million in HIF funding to 77 projects to construct or rehab 2,380 units in 26 urban and rural communities across the state.

[7] How affordable housing gets built (2016). www.urban.org/urban-wire/how-affordable-housing-gets-built



Figure 1. NDHFA Housing Incentive Fund projects awarded each year comparing HIF award amount and total project costs.
Source: NDHFA

Strategy 2: Improve Ability to Pay Rent

Eliminate Barriers

In addition to PSH, landlords must be willing to rent to individuals and families that have a history of justice involvement and financial instability. NDDHS administers the Money Follows the Person (MFP) program, which includes a housing initiative and regional supportive housing meetings to bring housing and service providers together to create successful transitions for vulnerable populations. MFP housing staff created regionally based landlord and service provider training focusing on fair housing, discrimination and service animals. The training also included presentations on current housing developments and programs that are successfully addressing challenges with tenants, community perception, and short- and long-term effectiveness to implement best practices in each region.

In 2018, NDDHS allocated $150,000 of MFP rebalancing dollars to Opening Doors: Landlord Risk Mitigation Fund which is a statewide program emulating a similar program successfully initiated by the Fargo-Moorhead Homeless Coalition. Opening Doors will provide insurance to landlords who lease to vulnerable populations and includes coverage for excessive damages or lost revenue. NDHFA implemented and is administering the program.

Vulnerable populations who are able to work cannot pay rent without securing reliable and sustainable employment. The NDDOCR authorized the Work Release While Incarcerated program at the Missouri River Correctional Center in Bismarck, ND. The program generated over $250,000 in compensation for inmates to secure funding for future housing and supplied the area with much needed labor in construction and food services.

JSND is leading numerous state- and region-based employment initiatives prioritizing individuals who are low-income, receive public assistance, are basic-skill deficient, incarcerated, or a veteran. On-the-job training, classroom training, trade adjustment assistance and building work experience are critical to assisting

individuals to become more self-sufficient and increase their earning potential. Some of the programs incorporate case managers to create a holistic approach for people to become successful. JSND staff also provide outreach to homeless shelters and correctional facilities on a monthly to quarterly basis if agencies are not able to bring their clients to JSND facilities.

In addition to helping individuals, JSND administers the Federal Bonding Program and the Work Opportunity Tax Credit. Both programs are an employer incentive guaranteeing the job honesty of a harder to employ individual by offering a safety net for employer reimbursement of up to $5,000 to hire ex-offenders, recovering substance abusers, and persons with poor credit or lack of work history.

Seeking and maintaining employment can be challenging, especially without reliable transportation. Many local service providers have funds to assist individuals with public transportation costs, however, public transportation is more accessible in urban areas than in rural areas. The NDDOT administers state and federal funding for transit services in rural, small urban and urban areas for individuals who are low-income, elderly or have disabilities to access employment, medical and educational facilities, and any other locations as needed. Figure 3 outlines the NDDOT's public transit provider service areas.

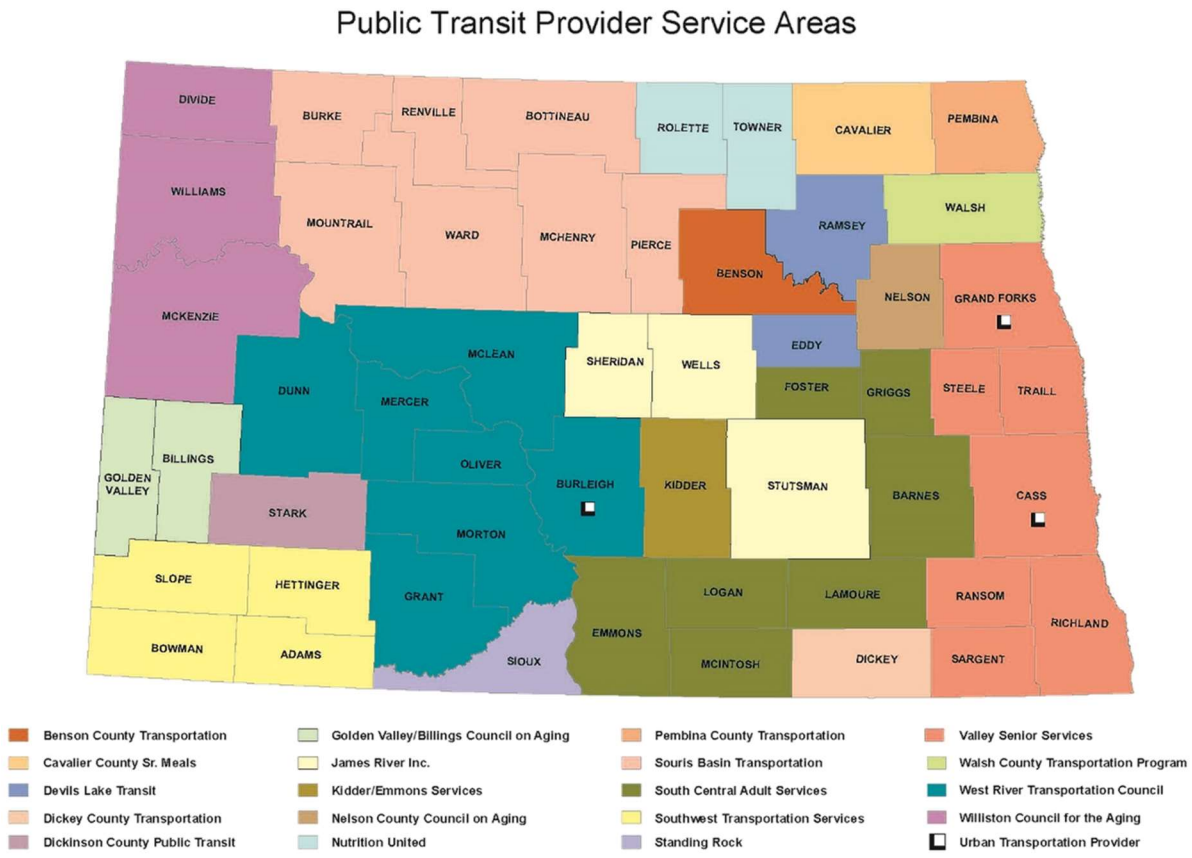


Figure 2. NDDOT Public Transit Provider Service Areas
Source: NDDOT

Rent Subsidies

Regional housing authorities and local service providers have access to funding or housing vouchers issued federally or through state agencies such as NDDOC and NDDHS. The vouchers are intended to assist very low-income, elderly and/or disabled individuals to be able to afford decent, safe and sanitary housing.

NDDOC's Emergency Solutions Grant for emergency shelter and homelessness prevention allows funding to be used for short- and medium-term rental assistance and services to stabilize and rapidly re-house individuals and families. The federal funds are consistently around $450,000 for this program and are distributed annually to more than 20 agencies across the state.

In 2013, the North Dakota legislature appropriated $2 million for the North Dakota Homeless Grant to be administered by NDDOC. The grant was designed after the federal Emergency Solutions Grant, but allowed for more flexibility to address the needs of homeless individuals and provide more rental assistance targeted to PSH. The grant also funds shelter operations, stabilization services, and rapid re-housing. The following biennium, the grant was appropriated $1.5 million and reduced to $300,000 during the 2017-2019 biennium.

HOME Investment in Partnerships program is another federal program administered by NDDOC that has provided subsidies to 666 households, totaling $1.1 million. Tenants can receive security deposit assistance, which contributed $1.2 million to 4,828 households over the past decade.

The U.S. Department of Health and Human Services awarded NDDHS for the Project for Assistance in Transition from Homelessness (PATH) grant. The program provides case management; one-time rental assistance to prevent eviction; security deposit assistance; and representative payee services. Recipients are those who are suffering from mental illness or co-occurring serious mental illness and substance abuse disorders and who are homeless or at imminent risk of becoming homeless. As a preventative measure, the program assists with one to three month's rent. Each of the state's eight regional Human Services Centers share the $300,000 PATH grant funds each year.

Strategy 3: Expand Supportive Services to Wrap Around Housing

Providing supportive wrap-around services is just as important as creating short- and long-term housing options for those in need. Services must address each person's and families' unique needs based on their current and historic housing and personal situations. Free Through Recovery, created in 2017, is a two-year, state-funded $7.5 million initiative administered by NDDOCR. The program pays for addiction counseling and behavioral health services delivered through social service, mental health, religious and cultural organizations throughout the state. The initial focus is on individuals on probation with a higher risk of recidivism. The program will require extensive local partnerships to meet urban and rural community needs creating on-going and consistent wrap-around services.

NDDOCR also has re-entry teams in Bismarck, Fargo, Grand Forks and Devils Lake consisting of community stakeholders that provide wrap around case management and supervision of offenders who are re-entering society. NDDHS, JSND, housing authorities, judges, tribal entities, local law enforcement and others are also involved. Among the outcomes tracked are housing status and this effort has improved housing stability for offenders and has been particularly successful in the Devils Lake area.

Finding employment is critical to becoming self-sustainable. JSND and NDDOCR host *Second Chance Job Fairs* in Bismarck, Grand Forks and Fargo for employers considered "felon friendly" to be able to interview individuals. In addition to job fairs, JSND actively provides workforce updates like job openings, recruitment efforts, and hiring events in communities across the state.

The Fargo area has successfully implemented a medical respite program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Medical Respite is short-term residential care that allows the homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. More than 20 community partners are providing funding for medical supplies, equipment, nursing services, case management, housing and living supplies for both men and women. Individuals can receive rapid housing and case management for six months after securing permanent housing if they agree to the program rules, are medically and behaviorally stable, and will comply with scheduled follow-up appointments. The average cost of Medical Respite care is $25 per day and the cost of acute care is $4,500 per day. Since 2016, the program has saved the Fargo region almost $3 million in acute care costs.

Navigating the process for support programs such as social security, SNAP benefits, Medicaid and Medicare can be challenging to understand the forms and program requirements in addition to the logistical barriers of accessing all of the agencies. NDDHS has designated PATH coordinators to assist helping individuals transitioning out of homelessness to apply for programs to promote recovery and wellness.

MFP is administered by NDDHS and is an $8.9 million grant from the Centers for Medicare and Medicaid Services to help approximately 110 Medicaid clients who are older adults or people with developmental disabilities transition from nursing homes or institutions and reintegrate them into the community. A full year of case management is provided in addition to $3,000 for one-time transition costs.[8]

MFP staff also created two pocket resource guides for six areas in the state providing contact information for supportive services and affordable housing providers. More than 25,000 guides have been disseminated across the state. Another publication created through the Supportive Housing Collaborative is The *Housing Resource Guide,*[9] which was created in partnership between state and federal agencies to bridge information and communication gaps for agencies, individuals and families needing to address the unique needs of persons with disabilities, who are elderly, and are experiencing economic hardship.

Strategy 4: Strengthen Prevention & Outreach Programs

State agencies assigned roles in the plan have worked together through programs such as MFP, Free Through Recovery, Opening Doors and PATH to assist those at risk of long-term homelessness to be able to find housing and successfully reintegrate back into the community. Another example of partnerships is Project Homeless Connect, which was an annual event in communities across the state. The Fargo-Moorhead Homeless Coalition transformed the event into a more on-going, holistic approach through a new endeavor, CARES (coordinated assessment referral and evaluation system). The regional system is a partnership between the Western Central Minnesota Continuum of Care (CoC), North Dakota CoC, Fargo-Moorhead Homeless Coalition, and White Earth Nation located in Minnesota. CARES streamlines access to services and makes the system client-centered.

Focusing on school-aged youth, NDDPI oversees approximately 150 district homeless liaisons to identify students experiencing homelessness, ensure their educational rights and provide a referral for the families or unaccompanied minors. Addressing the needs of homeless youth is a collaborative effort with state agencies and local service providers to determine a process for referring families to case managers.

[8] N.D. Money Follows the Person Grant. Retrieved from www.nd.gov/dhs/info/pubs/mfp/overview.html
[9] North Dakota Supportive Housing Collaborative: Housing Resource Guide. Retrieved from www.ndhfa.org/RentalAssistance/HousingResourceGuide0817.pdf

Project Service Connect has become an annual event in communities across the state. Homeless/Hunger Awareness Week activities have also been initiated. In most of the larger cities in North Dakota and the faith community has taken on an expanded outreach and emergency mission during winter months. These church sheltering operations have been crucial in providing a warm place to sleep for homeless individuals when weather conditions are life threatening.

Strategy 5: Collect & Disseminate Data Relating to Long-Term Homelessness

NDCHP organizes statewide collaborative meetings to share information pertaining to best practices, federal, state and tribal regulations, and serves as a connector between state and federal agencies and the local service providers. NDCHP also organizes the annual HUD Point in Time Count (PIT) with assistance from NDDOC to ensure homeless data counts for urban and rural areas.

Each state agency in addition to NDCHP works closely with the local media to promote program successes and to keep the public informed about the current homeless situation across North Dakota. In times of urgent response, such as severe winter weather, it is essential for the service providers to be able to communicate their needs and provide accurate information about homeless populations.

NDHFA sponsored a Statewide Housing Needs Assessment in 2012 and 2016 conducted by North Dakota State University's Center for Social Research to analyze population and housing trends. The 2016 housing assessment dove into the special needs of the state's subpopulations, which had not been analyzed before. Once the assessments were completed, NDHFA held regional forums with NDSU research staff to discuss the data and what the future looked like for each region. Economic developers, community leaders, legislators, service providers and the general public were engaged through the assessment process.

What We Learned

What We Learned

Counting homeless populations is extremely difficult due to multiple definitions of homelessness, the mobility of the population, rural isolation, and the cyclical nature of homelessness for many individuals and families. In addition, homeless people are often reluctant to be identify themselves as homeless, and many of them remain invisible even to the most diligent social workers. There is no uniform method for counting the homeless, instead indirect estimation, single-contact census, and capture-recapture studies are used to quantify this population.[10]

Local service providers use HUD's PIT methodology to conduct the annual PIT count for the state. The PIT focuses on counting sheltered and unsheltered homeless people. HUD requires communities receiving federal funds from the McKinney-Vento Homeless Assistance Grants program to conduct an annual count of all sheltered people in the last week of January. Electronic administrative records are used to enumerate people living in emergency shelters and transitional housing. Unsheltered counts are required every other year, although most communities conduct an unsheltered count annually. During the PIT counts, communities are required to identify whether a person is an individual, a member of a family unit, or an unaccompanied youth under the age of 18 or age 18 to 24. In addition, communities must identify if a person is chronically homeless, indicating long-time or repeated homelessness and the presence of a disability.[11]

In North Dakota, the homeless PIT count numbers have fluctuated as have the subpopulations. Figure 3 is a breakdown of the North Dakota's homeless subpopulations compared to the state's overall population growth. The subpopulations depict the complex issues surrounding homelessness that extends beyond not being able to afford housing. Local service providers and state agencies were unprepared for the magnitude of homelessness experienced across the state. When the 2008 plan was drafted, energy development catapulted North Dakota's economic development opportunities into the national spotlight attracting tens of

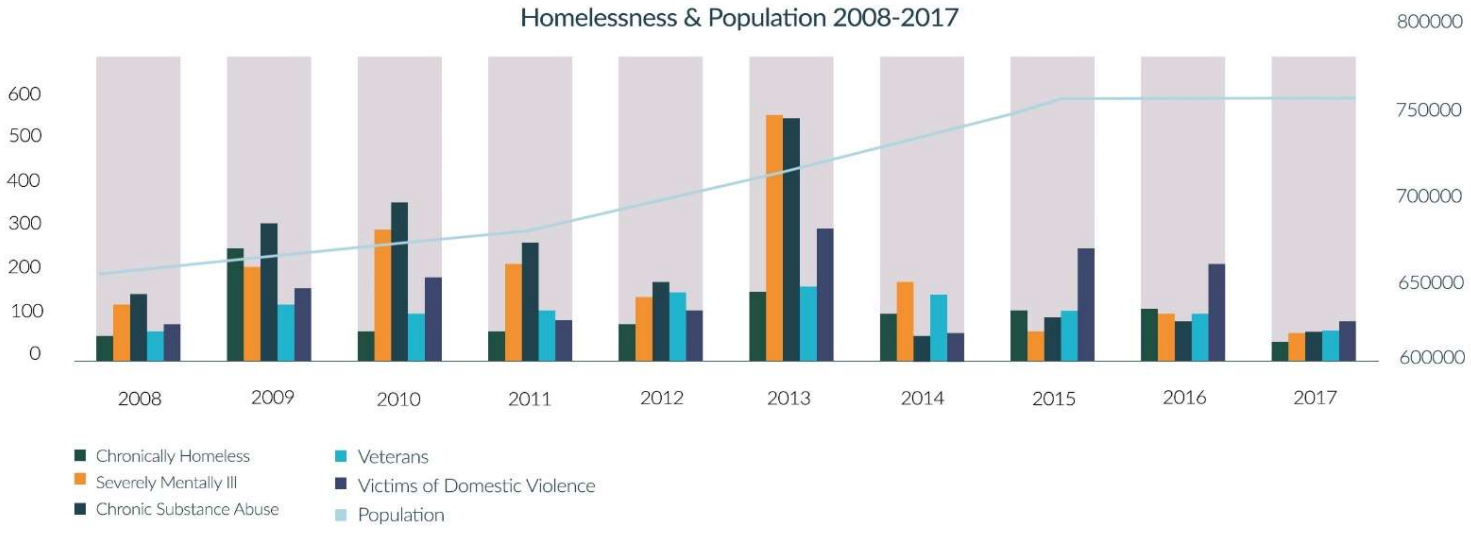


Figure 3. North Dakota's Homeless PIT Count and Population from 2008-2017
Source: North Dakota Homeless Coalition and U.S. Census Bureau

[10] The Methodology of Counting the Homeless. Retrieved from www.ncbi.nlm.nih.gov/books/NBK218229/
[11] What is a Point-In-Time Count? Retrieved from https://endhomelessness.org/resource/what-is-a-point-in-time-count/

thousands of people to the state, some without living arrangements. A statewide housing shortage forced people into homelessness even if they could afford to pay rent or purchase housing due to the limited housing stock available. People were doubling up, living in vehicles, and sleeping in churches. Some employers provided traditional housing options in addition to recreational vehicles or man camps. Along with the population influx and housing shortages, service providers were responding to increased domestic violence, human trafficking, substance abuse and incarcerations, which can be the cause as to why individuals experience homelessness.

Discrepancies between definitions of homelessness is evident based on NDDPI's school-aged youth homeless counts, which includes housing insecure and doubling-up. In 2016, NDDPI reported 2,166 children ages 5-18 either living in shelters, doubled-up, in a hotel/motel, unsheltered or unaccompanied by an adult. NDDPI's 2015-16 homeless student count is two times more than the state's PIT count; however, NDDPI tallies the count over the school year and has more consistent access to this vulnerable population resulting in more thorough identification and reporting.

North Dakota Department of Instruction Data
Homeless Youth Ages 5-18

School Year	Number of Students Identified as in Transition	Sheltered	Doubled Up	Hotel/Motel	Unsheltered	Unaccompanied
2012-2013	2,122	239	975	189	719	
2013-2014	2,395	236	1,096	256	807	171
2014-2015	2,715	196	1,397	246	876	150
2015-2016	2,230	151	1,440	151	371	193
2016-2017	2,166	228	1,186	107	179	223

Table 2. NDDPI Homeless District Liaisons Student Counts
Source: NDDPI

How Much Does Homelessness Cost

According to the U.S. Interagency Council on Homelessness, chronically homeless persons cost taxpayers as much as $30,000 to $50,000 per year. The cost is calculated based on public services utilized such as hospitals, shelters, jail, psychiatric centers, alcohol and drug treatment, and living on the street. PSH is estimated to lower that cost by 40 percent.[12]

The Cooper House, North Dakota's first Housing First project, opened in 2010 and a benefit-cost-analysis was conducted after 12 months of operation. Preliminary assumptions determined that the 66 tenants who lived in the Cooper House cost the public $552,895 the previous year. After being rapidly rehoused the public expense dropped to $348,755 a savings of $204,140 or 41.5 percent.[13] The savings were realized in the following cost centers: healthcare and medical, law enforcement and legal, detox, administration, and emergency shelters.

[12] Ending Chronic Homelessness in 2017. Retrieved from www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

[13] Cooper House Impact Report. Retrieved from http://fargohousing.org/files/pdf/Cooper%20House/Impact%20Reports/Cooper_House_Impact_Report_June_2013.pdf

In Fargo, healthcare facilities, housing providers, and case managers collaborated to create a medical respite program in response to the healthcare gap for homeless individuals. Respite care provides recuperative services for those who many not meet criteria for hospitalization, but are too sick or vulnerable to be discharged on the streets. National trends have documented lower mortality rates as well as a reduction in the inpatient length of stay, emergency department visits, outpatient clinic visits and readmissions to the hospital for homeless individuals who are discharged to medical respite compared to those that are discharged to the streets. In 2016, an analysis of the Fargo Medical Respite program demonstrated a savings of $2,658,150 in acute care costs in less than two years. The Fargo program is a hybrid of a traditional respite program, where patients are recommended to stay for approximately 45 days allowing medical staff to treat the individual and develop a plan to transfer them to housing with support services in place. The MFP Housing Program also gives each participant a small stipend to help them set up their new home as they transition into permanent housing.

Although there is data showing the successful implementation of housing and medical intervention for homeless individuals, much of the national data focuses on large metropolitan areas and does not represent the smaller urban centers and rural communities of North Dakota.

Vulnerable Populations

Progress has been made over the past 10 years to end homelessness, however, certain populations are still at a higher-risk of experiencing both short- and long-term homelessness. Housing, case management and healthcare needs to be customized to each of these groups to ensure the greatest level of stability and long-term success.

Chronically Homeless

Chronically homeless is defined as an individual or family that is homeless and resides in a place not meant for human habitation, in an emergency shelter, and has been homeless and residing in such a place for at least one year or on at least four separate occasions in the last three years. Chronically homeless families include the head of household with a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronical physical illness or disability.[14]

The median number of chronically homeless individuals in North Dakota over the past decade has been 75.5. The lowest count occurred in 2017 at 45, but averaged 138 annually from 2013-2016. The HUD PIT count is the only active means to document all chronically homeless individuals across the state, and it is conducted in January making it difficult to locate and document the unsheltered homeless.

North Dakota's chronically homeless population has more than likely experienced trauma in their childhood and have on-going mental health issues and substance abuse. For example, in 2017 of the 1,089 homeless and 45 chronically homeless individuals, 69 reported themselves as severely mentally ill, and 70 diagnosed themselves as having chronic substance abuse. The numbers for each category would probably be higher if they were medically diagnosed or if a case manager was able to document their condition instead of relying on self-reporting.

[14] HUD Defining "Chronically Homeless," 2015. Retrieved from www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

Housing the chronically homeless is challenging, and there is no one size fits all solution. Across the state, numerous partnerships have formed between federal and state agencies and local service providers to find housing models that best serve each community. Housing First is a rapid housing approach; homeless shelters are a temporary solution; and "harm reduction" shelters have been discussed in numerous circumstances as an alternative to dry shelters that are more prevalent and accepted by the general public. However, these housing models benefit urban areas and not rural communities. Rural-based homeless individuals and families are more "hidden" as they occupy tents, campers, abandoned houses, barns and ice fishing houses. Homeless individuals and families in rural areas have a more difficult time accessing services provided in urban communities.

Justice Involved

Persons with mental illness and substance use problems are overrepresented in jails and prisons as compared to the general population. Across the United States, deinstitutionalization, along with a failure to develop easily accessible and useful outpatient alternatives for treatment, has led to correctional facilities housing the highest concentrations of people with mental health and substance abuse concerns in the country. National data has shown that nearly 70 percent of adults entering jails and more than 50 percent in state prisons have a substance use disorder. Additionally, the number of mentally ill inmates in America's jails and prisons is reported to have quadrupled over the past 20 years. Research suggests that up to 50 percent of jail and prison inmates may have a mental health concern in addition to substance use disorders. Estimates of severe and persistent mental illnesses among incarcerated adults range from 15 to 25 percent, as compared to 5 to 8 percent in the general population.[15]

Data for North Dakota prison facilities in 2015 shows that over 70 percent of individuals entering prison have an active substance use disorder diagnosis. Beyond that, 41 percent of male inmates have a mental health diagnosis in addition to substance use disorders, and around six percent meet criteria for a severe and persistent mental illness. About 50 percent of female inmates have a mental health diagnosis in addition to substance use disorders, with 14 percent diagnosed with a severe and persistent mental illness.[16]

Individuals with behavioral health issues and criminal justice involvement have increased hardship in finding housing as many landlords are allowed to choose whether or not they lease to those with criminal records. If these individuals were treated for their behavioral health issues and not incarcerated as a form of treatment, they would have one less barrier to obtaining housing.

[15] Improving Access to Care for Justice-Involved Persons with Behavioral Health Needs. 2016. Retrieved from https://docr.nd.gov/sites/www/files/documents/media/Charter.pdf. p.4.

[16] Improving Access to Care for Justice-Involved Persons with Behavioral Health Needs. 2016. Retrieved from https://docr.nd.gov/sites/www/files/documents/media/Charter.pdf. p.4.

Characteristics of Justice-Involved Persons Utilizing HSC Services, SFY 2013-17

Characteristic	N	%
Gender		
Female	764	33.9%
Male	1,491	66.1%
Age		
Age 0 to 11	28	1.2%
Age 12 to 17	230	10.2%
Age 18 to 24	422	18.6%
Age 25 to 44	1,116	49.2%
Age 45 to 64	428	18.9%
Age 65 or Older	42	1.9%
Race/Ethnicity		
Latino/Hispanic	77	3.7%
American Indian or Alaskan Native	335	16.5%
Black or African American	89	4.4%
White	1,563	76.8%
Other Race	47	2.3%

Table 3. Characteristics of Justice-Involved Persons Utilizing HSC Services, SFY 2013-17
Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=2,271

Significantly more robust, wrap around services available to individuals within the community is critical, as individuals with justice involvement experience multiple barriers to accessing services. A common theme was that, in general, community-based treatment providers are resistant to serving individuals with criminal justice histories. Unfortunately, it is common for individuals to "burn bridges" with community treatment providers, which further limits their options. Another scenario described a "caste system" in both inpatient and community-based services, in which people who are justice involved face greater difficulty accessing services, receive lower-quality treatment, and are generally considered "less deserving" than those with no justice involvement.[17]

Another frequently cited challenge was access to housing. Felony convictions bar individuals from accessing HUD-funded and other publicly funded affordable housing options, and many private landlords are unwilling to consider renting to this population, especially if an individual is a registered sex offender. The instability of finding housing puts individuals at a higher probability of participating in activities that led to their incarceration. Justice involved individuals are not protected under the Fair Housing Act; therefore, landlords can reject their housing applications.

Even when individuals are able to find housing, they may have difficulty supporting themselves financially. Many have lingering justice involved issues as well as chemical dependency that needs to be addressed before being work-ready. As they address their behavioral and mental issues, seeking full-time employment may not be an immediate option as they need time and case management to adjust to life back in the community.

Another significant barrier to successful reintegration to the community concerns Medicaid eligibility. North Dakota is one of 19 states in which an individual's Medicaid benefits are terminated—rather than merely suspended—as soon as the person is incarcerated. This means that instead of activating coverage upon the

[17] 2018 North Dakota Behavior Health Study. 2018. p 83.

person's release, the person must reapply, impeding their successful transition back into the community. Since individuals are not eligible until they are officially released, prison staff assist individuals on what they need to do to get re-enrolled, but the individual themselves has to enroll again within 30 days of release.[18]

Behavioral Health

In 2016, almost 100,000 North Dakotans aged 18 and older met the criteria for a mental illness diagnosis, and an additional 23,454 people had a serious mental illness. The remaining 83 percent who have not received a diagnosis are nonetheless an important population for consideration, as this population includes young adults who may have behavioral health needs in the future, individuals from hard-to-reach populations who may be struggling with undiagnosed behavioral health challenges, and others for whom low-cost, proactive prevention strategies could prevent mental health conditions from occurring.[19]

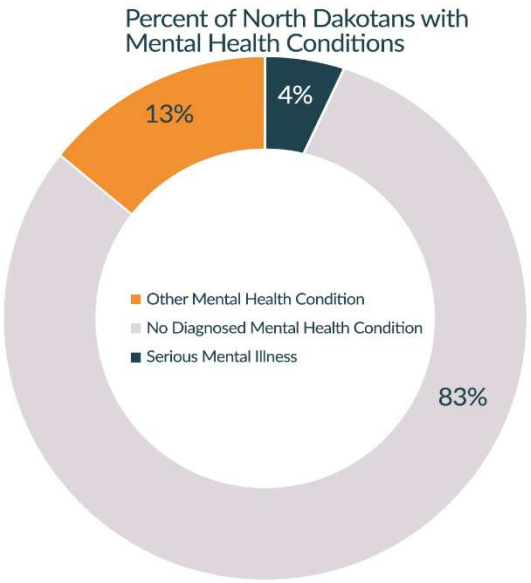


Figure 4. Percent of North Dakotans With and Without a Mental Health Diagnosis
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016, and U.S. Census Bureau, Population Division Release Date: June 2017

Among children and youth, the prevalence of mental health conditions is similar to national estimates. An estimated 12 to 25 percent of North Dakotan students have an emotional or behavioral disorder. In 2016, the annual average proportion of adolescents aged 12 to 17 with a major depressive episode in the past year was 11 percent, slightly lower than the corresponding national yearly average percentage of 12.8 percent.[20]

Table 4 presents numbers and characteristics of individuals who reported living in a homeless shelter or who received a health center service related to homelessness.[21] Table 4 likely underestimate the number of individuals with behavioral health needs who are homeless as the information only focused on recipients of some outpatient treatment.

[18] 2018 North Dakota Behavior Health Study. 2018. p 86.
[19] 2018 North Dakota Behavior Health Study. p 19.
[20] 2018 North Dakota Behavior Health Study. p 20.
[21] 2018 North Dakota Behavior Health Study. p 26.

Characteristic	N	%
Gender		
Female	695	40.3%
Male	1,030	59.7%
Age		
Age 0 to 11	15	0.9%
Age 12 to 17	10	0.6%
Age 18 to 24	154	8.9%
Age 25 to 44	825	47.8%
Age 45 to 64	672	38.9%
Age 65 or Older	50	2.9%
Race/Ethnicity		
Latino/Hispanic	64	4.0%
American Indian or Alaskan Native	281	18.2%
Black or African American	10	6.6%
White	1,121	72.6%
Other Race	40	2.6%

Table 4. Demographic Characteristics of People Who Are Homeless and Utilizing HSC Services, SFY 2013-2017
Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=1,735

Access to safe, adequate, and affordable housing is a critical element in supporting individuals with behavioral health needs to live independently in their communities. Unmet housing needs are obstacles to recovery and reduce the effectiveness of behavioral health treatment especially in rural areas. Most PSH units are based in Fargo and Bismarck, and other higher-population locations within the state and individuals will more than likely be relocated to these communities to be housed as part of their discharge plan from a mental health or substance use treatment facility. The lack of PSH in rural areas further complicates the accessibility for individuals seeking help outside of urban areas.

Within the Fargo-Moorhead area, three out of four homeless adults have serious health conditions, including mental and physical health problems, substance abuse disorder or evidence of a traumatic brain injury.[22] Based on an independent 2015 PIT survey commissioned by the Fargo-Moorhead Coalition for Homeless Persons, more than half of those surveyed were told by a doctor or nurse within the last two years that they had a serious mental illness, another 40 percent stated they had chronic physical health problems, and 30 percent considered themselves chemically dependent. These behavioral, mental and physical health issues impacted the respondents' ability to work, perform daily activities, manage finances and make sound decisions. Undiagnosed and untreated brain injuries may be an underlying cause of these issues. [23]

[22] Homelessness in Fargo, North Dakota and Moorhead Minnesota. 2016. Retrieved from http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2015/2015-homeless-fargo-moorhead-9-16.pdf

[23] Homelessness in Fargo, North Dakota and Moorhead Minnesota. 2016. Retrieved from http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2015/2015-homeless-fargo-moorhead-9-16.pdf

Native Americans

Native American's are the largest racial group other than whites in North Dakota, and in 2017 Native Americans totaled 21 percent of the state's total homeless population.[24] The amount of Native Americans experiencing homelessness is likely greater than then numbers reported due to the magnitude of homelessness both on and off of Reservations.

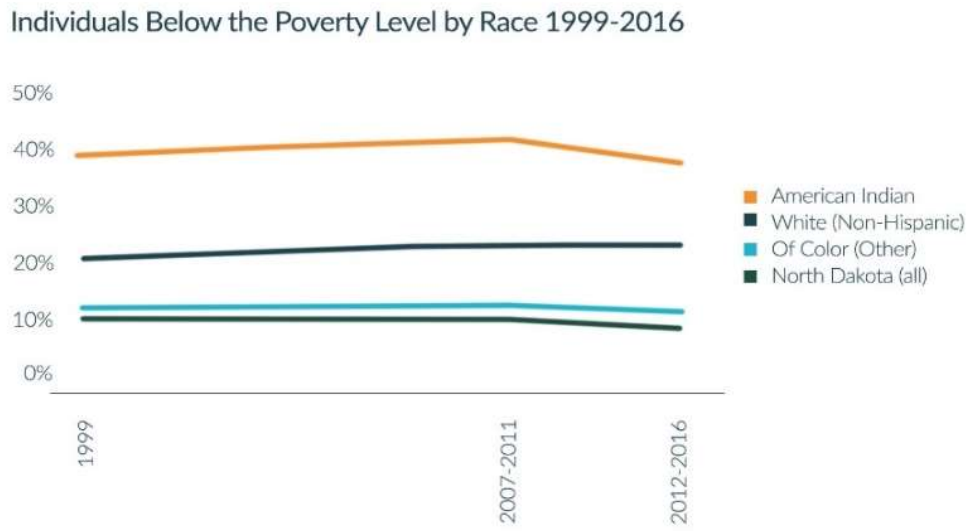


Figure 5. Individuals Below the Poverty Level by Race, North Dakota, 2012-2016
Sources: U.S. Census Bureau, Decennial Census and American Community Survey

The foundation of Native American culture emphasizes taking in family members and other tribal members who need a place to stay results in long-term doubling up of households. Therefore, the number of Native American's that would be considered homeless is more than likely higher than reported in the PIT count. Over-crowding and inadequate housing conditions put stress on quality of life, as the majority of Native Americans will not force members in their household out without another housing option.

Native American's face the highest percentage of poverty across all races in North Dakota, but the severity of poverty varies amongst the state's four Reservations.

[24] 2017 Point-In-Time Count ND. Retrieved from https://static1.squarespace.com/static/5570a318e4b02d3071ca7d2b/t/59934812db29d6ca444d0cde/1502824471561/PIT+Count+2017+%281%29.pdf

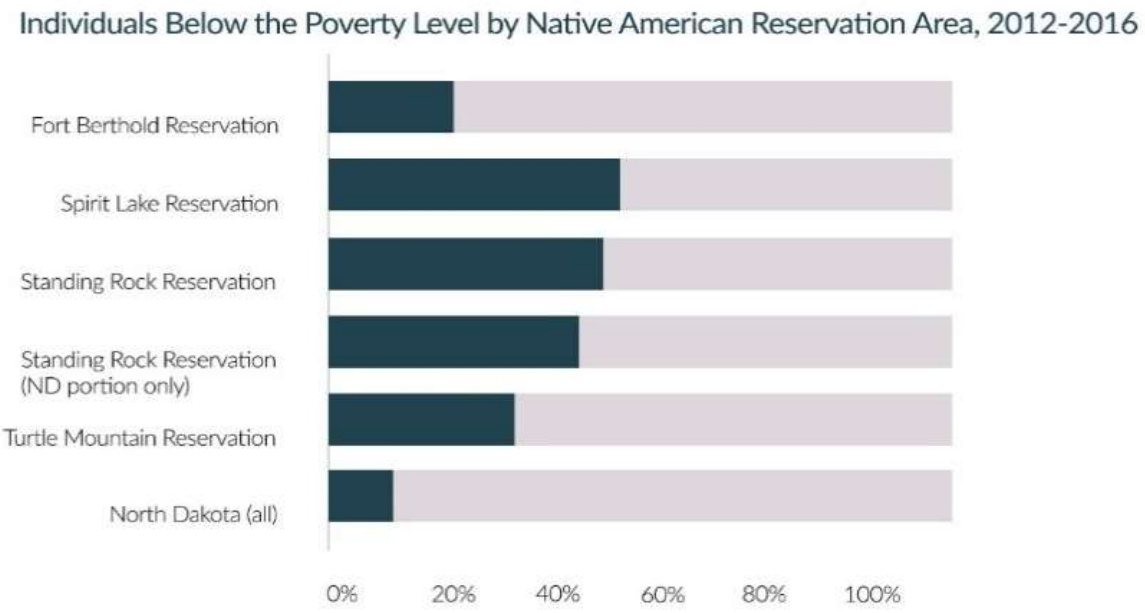


Figure 6. Individuals below the Poverty Level by Native American Reservation Area, North Dakota, 2012-2016
Sources: U.S. Census Bureau, American Community Survey

The poverty rate on the Fort Berthold Reservation is lowest due to the energy development that occurred on the reservation and surrounding area during the last decade. Other reservations do not have the same level of economic development opportunities which is exemplified by the percentage of cost-burdened households.

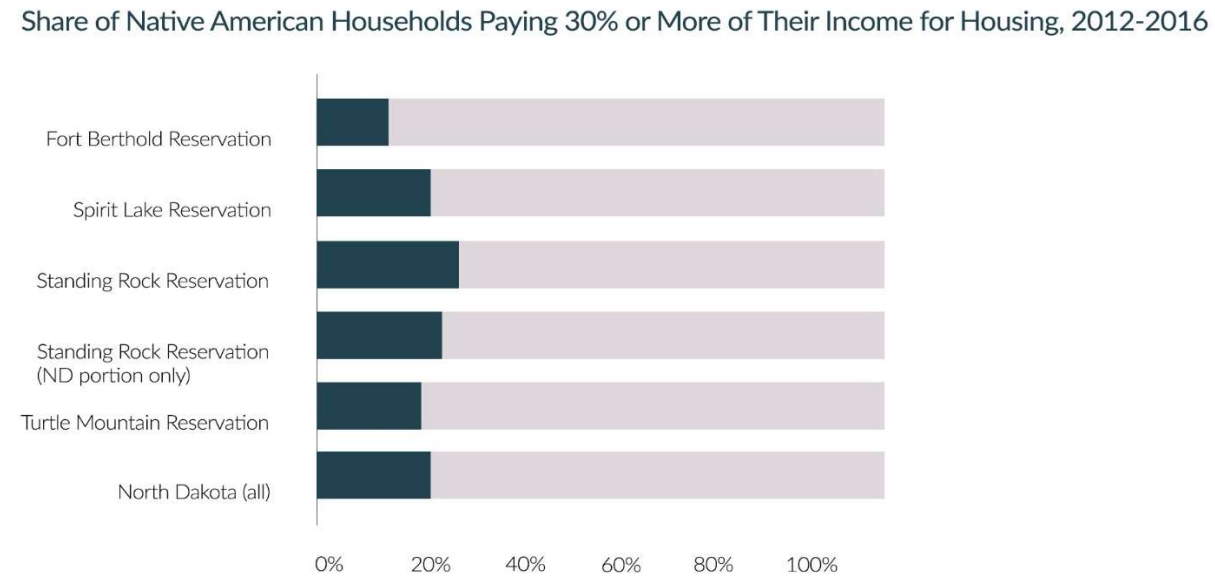


Figure 7. Share of Households Paying 30 percent or More of Their Income for Housing
Sources: U.S. Census Bureau, American Community Survey

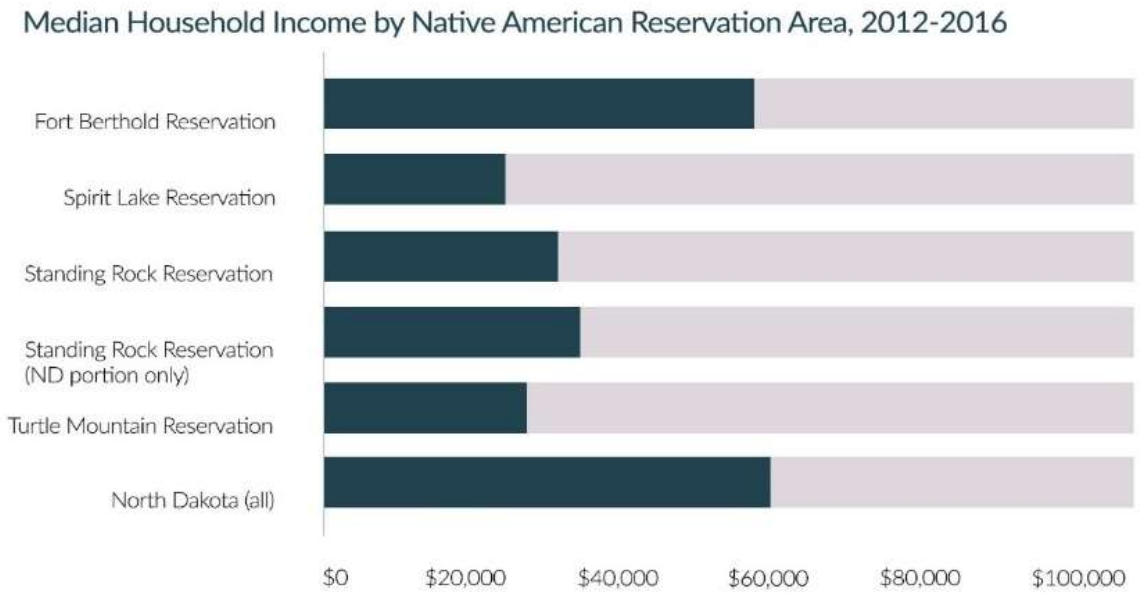


Figure 8. Median Household Income by Native American Reservation Area, North Dakota, 2012-2016
Sources U.S. Census Bureau, American Community Survey

Although there have been increased housing developments on the reservations, affordable housing options for homeownership and rental units is difficult to obtain. Construction of housing developments are usually smaller in total units and infrequent due to funding availability and fluctuating community needs; therefore, it is more challenging to access competitively priced building supplies and contractors willing to complete the project in a timely manner.

More than 40 percent of Native Americans are homeowners; however, mortgage lending on tribal land is an underserved market with unique challenges such as trust land, fractioned land ownership, and limited access to financial institutions. While tribal trust land status is no longer considered a major barrier since the implementation of Section 184 of the Indian Home Loan Guarantee Program, the volume of mortgage lending on tribal trust land is still quite small. Rental property managers on the Reservation deal with the same issues as properties off of the Reservation when renting to vulnerable populations: higher percentage of damaged the units, on-going criminal activity, and the tenants not paying rent on time.[25]

It is estimated that 78 percent of Native Americans live off of the Reservation, and poverty remains one of the most challenging aspects of urban Indian life. Whether or not Native Americans have financial stability off of the reservation, they have either experienced poverty themselves or know a family member who is living in poverty. Housing and homelessness remain at the top list of challenges they face.[26] The outmigration of youth and young families moving to more urbanized areas away from the reservations seeking higher educational and economic opportunities continues to increase. However, many Native Americans transition on and off the Reservation as they struggle to find support networks, fit in culturally, or they are not able to achieve financial stability.

[25] Mortgage Lending on Tribal Land. 20017. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/NAHSG-Lending.pdf

[26] Most Native Americans live in cities, not reservations. 2017. Retrieved from www.theguardian.com/us-news/2017/sep/04/native-americans-stories-california

YOUTH

In 2017, there were 178 documented homeless children ages 0 to 18 years old living in an emergency shelter, transitional living facility, or unsheltered according to the HUD PIT count.[27] School-age children, ages 5 to 18 years old, experiencing homelessness was reported much higher by NDDPI with 2,166 students documented as either sheltered, doubled-up with other families, living in a hotel/motel, unsheltered, or unaccompanied by an adult during the 2015-2016 school year.

Limitations in data collection and self-reporting may have resulted in a lower total number of homeless children or those at risk of homelessness across the state, as the U.S. Census estimated nearly 50,000 North Dakotan children are living in families with an income below 200 percent of the federal poverty level. Half of all Native American children living in North Dakota were impoverished in 2015, more than five times the rate for white children at nine percent.[28]

Further complicating the wellbeing of children is the state's rise above the national average for child maltreatment, which encompasses both abuse and neglect. In 2015, 1,760 North Dakota children were victims of maltreatment; specifically for every 1,000 children ages 0 to 17 in the state, 10.4 were abused or neglected. Of these victims, 77 percent were neglected, 32 percent were psychologically abused, 12 percent were physically abused, and four percent were sexually abused.[29] Physical, sexual and mental abuse during childhood are the leading causes for long-term homelessness as adults.

Juvenile delinquency has potentially high stakes for both individuals and society as a whole. Delinquency is linked to higher crime rates in adulthood and other adverse outcomes such as homelessness. One estimate suggests that between 50 and 75 percent of adolescents who have spent time in juvenile detention centers are incarcerated later in life. A total of 3,471 North Dakota juveniles ages 10 through 17 were referred to court at least once for delinquent or unruly behavior in 2016. [30] Following a national downward trend, the number of North Dakota juveniles referred to court has decreased an average of five percent annually since 2003. [31]

Local service providers have expressed their concern about assisting youth with opioid addiction and the difficulties in getting this population help and housing to keep them off of the streets. Youth with trust issues towards adults is extremely difficult to convince to seek help.

A major contributor to the financial stability and well-being of children is secure parental employment; however, many working families with children struggle to make ends meet. In 2015, the poverty threshold considered insufficient for a family of four with two children to afford basic necessities, was $24,036. In North Dakota, 21,716 children were living in families whose income was not meeting this threshold. Younger children, ages 0 to 4 in the state had a higher poverty rate than older children ages 5 to 17, 16 percent compared to 13 percent respectively. In eight North Dakota counties, at least one in five children was living in poverty. Children living on Native American reservations tend to have the highest child poverty rates in North

[27] Point-in-Time Count ND-500 North Dakota Statewide CoC. Retrieved from www.ndhomelesscoalition.org/new-page-2/
[28] U.S. Census Bureau. 2012-2016 American Community Survey 5-Year Estimates, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[29] Centers for Disease Control and Prevention (CDC).2016. Retrieved from www.cdc.gov/ace/ and www.ndkidscount.org.
[30] Child Trends (2015). Juvenile Detention. Retrieved from www.childtrends.org/indicators/juvenile-detention.
[31] Child Trends (2015). Juvenile Detention. Retrieved from www.childtrends.org/indicators/juvenile-detention.

Dakota. Data from 2015 indicate that about half of all children in Rolette and Benson counties were impoverished, 49 percent and 48 percent respectively.[32]

The Temporary Assistance to Needy Families Program (TANF), designed to help families in need to achieve self-sufficiency, assisted 4,649 North Dakota children ages 0 through 19 in 2016, down five percent from 4,887 in 2015.[33] The Supplemental Nutrition Assistance Program (SNAP) provided food to 37,758 North Dakota children ages 0 through 18 in 2016, 21 percent of children statewide. In North Dakota public schools, 37,928 children were eligible for free or reduced-price lunches in 2016, 33 percent of total school enrollment. In five of North Dakota's 53 counties, Sioux, Rolette, Benson, Sheridan and Mountrail, at least half of students were eligible for free or reduced-price lunches in 2016.[34]

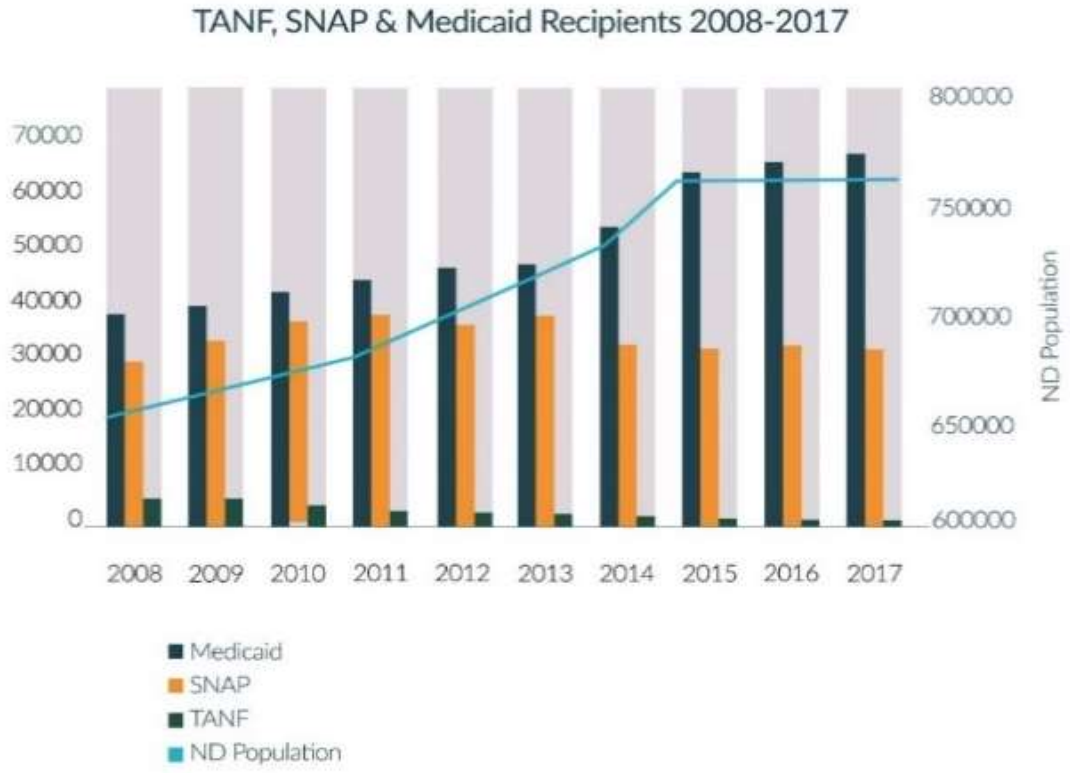


Figure 9. TANF, SNAP and Medicaid Recipients 2008-2017
Source: NDDHS

However, taking care of young children while holding down a job can be challenging. This is especially true for single parents who may have as many child-related demands on their time as married parents, but half as many adults in the household to meet them. To allow parents to work or attain the education necessary to become employed and self-sufficient, 6,610 children benefited from the North Dakota Child Care Assistance program in 2016, 5 percent of all children ages 0 through 13 statewide.[35]

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[32] U.S. Census Bureau. 2017 Poverty Thresholds for 2015 by Size of Family and Number of Related Children Under 18 Years. Retrieved from www.census.gov/data/tables/ time-series/demo/income-poverty/ historical-poverty-thresholds.html.

[33] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

[34] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

[35] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

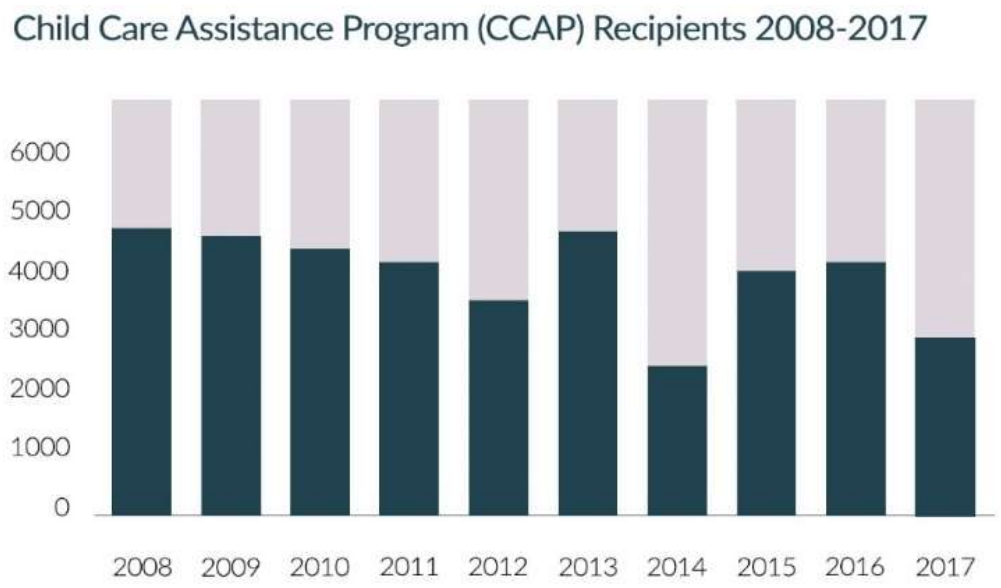


Figure 10. Child Care Assistance Program (CCAP) Recipients 2008-2017
Source: NDDHS

High-quality child care nurtures, stimulates and supports children as they build the confidence and critical thinking capacities they need to thrive in school and life.[36] In North Dakota, single parents pay 34.2 percent of their income for infant-center care. Married parents of two children living at the poverty line pay 66.9 percent of their household income for center-based child care. The cost of infant care in North Dakota is more than the annual cost of college tuition at a four-year college. The average price of center-based child care for an infant costs nearly a year of mortgage in North Dakota.[37]



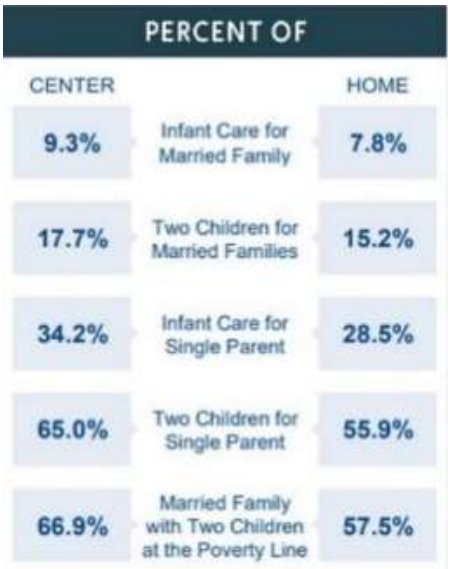


Figure 11. North Dakota Cost of Child Care in 2017
Source: Childcare Aware of America

[36] The Annie E. Casey Foundation (2006). Family, Friend, and Neighbor Care. Retrieved from www.aecf.org/
[37] ChildCare Aware of America. North Dakota. Retrieved from https://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/

Foster Youth

In 2017, 2,048 youth were placed in foster care with the median annual increase over the past decade at six percent.[38] Often youth in the foster care system have lived through multiple traumas and disruptive events such as abuse and/or neglect, multiple foster home placements, lack of continuity in education, and an array of lost relationships such as friends, families, and/or siblings by the time they begin their transition into adulthood. Their life experiences can create additional problems resulting in mental illness and substance abuse, and an increased likelihood of incarceration and homelessness.

On average, 130 foster care youth turn 18 years old each year in North Dakota. At this point, youth can either age-out of the system or enroll in the 18+ Continued Care Program, which allows youth to remain in foster care until they turn 21 years old as long as they are enrolled in higher education. Of those turning 18, approximately 37 percent utilize the 18+ program annually.[32]

North Dakota Youth in Foster Care

	Calendar Year									
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of Youth in Foster Care	1482	1615	1701	1678	1812	1990	2109	2264	2329	2408
Number of Youth Turning 18 in Foster Care	92	116	166	131	127	141	131	141	147	108
Number of Youth Using the 18+ Program	NA	NA	NA	NA	42	48	57	53	53	45

Table 5. North Dakota Youth in Foster Care, Turning 18, 18+ Program, North Dakota, 2008-2017
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

In 2015, NDDHS – Children and Family Services Division completed the National Youth in Transition Data Base (NYTD) Cohort Survey, which surveyed current and former foster youth at ages 17, 19 and 21 to measure outcomes for youth following their discharge from foster care. By engaging these individuals at three different ages, the state can better understand the experiences of foster youth following their release from the program. The survey compares North Dakota to the national average in homelessness, substance abuse, incarceration, giving birth to or fathering a child, employment, public assistance, and education. The following five outcomes are outlined in the survey report.[39]

Outcome 1: Experiences with Homelessness

Leaving foster care unprepared to live on their own, puts youth at risk of becoming homeless soon after discharge. At each age level surveyed, North Dakota foster youth experience homelessness more than the national average. These youth have more than likely been homeless before age 17 and will more than likely remain homeless for an extended period then youth not in foster care.

[38] North Dakota Department of Human Services-Children and Family Services Division.
[39] National Youth in Transition Data Base. North Dakota Department of Human Services-Children and Family Services Division.

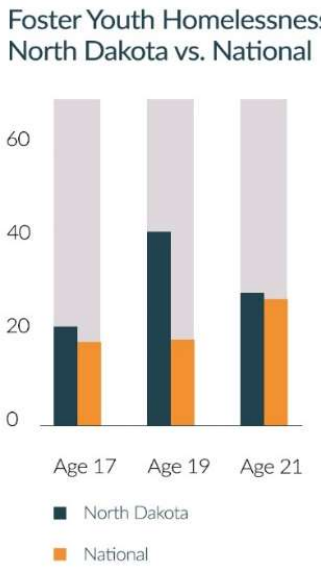


Figure 12. North Dakota Homeless Foster Youth vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 2: High-Risk Behaviors

North Dakota youth percentages are higher than the national average for substance abuse, incarceration and giving birth or fathering a child. These three scenarios hinder successful transition into adulthood among youth in foster care.

At age 17, almost half of the survey respondents had at some point during their lifetimes been referred for substance abuse assessment or counseling, and 20 percent of age 19 respondents and 14 percent of the age 21 survey respondents reported having had a referral to substance abuse assessment or counseling within the past two years. Youth incarceration rates in North Dakota are the third highest per capita in the nation. The data indicate that one out of every three homeless young adults surveyed has been in either foster care or correctional care as a juvenile. Youth emancipating from the Youth Correctional Center pose a particular challenge. Former foster youth continue to find themselves homeless at a significantly higher rate than their peers.

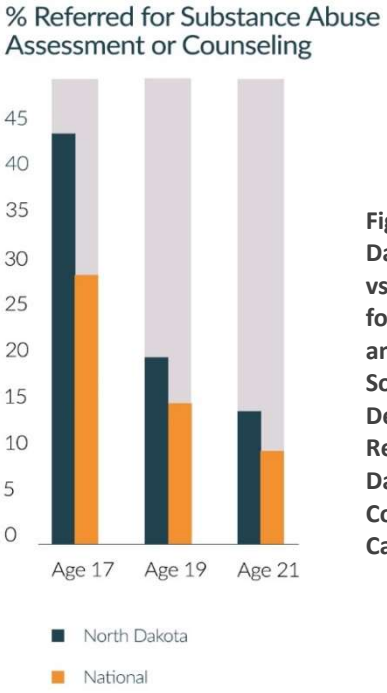


Figure 13. North Dakota Foster Youth vs. National Average for Substance Abuse and Counseling
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

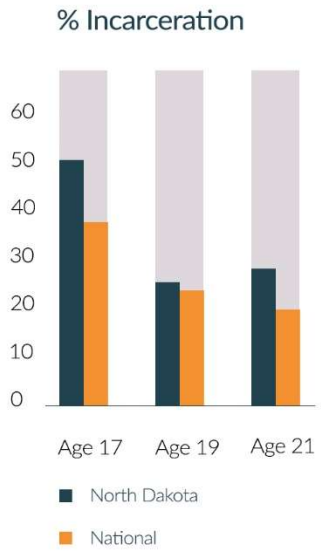


Figure 14. North Dakota Foster Youth Incarceration vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 3: Access to Health Insurance

Access to health care can help ensure that youth receive the prevention and treatment services they need to remain healthy and manage behavioral health issues or substance abuse. Youth in title IV-E foster care are categorically eligible to receive Medicaid. Additionally, some provisions under the Patient Protection and Affordable Care Act increased access to health care for youth formerly in foster care, including the extension of Medicaid coverage to young people up to age 26 in certain circumstances.

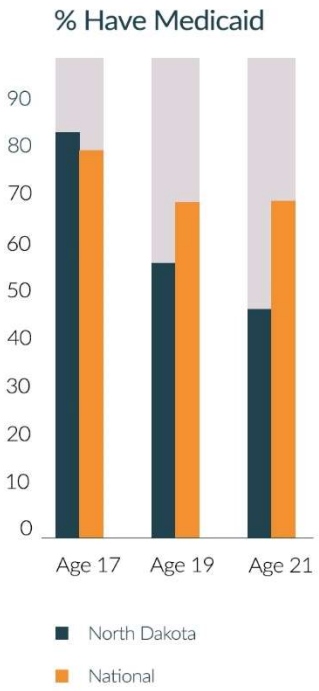


Figure 15. North Dakota Foster Youth with Medicaid vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

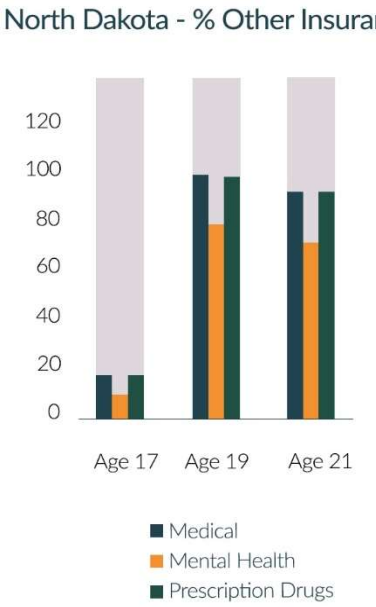


Figure 16. North Dakota Foster Youth with Insurance Coverage
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 4: Financial Self-Sufficiency

As youth age and make decisions about whether or not to remain in or return to foster care, financial stability becomes a crucial indicator of their readiness for independence. Over 18 percent of age 17 respondents reported working either full- or part-time; at age 19, 43 percent were working full- or part-time, and at age 21, 61 percent were working full- or part-time. By age 21, 24 percent of North Dakota respondents reported receiving public assistance compared to 38 percent nationally. Fewer respondents reported receiving educational, financial assistance than those responding on the national level.

Outcome 5: Educational Attainment

Achieving a high school diploma or General Equivalency Degree (GED) can be considered a minimal requirement for self-sufficiency and can assist in establishing a solid educational foundation that will prepare youth for future educational pursuits. Respondents were asked to report their current enrollment status in an educational program, and the highest educational certification received. Ninety-seven percent of age 17 survey respondents had not yet received any educational certification, but 91 percent of them indicated they were currently enrolled in and attending some type of educational program. By age 19, 65 percent of survey respondents had received a high school diploma or GED, and by age 21 the percentage had increased to 67 percent.

Frail Elderly

The number of elderly households is projected to increase substantially as a result of the baby boom cohorts aging forward into the next age category. Such households on limited or fixed incomes can be vulnerable to becoming burdened by housing costs. Nearly half of all North Dakota renter-occupied households ages 65 and older were cost-burdened in 2014, and 17 percent of owner-occupied households ages 65 and older were cost-burdened.[40] Increased healthcare costs put additional pressures on housing-burdened households forcing many elderly individuals to abstain from medical treatments and medications resulting in declined heath, eventually forcing them out of their homes and into assisted living and nursing home facilities.

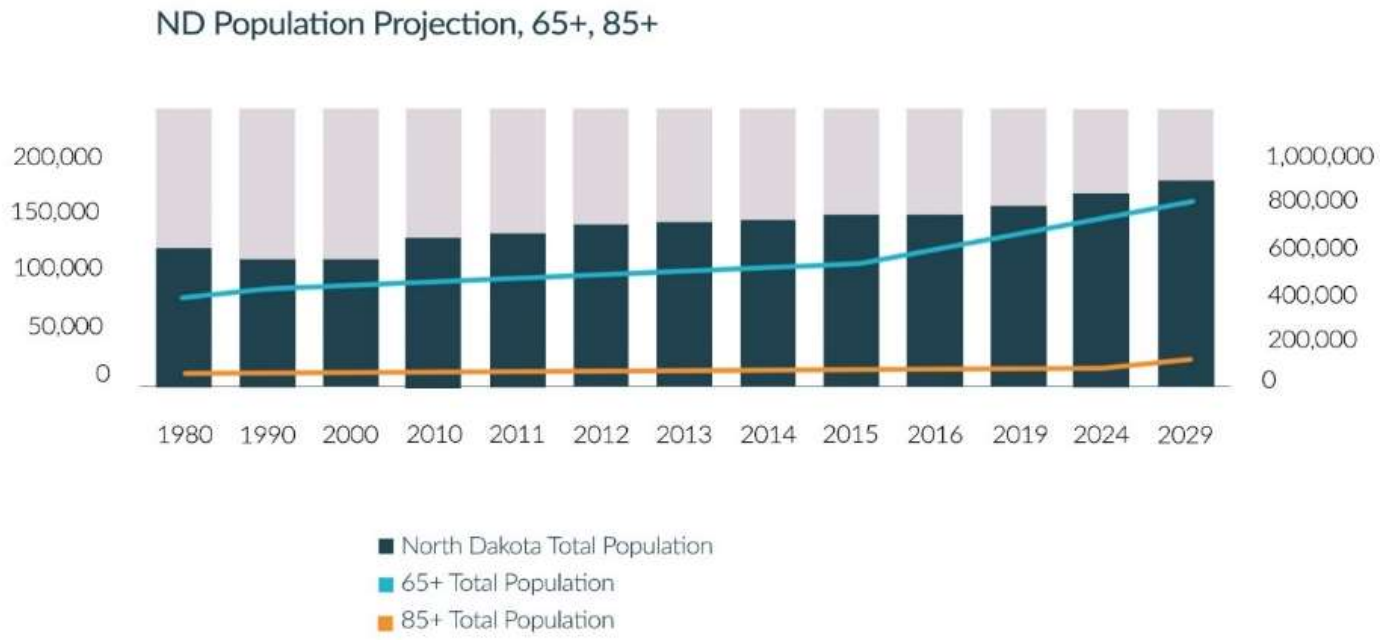


Figure 17. North Dakota Population Projections for the total state, 65+ and 85+, 2029
Source: U.S. Census Bureau, Decennial Census and Population Estimates, Center for Social Research at NDSU

[40] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 13.

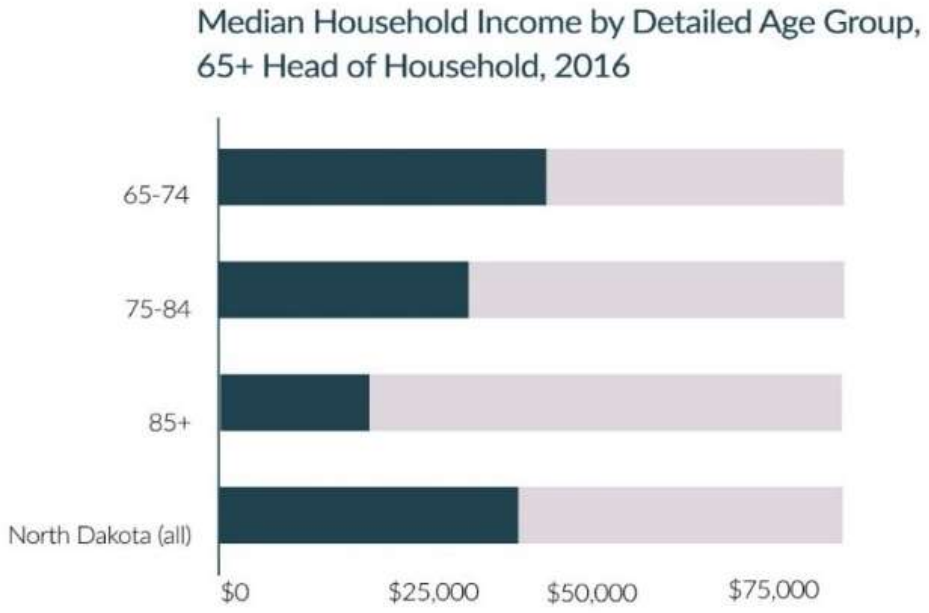


Figure 18. Median Household Income by Detailed Age Group, 65+ Head of Household
Source: Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey

North Dakota ranks seventh in the nation in the highest proportion of individuals age 85 years and older. Based on the aging population and extended life expectancy, it is anticipated that one out of two North Dakotans will need long-term care services such as nursing facilities, basic care, assisted living, swing beds or home- and community-based care in their lifetime. In 2017, there were more than 16,000 individuals in basic care, assisted living or skilled nursing facility. The state has the oldest nursing home residents with 47 percent aged 85-95 years, which is the highest in the nation and is the second highest in the nation with 9.2 percent over the age of 95.[41]

Table 6 below is an overview of the level of care North Dakotans receive outside of their home. Elderly households that are able to retrofit their homes to address mobility challenges are the least cost-burden solution for the individual and the state.

[41] North Dakota Long Term Care Facts & Figures. 2017. Retrieved from www.ndltca.org/image/cache/NDLTCA_Facts_and_Figures_2017.pdf

North Dakota Long Term Care 2017

	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Assisted Living	85%	7%	8%	51%	17%	9%	23%				
Reason	Assitance with daily care, social isolation, limited community services, need for supervision			Advancing medical need and growing cognition issues neccessitate the move to a higher level of care.				$2,341*	75	2,924	95%
	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Basic Care	54%	12%	34%	60%	8%	13%	19%				
Reason	Needs assistance and supervision, confusion			Medical needs, physical liminations and growing cognitive issues are why over half are admitted into a skilled nursing facility				$3,668**	62	1,818	82%
	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Nursing Facility	54%	12%	34%	na	na	49%	na				
Reason	Assitance with daily care, need for supervision, falls, dementia, and complex medical needs							$7,871	80	6,141	94%

* Cost ranged from $923 to $4,380 per month. Cost for services average $1,017, with a range of $13 to $4,000 per month

** Cost ranged from $2,300 to $5,100 per month

Table 6. North Dakota Long Term Care 2017
Source: North Dakota Long Term Care Association

Disabled

In North Dakota, 11 percent of the total population, or 72,674 people reported having a disability including ambulatory, visual, cognitive, and hearing to needing assistance with self-care and independent living. The employment rate for persons with a disability is much lower than for those without a disability. The disparity in employment between individuals with a disability and those without is illustrated by the difference in mean annual earnings. In 2014, mean annual earnings for the non-institutionalized population ages 16 and older with a disability in North Dakota was $22,377 compared to $31,754 for persons without a disability. Considering the lower rates of employment and lower mean annual earnings among individuals with a disability in North Dakota, the higher prevalence of poverty among those with a disability is not unexpected. Individuals with a disability were more than twice as likely to be living in poverty as individuals without a disability. Twenty-four percent of persons with a disability lived in poverty compared to 10 percent of persons without a disability.[42]

[42] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 16-8.

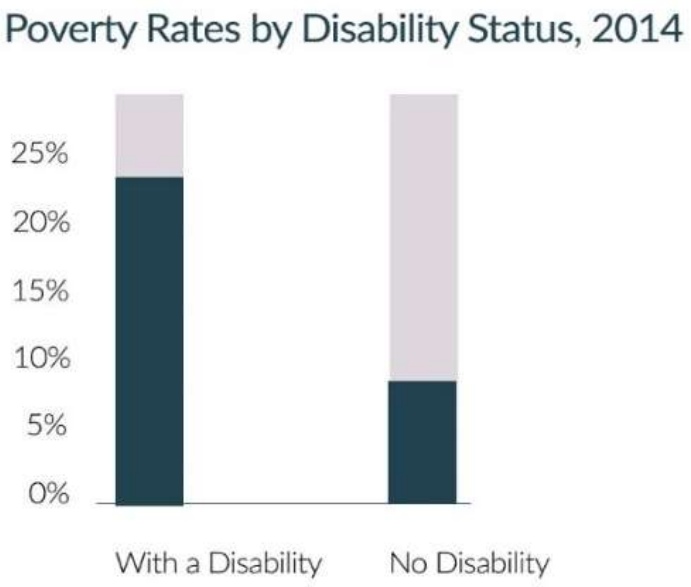


Figure 19: Poverty Rates by Disability Status in North Dakota, 2014
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates

Persons less than 65 years old with disabilities are projected to increase by 6,108 by 2029, a 15 percent increase. The number of individuals with a disability ages 65 and older is projected to increase by 17,092, a 52 percent increase by 2029. Disability rates were assumed to remain the same until 2029, 6.7 percent for the 0 to 64 age category and 34.4 percent for the 65 and older age group. However, future trends on the proportion of the population with a disability should be monitored. In recent years, the number of people with a disability increased faster than the increase in the number of people without a disability.[43]

[43] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 16-8.

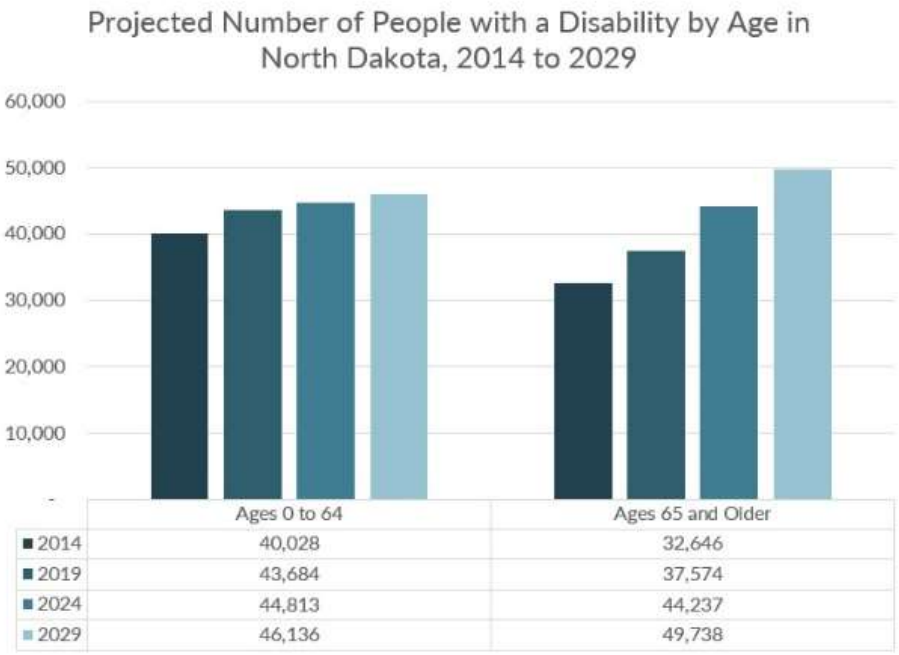


Figure 20: Projected Number of People with a Disability by Age in North Dakota, 2014-2029
Source: U.S. Census Bureau and the Center for Social Research at NDSU

The North Dakota State Hospital provides inpatient and residential care for substance abuse and severe mental illness. Individuals served by the State Hospital often have multiple needs and diagnoses—they may struggle with both mental illness and substance abuse, have developmental or cognitive disabilities, traumatic brain injuries, or other conditions that render them unable to care for themselves. Most patients treated at the State Hospital were discharged to their residence. Nearly all other patients were discharged to some other type of group-living or institution. Of all the discharges from 2010 to 2014, 60 percent were discharged to a personal residence, 14 percent were discharged to intermediate care facilities, 13 percent to correctional facilities, and 12 percent to another inpatient facility. While a majority of state hospital patients were discharged to known locations, a small percentage of discharges were classified as housing insecure. Examples of housing insecure discharge types include homeless shelters, left against medical advice, discharged after a court appearance, and unknown. The number of housing insecure discharges have increased since 2010. In 2010, 12 discharges were categorized as housing insecure. In 2015 the number of housing insecure discharges per year had doubled to 24. Put into another context, in 2015, on average, two discharges per month were housing insecure discharges. [44]

[44] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 18-9.

Veterans

In the past decade, the North Dakota Department of Veterans Affairs and the Fargo VA Health Care System's Homeless Veterans Program has worked with 1,200 veterans experiencing homelessness across the state. North Dakota's VA has 275 HUD-VA Supportive Housing (VASH) Program vouchers that are available to veterans and their families to live in market-rate rental units with the VA providing case management services. Utilization of the vouchers across the state is 90 percent, and no veterans are on a waiting list.[45]

Since 2006, the mortality rate among homeless veterans in North Dakota has dropped from 20 percent to 1.46 percent in 2016. Predominantly the cause of death is medically and age-related. Less than one percent is reported as suicides. Community Action of North Dakota is in the process of submitting data to HUD-VA to have North Dakota declared at "Functional Zero" for homeless veterans.[46]

Challenges of Affording a Home

Affordable housing is a function of both the supply of low-cost housing and the income levels of residents. Table 7 provides a benchmark of income levels for residents in the state and is designed to align closely with various federal housing programs. The benchmark of $69,600 in 2014 is based on median family income (MFI) of North Dakota residents as reported by HUD. Six categories of income are provided for program purposes and are based on a percentage below or above the state's MFI. Monthly affordable housing costs were estimated at 30 percent of the corresponding income category while affordable purchase price was based on a more complex formula that is typical of those used by lenders. The main assumptions include a 30-year loan fixed at 4 percent interest, 5 percent down payment, property taxes at 1.25 percent of the loan, property insurance at 0.6 percent of the loan, and total debt at no more than 20 percent of income.[47]

Income Categories Based on Income as a Percentage of the Median Family Income (MFI) FY 2014 (FY 2014 MFI = $69,600 in North Dakota)

Characteristic	Extremely Low: 0 to 30% MFI		Very Low: 31% to 50% MFI		Low: 51% to 80% MFI		Lower Moderate: 116% to 140% MFI		Upper: Above 140% MFI	Tax Credit: 0% to 60% MFI	
	From:	To:	From:	To:	From:	To:	From:	To:		From:	To:
Annual Income Ranges ($)	$0	$20,880	$20,881	$34,800	$34,801	$55,680	$55,681	$80,040	$97,441 and above	$0	$41,760
Monthly Affordable Housing Costs ($)	$0	$522	$523	$870	$871	$1,392	$1,393	$2,001	$2,437 and above	$0	$1,044
Affordable Purchase Price ($)	$40,351		$67,504		$108,612		$189,313		$227,168	$80,734	
Percent of Owner-Occupied Housing Units that Are Affordable	15.4%		22.1%		43.0%		63.3%		81.7%	29.9%	
Percent of Renter-Occupied Housing Units that Are Affordable	27.9%		69.8%		87.3%		90.2%		91.1%	75.7%	

Sources: Calculations based on data from the U.S. Census Bureau and the U.S. Department of Housing and Urban Development

Table 7. North Dakota Annual Income Level Category Characteristics, 2014
Source: Center for Social Research at NDSU, U.S. Census Bureau, HUD

[45] North Dakota Veterans Administration, Diana Hall, 2018.
[46] Fargo VA Medical Center, Diana Hall, Programs Manager for Housing and Appointment Programs. Email 2018.
[47] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 21.

Based on these assumptions, the purchase price of a home for a family below 30 percent of the MFI would be $40,351. At present, only 15 percent of the owner-occupied housing units in the state are affordable for people in this income circumstance. Similarly, only 28 percent of the rental units in the state are affordable to those below 30 percent of the state's MFI. In contrast, those in the moderate income bracket have a much greater inventory of appropriately priced housing; 70 percent of the current owner-occupied housing stock and 91 percent of rental units would be affordable for moderate-income households.[48]

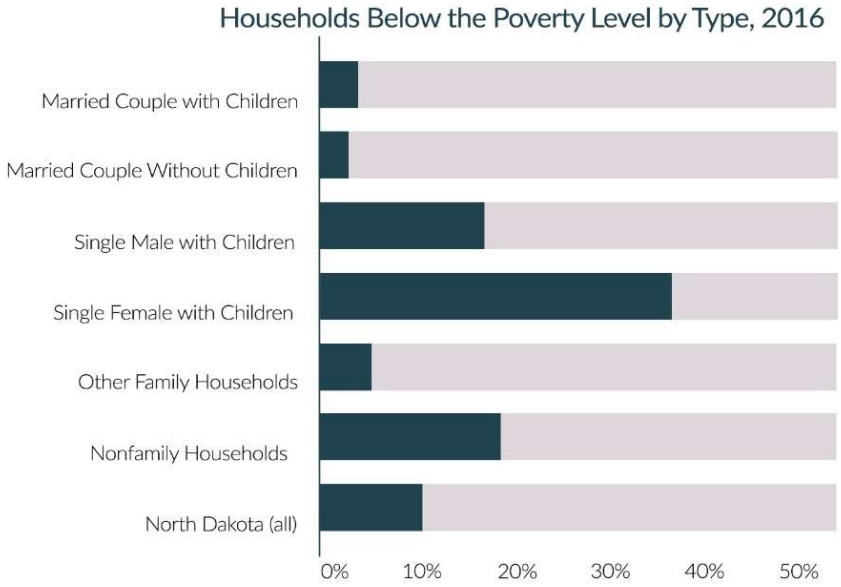


Figure 21. North Dakota Household Below Poverty Level by Type, 2016
Source: U.S. Census Bureau, American Community Survey

It is assumed that renting a home or apartment is more accessible than owning one; however, North Dakotans face extreme challenges to be able to afford an apartment. The state-set minimum wage is $7.25 an hour, and a person earning minimum wage would need to work 70 hours per week to afford a one-bedroom rental at the Fair Market Rent rate. Tenants would need to earn more than twice the minimum wage to only have to work 40 hours a week and be able to afford the Fair Market Rent for a two-bedroom rental home without paying more than 30 percent of their income. In addition to the income challenge, the number of rental housing units available in the state as of 2016 was only 40 per 100 extremely low-income renters.[49]

[48] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 21.
[49] The Gap: A Shortage of Affordable Homes, 2017. Retrieved from http://nlihc.org/sites/default/files/Gap-Report_2017.pdf

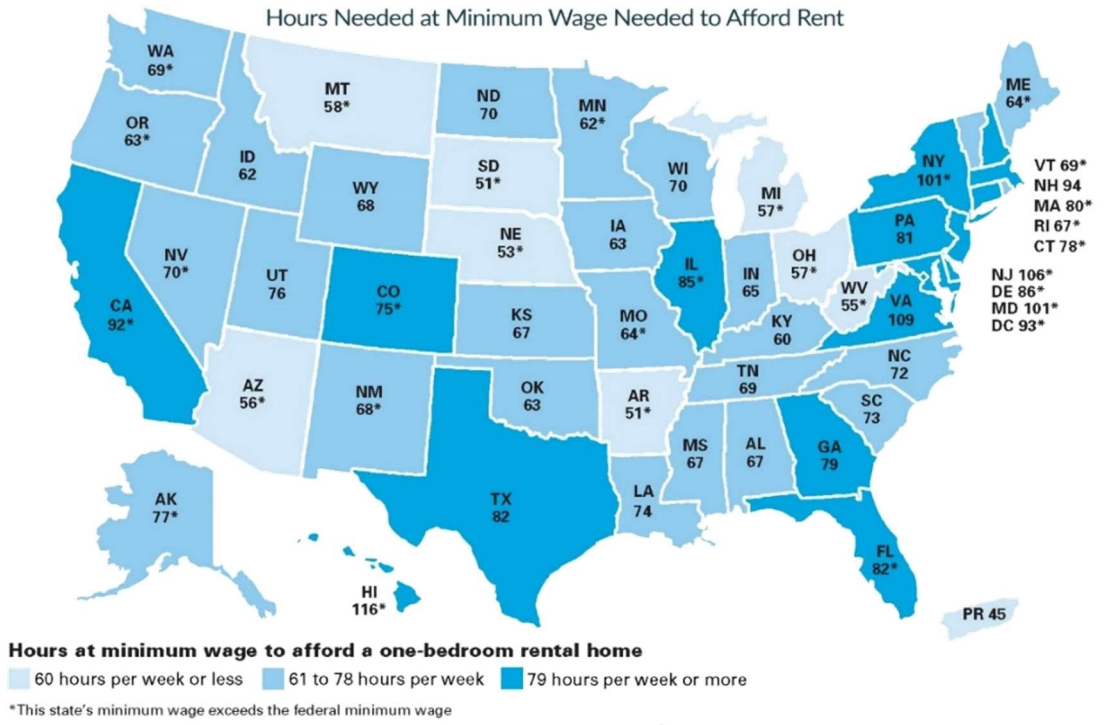


Figure 22. 2017 Hours Needed At Minimum Wage Needed to Afford Rent
Source: National Low-Income Housing Coalition

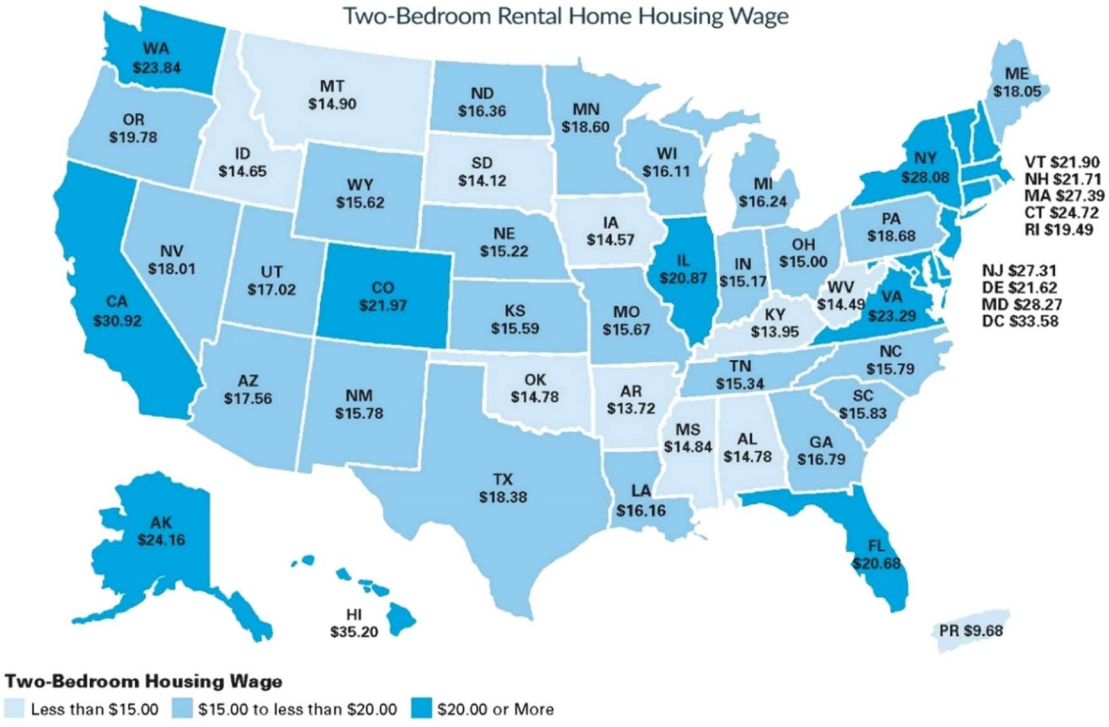
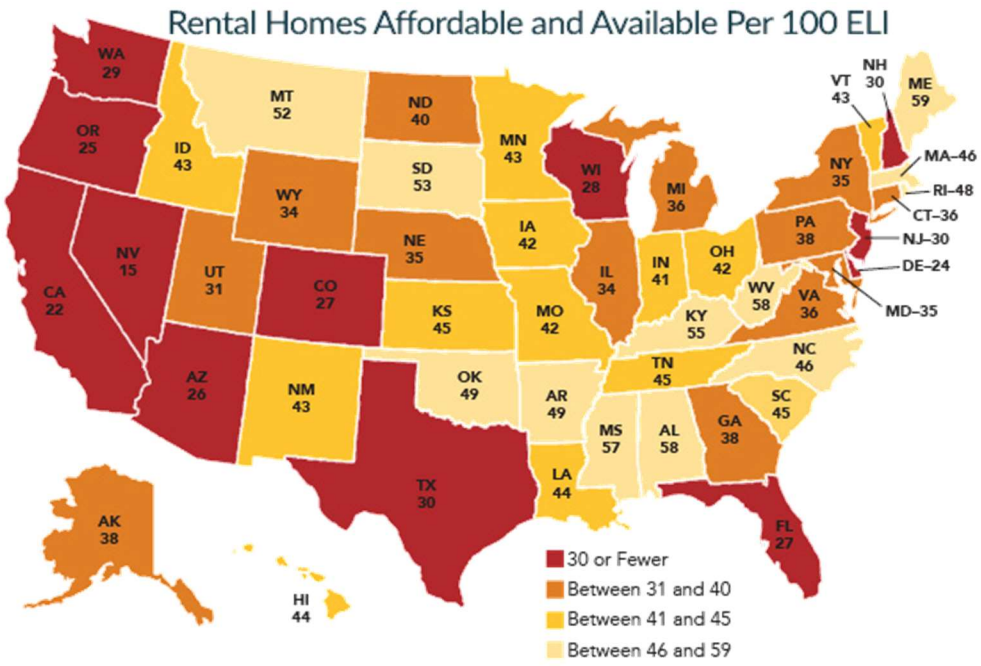


Figure 23. 2017 Two-Bedroom Rental Home Housing Wage
Source: National Low-Income Housing Coalition

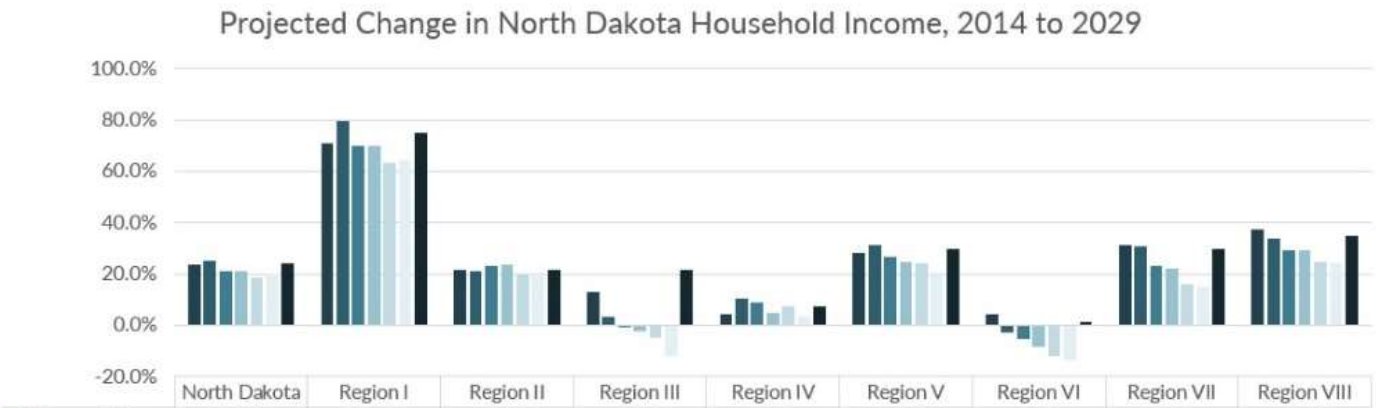


Note: Extremely low income (ELI) renter households have incomes at or below the poverty level of 30% of the area median income

Figure 24. Rental Homes Affordable and Available Per 100 Extremely Low-income Renter Households by State
Source: National Low-Income Housing Coalition

North Dakota is divided into eight housing and planning regions as shown in Figure 24 and each have unique strengths and challenges concerning housing stock, population growth and aging, economic development, and rural, urban and tribal reservations communities. Projected change in the number of households by income is an indicator of potential future housing needs. Double-digit growth is anticipated across all household income levels statewide as shown in Figure 25. Projected change is higher in the lower income brackets than the higher income brackets, and change in households is the greatest for extremely low and very low-income households with projected increases of 24 and 25 percent, respectively. Region I will experience the highest increase across all income groups while the most disparity in growth rates among household income levels is in Region VII where growth in the extremely low- and very low-income categories is double that of the higher income brackets at 31 percent. [50]

[50] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 27-8.



	North Dakota	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII
Extremely Low	23.6%	71.0%	21.5%	13.1%	4.2%	28.3%	4.2%	31.5%	37.6%
Very Low	25.4%	79.7%	21.3%	3.4%	10.3%	31.3%	-3.0%	30.6%	33.6%
Low	21.1%	69.7%	23.1%	-0.8%	9.0%	26.5%	-5.2%	23.2%	29.3%
Lower Moderate	21.1%	69.8%	23.9%	-2.5%	4.7%	24.8%	-8.5%	21.9%	29.4%
Moderate	18.6%	63.3%	20.0%	-4.7%	7.2%	24.4%	-12.0%	15.8%	24.9%
Upper	19.9%	64.4%	20.7%	-11.7%	3.5%	20.5%	-13.3%	15.0%	24.2%
Tax Credit	24.0%	74.8%	21.4%	21.4%	7.4%	29.6%	1.3%	29.9%	34.7%

Figure 25. Projected Change in North Dakota Households by Household Income 2014-2029
Source: U.S. Census Bureau, Center for Social Research at NDSU

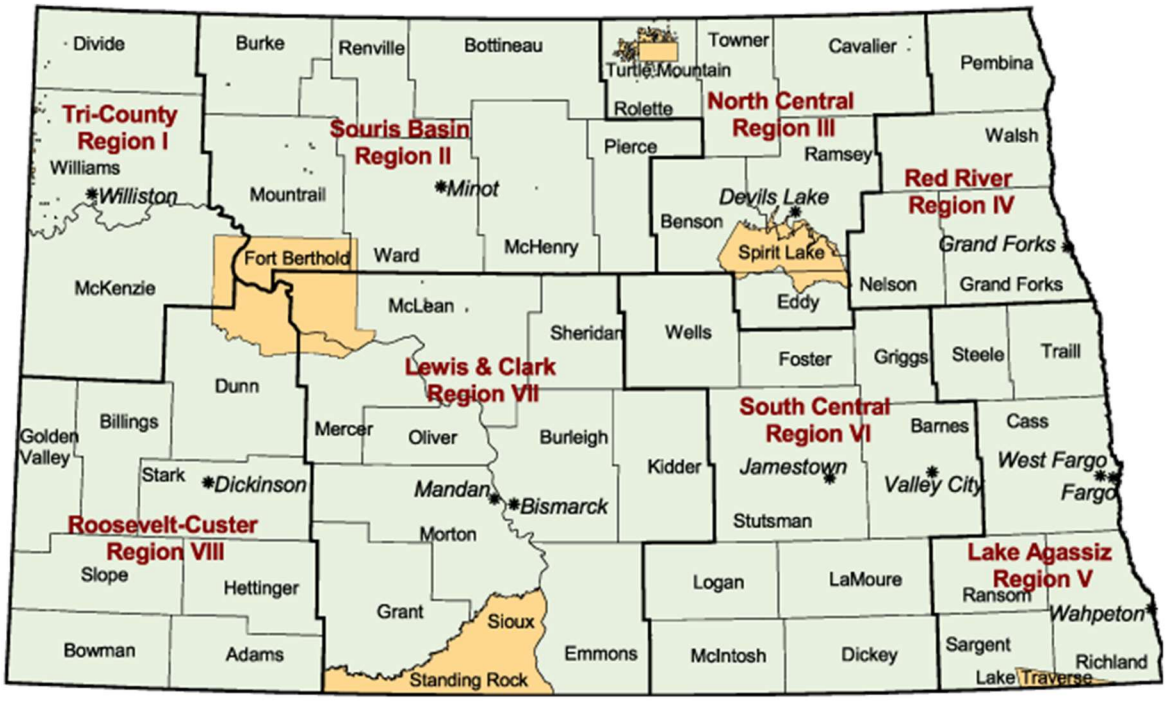


Figure 26: North Dakota geographic locations and boundaries used in the 2016 North Dakota Statewide Housing Needs Assessment
Source: Center for Social Research at NDSU

Housing Development & Voucher Programs

State and federal programs provide assistance through various mechanisms to assist extremely low, very low and low-income households. Several programs are project-based for finite periods, and a substantial number of those housing units will come to the end of the program participation period by 2029. The potential loss of housing units in both rural and urban areas could present substantial challenges for low-income households, especially considering the projected statewide increase in the number of such households. Planning to address the effects of the potential loss of this inventory will be critical to assuring that the state's most vulnerable citizens have adequate access to affordable housing.[51]

The U.S. Department of Agriculture (USDA) Rural Residential Housing Program makes loans to qualified housing developers as an incentive to build multi-family rental properties that meet the needs of low-income, elderly and disabled individuals and families in communities with a population of 35,000 or less. In addition to low-interest loans for development, USDA also provides rental assistance for low-income households. In 2015, USDA had 2,477 housing units in 146 multi-family properties in 99 communities around North Dakota. Three-fourths of USDA's housing units receive rental assistance. By 2029, 635 units or 26 percent of USDA housing will reach maturity and no longer be enrolled in the program. While the number of properties set to expire appears to be relatively small, the loss of even a few low-income housing units could have substantial impacts, especially in communities with low inventories of rental properties.[52]

HUD's Low-Income Housing Tax Credits (LIHTC) provides federal income tax credits to individuals, partnerships, LLCs or other entities, such as housing authorities and other legal entities, for the construction or renovation of properties that serve the needs of low- income households. Currently, there are 5,683 housing units in the LIHTC program. Like USDA's low-income housing, a substantial portion of the LIHTC properties, 37 percent or 2,124 units, in North Dakota will reach maturity by the end of 2029. Most of the maturing properties are located in the state's largest cities. Given the projected increase in the number of low-income households in the state's five largest urban centers, the need for affordable housing for such households is likely to increase making the potential loss of this housing inventory problematic. [53]

HUD's Housing Choice Voucher program, administered by public housing agencies, assists very low-income, elderly and disabled individuals and families. During the first quarter of 2016, 6,514 housing units in North Dakota were supported by the program. HUD's Public Housing program is administered by local housing authorities, which also owns and manages the rental housing for eligible low-income, elderly and disabled individuals and families. There are 1,709 units of public housing in North Dakota managed by 15 public housing authorities.[54]

NDHFA provides rental assistance with project-based programs known as Section 8 Performance-Based Contract Administration (PBCA). Currently, NDHFA has project-based assistance contracts with 98 properties with a total of 2,964 housing units. When contracts expire, properties may opt out of the program. NDHFA also administers the HUD Moderate Rehabilitation (Mod Rehab) program, and as of 2016, there were 10 properties with 157 units. The Mod Rehab program was repealed in 1991, and no new projects are allowed, therefore, once a property opts out, it cannot reapply. Because both programs are closed, properties in the PBCA program and the Mod Rehab program will likely decrease over time.[55]

HIF was authorized by the North Dakota Legislative Assembly in 2011 and has become one of the most successful tools to create affordable housing in the state. Housing units in the program are to benefit low- to moderate-

[51] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 9.
[52] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 23-4.
[53] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 27-9.
[54] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 30.
[55] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 31-2.

income households or below 140 percent of area median family income. Like the LIHTC program, units are income- and rent-restricted to the target households. NDHFA has allocated more than $89.6 million to 77 projects to support 2,380 new units in 26 communities across the state. HIF was reauthorized in 2017 by the North Dakota Legislature, but no funding was allocated to the program.[56]

MFP is administered by NDDHS and is an $8.9 million grant from the Centers for Medicare and Medicaid Services to help approximately 110 Medicaid clients who are older adults or people with developmental disabilities transition from nursing homes or institutions and reintegrate them into the community. A full year of case management is provided in addition to up to $3,000 for one-time transition costs.[57] Funding for the program will no longer be available after 2019 and operation of the program will cease in 2020.

[56] NDHFA and 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 32.
[57] N.D. Money Follows the Person Grant. Retrieved from https://www.nd.gov/dhs/info/pubs/mfp/overview.html

Moving Forward

Moving Forward

The North Dakota 10-Year Plan to End Long-Term Homelessness focused on the immediate need for PSH and affordable housing as the cornerstone of ending homelessness. In order to prevent, reduce and end homelessness, a more systematic and collaborative approach to early intervention is needed to identify individuals that need short-term, assistance-based solutions and those that need more intensive, ongoing care to conserve local, state and federal resources.

According to the U.S. Interagency Council on Homelessness, in 2017 a chronically homeless person costs taxpayers as much as $30,000 to $50,000 per year.[58] That same year North Dakota counted 1,089 homeless individuals, of which 45 were chronically homeless. Using the base national average of $30,000, North Dakotan taxpayers spent $1,350,000 on emergency medical care, inpatient bed visits, detox programs, jails, prisons and psychiatric institutions for those chronically homeless individuals.

After reflecting on progress and roadblocks at the state and local level to address homelessness, members of the NDICHP and local service providers identified specific groups that are more vulnerable and would benefit the most from concentrated efforts. The following recommendations are broad-based and will require dedication and investments from numerous state agencies to ensure vulnerable populations are getting adequate services to accommodate their unique needs and help them be functioning and contributing members of North Dakota's communities. Some of the recommendations are within the 2018 North Dakota Behavioral Health System Study[59] and the State of North Dakota's Information Technology Department's Citizen Experience Initiative.

Breaking the Cycle of Generational Poverty

To end the cycle of generational poverty, children and their parents both need to be housing stable. Screening mechanisms need to be in place for service providers, primary care providers and school counselors to be able to identify problematic family dynamics and refer them to a case manager based on their current situation and complexity of need.

- Create more wrap-around service based housing programs for single parents with children. The Jeremiah Program and Grace Gardens, both located in Fargo, provide safe and affordable housing, support for continued education, quality early childhood education, life skills training and a supportive community. Parents can focus on personal and professional development to become self-sufficient. During the day, young children are enrolled in reliable daycare, receiving early childhood education opportunities so they are school ready. School-aged children are in a controlled environment where they feel safe and receive the support they need to succeed in school. Research conducted for the Jeremiah Program determined that every dollar spent on the Program resulted in a $4 savings in public services across two generations.[60]

- Expand outpatient and community-based services that are flexible such as peer support, community health workers, in-home and school-based clinical services and substance use disorder treatment services to address the behavioral health needs of children, youth and their families. Stabilizing the

[58] Ending Chronic Homelessness in 2017. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

[59] 2018 North Dakota Behavioral Health System Study. Retrieved from http://www.nd.gov/dhs/info/pubs/docs/mhsa/2018-4-nd-behavioral-health-system-study-final-report-hsri.pdf

[60] Jeremiah Program-Our Impact. Retrieved from https://jeremiahprogram.org/our-impact/

family in their home in their community will lessen the need for relocation and out-patient treatments.

- Expand targeted proactive in-home supports for families with children and youth at risk of foster care placement and justice involvement. There is a need for targeted support for children and youth as well as for parents whose children are at risk of out-of-home placement and justice involvement. Parental behavior is the main barrier to family reunification, therefore if more services were provided, youth may not need to enter the foster care system. Many youth who are justice involved also have a parent or close relative with justice-involvement.

- Develop a streamlined process for NDDPI homeless liaisons located in school districts across the state to be able to refer a case manager to assist families in accessing housing both in urban and rural communities.

Children that are not housing stable, are within the foster care system, do not graduate from high school, or have mental health or substance issues have a much higher probability of needing public assistance as an adult. Early detection and prevention are the best methods to help youth navigate difficult living situations.

- Explore barriers to create emergency shelters, low-barrier housing, host homes and other short- and long-term housing options for youth and young adults who are unsheltered, fleeing an unsafe situation, or experiencing a housing crisis. There is an unfilled gap for those ages 16 to 24 that need refuge in a safe space without being housed with chronically homeless adults.

- Coordinate entry processes and support services that are trauma, age and developmentally appropriate. Ensuring youth are housing stable is critical to their overall well-being especially for them to be able to create permanent and healthy connections with adults and continue to pursue educational or employment opportunities.

- Review state and federal policies and processes impacting unaccompanied youth as well as youth aging out of the foster care system to determine any barriers that can be eliminated. Unaccompanied and emancipated youth experience legal barriers that prevent them from accessing housing, employment, and government documents.

Lessening the Cost

Some individuals have complex medical and emotional needs, which prohibits their ability to live on their own without some sort of social network assisting them. These individuals are classified as the chronically homeless and create the biggest financial burden on local medical, law enforcement and service providers.

- Finance more Housing First facilities creating more homes to stabilize the chronically homeless. When basic needs are taken care, residents can focus on treating their issues, ultimately saving lives and reducing costs. The Cooper House in Fargo and LaGrave on First in Grand Forks provide permanent housing to the chronically homeless. Residents are charged rent, can have limited access to alcohol and receive services at their request. This housing model helps control public service costs these residents would have used for emergency shelter, emergency room visits, incarceration, and

detox centers. An independent study from Eide Bailly reported housing 66 individuals in the Cooper House saved the public $204,140 in service costs over 12 months.[61]

- Provide funding for support services and operational expenses. If service providers are not able to staff the facility and provide onsite, person-centered treatment, individuals living at the facility will not be successful in their recovery, stabilization, and integration back into the community.

- Explore the cost and benefit of funding "harm reduction" shelters, where residents can consume substances or come into a shelter under the influence of drugs and alcohol. Traditional homeless shelters have strict sobriety rules. If individuals are not sober or if they want to continue to consume substances, their only option is to do so in public. Individuals in the harm reduction shelter may form a pattern of consistency and service providers can develop relationships to help them reduce substance use or focus on sobriety and find more permanent housing options. Studies have identified the effectiveness of harm reduction shelters to curb consumption by creating a stable environment, therefore reducing the cost of public resources.
  - Withdrawal Management Unit also referred to as a Detox Shelter have proven successful in the city of Fargo and is adjacent to the Gladys Ray Shelter and the Veterans Drop-In Center. The Unit provides short-term residential and social (non-medical) detoxification services in a clean, supportive and calm environment designed to assist individuals through the difficulties and dangers from substances in a non-medical setting.[62] This format is more cost effective when it can be leveraged instead of seeking emergency medical treatment.

- Create consistent funding for state housing and service programs such as HIF and the North Dakota Homeless Grant. Developers and local service providers can leverage the funding with private investments and charitable donations to create customized local solutions based on community needs in rural and urban areas. The upfront investment in state funding is critical in delivering upstream and midstream services to vulnerable populations.
  - Explore the cost and benefit of state funded housing vouchers to be leveraged in emergency situations.

Government Efficiencies

The key to enhancing government efficiencies is to establish a systematic approach of clearly defined and repeatable steps where outcomes can be evaluated to generate consistent, optimum results. State agencies and local service providers are well connected and reach out to one another for assistance for the individuals and families they are helping, but most agencies expressed the need for more collaborative efforts to leverage resources and to be more responsive.

- NDICH consists of seven state agencies, one state-wide homeless coalition, and the communities of Fargo, Grand Forks and Bismarck. Moving forward it is recommended that the same state agencies be a part of NDICH; however, involvement is expanded to engage multiple people from each agency especially if the agency has more than one division involved in any aspect of preventing, reducing or ending homelessness.

[61] Cooper House Impact Report 2010. Retrieved from http://fargohousing.org/files/pdf/Cooper%20House/Impact%20Reports/Cooper_House_Impact_Report_June_2013.pdf

[62] Gladys Ray Shelter & Veteran's Drop-In Center. Retrieved from http://fargond.gov/city-government/departments/fargo-cass-public-health/gladys-ray-shelter-veteran-s-drop-in-center

- The NDICH would convene twice a year fostering an environment where each agency thinks and works beyond specific duties of their agency/department to achieve services and results that are broader in scope. The goal is to have more of the "right" people at the table to rethink processes that restrict developing new perspectives without hindering innovation or opportunity development. Each agency needs to critically think about the programs offered to be able to develop synergies and identify gaps that impact vulnerable populations. Engaging a diverse stakeholder group from the vulnerable populations and their family members will be insightful in creating comprehensive solutions.
- Develop a communication process to inform other state agencies and the public pertaining to the focus areas, tasks, and progress made through NDICH endeavors.

- Identify barriers preventing state agencies from accessing and leveraging HUD's Homeless Management Information System (HMIS). HMIS is a software application designed to record and store client-level information on the characteristics and service needs of homeless persons throughout a Continuum of Care (CoC) jurisdiction. Service providers currently utilize HMIS to coordinate service provisions, manage their operations and better serve vulnerable populations.

- Map the entry points for vulnerable populations and how they transition throughout state agencies and local service providers. The intent is to streamline the intake/assessment process and ensure they have access to the services they need at a specific point in time. The map will diagram how people and information are shared, gaps, overlapping functions and where efficiencies can be made.
  - Minnesota Department of Human Services – Housing and Supports Division created the Housing Benefits 101 website as tool to assist people who need affordable housing and support systems to maintain their housing, and understand the range of housing and support services available. The website allows each person to identify their current housing situation whether they are looking for a home; moving out of a facility, group home or foster care; need to relocate; are at risk of losing their home; or are experiencing homelessness. The client-centered focus streamlines research and resources that each person needs.[63]

- Identify local, state and federal policies and regulations that hinder vulnerable populations and prioritize actions for change. For instance, the definition of homelessness, case manager, and youth creates issues. Felony convictions inhibit individuals from acquiring housing as well as other social services and create a stigma when employers are reviewing employee applications.

Covering the cost of public assistance is challenging for federal and state government and at the local community level. However, there are ways for the state to access additional federal funding through Medicaid to provide direct support to individuals and families.

- Pursue 1915(i) Medicaid state plan amendments to expand community-based services for vulnerable populations. The 1915(i) state plan amendment has been the most common avenue for states to pursue funding for community-based services that include a wide range of home and community-based services as a state plan option. Adding services through 1915(i) could significantly reduce demand for emergency, inpatient, and long-term care services that are not reimbursed by Medicaid, which could reduce overall system costs in the long run.

[63] Minnesota Housing Benefits 101. Retrieved from https://mn.hb101.org

- Review long-term care facilities placement policies and explore options for community-based alternatives for persons with disabilities and behavioral health issues. In a recent study, it was documented that approximately one in four individuals under the age of 65 were receiving behavioral health-related services in long-term care facilities, which can cost $96,000 per year. With the right supportive services, these individuals could live in community-based PSH units, which are more cost effective solutions.

Client-Focused Delivery System

In order to expedite information gathering and to ensure current and accurate information is available, the state needs a consistent, end-to-end experience across all channels and departments where information can be obtained for any service, on any device and at any time. State agencies and local service providers expressed challenges they have noticed in their specific area and feedback from clients. Below are some of the ideas that were recommended:

- Housing Inventory - create an affordable housing inventory for each community/region
- Housing Forms - create a single form used by all regional housing authorities
- Database - create profiles for each client within a centralized database, so individuals or families applying for state or local benefits do not have to re-enter information
- Privacy Laws - review state privacy laws to ensure clients are protected, but at the same time do not hinder state agencies from accessing the information they need to be able to help a client that is transitioning services from one state agency to another.
- Consent Form - create a consent form signed by the client to release information to all state agencies and case managers
- User Profile - create an app or web portal where clients can enter their information that is stored and they can return at any time to complete.
- Online Chat - through an app or web portal, create an online chat function for clients to ask questions and be directed to the correct state agency or local service
- Services Portal - structure website into user categories and group information based on the client scenario, such as homeless or risk of becoming; searching for housing, employment or daycare, needing social services, youth, tribal, etc.

COOPER HOUSE, FARGO, ND #2449
PERMANENT SUPPORTIVE HOUSING
Financial Community Impact

Per a Cooper House Impact Report & Cost Study completed by Eide Bailly:

- Cooper House saves taxpayers money. There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that study was conducted, through October 31, 2011
- Costs tied to emergency shelters virtually disappeared once individuals moved into Cooper, dropping 98% from $139,200 to $3,200
- Detox costs also dropped dramatically, falling 71%, from $75,360 to $21,840
- Jail expenses fell 48% from $169,455 to $87,768

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community & Tenant Impact

Cooper House has made a positive impact to the Community of Fargo and in the lives of the Tenants

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The RIGHT THING for "GI JANE" – Veteran, Chronically Homeless & Dually Diagnosed:

- Periodic episodes of homelessness for 3 years; Has successfully maintained housing at Cooper House for 24 months
- 1 Year Prior to moving to Cooper House: Hospital/Emergency Room Charges $38,500
- 1st year at Cooper House: Hospital/Emergency Room Charges $1,000
- Now engaged with case management and Veterans Administration Services

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community & Tenant Impact

The RIGHT THING for "Pete" - Chronically Homeless & Dually Diagnosed

- Homeless for 20 years; Has successfully maintained housing at Cooper House for 25 months
- 1 Year Prior to moving to Cooper House: 201 days in Detox at a cost of nearly $30,000, Emergency Room/Hospital Charges 30,000
- By 2nd year at Cooper: 0 days in Detox, Emergency Room/Hospital Charges approximately $6,000
- Newly engaged in Case Management

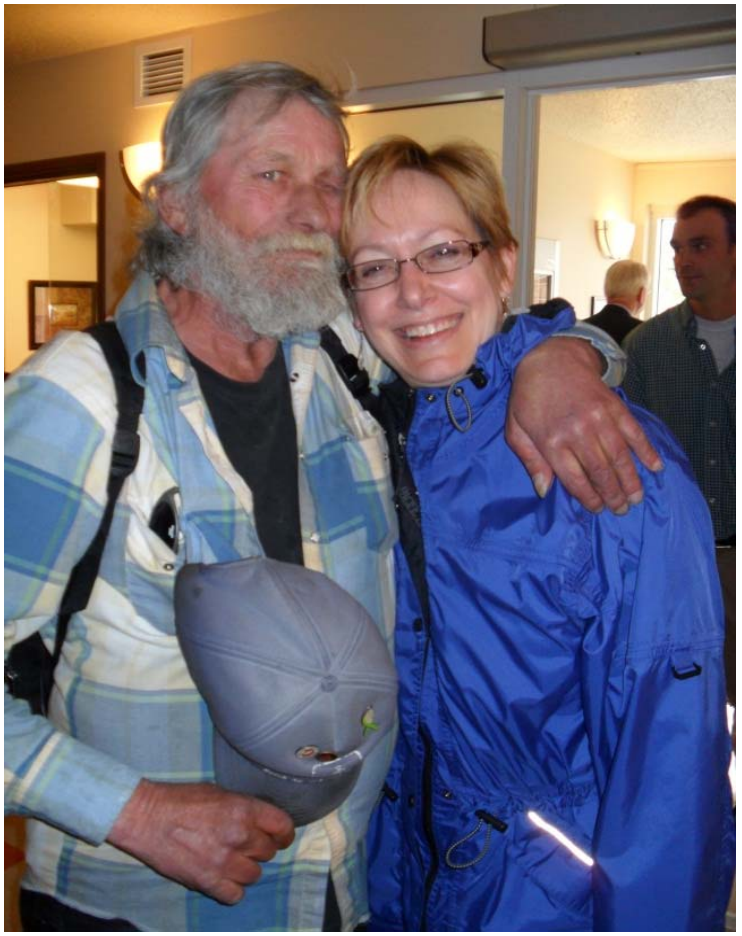
Note: CY2013 Vacancy Rate was 2.3% which equals an average of 1-unit per month.

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Project Description

- ❑ No expectation of sobriety, however there is an expectation of mutual respect

- ❑ Relies on strong partnerships with community-based service providers to meet the varied needs of tenants

- ❑ Front Desk is Staffed 24/7
  - ➔Check Tenants & Guests In and Out
  - ➔Monitor the Security Cameras
  - ➔Perform Wellness Checks
  - ➔Work to Link Tenants with appropriate services



COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Project Description

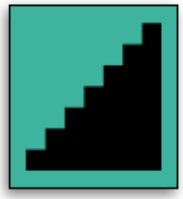
- Employs a "Housing First" model, which recognizes a home as a stable platform for delivering supportive services to help the tenant stabilize their life and keep them housed.

"We give people A HOME FIRST, then offer a variety of services to help them improve their lives."



Our **On-Site Nurse** breaks down barriers and builds trust with tenants to help them manage their chronic health conditions BEFORE they escalate to an Emergency Room visit or a hospital stay.

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Stakeholders/Partners/3rd Party Service Providers



Beyond Shelter, Inc.

A Regional Nonprofit Developer of Affordable Housing

















COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



Typical kitchen in an efficiency apartment



Typical living area in an efficiency apartment

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



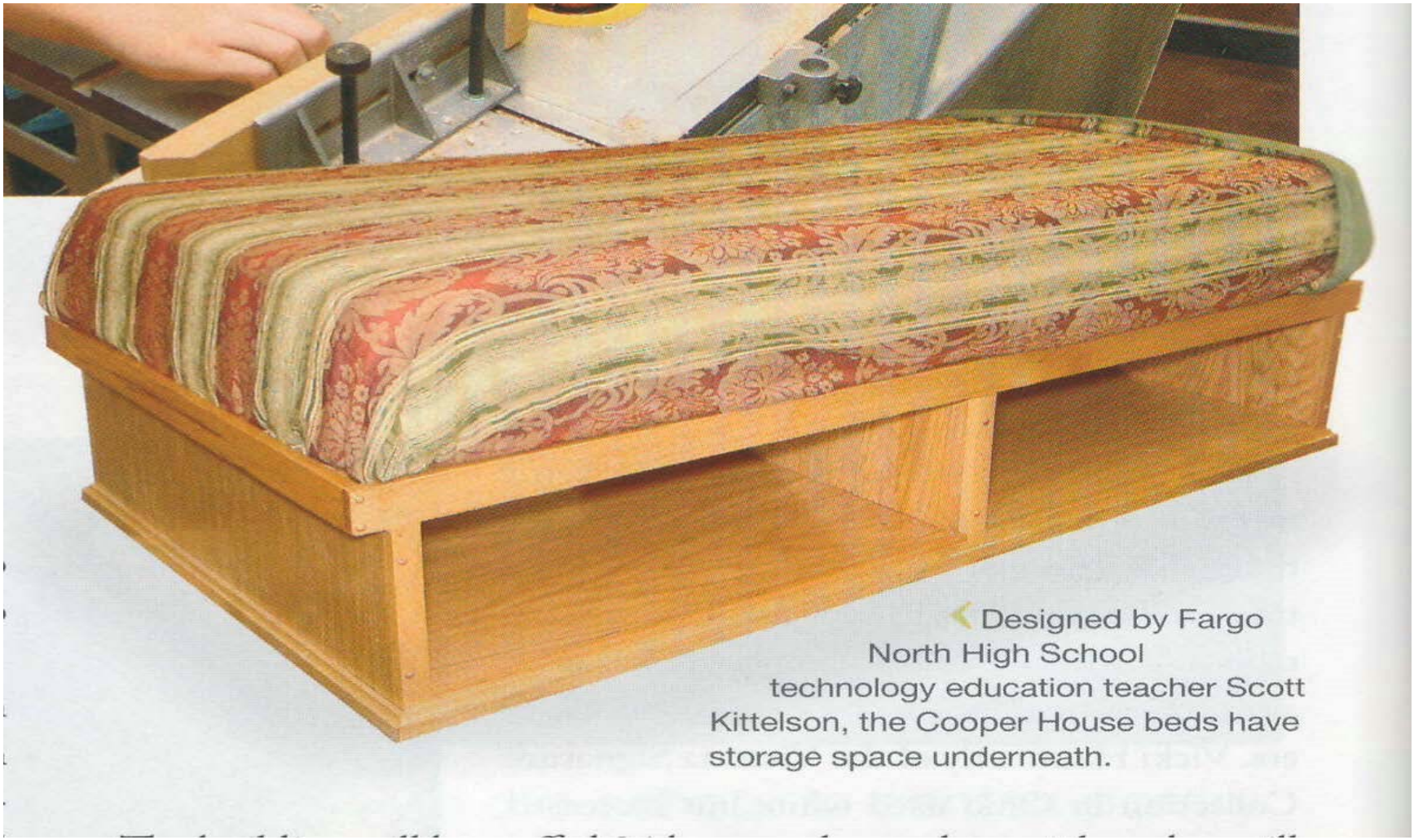
Typical living area in an efficiency apartment



Typical bedroom in a one bedroom apartment

All 42-Beds were built by Fargo North High School technology students

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



Designed by Fargo North High School technology education teacher Scott Kittelson, the Cooper House beds have storage space underneath.

Human Services Committee Members; #3079

My name is Jesse Jahner, and I am the Sheriff in Cass County, North Dakota. As the Sheriff, my staff and I oversee the Cass County Jail, which has a current capacity of 348. Over the past year, the Cass County Sheriff's Office has collaborated on multiple occasions with various community partners to discuss and attempt to resolve gaps in the mental health services available in Cass County and statewide. That collaboration has included local hospitals, legislative members, service providers, representatives from state agencies, and local law enforcement. We have discussed alternative options for obtaining care where a need is identified. We have considered modifications to various stakeholders and providers' processes to work towards improved access and improved outcomes. Significant gaps still remain for those patients who have needs that are not or cannot be effectively treated in the community, and that would qualify for commitment to the state hospital. We are experiencing year over year increases in the number of people who end up in jail for serious offenses that threaten public safety and have limited access to psychiatric care. Of even more considerable concern is the number of people with such acute and immediate needs that hospitalization is deemed necessary by all parties, including the local human service center.

The number of referrals that we make in Cass County for the required pre-screening assessment has risen each year over the past few biennia, as have the number of persons who have been admitted into the state hospital. We feel that we have a strong sense of the commitment criteria and only refer those people that a qualified mental health practitioner has assessed for appropriate referral. Even more frustrating are the increasing instances where the process has determined that a person meets the criteria for admission to the state hospital, but there is no room. The access is denied or delayed beyond what is established in state law.

We have had Inmates sit in the Cass County Jail for up to as much as two weeks who were not committed due to capacity issues. This has been a recurring theme on several occasions throughout 2020. North Dakota Century Code requires us to move such persons out of jail within 24 hours of an issued commitment order. Still, we have experienced delayed entry and, on occasion, access denial because of resource issues. This delay from pre-screen to transfer has occurred in cases ranging from a few days to 13 days, and in one case, 31 days total before admittance occurred.

The pre-screening process should determine the condition of the patient and not an assessment of the conditions at the hospital. Suppose people are being denied access after a determination has been made that they do need hospitalization. In that case, at least some of the decisions that a person does not require hospitalization must be partially impacted by capacity considerations.

There are instances in Cass County where pre-screens were approved, commitment paperwork submitted, and then a delay led to expiration of the commitment paperwork and the need to repeat the process. There have also been instances in Cass County where pre-screens have been completed. Still, days or even a week passes before commitment paperwork is completed and submitted, which we are told was due to capacity issues.

There is no doubt that COVID-19 has complicated everyone's situation at every level in this continuum of care. But the numbers show that we are also dealing with an increase in cases of significant and even severe need of care. One of the striking observations we have made this year is the increased number of people landing in jail who are already open and active patients of the local human service center, who are subsequently determined to need acute care. These are not cases where it is appropriate or safe to release the individual back on to the street through the bond process. Multiple cases of residential arson, barricading with weapons, attempting to run over people and law enforcement with vehicles, aggravated assault and possession of explosives, and one person who was digging up the grave of a family member due to delusions. What we are seeing is that the need for additional capacity is greater than ever before.

I write this testimony and provide this information because I do not want to see services cut from the North Dakota State Hospital. When we see the need for additional capacity and services more than ever before, I respectfully ask that their budget is increased to meet the demand for those needing services. When Individuals receive services through the State Hospital, we see a dramatic difference in their mental health wellbeing. This is a testament to the type of work they are doing there. Please move to approve an increased budget and provide them the appropriate funding for the services they need to effectively treat those with mental health issues and, in doing so, keep our communities and citizens safe.

Respectfully,

Jesse Jahner

Jesse Jahner
Cass County Sheriff

Testimony HB 1012 #2465

House Appropriations Committee

January 25, 2021

Good afternoon Chairman Nelson and members of the Committee. My name is Trina Gress, I am Vice President of Community Options. I stand before you today to represent Community Options and the clients we serve. My testimony is in opposition HB 1012. There are three items I will be addressing with this committee today.

1. Request to add funds back into South East Human Service Center (SEHSC) and West Central Human Service Center (WCHSC) budgets to fund the Evidence Based Supported Employment Programs (EBSEP) until the clients can be transition to the 1915i. For the current biennium, SEHSC services total = $564,947.28, and WCHSC services total = $61,944.00.

2. Request to add funds back into Behavioral Health budget to fund the Pre-Vocational and Return to Work services for Brain Injury (BI) clients until the clients can be transitioned to the 1915i. Also, for the remaining 50% of services listed in DHS budget, increase existing rate to be competitive to other employment service rates. For the current biennium, Pre-Vocational services total = $337,499.00 and Return to Work services total = $348,553.00 plus the increase the existing rate to be competitive total of $92,340.00 for a total of $440,893.00 for Return to Work services.

3. Note that the 1915i does not serve clients with Acquired Brain Injury which is included in the state definition.

I will address the first and second items together. HB1012 proposes to cut the services listed above with the intent that the clients will be served in the 1915i Medicaid State Plan Amendment (1915i) after 7/1/2021. This is an unrealistic target date. Providers and clients need time to gather the proper documentation required for 1915i eligibility. Below are listed the extra hoops clients must jump through to receive services from the 1915i.

- There is no guarantee that the clients currently enrolled in the EBSEP, Pre-Vocational and Return to Work services will be 1915i eligible. There are <u>four</u> variables to receiving employment supports in the 1915i.
  + Must be Medicaid/Medicaid Expansion eligible.
  + Must get a score on the World Health Organization Disability Assessment Schedule (WHODAS) of 50 or higher.
  + Must identify employment as a need on the WHODAS.
  + Must have a diagnosis according to the attached handout. There are clients who may need to get a psychological or neuropsychological evaluation to attain the diagnosis. This could take months to attain.

- Need to secure Care Coordinators to meet the requirements of 1915i. Community Options is unable to provide care coordination and employment supports so a 3rd party will have to be

secured to do Care Coordination. Last week, Department of Human Services Medical Division reported that there are only 5 providers enrolled to provide 1915i services.

- Once a client secures full-time employment and their Medicaid is reviewed, income limits will more then likely cause their Medicaid (1915i) services to discontinue. Thus, the employment services are time limited. If an individual needs ongoing support, there will not be a service to meet the client's need.

Finally, just last session, the Legislature formally changed the definition of brain injury in North Dakota to include of all types of brain injuries. The NDCC 50-06.4 states "Brain injury" means damage to the brain or the coverings of the brain that produces an altered mental state and results in a decrease in cognitive, behavioral, emotional, or physical functioning. However, the 1915i only allows for three eligible diagnosis of traumatic brain injury (listed below) and no diagnosis of acquired brain injuries.

- F02.81 Major Neurocognitive Disorder Due to Traumatic Brain Injury, with behavioral disturbance
- F02.80 Major Neurocognitive Disorder Due to Traumatic Brain Injury, without behavioral disturbance
- G31.84 Mild Neurocognitive Disorder Due to Traumatic Brain Injury

In conclusion, Community Options is requesting this committee add funds back into the DHS budget to re-contract with provider to ensure there is enough time to find 1915i providers and transition the clients that do meet the eligibility criteria. If funds are not replenished in the DHS budget there will be 227 clients affected by this decision and going without services.

The creation and implementation of the 1915i took the North Dakota Department of Human Services (ND DHS) almost two years to complete and we are still awaiting the implementation. Yet ND DHS is requesting providers and clients to adapt in less than six months. This is not fair to the providers nor to the clients we serve. Thus, we are asking for funding to be added back into the DHS budget so there is additional time to ensure a smooth transition to the 1915i services while also mediating the risk of clients falling through the cracks.

I appreciate your time and consideration in these matters listed above. Thank you, do you have any questions?

House Human Resources Appropriations Committee Testimony #2457

Committee Chair Nelson and Members of the Committee, my name is Marissa Mahanna, Program Supervisor of Cooper House, Dacotah Foundation Fargo. I am writing this testimony in opposition to the budget cuts offered in HB 1012.

I have been employed at Cooper House, North Dakota's first permanent supportive housing program, prior to its opening in 2010. Over these past 10+ years, I have seen firsthand the effect that it has had on the lives of many previously homeless individuals. Cooper House has established a place of residency for those who have not been able to secure or maintain housing in the private sector due to criminal history; severe and persistent mental illness; and/or substance abuse. By eliminating the initial barrier to housing, tenants have been able to focus on the underlying issues and precipitating factors that initially lead to homelessness. Staff play a crucial role in the tenants' ability to maintain housing, work on addressing maladjusted behavior and promote their personal health and wellbeing.

I feel having 24 hour staffing in a building serving chronic homeless populations is essential to the safety and security of the tenants, their quality of life and the residential environment as a whole. Staff monitor the security for the tenants and the building, permit entrance to tenants who reside at Cooper, and document the tenants have been seen throughout the day. This process insures that all tenants are safe and accounted for, and gives a general knowledge of tenant capacity within the building in case of emergency such as fire, natural disaster, etc. Safety is also partially achieved by conducting contraband searches at the point of entrance. This eliminates possible weapons, illegal substances, and non-consumable forms of alcohol from being in the property. Cooper House is founded on the Harm Reduction Model. This model assists in decreasing the intensity, duration, and frequency of the usage of substances. Staff monitor and track consumable alcohols brought into the building based on a set policy that supports safer levels of consumption. This assists in reducing prospective bodily harm; less violence and or escalation of behaviors; use of dangerous mind altering substances; reduction in medical interventions; and maintaining a safer blood alcohol content for those that have not fully entered recovery. These interventions support the mission of utilizing less emergency services, supports harm reduction; and promotes tenant safety.

Staff also work as a gatekeeper of the building by monitoring access of visitors. This allows tenants to only receive visitors that they trust, keeps out individuals who have a history of violating the rules or criminal laws during prior visits, only allowing two visitors per tenant, and not allowing visitors to bring in alcohol outside of what is set policy for the tenant who resides at Cooper. These rules are all agreed upon at move in by the tenants with the objective to decrease noise disturbances and disorderly conduct. Also, many transient populations tend to double up or couch surf in standard housing which often results in eviction and unsafe circumstances. Staff being available onsite is necessary in eliminating potential housing violations that could result in eviction and continue the cycle of homelessness. Without staff, the building would not be regulated in this capacity and potential victimization of those who are vulnerable would have grave consequences.

Besides acting as the gatekeeper for the safety and security of the tenants, staff provide additional supports. The staff allocate and distribute donated food items to insure that tenants have access to minimal and appropriate nutrition. Staff work collaboratively with other entities in the community to promote residents well-being and address needs. They also safety plan with the tenants when needed to assist in the reduction of higher level of care and/or use of emergency services. Staff implement and facilitate psychosocial support activities in the form of recreational groups and individual informal life skills training. They assist in the form of mentoring, education, role playing, etc. Staff play an instrumental part in procurement of wrap around services, access to community based providers, and liaison to community supports.

Without having staffing 24 hours a day, the building would not function in a safe manner, would not be able to house its target population of the most vulnerable chronically homeless and would jeopardize the integrity of the program. Alcohol consumption would not be regulated, illegal substances or dangerous items could be brought into the building, there would no longer be screening or supervision of visitors thus allowing anyone in at any time. I would foresee that the usage of legal and illegal substances would rise without the presence of staff onsite full time. Additionally, criminal activity, violence, overdose, and death could be a result of lack of regulation, assessment, and intervention provided by staff. I am aware of some properties in downtown Fargo that serve similar populations as Cooper House, that struggle with these concerns. Oftentimes, due to lack of assertive skills or cognitive function, vulnerable populations are not able to protect their housing or their physical or mental wellbeing. It is well known that individuals, without the supportive housing, are preyed upon by others they have met in the homeless community. They use them for shelter and other needs or desires. Without staff, Cooper House tenants could potentially fall victim to the same type of exploitation.

Cooper House has created a supportive and compassionate environment for this specific disadvantaged population. I have seen the impact of how providing basic needs have created a space and opportunity to work towards achievement of psychological needs and self-actualization. This process is what creates self-reliant and productive citizens. Having staff monitor the safety and security of the Cooper House building and tenants is an indispensable component to protecting some of our states most vulnerable people.

Thank you for your time and consideration of our request.

Marissa Mahanna

HOUSE HUMAN RESOURCES APPROPRIATIONS COMMITTEE #2372

TESTIMONY

Committee Chair Nelson and Distinguished Members of the Committee, my name is Kandia Qual, Program Director for the Dacotah Foundation in Fargo. Our agency provides staffing, supervision, and emergency interventions to the permanent supportive housing project, Cooper House. I am here today to give testimony in opposition to the budget cuts made to mental health services offered in HB 1012.

Cooper House permanent supportive housing is a proven, cost-effective, person centered, and humane way to provide stable homes to individuals who have difficulty finding and maintaining housing due to their on-going struggles with severe mental illness, substance use, vulnerability, or previous traumas.

Supportive housing creates stability in the lives of its tenants, allowing individuals who have often spent years living on the streets to live full, rewarding lives integrated into our community. It allows them to engage in services that they previously may not have engaged in because they were always consumed with trying to find where they would safely lay their head that night or where their next meal was coming from. It allows service providers to locate individuals on a regular daily basis to provide engagement and build motivation for change through offering assistance with their mental health and physical health concerns. It allows individuals a safe and secure home to protect themselves from being taken advantage of, trafficked, assaulted, or victimized as often occurs with many homeless individuals.

Having staff present 24/7 in supportive housing projects contributes to the overall success in tenants maintaining their housing and moving towards larger goals of addressing their mental health or substance use concerns, obtaining employment or educational goals, and eventually moving out to mainstream housing through a variety of services and supports the staff provide.

Based on my professional involvement in Cooper House since it's origination in 2010, I can attest to the essential nature of the services provided by staff within the Cooper House program and how those services directly contribute to the success of the tenants.

The ability to have staff 24 hours a day 365 days a year at Cooper House plays an immense role in the safety of the tenants as well as engagement into services that enhance the quality of their lives. The proposed cuts to the Cooper House portion of HB 1012 would directly impact the ability to continue these essential services. This change in staffing would result in increased safety and welfare concerns for the tenants of Cooper House. It also potentially would decrease their engagement in other services intended to enhance the quality of their lives and promote their ability to move on to mainstream housing as staff often bridge the engagement into these services. A decrease in staffing hours would also result in a vastly increased demand for emergency services such as police and ambulance services as staff would no longer be present in the same capacity to intervene and assist before events reach the level those services are needed.

Staff monitor and regulate who enters the building so individuals who are vulnerable or that haven't developed assertiveness skills can remain safe and not put their housing at risk by having individuals that may cause issues manipulate or force their way into their home or take advantage of them. There have been several situations where a resident has allowed a non-resident visitor into their apartment

and the visitor has engaged in illegal activity, domestic violence has occurred, or the visitor simply refuses to leave and staff have been able to intervene in the situation. The staff are able to have the visitor removed from the apartment and prevent the individual from entering the building in the future. This monitoring by the staff protects the initial resident involved as well as other residents of the building from that visitor causing further issues that could result in evictions or safety concerns.

Due to the intensity of mental health, substance use, and physical health concerns with the population we serve, staff complete welfare checks on individuals that we haven't had regular contact with each day. There have been many instances over time, where the hospitals and emergency services have indicated that individuals would have died if staff hadn't been present to complete welfare checks and initiate emergency services. One of many possible examples I could share would be that of an individual with a seizure disorder. The staff completed an immediate welfare check after a neighboring tenant called down to staff reporting an odd noise from that unit. Staff discovered that the individual was having a seizure and bleeding profusely from a wound to their head. Staff performed immediate lifesaving first aid and accessed emergency services. The individual had an extended stay in the ICU but because staff were there and able to intervene as quickly as they did, that individual was able to have a successful recovery. They are now living independently in the community.

Another quite recent example is an individual that tested positive for COVID and deteriorated rapidly due to other compromising health issues. Because staff were present and monitoring the individual's condition, emergency services were initiated for this individual when their condition deteriorated. The individual's condition required them to be hospitalized and on a ventilator. They have since made a full recovery and are back at their home in Cooper House.

These situations likely would not have had the same end result had staff not been present to complete welfare checks, administer first aid, assess the need for emergency services, and initiate that response as rapidly as they did.

Staff are constantly building rapport and relationships with residents from the moment they move into Cooper House. Staff use those relationships to bridge residents into services with care providers. Staff build bridges to service providers in many ways such as coordinating with the on-site nurse if someone is having physical complaints or appears to be deteriorating in health. Staff work side by side with SEHSC to introduce residents to team members of SEHSC, build motivation with them to be open to or engage in services, and to outreach residents in their apartments when case managers haven't been able to reach them. Staff contact SEHSC case managers when they are seeing a deterioration of mental health or when incidents of concern have occurred so the case manager can get involved quickly to assist the resident. Staff also express concerns to case management if they see an increase in an individual's substance use. Staff promote resources, referrals and service linkage for individuals that may require county social services such as homemakers or cleaning services. Without staff present, and having developed those levels of trust, residents may not enter into some of the services that assist them to improve the overall quality of their lives.

Staff provide mental health support, at all hours of the day and night, to individuals that may be struggling with negative symptoms of their mental health such as extreme paranoia, delusional thinking, suicidal thoughts, cravings for substance use when they are working towards recovery, thoughts of violence towards others, and emotional support when trauma has occurred in a tenants life. Prior to being a resident at Cooper House, many of these scenarios would have resulted in the individual

presenting at the hospitals and ER's, attempting to end their life, relapsing in their chemical usage, or causing injury to others. Tenants have vocalized that having staff there in the moment to process these thoughts and feelings has assisted them to avoid the negative results or accessing higher levels of care.

As indicated, the 24/7 staffing provides many essential and critical services to the chronic and vulnerable population this program is intended to serve outside of just monitoring an entrance. Based on my observations and experiences working directly with the program and its target population, I feel that without having the funding for staffing present in its current capacity the safety of the residents, their quality of life, their engagement into services, and the building program as a whole would be at risk.

We know that there has been mention of 1915i being a supplement to the funding currently being proposed. However, this is a new funding source that will require eligibility and take time to enroll individuals. It is yet to be determined how it may be implemented and assist the Cooper House program. Many individuals served by Cooper House are not enrolled in Medicaid when they move in so they would have to establish eligibility for reimbursement of services. It takes time and engagement to build the relationship required to complete enrollment of residents into programs such as Medicaid as well as to assure they stay enrolled. We have also understood that 1915i will be tied to individual services provided and many of the routine services and safety interventions are procedures that intermingle with the building population as a whole and can't immediately be tied to a specific individual on a day to day basis for reimbursement purposes. While 1915i will be a beneficial source to augment and grow services within Cooper House on an individual basis, we are unsure how this will immediately transition towards covering all the essential services currently provided if the proposed decrease in funding were to occur.

We are requesting that consideration be given to maintain the current funding for Cooper House. We feel this is essential for the continued operation of Cooper House and the program's ability to serve the intensity of the target population in a safe and effective manner.

Thank you for your time and consideration of our request.

January 12, 2021 #2466

Good afternoon, Chairman Nelson and members of the committee,

My name is Taylor Restad, I work for the Grand Forks Housing Authority as the Program Director at LaGrave on First. I am here to respectfully request $515,000 be included in Field Services - Northeast Human Service Center's budget in House Bill 1012 to fund the 24/7 housing support staff at LaGrave on First in Grand Forks.

During the last session, $375,000 was included in SB 2012 for our Housing Support Specialists at LaGrave on First, a permanent supportive housing project for people in the Grand Forks region who have experienced chronic homelessness. The funding supports certified Mental Health Technicians for the residents of LaGrave on First. These staff members provide year-round, 24/7 necessary housing supports and monitoring to create and maintain a safe and supportive environment for residents. LaGrave on First is an apartment complex that offers one-bedroom/bathroom units of affordable housing and on-site support services without prerequisites such as sobriety, participation in services, or clean background checks as the program is based on the Housing First approach to ending homelessness. People with behavioral health needs first need a safe, affordable place to live before they can pursue other goals related to their health, well-being and quality of life. By all accounts LaGrave on First has been greatly successful in its mission to provide needed housing and opportunity to our chronic homeless population.

Last session's amount was reduced from our initial request of $550,000 due to the anticipated approval and implementation of North Dakota's 1915i State Plan Amendment in July of 2020. If approved and implemented as we had anticipated, this amendment would have allowed us to bill Medicaid for the housing services provided by our Housing Support Specialists rather than need a line item in the DHS' budget. DHS submitted the 1915i State Plan Amendment in April of 2020, although it has recently been approved by CMS the ability to begin functionally using it will take time and the amendment does not include daily rates. The Grand Forks Housing Authority has begun the process to become a Medicaid biller in order to take advantage of this funding opportunity. Additionally, while we are grateful that the 1915i State Plan Amendment includes housing support services, as they are key to keeping people housed, we are deeply concerned regarding the maximums of 156 hours per year versus inclusion of daily rates. To this end, I stand before you requesting $515,000 be included in House Bill 1012 for LaGrave on First until we have an implemented 1915i State Plan Amendment that includes daily rates.

I appreciate the opportunity to make this request in front of you today, I'll be happy to take any questions.

Sincerely Submitted,
Taylor Restad

#2367

In Search of an Answer

Listening and Responding: North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs



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In Search of an Answer
Listening and Responding:
North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs

A report of the Family Voices of North Dakota qualitative interview results to help identify the experiences that families may face as they search for resources, information, financial support, emotional support, and access to services.

Thank you to the families and professionals who provided their time and expertise on this project:

FVND Board
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This document was developed and written by C. Wells, Axis Group I, LLC

FAMILY VOICES OF NORTH DAKOTA

FVND was started in 1996 and became a State Chapter formally sanctioned by National Family Voices, Inc. in the first quarter of 2001. FVND aims to achieve family-centered care for all children and youth with special health care needs and/or disabilities. Through our national network, we provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on health care.

The FVND Health Information and Education Center:

- Assists families as they navigate public and private systems, including health systems and insurance plans;
- Provides assistance to families in accessing services and resources for their children and how to partner with providers and caregivers;
- Listens to families as they describe their encounters with systems and helps guide them to possible solutions;
- Works with families, health care providers, public and private agencies, and advocacy or support groups to promote family-centered care and medical homes for children with special health care needs; and
- Promotes discussions and linkages among families, providers, managed care programs, and government to better serve the health care and related needs of children and families in North Dakota.

ND Parent to Parent Project:

- Is a statewide network of parents supporting families of children with developmental delays, disabilities, and special health needs;
- Offers emotional support and information;
- Acts as a valuable resource to families;
- Offers assistance in learning the necessary skills to help parents face the challenges of raising their child;
- Offers moral support and encourages parents to feel comfortable and optimistic about the future; and
- Is dedicated to supporting families at their most challenging times and to celebrating each new victory.

As a component of these services, FVND offers leadership institutes, training, workshops, and resource development. They also participate as a major partner on the local, state, and national levels in system transformation, facilitating a responsive system of care for children and youth with special health care needs (CYSHCN) and their families based upon a family-centered approach.

FVND Health Information and Education Center funding is provided by a grant from the US Department of Human Services' Health Resources and Services Administration, Maternal and Child Health Bureau and the North Dakota Department of Health (Title V, Children's Special Services) and ND Parent to Parent Project funding is provided by the ND State Council on Developmental Disabilities.

"We who have children with special health care needs have learned patience, joy and resilience which come from the lessons our children have taught us. Through them our lives have been enriched, learning from those lessons and sharing them with those who also have devoted their lives, partnering with parents and providers in each step. Family Voices of ND is an important connection for families not only to connect with one another but in assisting them in accessing vital information"

D. Feist

Listening and Responding:

North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs



Over the past eleven year, Family Voices of North Dakota (FVND) has utilized a qualitative interview system to gather information regarding the capacity of the system of care for families of children and youth with special health care needs (CYSHCN) to help identify the experiences that families may face as they search for resources, information, financial support, emotional support, and access to services.

This effort serves as a bridge to a better understanding of what is working well for families, barriers that families encounter, a celebration of successes and models of excellence, and opening a dialogue regarding the identified challenges that families may be facing. This paper highlights background information (including population, about FVND, about family-centered care, and need), study design (including intent and proposed outcomes, potential uses, and methodology), overall results (including data collection results, description of the response and respect scale, and interpretation), and FVND recommendations for use of results to improve the capacity of the system to be responsive to the needs of families of children and youth with special health care needs as they navigate their care and support options.

"Instead of depending on case workers and teachers deciding what was a need for our family, give us the choice of what our family needs and allow us to pick and choose, with assistance, what we think we need."



Background



Children and youth with special health care needs (CYSHCN) have been defined federally as children or youth with or at risk for chronic physical, developmental, behavioral, or emotional conditions who also require health and related services beyond what is needed by children generally. This definition includes children with:

- Disabilities
- Chronic illnesses and conditions
- Health related educational and behavioral problems

Based on the information from the 2016 National Survey for Children's Health Children with Special Health Care Needs (CSHCN) provided to North Dakota's Children's Special Health Services (SHS), 19.4 percent of North Dakota's children (about 30,876) have a special health care need. Survey data indicate that the prevalence rate of special health care needs in ND is 8.3 percent for children ages 0-5, 19 percent for children ages 6-11, and 29.3 percent for youth ages 12-17, and is 21 percent for males and 15 percent for females.

The data show that CSHCN families experience an economic impact; 12 percent of these families who had a child with special health care need of a lesser degree experienced financial problems due to their child's health needs. For those families with complex medical needs nearly 18% experienced financial problems due to their child's health needs.

About Family-Centered Care

Family-centered care assures the health and well-being of children, youth, and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions, and expertise that everyone brings to this relationship. Family-centered care is the standard of practice which results in high quality services.

The foundation of family-centered care is the partnership between families and professionals. Key to this partnership are the following principles:

- Families and professionals work together in the best interest of the child or youth and the family. As the youth grows, they assume a partnership role.
- Everyone respects the skills and expertise brought to the relationship.
- Trust is acknowledged as fundamental.
- Communication and information sharing are open and objective.
- Participants make decisions together.
- There is a willingness to negotiate.

"We were alone, and I SEARCHED for resources and made calls and went to meetings and filled out paperwork. I spent more than two years searching for help, including at social services, and they never even told me about CSHS. Very sad and frustrating at how much money and stress it could've saved our family. Accessing existing programs should be a simple, streamlined process."

Based on this partnership, family-centered care:

- Acknowledges the family as the constant in a youth's or child's life.
- Builds on family strengths.
- Supports the child or youth in learning about and participating in his or her care and decision-making.
- Honors cultural diversity and family traditions.
- Recognizes the importance of community-based services.
- Promotes an individual and developmental approach.
- Encourages family-to-family and peer support.
- Supports youth as they transition to adulthood.
- Develops policies, practices, and systems that are family-friendly and family-centered in all settings.
- Celebrates successes.



Sources: 1) National Center for Family-Centered Care. *Family-Centered Care for Children with Special Health Care Needs.* (1989). Bethesda, MD: Association for the Care of Children's Health; 2) Bishop, Woll, and Arango (1993). *Family/Professional Collaboration for Children with Special Health Care Needs and their Families.* Burlington, VT: University of Vermont, Department of Social Work; and 3) Family-Centered Care Projects 1 and 2 (2002-2004). Bishop, Woll, and Arango. Algodones, NM; Algodones Associates.

The Needs of CYSHCN in North Dakota

The 2016 Data Resource Center for Child and Adolescent Health indicate that families varied greatly in their knowledge of community services and programs they can access. Specifically the report showed that:

- In an average week, how many hours do you or other family members spend arranging or coordinating health or medical care for this child? 35 percent of families did not receive coordinated health care. 52.4% spent less than one hour, 10.3 % 1-4 hours weekly and 2.2% spend 5 or more ours weekly

Over the past decade, national surveys have indicated that families who are informed are better decision makers for their CYSHCN. The Health Care Experiences of Families of Children with Special Health Care Needs conducted by the Heller School at Brandeis University and Family Voices also confirmed this family need. Research shows that family and child health outcomes improve dramatically when they can consistently access accurate and quality information in a timely manner.

"I found it very hard to learn about services for children with special healthcare needs. I was always given the run around and always had to wait for answers. For new families I would suggest sending out a packet of information containing information for all services available and support groups for families dealing with a child with special healthcare needs."

As a reality check to assessment and survey indicators, families who have contacted FVND via phone or in person shared their lack of health care information and knowledge and available resources in ND. In addition to problems accessing medical and community based resources, families reported difficulty in locating information that is easily understood for diagnosis and treatments of their children, and in understanding public and private insurance benefits and limitations.

Study Design

Intent and Proposed Outcomes

The intent of this project was to help identify the experiences families of children and youth with special health care needs may face as they search for resources, information, financial support, emotional support, and access to services. The project sought to identify what was working well and how that was influencing the family capacity to access information. Barriers encountered by families serve as real life examples of specific challenges faced by families as they navigate the system of care for CYSHCN.

Potential Uses

The survey can enhance family capacity to seek and access appropriate services for their CYSHCN by providing a snapshot of the strengths and challenges within the information navigation trail. It will serve as a base for identifying and celebrating success and beginning a dialogue to identify barriers that families may face. The information will be used to identify areas for FVND to work as an organizational partner with the system of care to effectively improve the capacity of families to navigate, locate, and access appropriate services and supports.

Methodology

The methodology of this initiative had several stages, each serving as a progressive way of gathering information that would meet the anticipated outcomes and assist organizations, families, and systems to better meet the needs of CYSHCN.

STAGE	DESCRIPTION
Targeting Programs:	Using traditional avenues of information seeking by families, FVND developed a database of organizations and agencies across ND that serve CYSHCN to call in search of resources and information.
Notification of survey:	Before the survey was conducted, a letter was sent to administrators of the main agencies that were going to be called to let them know about the upcoming survey.
Scenario:	A family scenario was created to serve as the purpose of the call and a consistent way of soliciting information, resources, and referrals.
Seeking information calls:	A parent caller, using the scenario and acting as a parent seeking information and resources, called agencies, organizations, and providers in the database with the scenario.
Data collection:	The parent caller documented each call individually by noting the responses she received from each person (at each agency). The caller also rated each call on both responsiveness and respectfulness, based upon a subjective scale and interpretation from the vantage point of a parent of a CYSHCN.
Aggregate findings:	The responses were collated into an Excel database.
Rating responses:	A group of individuals from across the state rated each agency on a scale of 1-5, based on the data and indicated if the agency was responsive and respectful.
Disseminate information:	The results and information were shared at meetings with agency directors and partners.

Overall Results

The results yielded good responses from a variety of programs and agencies that were genuine in their willingness to help and find information, care about the situation, follow up by email, and emulate an overall desire to cover the needs of the family. Specific "helping" behaviors included:

- Referrals to county offices
- Referrals to FVND and other family support agencies
- Offers to make calls on behalf of the family
- Willingness to check back to see how they were doing
- Follow up emails
- Active listening

Some responses and behaviors that were not found helpful included:

- Multiple "baton tosses"; passing the parent caller on to other programs and services
- Referrals to other programs that were not knowledgeable or helpful
- Not referring to their own agency's programs
- Offering websites, but not asking if the family had internet access
- Offering information without the contact information
- Using incorrect names such as "Human Resource Center" instead of "Human Service Center"
- "Good Luck" wishes when they were unable to assist

Table 1. Data Collection Results	
Number of programs called	215
Number of calls completed (sometimes spoke with multiple individuals within the same program)	324
Number with wrong 800#	8
Number with wrong local number	13
Number disconnected	14
Number totally unreachable	15
Number answering to a different name	11
Number rated as responsive	235
Number rated as respectful	146

Response and Respect Scale

1. Not responsive or respectful; gave no information or help on where to go or what to do.
2. Somewhat responsive or respectful, but not both; gave no information or help on where to go or what to do.
3. Responsive and respectful, offered some information, but it was not the best or was lacking in contact information
4. Responsive and respectful, gave information, but did not give all needed information (both parent support and other needs)
5. Responsive and respectful, gave correct information on who to call or connect to or what to do.

Table 2. Rating Results

1 – Worst	65
2	73
3	44
4	26
5 – Best	7
Rating average	**2.2**

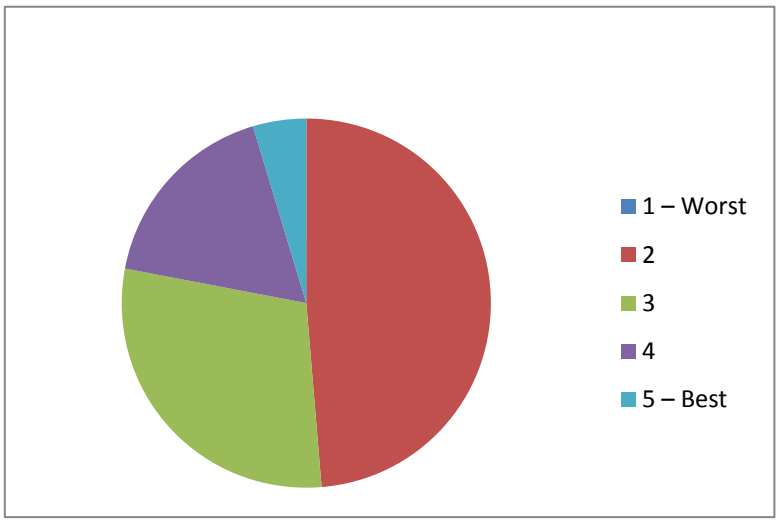

Figure 1: Response and Respect Results

Interpretation

A review of the outcomes of this exercise indicate that there are locations, agencies, and programs that are well prepared to assist families when they turn to them in search of resources, information, and assistance. Some seemed to be inclined to assist, regardless of whether it was a population that they were responsible for helping or not. Several, albeit a small number, seemed to be prepared and well organized in their approach to assisting over the phone. Because of the many barriers to communication and understanding inferred by phone conversations, those that were considered respectful are to be applauded.

While there is no current national standard to help us determine whether an average state rating of 2.2 is adequate, we feel strongly that we would like to see this number improve. This project also highlighted the plight of families as they blindly stumble through the system of care in search of resources, information, and assistance for their CYSHCN. The study suggests that there was an abundance of wrong numbers, disconnected numbers, and a general lack of available resources without "digging" from one level within a program to another. There is an obvious lack of knowledge of the system of care in general by many programs and service agencies – sometimes within their own program. The "loop" of information had many missing links such as a failure to ascertain the capacity and resources of families to follow the suggested resource or failure to offer the contact information. First contact employees (those who answer the phone) may have created a barrier by not stating the program name appropriately or not offering a clear and concise description of what they could offer families of CYSHCN.



FVND Recommendations



Transformation of the health care system for CYSHCN will be dependent upon ensuring that families have accessible, accurate, family centered and culturally competent information. Through FVND with the Family to Family Health Information Center and ND Parent to Parent Project, FVND recognizes their role and responsibility in working in collaboration with other partners to create an accessible and accurate information system for families. Recommendations that warrant follow up include the following.

Training that facilitates:

- Information sharing and cross training within an agency on the various programs, including the full scope of the agency, not just a specific program.
- Orientation and ongoing training for all front line/first contact staff, such as operators, receptionists, or outreach workers.
- Cross training and sharing of information and resources between agencies, programs, organizations, and service providers within the state's communities.
- Staff that are trained on accessing family support partners, such as FVND.
- Utilization of FVND training on family-centered practices and encourage agencies to have FVND staff present at staff meetings, trainings, and conferences.

Partnerships that:

- Encourage networking opportunities between agencies and service providers.
- Promote statewide information and resource partnerships that will promote consistent and predictable methods for sharing information that ensure service agencies, programs, and organizations can be responsive to the requests and needs of families and their CYSHCN.
- Ensure that agencies and programs include families and youth on advisory boards and committees.
- Provide families with information on FVND and other family organizations with all referrals.

Tools that promote:

- Quality improvement for monitoring and improving the information and resource system.
- The use or development of a shared database of information for families and providers with accurate contact information.
- The utilization of data from family support partners such as FVND to evaluate program and agency effectiveness in supporting families.

Accountability that will:

- Identify and use regular "check points" between critical partners within the CYSHCN system of care to identify gaps in the provision of information and resources.
- Lead to a strategic plan for a family centered and culturally and linguistically competent approach to addressing the needs of families.
- Assure that family support partners such as FVND are included in the planning, implementation, and evaluation of the information and referral system.
- Utilize FVND as an outside evaluator of the information and referral system.
- Continue to discuss available opportunities for family support organizations to provide information regarding family perspective in accessing services and support.

FVND Next Steps

As an immediate response, FVND met with state agency directors to review the survey, results, discuss recommendations, and explore partnership opportunities for improving information and resource access. After meeting with state agency directors, FVND met with agency staff and presented the results and discuss approaches to improve family access to information and resources.

FVND is working on a "North Dakota Roadmap" to begin addressing the information gaps experienced by families. We invite partners from across the state to join in this endeavor and other approaches to develop the capacity of the health care and information system to be more responsive to the requests for information and services of families of CYSHCN.



Finally, FVND is invested in the vitality of this survey and its potential to expand the capacity of families to access accurate information and support. We will continue to seek resources to support the survey each year, hoping to document improvements in information, support, service, and resource access for CYSHCN and their families.

FAMILY VOICES OF NORTH DAKOTA

#2368

Who are Children with Special Health Care Needs?

Nearly 20,000 children in our state have some kind of special health care need and over 40% of these children have a health condition that limits their play and school activities.

This means 1 in 5 families within our state have children living with a special health care need and includes: physical, mental or emotional disabilities; others live with a chronic illness and many present a brief, but life-threatening medical problem.

If you are the parent or caregiver of a child, youth or young adult with special health care needs you are not alone! Family Voices of North Dakota is available in all eight regions across the state. Contact us; we understand your concerns.

ONE in FIVE
FAMILY VOICES®

What makes Family Voices different?

Family Voices of ND is a parent led organization. All staff are parents of children with special health care needs and disabilities.

All services that are provided to your family are at NO cost to you!



For more information about Family Voices of North Dakota please contact us!

P.O. Box 163
Edgeley, ND 58433
1-888-522-9654
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fvnd@drtel.net
www.fvnd.org

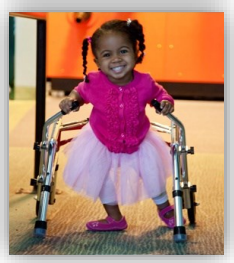
FAMILY VOICES OF NORTH DAKOTA®

Navigating Crossroads to Hope

As part of a grassroots national network, Family Voices of North Dakota is the Family to Family Health Information Center to help you navigate the complicated issues surrounding health care for your child or youth with special health cares needs and/or disabilities.









KEEPING FAMILIES AT THE CENTER OF THEIR CHILD'S HEALTH CARE

What does Family Voices do?

Family Voices of ND:

- Provides families with tools to navigate systems and help make informed health care decisions.
- Provides leadership and brings the voice of families to health care programs and policies.
- Promotes family/ professional partnerships.
- Offers opportunities to interact with policymakers, educates families about the legislative process and teaches advocacy skills.
- Hosts trainings, workshops and topical calls for parents and professionals.
- Provides support, encouragement and peer mentoring.
- Walks you through transition phases into adulthood.

Parent to Parent USA Program

Parent to Parent (P2P) matches families with children/youth with special health care needs/disabilities with a trained volunteer Support Parent who has had similar experiences.

P2P is a valuable source of assistance and information for parents because they can talk with an experienced parent who really understands.

Families often look to P2P for help and information such as:

- Resources
- Financial supports
- Similar experiences
- A listening ear

Member of the Parent to Parent USA Alliance, Committed to Parent to Parent USA-Endorsed Practices

If you are looking for another parent to visit with, please call FVND today

Project Carson

Project Carson offers support to new parents who receive a prenatal or at birth diagnosis. Project Carson's goal is to assure that families receiving a diagnosis have access to a support network of parents and organizations that understand the emotions, joys and challenges that come with the word diagnosis."

Our network of experienced parents can help you access supports that may be available to you such as:

- Financial Assistance
- Family Support
- Early Intervention Services for your child and family

To be referred to Project Carson, call 1-888-522-9654.

#2369

Supporting Families in North Dakota: Through the Lens of Lived Experience



Family Story

Family Voices of ND has been a valuable resource for me and my family. They have provided me with valuable training and knowledge about resources networking in my community and areas around me. My husband and I now have a better understanding of how "the system" that our child, with special health care needs, is in. Everything can be so confusing, but this knowledge has better equipped us. There have been topical calls to further enhance our learning. This is extremely beneficial to us and other families, so we can understand what everything is all about in this world that we must now live in, that we were so totally unprepared for. Also, a big thing I am so thankful for, about FVND is that their line is always open. Sometimes, I just don't know where to begin. I know I need something for my child, I know something just isn't right, but where do I start, where do I go from here? One call is all it takes. This is immensely valuable. FVND usually doesn't just give me the number and say, "try this." Often, the call is made for me, and things get going. Then, I get a call from someone if I needed a referral to another place. I don't end up spending an hour or more on the phone trying to get to where/who I need to. What a relief.

The Parent to Parent program has been an excellent resource as well. I was matched with another parent when I wanted to talk to another parent close in my area who had a child similar in diagnosis to mine. It was very nice not to be paired with someone in another state away. We could discuss what works, what doesn't, and things like local providers and state resources. I felt reassuring to have someone near by to talk with. Then, I was paired with a parent to who wanted to talk to me about their child and I was going to support them. Interestingly, it worked both ways. We enjoyed talking with each other and were able to learn from each other. What kind of things had worked and providers we had found. We actually both benefited and were able to improve the care for both our children!

Supporting families *involves the connection to another person who has also raised a child/youth with a special health care need and/or disability and who has a shared life experience. This connection assures that families get resources and services in ways that are respectful, relevant, and honor their unique choices and perspectives so that they can make informed decisions to achieve the best possible outcomes for their children and/or youth.*

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members, we nurture, protect, and influence each other. Families are dynamic and are cultures unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations.

Developed and adopted by the New Mexico Legislative Young Children's Continuum and New Mexico Coalition for Children, June 1990.



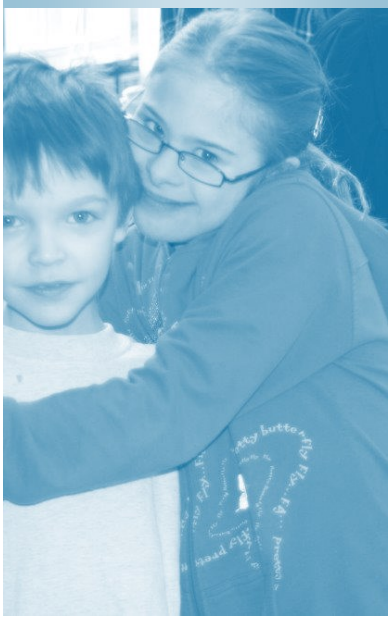
Family Driven

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing supports, services, and providers;
- Setting goals;
- Designing and implementing programs;
- Monitoring outcomes;
- Participating in funding decisions; and
- Determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.

Osher, Osher, & Blau, 2006

Fidelity is trust, accountability, and predictability across the systems of care between all stakeholders within an established and accepted practice. Families of children and youth need fidelity from the people in their lives; teachers, providers, support team, and others. The expectation of fidelity to family driven or centered practices is a fundamental value in family support.



Background

There are an estimated 27,000 children and youth with special health care needs and another 23,000 children and youth with an emotional, behavioral, or mental health condition in ND; 13,000 of these children receive special education.

Research and experience shows that there is much more to meeting the needs of children and youth with special needs than those services offered by providers. Most services are provided according to guidelines that dictate the eligibility, type of service, and access. Because of this, families of children and youth with special needs often serve in a variety of roles to ensure the well-being of their children and youth, such as care management, transportation services, social support, socialization, advocacy, medical treatment, therapies, and other necessary services. And, because family caregivers are generally the primary and/or sole caregivers to their children and youth with special needs, their own physical, mental, and emotional health and wellbeing can impact how they provide that care. As a result, parents of a child or youth with special needs may also experience increased stress, guilt, blame, or reduced self confidence in parenting, which can divert attention from other aspects of family functioning. In turn, this can effect the physical, mental, and emotional health and wellbeing of all of their children and youth.

Children and youth with special health needs include all children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Further...

Researchers and leaders across the nation agree that key to this support is:

-**Connections** to others who have lived experience in successfully navigating the system of care for their own child or youth;

-**Access** to formal and informal information and resources that are family and youth driven/ centered and culturally responsive; and

-Family and youth **choice** based upon their interpretation of that information.

Each component is essential as the foundations of family and youth driven/centered care and support. Family driven/ centered care assures the health and well-being of children and their families through a respectful family professional partnership. Family driven/centered means that families have a primary decision-making role in the care of their children, as well as in the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. Family-driven/centered care is the standard of practice which results in high quality services.



Current State of Supporting Families

Historically, until the past decade, families, youth, and consumers of services had to fight to secure a place at the decision-making table, and typically served in a volunteer advisory capacity. Later, some were paid a "stipend" to cover childcare costs, travel related expenses, and income lost due to missed work. As organizations and individuals became more experienced and skilled, and as programs and service providers saw the value of ongoing support, some agencies contracted with family run organizations and leaders as providers of lived experience, peer to peer support for families of children and youth with special needs. States and their communities have taken the task of developing sustainable support as a critical component to the provision of a continuum of services for families of children and youth with special needs. Many are offering funds and resources for family run organizations to provide support services.

Using representatives from lived experience populations has been on an upward evolutionary process for over three decades. Federal, State, and private funding sources require family, consumer, and youth representatives and a shift towards a more family, consumer, and youth driven approach to serving vulnerable populations. Aside from organizational and funding requirements, the inclusion of a lived experience representative to provide family support has multiple benefits.

Across the Country

In **Arkansas** a community based, family run organization was awarded a contract from the state to provide peer to peer home visiting for targeted families of young children at risk for special needs. The organization was given enough funding to train the trainers of home visitors, hire and supervise home visitations, and to manage the program within nonprofit business practices.

In **North Carolina**, the statewide, family run organization for children and youth with mental health needs received a large, state contract to hire, train, and supervise Family Support Specialists with lived experience across the state to work with providers and ensure a family driven approach to service delivery and evaluation.

Lived Experience

The term "lived experience" has been used to characterize consumer and family members whose experiences are likely to match up to individuals currently receiving services. The term can be used to describe the first-hand accounts and impressions of living as a member of a group, such as those who have used mental health services, families who have been involved in the child welfare system or families who received services through a federal or state program. The core concept of supporting families is based upon an embedded lived experience and a peer to peer approach. One or more of the following might describe an individual with lived experience:

- A parent, family member, caretaker who has raised or is raising a child or youth with special needs;
- Willing to share life experiences in a positive manner;
- Has been involved in and understands multiple service delivery systems;
- Can separate both the good and bad experiences and use them to improve the system response to the families they serve;
- Can use experiences to help other families move beyond perceived limitations;
- Can transfer knowledge to build the capacity of the families served/supported;
- Builds their knowledge of systems through interactions with different families and their needs;
- Has an understanding of where and how to get answers regarding identified needs; and
- Persistence in securing necessary resources and information.

Guiding Principles of Supporting Families

The following Guiding Principles were developed to serve as a foundation for supporting families across the state with special needs.

- **Lived Experience:** Support evolves from lived experience, where families have access to persons familiar with the road who understand the questions, worries, joys, heartache, and celebrations that are a part of the journey;
- **Coactive Navigation:** Families build their capacity, confidence, and strength through support and coaching from another parent who can share their experiences when traveling new paths with their child's or youth's diagnosis.
- **Meaningful Connections**: Families build their capacity, confidence, and strength in navigating systems through active support and coaching from another parent.
- **Active Engagement:** Responsive listening and translation is provided through shared experience and serves as a vital component to assist families in a manner that allows them to receive the services necessary to meet their authentic needs.
- **Critical Partnerships:** The system promotes and models family-professional partnerships as a predictable aspect in establishing family identified needs and services.
- **Unbiased Respect:** ALL support recognizes and builds on the strengths of each family member and respects their choices, culture, and beliefs in an impartial and nonjudgmental manner.
- **Sense of Belonging:** Families have peers with similar experiences standing with them as they identify and use their natural networks to promote a sense of belonging.
- **Ongoing Sustainability:** Adequate efforts and resources are identified and available to ensure the continuity and longevity of supporting families for the duration of need.

Supporting Families: A Sampling of Services

Some of the supporting families services that could be offered to families and the systems that serve them includes:

- Serving on care planning teams with families;
- Building the capacity of families to identify and express their needs;
- Advocating and sharing information on the needs of families;
- Developing or editing material that builds the knowledge, capacity, and skills of families;
- Creating special programs or activities to meet family needs;
- Evaluating the program's response to the principles of family, consumer, and youth driven-centered;
- Creating and collecting satisfaction surveys;
- Discussing with families their specific needs and guiding them to resources;
- Serving as a trainer for in-service trainings;
- Representing the families served on workgroups, taskforces, and/or interagency councils;
- Reviewing program policy to ensure sensitivity to the needs and experiences of families served;
- Creating and facilitating family advisory committees;
- Serving as an family advocate or voice at service planning meetings; and
- Serving as a peer mentor to those served when partnering with professionals or navigating the system of care.

Recommendations

In light of the previous discussion, the following recommendations emerged from the group.

- **Families must have access to organizations that represent the lived experience through:**
    - Referrals to supporting family organizations by all child and youth serving agencies and programs within a specified period of time;
    - Systems that use available evidence based, parent to parent models and family driven principles to connect families; and
    - Family run organizations that provide family support through a memorandum of agreement and within the guiding principles of this paper.
- **Support to families must be accessible on all levels of planning, treatment, and evaluation and feature the following:**
    - Statewide coverage without gaps;
    - Transparency that allows families to make choices on what will work best for them;
    - 24/7 availability;
    - Family driven and centered approaches;
    - Opportunities to access culturally competent support that is respectful and responsive to their own beliefs, values, and customs; and
    - Adequate provisions for urgent and emergency support needs.
- **Families are engaged and have opportunities to build their skills as a parent of a child or youth with special needs through:**
    - Agencies and programs that are committed to assisting family run organizations in identifying families that could benefit from additional training and support;
    - Utilization of family run organizations and their expertise to develop and manage training programs for families that are responsive to their identified needs;
    - Annual trainings within the state to build the leadership capacity of families; and the
    - Availability of a formal career ladder for families with lived experience through a rigorous training and certification program.
- **Family support is viewed as a critical and professional service to the well-being of families of children and youth with special needs and demonstrated through:**
    - An examination of the extent to which current supports are aligned with these principles;
    - Ongoing opportunities for funding and resources to ensure that family run organizations have the capacity to sustain the support they offer;
    - Family leaders have regular opportunities to meet with the Governor, policymakers, and agency management to discuss and review the state of the state in family support;
    - During budget discussions, family support will be considered as a viable alternative to more costly interventions;
    - Regular, consistent, and predictable funding from the state; and the
    - Recognition that program management does not constitute family support in itself.

"Overall, there have been fabulous things going on in the state of North Dakota to support families with children with special health care needs. At the beginning of our diagnosis of our daughter, I felt disconnected, afraid, and outnumbered by children who seemed to live lives as "usual." I have felt quite thankful for the groups that I have been a part of and believe they are a vital part of our system."

A.L. North Dakota

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Next Steps

In an effort to promote the principles and intent of this paper and promote the fidelity of supporting families, we have agreed to the following next steps:

1. Development of a short and long term strategic plan that will outline goals, activities, outcomes, and accountability;
2. Meet with stakeholders and policymakers to establish direction and resource options to finance and sustain family support;
3. Work collaboratively to align our organizations with responsibilities; and
4. Create memorandums of agreement between organizations to minimize competition, repetition, and confusion.



Changing the future,

one family at a time

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#2370

Testimony on HB 1012
2021 Legislative Session
January 26, 2021
Rep Nelson, House Appropriations Chairperson

Representative Nelson and Members of the Committee

My name is Donene Feist, I am the Director for Family Voices of North Dakota. I come before you today to regarding HB 1012.

Family Voices of North Dakota is statewide family to family health information and education center who serves families of children with special health care needs in ND. Each state in the country and our territories has one family organization that has been designated as a family to family health information and education center by HRSA federally. We are that entity for ND. We provide emotional and informational support to many families across North Dakota who have a child who has a chronic health condition and/or disability. In addition to the support and 1:1 assistance we provide to families, we also provide various trainings and workshops, which help families understand how systems work so that they can also be good stewards of state dollars and the programs of which their children are enrolled. Our staff, who all are parent to children with special health care needs, provides assistance to families by helping them access and navigate services; explaining what the services mean, how systems work, and where the funding comes from; by providing emotional support to assist with their unique and individual needs.

FVND follows the Maternal and Child Health definition of children with special health care needs, which is those children and youth who have a chronic condition of at least one year, a physical disability or mental health/behavior health diagnosis. Additionally, there are many children and youth who may have a physical disability and a chronic health illness but also may have a co-occurring mental health diagnosis. Because of many families have a co-occurring condition, it often leaves families having to understand and navigate many systems and complicated silos. We receive our referrals through agencies, physician offices, out of state hospitals where a child/youth may be receiving services.

All of our services under the auspices of the statewide health information and education center are performed through parent-to-parent mechanisms through our staff. In addition, we run a parent-to-parent matching program called North Dakota Parent-to-Parent which provides connection of one parent to another as a mentor for emotional support. This program mirrors the "peer support" program that you may be familiar with in the behavioral health system; however funding for peer support outside of the behavioral health system has not been prioritized.

In partnership with Designer Genes in 2012, we provide support through a project called Project Carson. Project Carson provides emotional and informational support to families who may receive a prenatal diagnosis or an at birth diagnosis.

FVND is affiliated with two national organizations: Parent to Parent USA and the Family Voices National organization, who provide ongoing technical assistance to all states across the country

We continue to experience an increase in the number of calls and requests for assistance from families and providers. On the last few pages of my testimony I have included the data we collect on the calls we receive and the help that is provided.

We are requesting that the dollars described and removed above be placed back into the budget for HB 1012. The need for family support is not going away. Sadly, dollars for family support have been nearly eliminated in the 1012 budget.

Families desperately need a place to go to get the help that they need. Through funds appropriated in the 2015 session and 2017 session, we have been able to increase staff time. Current staff are assisting families across ND. Funds allocated, not only help meet increase in demands for assistance to families and professionals 1:1, but also for ongoing training, and development of educational materials. Our mailing list has steadily increased to nearly 7394 across the state.

In 2015- present we were provided flow through dollars through: **SECTION 20. GRANTS - EXEMPTION - REPORTS TO LEGISLATIVE MANAGEMENT**. The grants line item in subdivision 2 of section 1 of this Act includes $75,000 from the general fund for a grant to a statewide family-to-family health information and education organization which provides parent-to-parent support for families and is

located in a county with a population of less than 6,000 based on the 2010 decennial census, for the biennium beginning July 1, 2015, and ending June 30, 2017. Funds awarded must be used for family-related information and education services. The organization receiving a grant under this section shall provide a report to the legislative management during the 2015-16 interim on the use of grant funds. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

In 2017-present we were provided flow through dollars through: HB 1040 from 2017. FAMILY-TO-FAMILY SUPPORT SERVICES. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the department of human services for the purpose of providing funds to one or more organizations to provide family-to-family support services, for the biennium beginning July 1, 2017, and ending June 30, 2019. Funds provided under this section must be used for providing support services to families with children who have disabilities or behavioral health needs.

Most recently we have been told that we would be cut $100,000 and the remainder would need to be put out for a Request for Proposal versus flowing directly through to our organization. We have not received an answer on why this change is occurring. This was flow through dollars through Children and Family Services.

We often encounter families who are in crisis and experiencing difficulty accessing services because of denials and ineligibilities. We end up providing assistance similar to an ombudsman because nothing like this exists for families who are raising children with special health care needs and disabilities in North Dakota.

To be clear, not all of the families that we assist receive Medicaid services. Not all of the families we serve will be served under the 1915i state plan amendment. In previous testimony, Chairman Nelson, you had asked the question of whether some general funds were eliminated due to being able to bill through the 1915i, and the response was yes. We want to be clear that this isn't always the case, as other families may have private insurance and be on one of the waivers. Some may be just on income based Medicaid. There are no two families alike.

IN 2016 ND Kids Count Data indicates that 86% of parents with children eligible to receive services are not aware of available programs. We feel that this is still an issue five years later. ***People cannot access what they do not know exists*****.** In essence, we do the work to help families, one of our most vulnerable population the how to access the provider networks they will need in raising their child with a chronic illness and disability. Who then would provide this service to families?

Most recently, through focus groups to identify family's needs through the Money Follows the Person initiative, we learned families needed assistance in navigating and understanding the various systems and silos, a streamlined approach, need to connect with others, application assistance and help coordinating services. We also know through a survey that we completed with DD Program Managers which revealed many of them do not know local resources and this is where FVND plays a very valuable part to systems of care.

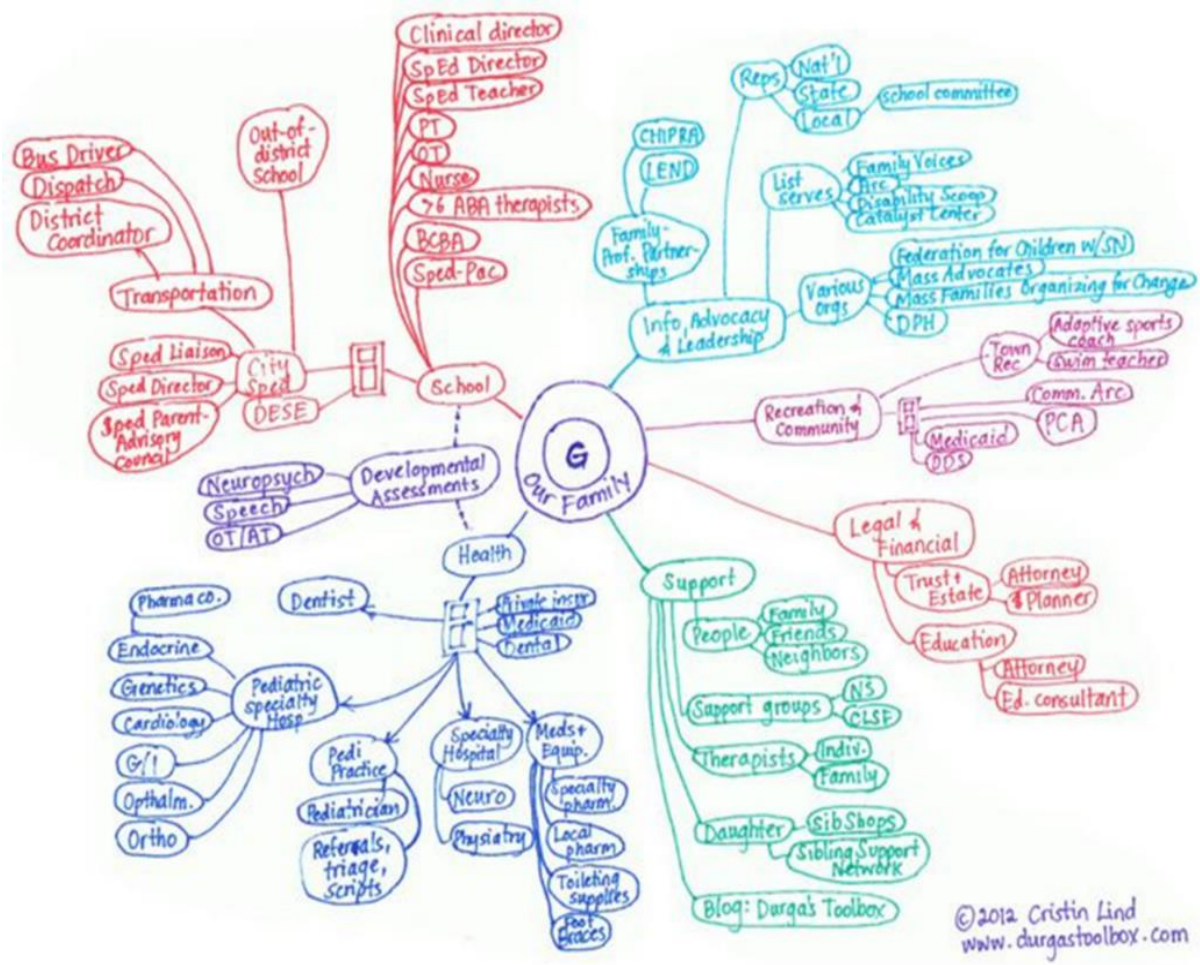
Our data collected below and on the final sheets of this testimony, is information that all staff collect and is aggregated. I share the information to help you understand the magnitude of information that we collect daily.

The included table identifies the ongoing increase in the number of calls that are received by our office. We are on our 20th anniversary as a nonprofit. Eighteen years ago, our total contacts were 518 families and 427 providers. As you can see we have had a steady increase in the number of contacts to staff from families and professionals. Our federal fiscal year is July 1 through June 30 of which this data is reflective.

Total Encounters of all calls	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**June 1, to Dec 31, 2020**
Families	**2865**	**3260**	**3712**	**4026**	**4172**	**4233**	**2296**
Professionals	**2339**	**2499**	**2893**	**3076**	**3158**	**3273**	**2173**
Totals	**5204**	**6059**	**6605**	**7102**	**7330**	**7506**	**4469**

As stated earlier, many times, our encounters with families are heightened because the family is in crisis. We have noted that the issues being presented by families today are being increasingly complex. Our staff work with a large number of families who experience gaps in service, have difficulty understanding the complexities of our Medicaid systems and Medicaid waivers, and their private insurance who have children with very complex medical issues. Many providers contact us to make a referral or to assist them in locating resources for families they are working with. Families often do not know where to begin. We will partner with them in making those connections to community resources, possible eligibility criteria and programs, assist them with the application process, follow up with them to assure their family needs are being met, and provide ongoing emotional and informational support.

In the diagram below you will see children with a chronic condition or disability utilize many services. Most services that families encounter are in silos.



National prevalence data estimates from the National Survey obtained through the Data Resource Center indicate there is an estimated 30,118 CYSHCN in ND. One in five families in North Dakota has a child with special health care needs.

IN 2016 ND Kids Count Data indicates that 86% of parents with children eligible to receive services are not aware of available programs. We feel that this is still an issue five years later. ***People cannot access what they do not know exists*.**

We know and can identify as best practice that families thrive when supported by others with lived experience. We also know that families build capacity, strength and confidence through support and coaching from another parent. Active engagement with families through responsive listening from others who have walked in the same shoes assists families in a manner that allows them to receive services necessary to meet their family and child's needs.

Families across North Dakota have repeatedly shared the difficulty in locating and accessing services when they call our offices. Raising a child or youth with special health care needs, accessing quality services and paying for them while still meeting the needs of the entire family and maintain employment is stressful.

Chairman Nelson and members of the committee, I have stood before you all for many years. The needs for families to live, thrive and survive in their community has also increased. We often **hope for the best, but don't know what the future holds in a world and system that wasn't built for our children.** There is no handbook or parenting book about raising a child with special health care needs and disabilities.

Most of our children don't fit a mold. All are uniquely their own, and many have multiple diseases or disorders so rare that often doctors have never seen. Early on families realize with a heavy heart, the world we live in isn't built for our children. Each and every day families are fighting someone about some aspect of their care. It could be a doctor, nurse, therapist, educator, or an insurance company. Every day families launch battles for what we know our children need to thrive, and sometimes our fight ends in defeat. We cry in our bedrooms at night. In the dead of night, many families lie awake, overcome by fear of the unknown.

Every day many families are fighting a battle against a disability, disease or chronic illness that we will never beat. Most of families know the very real implications of what can happen to our children at any given time. *All we want is for our children*

to not have to fight so hard to simply be. Families need support often to get from point a to point b. This is an ever fluid and changing environment.

Our role is not only to provide support, assistance in navigating and connecting to services to families, but through or various trainings and workshops, help families understand how systems work so that they can also be good stewards of state dollars and the programs of which their children are enrolled. A valued provider has stated "It is important to ensure that there are adequate supports for families, as these strengthen the family unit as a whole. This results in a decreased demand for providers as you are creating lasting change within the family unit.

Again, we are requesting that the dollars described and removed above be placed back into the budget for HB 1012. The need for family support is not going away. Sadly, dollars for family support have been nearly eliminated in the 1012 budget. Dollars for the Experienced Parent program which is in the DD Budget has also been eliminated. Do the most vulnerable families in the state not deserve assistance?

In closing, let us remember as each of us makes decisions that will affect children—whether we are parents, educators, health professionals, or government officials—it is our duty to consider if that decision either affirms or denies a child's most basic human rights. **Families are not looking for handouts, but they do often need a rope to hang on to, to keep from drowning in an every changing system. Family support is vital, to help them live, thrive and survive in an every changing world.**

The data shared on the last few pages are from federal fiscal year July 2019-June 2020 is to illustrate not only the number of calls but the type of information families and providers call us about. Additionally, several families we have assisted have shared information with you.
We thank you for your consideration.

Donene Feist
FVND Director
701-493-2634; fvnd@drtel.net

Family Voices of North Dakota

Family Voices Data Report

From 7/1/2019 Through 6/30/2020

The following data has been tracked and summarized from contacts and activities recorded in FV Solutions. Please print this report and input these totals, matching the questions, along with your other information into the online Data Report Form.

SECTION A.UNDUPLICATED COUNTS

OVERALL # of Families and Professionals Served

Families	Professionals
1116	560

of Families and Professionals Served by Type of Assistance

Families	Professionals	
1074	534	through 1-1 assistance
272	134	through training (identified individuals)

SECTION B. DUPLICATED COUNTS

of Families and Professionals Served by Type of Assistance

Famlies	Professionals	
4233	3273	through 1-1 assistance
640	247	through training (identified individuals)

O1 THRU O6. # of Families and Professionals Served by Outcome

Community-Based Svcs	Families	4186
Community-Based Svcs	Professionals	3362
Financing	Families	717
Financing	Professionals	388
Medical Home	Families	718
Medical Home	Professionals	302
Partnering	Families	1513
Partnering	Professionals	4071
Screening	Families	189
Screening	Professionals	211
Transition	Families	391
Transition	Professionals	263

Duplicated Totals of Health Care Financing Issues Reported through 1-1 Assistance

Financing Issue: Denial of Coverage Service/Other

Professionals	1	Medicaid
Families	16	Medicaid

Financing Issue: Denial of

Professionals	2	Medicaid
Families	33	Medicaid

Families	1	Private Healthcare	Families	1	CHIPRA
Families	1	Other	Families	1	State Financing Pgm
			Families	1	Other Public Pgm
			Professionals	1	Private Healthcare
			Families	3	Private Healthcare

of Families and Professionals Served by Outcome Sub Category

	# of Families/Profs Assisted 1-1:	# of Families/Profs Trained (Tracked Individually)	# of Families/Profs Trained (Estimated)
Community-Based Services			
Basic Needs (food, clothing, etc)	89		
Bullying/Violence	5		
Child Care	17		
Comm Relationships-Resources	4699	621	946
Cultural Brokering	2	1	
Disability Awareness	19	5	
Disability-Specific Info	849	112	204
Emergency/Disaster Planning	107	26	
Family Support	3507	512	963
Home Care	2		
Home/Vehicle Modification	2		
Hospitals/Clinics	39	3	41
Housing	33		
Immigration/Citizenship		1	
Legal Services	102		
Other	46		
Parenting/Foster Care/Adoption	32		
Pet Therapy/Service Dogs	1		
Recreation	916	10	
Respite	209	23	
Safety/Injury Prevention	15		
Schools	696	65	
Social Determinants of Health	182		43
Special Needs Planning	15	71	
Substance Abuse	1		
Transportation	47		
Unspecified	49		
Utilities	2		
Financing			
CHIPRA	23	69	104
Donations/Grants	3	8	
Health Exchange	22	83	
Medicaid	436	109	207
Other	65	4	37
Other ACA	14		

Other Public	206	26	29
Prescription Assistance	1		
Private	267	4	29
Public Assistance (SSI/TANF)	113	128	
School-based	3		
State-funded	12		
Tri-CARE/Military	1		
Medical Home			
Assistive Technology	27	14	
Care Coordination	330	22	64
Child Development	45	62	
Cultural Competence	24	7	
DME	25		
Healthy Weight	1		
Immunizations/Vaccines	1		
Interpreters/ASL	2		
Life Course		3	
Medical Home (model/concept)	1	25	18
Medications	35		
Mental/Behavioral Health	429	10	
Nutrition	12		
Oral Health	8		
Other	6		
Physical Activity	1		
Primary Care	6		
Record Keeping/Care Notebooks	1	13	
Sexuality	3		
Specialty Care	54	6	
Supplies (diapers, Formula, etc)	5		
Testing	12		
Therapies	83	26	
Unspecified	12		
Partnering			
Advancing Knowledge	435	244	946
Advocacy	749	102	139
Communicating w/ Providers	2780	262	584
Cultural Competence	54	88	315
F2F Collaboration w/ Professional	1651	174	238
Family Collaboration w/ Protessional	24	27	
Family-Centered Care	66	95	202
Involvement w/ Title V	494	47	610
Mentoring	98	126	120
Other	10	1	37
Parent Leadership Development	7	87	8
Systems Involvement	1113	227	1063
Unspecified	2		
Screening			
Autism Spectrum Screening	42		
Developmental Screening	64		79
Diagnostic Testing	22		

EI / IEP Screening	49		29
Genetic Testing	71	30	100
Mental Health/Behavioral Screening	17		
Neuropsych Evaluation	4		
Newborn Hearing	121		66
Other	14		
Speech/Language Screening	1		
Unspecified	1		
Transition			
Adult Provider	20	3	
Community Involvement	2		
Driving/Transportation	1		
Guardianship Alternatives	10	80	
Health Skills Training	20	63	15
Higher Education	15		
Independent Living/Housing	5	2	
Navigating Adult Services	142	100	95
Other	14		
Person-Centered Planning	4		
Relationships/Socialization	1	13	
School Transitions	45	18	95
Self-Determination/Self-Advocacy	9		80
Sexuality/Sexual Safety	28	15	
Special Needs Trusts	3	68	
Suicide Prevention	12		
Teen Councils / Leadership	12		
Unspecified	137		
Vocational / Employment	23	16	80

Total # of Hardcopy Materials Disseminated

Total Materials Disseminated Through 1-1 Assistance: 1718

Total Materials Disseminated Through Activities: 55262

Total: 56980

Total # of Trainings: 144

Total # of Meetings (not including Trainings): 518

To the Members of the House Human Resource Committee,

Three years ago, my six year old daughter, Addilynn, was fighting for her life in PICU in Minnesota after seizures nearly took her from us.

Four years ago, I attended the Parent Leadership Institute through Family Voices of North Dakota. I have also reached out to their staff on numerous occasions for guidance and support.

Both of these moments have changed my life and my daughter's. Addilynn has a very rare genetic disorder that causes developmental delays and difficult to treat epilepsy. My ability to advocate for her changed dramatically after attending the Parent Leadership Institute. It has helped Addilynn get the medical treatment, equipment and therapies she needs to thrive. It has helped me insure that she has qualified and competent individuals caring for her when her family cannot. Without the services that Family Voices of North Dakota provides, I would not be able to advocate for her in the manner in which I do now…which would have a great effect on her quality of life.

I urge you to reconsider the budget cuts made to the Family Voices of North Dakota programs. Family of children with special health care needs NEED agencies like Family Voices to help them navigate a confusing and sometimes scary system for their children.

I know that my daughter would not be thriving today without the advocacy skills and support that I have received from Family Voices of North Dakota.

toby.jean.carlson@gmail.com

To the Members of the House Human Resource Committee,

I would just like to give due praise to Family Voices of North Dakota. This particular program has been so helpful to my family on many levels.

I have a son who is now 18 his name is Kaden and he has a rare disease called leukodystrophy. He is totally dependant on us for all his care. Being a parent of a child with special healthcare needs can be very overwhelming, which is why programs like Family Voices are absolutely vital to families in ND.

I have many stories I could share of the help they have delivered, but I will tell the one that really introduced us to them and what they stand for. In 2010 my son Kaden suffered a brain hemorrhage and needed brain surgery along with months of recovery. It was the most afraid and overwhelmed I ever have been. In that moment I called Family Voices for guidance and support and they were there for my family.

They went above and beyond in support and pointing me in the direction I needed to go. They were amazing in their ability to jump in and really be there. I have used their services for many things from emotional support, help in guidance through the medical system, training me to be a better parent to my son, and help in general questions.

I have worked with many non-profit organizations, and Family Voices has been the most efficient and caring. I can't express enough how much FVND has meant to our family. I know if I call them tomorrow with a question it will be answered. In a world with a lot of runaround that means so much. They are worth every bit of funding and need to stay as a big presence in our state. As a parent I am so grateful for them!!

Amanda Burner

Minot ND

amanda.burner@outlook.com

To the Members of the House Human Resource Committee,

We are so thankful for Heather Wheeler staff of Family Voices of ND in Williston.

Our family has been blessed with a beautiful little boy who is now 6 years old who faces many challenges due to his disabilities, including Fetal Alcohol Syndrome, Autism Spectrum Level 2, ADHD and anxiety.

As we embrace these challenges along side him we have often felt lost, afraid and very alone. This path will never be easy, but after my first phone call with Heather, I realized that we will never be alone. There will always be someone there to help us navigate through this uncharted path and help us get back up if we fall.

In the world of FAS they say that if you know one child with FAS, you only know one which with FAS. This is because FAS is so different due to the brain damage to each child.

Heather and Family Voices of North Dakota, although she may only know Jaxson; Jaxson is who she knows well. Jaxson needs her and so do we. Thank you so much for putting this support in our lives

The Kostad family

Williston ND

kostadcrew@hotmail.com

HB 1012 #2534
House Appropriations – Human Resources Division
Monday, January 25, 2021
Rep. Jon Nelson - Chairman

Chairman Nelson and Members of the House Appropriations – Human Resources Division:

My name is Roxane Romanick and I'm representing Designer Genes of ND, Inc., as their Executive Director. Designer Genes' membership represents 260 individuals with Down syndrome that either live in our state or are represented by family members in North Dakota. Designer Genes' mission is to strengthen opportunities for individuals with Down syndrome and those who support them to earn, learn, and belong.

Individuals with Down syndrome have made many strides in living in their homes, schools, and communities because of educational and medical advances, public policy, and advocacy efforts. Public investments in early intervention, family support, public schools and special education, post-secondary school options, and home and community-based services do make a real difference for people with Down syndrome. The vast majority of our membership are living in home and community-based settings. Thank you for your important part in opening up these opportunities.

My daughter, Elizabeth, and our family are an example of the positive outcomes of this investment. Elizabeth has been a consumer of services from the first day of her life when her Early Intervention staff visited her in the hospital until the present with support from Vocational Rehabilitation and the Minot State Access Disability Services and the ASTEP program. Her education was supported by special education and general education from 2002 to 2018. A number of her job experiences have been supported by Vocational Rehabilitation. As a family, we have been supported by Family Voices of ND as well as the connections we've made through Designer Genes and the rest of the Down syndrome community across a wide arena of areas. All of these services and supports poured into a reservoir that she is depending on as she works on an Early Childhood Paraprofessional Associates from Dakota College of Bottineau. Who would have thought?

Our organization has interest in a number of areas of HB 1012 and this single piece of testimony is presented to draw your attention to those areas:

1. **Developmental Disabilities Division**
    a. **Payments for providers** – We stand in support with other advocacy efforts and the recommendation to award providers within the Developmental Disabilities system up to a 3%/3% increase. Our individuals across the life span from infants and toddlers in

our Early Intervention (Infant Development) to our oldest individuals with Down syndrome rely on this system.

b. **Eliminate the $11 million in state cost savings to the adult services providers -** This cut to our providers is devastating. The provider system has been stressed due to COVID, recruiting and maintaining staff, and assuring health and safety for everyone that they serve. These challenges put individuals at risk of institutionalization and instead of helping more individuals to move out of the Life Skills Transition Center, we will see the reverse happening.

c. **Restore and reallocate $100,000 Experienced Parent Funding –** In the 65th session, a number of advocates worked with legislators to secure an amendment on HB 1012 for $100,000 in state general funds and $160,000 in designated funds from the federal Part C grant to support the Experienced Parent program within the ND Part C Early Intervention system. In her January 20, 2021 budget detail testimony, Tina Bay, Director of the Developmental Disabilities Division, reported that this funding (both state and federal grant) would be cut as part of the state's cost saving plan.

Family-to-family support, parent support, peer support – call it what you want - is a critical element in sustaining the confidence and competence for families who have children with special health care needs. Our organization for one is designed expressly with that purpose in mind. In a 2005 research study of postnatal support of mothers of children with Down syndrome (mere_43_304.196_212.tp (brianskotko.com), the vast majority of mothers reported a desire to be connected to their local down syndrome organization "which can provide practical knowledge in addition to establishing the beginnings of a long term support relationship."

Our families who are raising children with special health care needs need other families to connect with who have lived experience either through their own experiences or through helping other families. We need structured approaches to matching families with other families like Family Voices of North Dakota does through their Parent-to-Parent program. I am requesting that upon restoring the $100,000 cut from the DD budget that it is reallocated to the Children and Family budget and passed on to Family Voices of North Dakota. (See below). Family Voices will put this money to work from Day 1 for the citizens of North Dakota and has the resources to do so.

2. Children and Family Services

a. Restore $100,000 to Family Voices and Reallocate $100,000 from DD

I am requesting that $200,000 be restored and given to Family Voices of North Dakota. They currently have $175,00 in the 2019-2021 biennium and have been told that $100,000 is being eliminated due to the cost savings plan. With your restoration and reallocation, they would have $275,000 to continue, plus expand the work they do to help families navigate and access a variety of service delivery systems. Believe your

money will go to work. Without an amendment from your committee, our North Dakota families will have lost $200,000 in critical supports.

3. **Vocational Rehabilitation**
    a. **Restore state general funds for the Centers for Independent Living –** If anyone should be testifying on this section, it's my daughter, Elizabeth. Through Dakota Center for Independent Living (DCIL), she was able to get her driver's permit. DCIL's active engagement on the Bismarck-Mandan Mayor's Committee on People with Disabilities helped her to know about their scholarship program, of which she's been awarded funding the last 3 years. Probably what she would tell you about the most though is their Youth Empowering Social Status (YESS) movement and the opportunities that she's had to develop leadership, speak publicly, and connect to other youth and young adults with disabilities and without. Sustaining our four Centers for Independent Living is another piece if assuring individuals with disabilities in our state live quality lives.

Thank you for your time and I will take any questions that you may have.

Roxane Romanick
Executive Director
Designer Genes of ND, Inc.
701-391-7421 info@designergenesnd.com

Testimony on HB 1012

2021 Legislative Session #2375

January 26, 2021

Representative Chairman Nelson, Representative Vice-Chairman Kreidt and Members of the House Human Services Appropriations Committee:

My name is Vicki Peterson, and I am here to testify to restore the $100, 000.00 that has been eliminated in the budget for the Department of Human Services flow-through dollars. I am a Family Consultant for Family Voices of ND. I have been a Family Consultant for nearly 18 years. I first gained knowledge of Family Voices of ND through my son's Early Intervention Experienced Parent, (also a vital program that is having funding eliminated). My son, Aaron has Autism with an Intellectual Disability and chronic health conditions. At the time, my son was non-verbal but did not have a diagnosis yet, and our insurance was denying speech therapy. I was angry, how could they deny a child who was non-verbal, speech therapy. I spoke with Donene, the director of Family Voices of ND, she guided me to the resources I needed, and I got two bonuses, the first was help with insurance covering speech therapy and I had a connection to another parent who also had a child with an intellectual disability and turned out as well a diagnosis of autism which my son soon received. This started my path to help other families as well and I was immensely proud when I was asked to be a part of this most wonderful family, Family Voices of ND. Over these years I know I have helped many families just as I was helped.

Family Voices of ND is the Family-to-Family Health Information Center in ND. We navigate all systems of care, including those families who have children and youth with special health care needs, chronic health conditions and disabilities. All systems of care mean physical health, mental and behavioral health, navigation of health programs and insurance both private and public. We offer a unique component, lived experience. All staff has a unique connection to other families who have children with special needs as we all have children with special needs, or young adults now with special needs. This is essential for making those connections, not only with families but providers as well.

I would like to briefly describe what a referral to Family Voices of ND and specifically to me may look like.

- Referrals come from providers, schools, lead agencies, could be anywhere that had connections to families that have children and youth with special needs.

- I contact the family within 72 hrs. of receiving the referral and I pride myself that I stick to that rule, as families many times are connected to us when the family may be experiencing some crisis.
- I first need to listen to the issue, or crisis, and need. It is extremely important that the family knows I understand that I too have had some of the same experiences.
- There may be financial issues, they may need resources to find programs that will be of support to their child, they may need and most often do, emotional support, the need to speak with another parent that has some same experiences, maybe they lost health insurance, maybe there are family members with mental health issues and might need referrals to programs, maybe a child's school plan is not working and need support. Many times, they need multiple resources to, multiple programs, the care coordination and navigation of systems, many systems.
- Average calls are around 35 to 45 minutes. I must make sure to follow-up and follow-through for families, as they are counting on the support.
- Typically, there will be referrals to programs and or other resources, often there are many referrals and research as well to make sure we are looking for all resources.
- A call may come from a provider who already has a family on a case load but does not know how to connect them to informal or other formal supports.
- We are not a 1 call and done. I have families I have and continue to help navigate systems of care for over many years, as their child becomes a teenager, and teenager becomes a young adult.
- I am there to listen, I am there to navigate, I am there to support.

Family Voices of ND helps train many family members to become strong advocates for their children, a voice. We help families with positive communication with the providers. We help providers communicate with families.

You will hear many times throughout this session, about Person- Centered Planning, keeping children and youth from being institutionalized, more focus on home and community-based services, juvenile justice reform, family-centered care. Family Voices of ND is a part of this, we are all about family-centered care. We focus on the family with children with special needs. Wrap-around services must be in place for the families. If the family is not healthy, the child will not be healthy.

Being a part of Family Voices of ND, has changed my life. It has made me a better communicator and better person. I have opportunities to make a difference in the lives of families with children and youth with disabilities and chronic health, because

someone made that difference for me and my family. Family Voices of ND is reaching out to the 1 in 5 children in ND that have those special needs.

I am requesting to restore the monies that were cut from the Department of Human Services so that we can continue to do what we need to for those families that need us the most, the more vulnerable.

Thank you for your time and consideration.

Vicki L Peterson

Family Voices of ND

Family Consultant

vickiasdc@bis.midco.net

701-258-2237 #293

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/26/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 2:18 p.m.

Discussion Topics:

- Behavioral Health Division budget
- North Dakota Brain Injury Network
- NIAM Brain Injury Services
- ND Long Term Care Association
- Fair Value Rentals
- northland pace
- Dakota Central Human Service Zone

Debra Johnson, CEO of Prairie Harvest Mental Health (2:20 pm) testified about Prairie Harvest Mental Health #2260

Heather Simonich, Operations Director of Nexus-PATH (2:39 pm) testified about the Behavioral Health Division budget, relating to implementation of 1915(i) services #2714

Stacey Hunt, Licensed Clinical Psychologist in the state of North Dakota and CEO of St. Thomas Counseling Center, PLLC (2:45 pm) testified about the SUD Voucher program #2604

Rebecca Quinn, Program Director at the Center for Rural Health (2:57 pm) testified about the North Dakota Brain Injury Network #2311 #2312 #2313

Nan Kennelly, speech-language pathologist and certified brain injury specialist (3:08 pm) testified about the Brain Injury Advisory Council #2510 #2512

Toni McCarty, Brain Injury Specialist (3:21 pm) testified about NIAM Brain Injury Services #2307

Shelly Peterson, President of the ND Long Term Care Association (3:24 pm) testified about the ND Long Term Care Association #2849

Bradley DeJong, CPA (3:47 pm) testified about Fair Value Rentals #3731 #3732

Reier Thompson, President/CEO (4:09 pm) testified about the Missouri Slope #3728

Ryan Bosch, Executive Director (4:22 pm) testified about northland pace #3481 #3482

Lynn Grimm, Chief Financial Officer (4:30 pm) testified about northland pace #3481

#3482

Lynne Ostrem (4:40 pm) testified about brain injured people in ND #3436

Kim Jacobson, Agassiz Valley Human Service Zone Director (4:51 pm) testified about the DHS Budget related to Human Service Zones #3222

Steven Reiser, Dir. (5:05 pm) testified about Dakota Central Human Service Zone #3171

Terry Traynor (5:12 pm) testified about DHS Budget/Zones #3144

Chair Nelson closed the meeting at 5:22 p.m.

Cole Fleck, Committee Clerk

PRAIRIE HARVEST
MENTAL HEALTH
930 N. 3rd St., Grand Forks, ND 58203-2408 #2260

To: Chairman Jon Nelson and Members of the House Appropriations – Human Resources Committee

RE: HB1012

I am Debra Johnson, CEO of Prairie Harvest Mental Health in Grand Forks.

Prairie Harvest Mental Health is a private non-profit agency providing permanent supportive housing, work opportunities and a variety of services designed to help people with serious mental illness succeed on their mental health wellness and recovery journey.

I have prepared this testimony asking the Legislature to consider restoring the recommended budget cut for Prairie Harvest Mental Health of $1,414,800. Justification is included in this document.

Since our inception in 1991 Prairie Harvest Mental Health has worked in a successful public/private partnership with Northeast Human Services Center. This structure has allowed us to focus services on our respective strengths. Northeast Human Services Center provides the treatment services and in a team approach with the consumer and Case Manager, Prairie Harvest provides the services and permanent supportive housing.

Over the years Prairie Harvest Mental Health has successfully raised over $4 million in grants to build 42 units of permanent supportive housing all at varying levels of support (see attached Exhibit A). These properties are owned with zero debt. Northeast Human Services Center refers consumers to the housing based on their unique needs. Prairie Harvest has units that are staffed 24/7 as well as four hours per day. In addition, there are two peer supported lodges (that are operated in a family like setting).

One home, a one-bedroom dwelling was purchased in 1998 with funds from the State Hospital and suits one or two individuals.

Our partnership with Northeast Human Service Center has allowed consumers to remain in the community which is, of course healthier as well as cost effective. Our data indicates for example that one young man prior to receiving Prairie Harvest services experienced 193 days in institutional care. He lived in Prairie Harvest Housing beginning in 2004. The Prairie Harvest supportive housing enabled him to work on his recovery, resulting in his hospitalization days decreasing to 46 in 2009, two in 2010 and he has not been in the hospital since. He currently lives and works in the community with minimal staff contact (just brief medication monitoring assistance).

In addition to the housing, Prairie Harvest Mental Health provides:

- Scattered sites Supported Residential Program & Medication Monitoring (60 consumers)
- Representative Payee (63 consumers) (No State funds)
- Life Skills/Job Development (40 consumers) (No State funds)

Also included in Exhibit A are the costs associated with institutional care, transitional housing and crisis care, as well as the supportive services provided by Prairie Harvest Mental Health.

Working with consumers on a daily basis has given us insight of their on-going needs.

During the COVID pandemic Prairie Harvest Mental Health has worked tirelessly to keep the consumers safe and healthy. We implemented policies related to PPP and other precautions immediately. Mask mandates and limited visits from others was required. As a result, we only had two positive individuals with no symptoms and one who was hospitalized and later recovered. Our staff implemented programs and services over Zoom to help keep consumers busy and connected as they work on their recovery journey. Staff helped keep them connected to family and friends using Zoom and Facetime and established telehealth procedures. As this document is being written Prairie Harvest Mental Health consumers and staff are receiving vaccines. Prairie Harvest Mental Health services are vital to continued success in living in a least restrictive yet supportive environment.

The recommendation to cut the Prairie Harvest Mental Health budget by $1,414,800 (over 50%) came without warning.

We have been aware of and took part in the 1915(i) amendment discussions as well as by providing testimony to State Employees who crafted the 1915(i) amendment.

While we can agree there is potential for providers to recoup some expenses there is little time to prepare for transitioning from a daily rate system to one that is just in development stages.

Other concerns include: (1.) trainings have only recently begun (1/20/21); (2.) As we have attempted to project a revenue forecast for our agency, we have had challenges getting answers clarified. We have been told that no one in our State is an expert in 1915(i) billing. Example: in the 1915(i) presentation brought to you by Pamela Sagness on page 12 (Exhibit B) there is an example of how the 1915(i) can reimburse a community provider. While it appears very encouraging, when looking through the information provided it contradicts what we were told in the 1915(i) training of 1/20/21. In this case it states the provider could bill 1915(i) for $763,774 for Care Coordination, as well as three other areas, including Supported Employment. The training indicated a provider cannot provide both Care Coordination and the other services. If this is in fact true, the reimbursement would be closer to $500,000 than $1,237,616. In the case of Supported Employment in the amount of $52,366, I understand there is a requirement for the provider to be accredited. The cost for accreditation could greatly reduce this revenue stream.

Prairie Harvest Mental Health has no billing system in place as we have been operating in pass-through funding within the Northeast Human Service Center billing system.

We are asking that the $1,414,800 be restored for the 2021-2023 biennium so we can assure services are not interrupted.

Prairie Harvest Mental Health has a stable supportive Board of Directors and staff. We advocate for individuals living in the least restrictive housing of their choice.

Following are letters of support from family members, consumers, and professionals.

In closing, I am not only the Chief Executive Officer of Prairie Harvest Mental Health, I am also a daughter, sister and mom to people with behavioral health concerns. My late Mom struggled her entire life with schizoaffective disorder and chronic anxiety. Because services such as those provided by Prairie Harvest Mental Health were not available to help, my Mom lived in a nursing home for 12 years beginning when she was 69 years old. I am asking you to help us remain a source of support for those who have long been underserved or overlooked.

Thank you.
Respectfully,
Debra Johnson

Exhibit A

PRAIRIE HARVEST
MENTAL HEALTH
930 North Third Street * Grand Forks, ND 58203-2408
Phone: 701-795-9143 * Fax: 701-772-5560 * E-Mail: info@prairieharvest.net * www.prairieharvest.net

Prairie Harvest Mental Health Permanent Supportive Housing

Harvest Homes 12 apartments 24-hour support 	Prairie Lodge 6 bedrooms Peer support 
Harvest Lodge 6 bedrooms Peer support 	Single Family Residence Limited staff support 
Siewert Plains 8 bedrooms 24-hour support 	Stern Place 9 apartments Limited staff support 

Total asset value: $4,031,607
Debt: $0

Operating Funding

	2019-2021 Biennium	2021-2023 Biennium
Northeast Human Service Center	$2,752,536	$1,337,736

Other Funding Used to Augment State Funded Services

Rents	$ 464,400
Grants (includes PPP grants)	$ 302,000
Work Contracts	$ 14,000
Donations/Fundraising	$ 96,000
Thrift Store Sales	$ 240,000
Client Service Fees	$ 68,600
Federal	$ 187,200
	$1,372,200

Mental Health Daily Rates Comparison

Local Hospital Psychiatric Ward	$2,126
State Hospital	$ 535
Basic Care Nursing Home	$ 147
Transitional Housing – State Run	$ 82
Local Jail	$ 75
Crisis Beds	$ 74
Prairie Harvest Mental Health	
24 Hour Group Living	$ 82
24 Hour Apartment Complex	$ 82
Peer Lodge	$ 38
4 Hour Supported 9 Plex	$ 28

Revised 1/15/2021

Example 1: Community Behavioral Health Provider

NOW

- $1,000,000 **general** fund/biennium
- 60 individuals served at any one time/biennium
  - 50% qualify for Medicaid
  - 25% qualify for 1915i (15)
- Individuals receive support services 24/7

FUTURE

- 15 individuals (qualify for 1915i) - Provider reimbursed for person-centered services based on individuals need

EXAMPLE→

- *An individual receives 2 hours of Care Coordination/3 days a week/biennium = $50,918.40*
  - *For 15 individuals = **$763,776***
- *An individual receives Peer Support 4 hours/week/biennium = $12,280.32*
  - *For 13 individuals = **$159,644.16***
- *An individual receives Supported Housing 1 hour/day/5 days a week = $21,819.20*
  - *For 12 individuals = **$261,830.40***
- *An individual receives Supported Employment 3 hours/week/biennium = $13,091.52*
  - *For 4 individuals = **$52,366.08***
- *Total amount billed to the provider = **$1,237,616.64***
  - *$618,808.32 general funds/biennium for the 15 individuals serviced*

In current budget most providers continue to receive 50% of the original amount - $500,000

12

Exhibit B

Protection & Advocacy Project
400 East Broadway, Suite 409
Bismarck, ND 58501-4071
Phone: (701) 328-2950 Fax: (701) 328-3934

January 22, 2021

Debra Johnson, CEO
Prairie Harvest Mental Health
930 North Third Street
Grand Forks, ND 58203-2408

Dear Deb:

As I understand it, the proposed DHS budget for the 21-23 biennium includes a cut of $1,414,800 to your contract. While it is suggested that this amount can be recouped from Medicaid through the 1915(i), this is really an unknown as the 1915(i) is not yet being implemented in ND. I'm further concerned that this means it is expected that individuals you serve must be on Medicaid and additionally eligible for services through the 1915(i); that individuals not on Medicaid and otherwise eligible for the 1915(i) will not be able to access services through you without another funding source.

Your organization is essential to the types of Home and Community-Based Services (HCBS) needed in ND, including the provision of permanent supportive housing and recovery-based services. Without these services, individuals will be at a greater risk for institutionalization.

Please consider this is a letter of support for Prairie Harvest Mental Health. State funding for Prairie Harvest Mental Health should not be cut. ND is trying to expand HCBS to try to meet the needs of individuals with behavioral health issues... not cut them.

Sincerely,

Teresa Larsen
Executive Director

www.ndpanda.org
Relay ND: 711
Toll Free: 1-800-472-2670
24 hour emergency service: 1-800-642-6694

The independent, federally mandated protection and advocacy system for the State of North Dakota

January 12, 2021

To Whom It May Concern,

I am writing to express my support for Prairie Harvest Mental Health and the positive impact it has on my brother and my family. My brother has been a client and resident of PHMH for 4 1/2 years and in this time has he greatly improved his mental and physical health.

For 43 years he had lived with our mother in Minot, ND. With age and illness, she became unable to care for him. I took guardianship of him and moved him to Grand Forks in 2016. He moved into Siewert Plains, a group home operated by PHMH that has 24-hour staff. As with the majority of people with mental health illnesses, counseling and the adjustment of medication is an ongoing process. The staff at SP are able to monitor and address any changes that they see in his behavior before it becomes a larger issue. It is a great feeling knowing that he is under such great care in a positive, healthy environment and that he has someone there for him at all times.

PHMH has also provided a social outlet for my brother that he never had before. He enjoys his groups and social activities, such as cooking, games, exercise, and other activities. He has developed social interaction skills that he has never had. All of this has had an amazing impact on the mental health of my brother.

Prairie Harvest has been the perfect fit for my brother and I can't imagine what we would do without the support and care that they provide. My brother is as mentally healthy as he has ever been and has grown so much from the support that PHMH provides.

Sincerely,



Les Moore
3649 15th Ave South
Grand Forks, ND 58201
Mobile 701-330-3547
les@iconarchitects.com

To:

From: The Guardians of Gene Pelton, Dawn Pelton Malene, guardian and Sister and Ray Pelton, Father and Guardian

Re: Support for Harvest Home in Grand Forks, North Dakota

Date: January 13, 2021

Our family offers our heartfelt support for and thanks to the staff and administrators of Harvest Home in Grand Forks North Dakota where Gene Pelton , our brother and son, has been a client/resident for 15+ years. Without the safety and compassion shown to him, Gene would have been a street person many years ago and may not have survived.

Gene, diagnosed as having paranoid schizophrenia ,relies on medication to stabilize his medical condition; and the staff has monitored his medication which Gene proved not be able to do on his own. This truly has saved his life.

We are impressed that Gene has been taught to take responsibility for his own apartment keeping it clean and orderly. The staff provides support for off-campus needs such as transporting him to medical appointments, grocery shopping and occasional recreational activities.

This safe environment offers companionship when it is desired while providing the privacy dictated by his illness. Gene loves living at Harvest Homes and says often, " This is my home." He enjoys visit with us but is always ready to "get back to my home" .

Our family is so grateful that the state of North Dakota has developed and funded this forward thinking place for adults with mental illness. The caring staff provides a perfect balance of providing support and encouraging appropriate independence. Please continue the fund this life saving concept, safe and facility.

Respectively submitted,

Guardians: Dawn Pelton Malene
Ray Pelton

1-13-21

Sara Vogel's' story:

Hi, my name is Sara Vogel and I live at Siewert Plains. I have been here for over 5 years. Prairie Harvest has helped me to reach my goals and become a better person. I have more confidence in myself then I did before I came here. My mental illness was horrible. Before I came here, I was using drugs, alcohol, hanging out with the wrong people. I was also manic. My symptoms got worse and I could not cope with the stress of my life. It got better for me when I got into Prairie Harvest and got on the right medicine, started attending groups, learned how to cope with stress and how to socialize. I have made a lot of friends through Prairie Harvest. Now that I feel better and able to cope with stress, I am looking for a job with my job coach and would like to get my own place. I would like to thank the staff and nurse at Prairie Harvest for everything that they have done for me.

1/13/21

David Hird
675 N 43RD ST #103
Grand Forks, ND 58203

To Whom it may concern:

PHMH means care for mental illness. My vital medication is given to me and for me.

PHMH means staff support and peer support for me. Staff are both friendly and professional. I make connections with peers.

PHMH means security for me. I live in a safe place in and environment that is far better than anywhere else I formerly lived.

PHMK means that my daily needs are taken care of. My mother always asked what I had on the meal plan and she marvels at the variety of the things I eat.

PHMH means improvement in many types of living needs. The groups contribute to many facets of my life. From hypothermia to core-values I get patient education.

Sincerely,
Shavid Hird

I like having Prairie Harvest to lead me during difficult times. I like having hellos and they always find a way to make you feel at home. I like it here at the Lodge and the support it shows me. Prairie Harvest is always involved and helpful.

Thank you,
Danny O.

Kelly – **wishes to remain anonymous**

I just got out of jail. I was in for mental health related reasons. Next, I went to the state hospital in Jamestown, ND. I was there for 8 months and was basically homeless and mentally distraught. Deeply distraught. I was afraid and homeless. My psychologist promised he would let me stay at the hospital until I was safe. The people I worked with at the hospital had never heard of PHMH in Grand Forks, and so, I was the first patient to get a tour of Prairie Harvest facilities.

There was a work sight permanent housing opportunity and programs to help with medication, help getting into school, and hundreds of other clients in my same position, mentally. I liked it. I met with Prairie Harvest staff and they invited me to be a client. I ended up in the Lodge Program, which is permanent housing for clients where we govern most of our own lifestyle without too much interference from staff.

Since I've been with Prairie Harvest, I've gone to college and worked steady for the entire time I've been here. I'm on my medication everyday and feeling much healthier. I made a ton of friends. I quit smoking, drinking, and using drugs for almost 16 years. I've been honored with being made Prairie Harvest client of the year as well as CCL Lodge Member of the Year, which is an award given to one person in the entire Lodge Program nation wide.

My family is so relieved that I'm getting the help from Prairie Harvest staff. They have a person to help me in any cat3egory of help I may need. I'll probably stay a client for the rest of my life. I pray that other with mental health problems are as lucky as I've been to find a place like this.

PRAIRIE HARVEST
MENTAL HEALTH
930 N. 3rd St., Grand Forks, ND 58203-2408

PRAIRIE HARVEST MENTAL HEALTH

930 North 3rd Street
Grand Forks, ND 58203-2408

Phone: 701-795-9143
Email: info@prairieharvest.net
Web: www.prairieharvest.net



You can make a bigger difference than you think.

Mission Statement

We promote independence and an enhanced quality of life for adults with serious mental illness.

PRAIRIE HARVEST
MENTAL HEALTH

Vision

Prairie Harvest Mental Health envisions people with serious mental illness living free from stigma and fully integrated into our community.

Values

Service: Serving people with serious mental illness is our highest value.

Dignity: We treat everyone we serve and each other with courtesy, compassion and respect.

Recovery: We focus on individuals maximizing their fullest potential.

Competence: We strive for excellence and effectiveness in all that we do.

Education: We educate ourselves and the community which decreases stigma and enhances community awareness.

Health: We believe there is no health without mental health.

Parity: We believe that health insurance plans should cover mental health at levels that are equal to any other medical benefits.

Prairie Harvest Mental Health

Who are We?

- A private non-profit organization classified as a 501 (C)(3) by the Internal Revenue Service;
- Concerned citizens serving on a volunteer board of directors;
- Community volunteers;
- Advocates, family and friends of clients;
- Clients;
- Paid Staff

What Do We Do?

Prairie Harvest Mental Health provides community and facility based services to vulnerable adults. Quality of life is greatly enhanced through improved living environment, access to services and programs and the opportunity for employment.

What Are Our Goals?

- To help improve the quality of life for clients;
- To expand housing choices;
- To increase employment opportunities;
- To incorporate peer-support in agency programming;
- To educate the public to a better understanding and acceptance of mental illness and other forms of human needs;
- To reduce stigma for individuals with serious mental illness;
- To encourage community involvement and support for community based programs;
- To develop financial resources to enhance and expand Prairie Harvest Mental Health and its activities;
- To expand delivery to rural communities.

Prairie Harvest Mental Health Programs For Adults with Serious Mental Illness

Community Based Services:

- Supported Residential Program
- Extended Services Program
- Representative Payee
- Life Skills
- Job Development

Facility Based Services:

- Harvest Homes - 12 apartment complex
- Prairie Lodge - Peer-supported 6 bedroom house
- Harvest Lodge - Peer-supported 6 bedroom house.
- Siewert Plains - 8 bedroom 24-hour support house
- Stern Place - 9 apartment complex
- Singe Family Dwelling

One out of five families is affected with mental illness.

Community Based Services

Supported Residential

Daily Living Activities

Under the guidance of Direct Care Workers, clients learn skills that lead to independent living which include:

- Housekeeping
- Laundry
- Hygiene
- Grooming
- Grocery Shopping
- Meal Planning
- Nutrition
- Budgeting

Housing and Subsidies

Direct Care Workers provide assistance to clients in locating independent housing and applying for: Supplemental Security Income, Social Security Disability Income, Medical Assistance, Food Stamps and Fuel Assistance.

In addition, clients are assisted through subsidizing their rental and security deposits until housing assistance is received. Subsidies are also available for utility deposits and grocery allotments to get them on their feet. Through our Home Place Thrift Store, clients receive basic household items to furnish their apartments.

Financial Management: Representative Payee

Upon approval from the Social Security Administration, Prairie Harvest Mental Health provides Representative Payee services to individuals who are unable to manage his or her Social Security benefits. Prairie Harvest Mental Health helps ensure benefits are first used for the basic needs of the individual, providing the beneficiary with a more stable living environment.

Supported Residential - continued

Loan Fund

Clients are eligible to obtain interest free loans to obtain items such as medications, furniture, telephones, DVD players and televisions. Clients make regular payments based on their incomes.

Medication Management



We offer two medication monitoring programs:

1. Under the self administered medication program, a Prairie Harvest Mental Health nurse is available on a weekly basis, or as needed, to review, update and educate clients about medications and medical issues or questions.
2. For those needing closer supervision, a Prairie Harvest Mental Health nurse oversees certified Medication Monitors who go into the client's home up to two times a day to observe that medications are taken correctly and in compliance.

3. Medical Guidance

Prairie Harvest Mental Health nurse assists clients with any medical concerns they have;

- Notifies the appropriate medical staff;
- Schedules appointments;
- Arranges for annual physical, dental and vision exams;
- Compiles medical histories for clients;
- Maintains emergency data forms.



Socialization Activities

Socialization is encouraged through a variety of activities designed for our clients. Coordination and transportation are provided for clients.

- Birthday Club
- Recreational Activities
- Y Family Center - reduced rates
- Peace of Mind

Extended Services

Why is Extended Services Needed?

Extended Services is based on the premise that work should be accessible to everyone, regardless of disability. It offers a vocational solution for many individuals who were, in the past, considered unemployable. Extended Services is a concept that allows all persons with disabilities to work in the community and to ensure that the employer and the employee receive the assistance and support necessary for this to happen.

How Does Extended Services Work?

Extended Services match competent workers with available jobs in the community. Services include a careful matching of worker abilities and interests with specific job requirements. Specialized training is provided to the new employee at the job site by an Employment Training Specialist and follow-up services are available for as long as the worker is employed.

Who Will Benefit From Extended Services?

Employers:

- Will gain a conscientious, punctual, competent worker, receive free screening and training of supported employment workers, receive an opportunity for tax incentives, and reach equal opportunity affirmative action goals and positive public image.

Employees:

- Will gain increased self-esteem and a sense of fulfillment, structure to their daily lives, greater financial security, and have increased involvement in the community.

Who Will Benefit From Extended Services?

Our Community:

- Will have tax dollars redirected to independence and productivity., enhance rights and roles of all people, and expand the number of people looking for entry level positions.

What Does Extended Services Involve?

Job Placement – Qualified individuals are assisted in locating available jobs in the community. Many factors are considered when an individual is matched to a position such as: job duties, job locations and work hours, transportation available to the worker, worker's skills and interests, employer expectations.

Job Training – There is no cost to the company. If needed an Employment Training Specialist provides the new employee with one-on-one training and support at the job site. This on-site assistance is reduced as the employee becomes proficient in completing the job to company standards.

Ongoing Support – The employee's work performance is monitored by the Employment Training Specialist for as long as the individual is employed. Additional training or support, if needed, will be provided at any time.

Life Skills

What is Life Skills?

Life Skills promotes a well-balanced and healthy lifestyle to clients who would be homeless without services by:

- Teaching individuals how to care for their immediate needs,
- Preparing individuals to care for themselves on a long-term basis,
- Encouraging individuals to remain active through participation in various activities and hobbies, and
- Educating individuals, as well as the community, about mental illness.

How Does The Life Skills Program Work?

Prairie Harvest Mental Health clients are referred to the Life Skills Coordinator for Life Skills. Once individuals are referred, the Coordinator determines what assessments need to take place. Based upon those assessments, the Coordinator plans a program with the help of the client. For example, the client and Coordinator might conclude that they need to work on their laundry skills as well as developing a hobby. That client's program would focus on those needs.

Life Skills

Household Chores	Meal Planning	Meal Preparation
Grocery Shopping	Hygiene	Transportation Training
Budgeting	Laundry	Emergency Preparedness
Organization	Scheduling	Social Skills
Safety Training	Health Training	Medication Training
Hobbies	Recreation	Socialization Activities

Skill Groups

Leisure Club	Health & Wellness Group	Exercise Group
Walking Group	Road to Healthy Living Group	

Wellness Club

With health and wellness the primary focus, clients participate by earning points for healthy choices. Points are redeemed at the 'Wellness Store' for merchandise.

Job Development

What is Job Development?

Job Development provides a range of services to the community and clients who, without services would become homeless. This range of service includes: service coordination, client assessment, service monitoring and employment education to clients, businesses and the general public.

The Job Developer will work on expanding job opportunities in the community as well as providing participants with skill building activities so they can return to work. The Job Developer helps work on changing society attitudes about hiring people with disabilities as well as to work with participants in changing their perceptions about working. Social benefits that go along with work are: a reason to get up in the morning, respect from co-workers, improved self-esteem, to name a few. The Job Developer helps educate the community business leaders and citizens about the potential people with mental illness have in working in competitive jobs.

The Job Developer:

1. Provides an assessment of each client in the following areas: need to work, interest in working, ability to work and type of work that the client is interested in doing.
2. Establishes relationships with community employers.
3. Provides direction and assistance to participants in obtaining jobs with livable wages and benefits.
4. Helps to identify, secure and supervise potential work contracts for work teams.
5. Works to create better paying jobs with the opportunity for advancement for participants.
6. Conducts individual and group training sessions on various work related skills such as: Job Searching Skills, Interviewing, Resume Writing, Co-worker Relationships, Appropriate Hygiene and Clothing for Work, Accepting Change in Schedules, SSI and SSDI Benefits.

Employment Groups

- Pathways to Wellness
- Lodge Job Club

Facility Based Services

Harvest Homes

This 24-hour staffed facility is an important addition to the continuum of care for individuals with mental illness. It bridges the gap between living independently in one's own apartment and group home living.

Harvest Homes consists of twelve one bedroom apartments, where one is an accessible dwelling unit.

Facility includes a common area kitchen and recreation room, where meals and socialization can be shared by residents.

Supportive services are provided through the partnership with Prairie Harvest Mental Health and Northeast Human Service Center. Referrals to the facility are through the case management system at Northeast Human Service Center. The services provided are designed to enhance and maintain the individual's level of independence, while improving their quality of life.

These services include:

- Case Management
- Crisis Management
- Nursing
- Medication Monitoring
- Daily Living Activities
- Socialization Opportunities
- Community Involvement
- Employment Groups
- Skill Groups



Opened in1997

Lodge

What is a LODGE?

A Lodge is an affordable dwelling for 6 people who share in running the home, including domestic chores and the purchase and preparation of food. The residents make their own house rules and manage their own activities. In addition, they are employed at a business run by their sponsoring agency, in this case, Prairie Harvest Mental Health. The work is part-time or full-time and organized so that one member can readily substitute for another whenever necessary.

The Lodge program at Prairie Harvest Mental Health is designed to follow the Fairweather Lodge Model. This is a national model developed by Dr. George Fairweather for adults with persistent mental illness. This model is currently implemented in 10 states, including North Dakota. The primary philosophy driving this model is that people that live together and work together can more easily recover and find stability for the long term.

What is a Prairie Harvest Mental Health Lodge like?

Prairie Harvest Mental Health supervises two Lodges in Grand Forks: Prairie Lodge and Harvest Lodge. Each Lodge has the capacity to accommodate 6 individuals in private bedrooms. The Lodge resembles a healthy family, with each member contributing to the maintenance and care of the house and of each other. Staff presences at the Lodge is very minimal. Their role is mainly to mentor, advise, mediate and help out in emergencies.



Prairie Lodge

Opened in 2000

Lodge - continued

How do I refer someone to the Prairie Harvest Mental Health Lodge Program?

Prairie Harvest Mental Health currently contracts with Northeast Human Service Center, located in Grand Forks, North Dakota. All referrals must come through Northeast Human Service Center. For more information on **Northeast Human Service Center,** call **701-795-3000.**

Groups:

- Job Club
- Exercise Group
- Other Groups as needed



Harvest Lodge

Opened In 2001

Siewert Plains

An 8-bed permanent living facility for adults with serious mental illness, Siewert Plains opened in May of 2008. In an effort to bridge the gap between transitional and permanent living, Siewert Plains offers 24-hour support along with educational groups and trainings to augment Prairie Harvest Mental Health's supportive services.

These services include:

- Case Management
- Crisis Management
- Nursing
- Medication Monitoring
- Daily Living Activities
- Socialization Opportunities
- Community Involvement
- Employment Groups
- Skill Groups



Opened in 2008

Stern Place Apartments

Stern Place has been made available through an Economic Stimulus grant through our local Grand Forks Urban Development. Stern Place augments the Grand Forks communities permanent supportive housing with the addition of 9 self-contained apartments. This complex opened March 2012

Supportive services are available on a limited basis. A nurse assures all tenants receive medications in the mornings. Additional staff work four hour shifts from 4:30—7:30 PM. Monday through Friday. Medication monitors ensure medications are taken twice daily over the weekends. Case Management is provided through Northeast Human Service Center. Limited staff support provided through Prairie Harvest Mental Health, includes Life Skills, Job Development and Case Assistance.

Stern Place is suited for independent individuals. With limited support services and staff presence, tenants need to be capable of supporting themselves. Expectations include: independence with self-care, housekeeping, cooking and laundry.



Opened in 2012

Single Family Dwelling

This residence houses one to two people, providing another choice for individuals with serious mental illness who prefer independent community living. All supportive services are available to tenants in this home.



Purchased in 1999

Work Opportunities

Prairie Harvest Mental Health believes that everyone deserves the opportunity to work in competitive employment and to be paid fair wages. Prairie Harvest Mental Health and the Home Place Corporation have various positions for people with disabilities.



Home Place Thrift Store

Clerking, sorting and custodial positions in a retail setting provide opportunities for learning the skills necessary for similar positions in the community.

Community Support

Prairie Harvest Mental Health provides one-on-one support to individuals with serious mental illness to help them succeed in the competitive employment field. Services are individualized and focus on the skills areas needed to strengthen work related activities.



Rag Contract

Prairie Harvest Mental Health cuts clothing into rags to sell to community and state agencies. State agencies can now order goods and services directly from work activity centers. The rags are cotton or cotton blend. We get out of style, stained, or overstock clothing from the Home Place Thrift Store to cut into rags. The rags are sold in 50 pound lots or as requested by customer.





Cleaning Contract

Prairie Harvest Mental Health provides cleaning services at Augustana Lutheran Church.



The Home Place Thrift Store

The Home Place Thrift Store is a division of Prairie Harvest Mental Health, a business in the Grand Forks community. The Home Place Thrift Store exists to provide customers with affordable goods and clothing and to provide resources to Prairie Harvest Mental Health.

The Home Place Thrift Store provides a great shopping experience for any member of the family.

You will find something for everyone at the "Home Place", located at **1811 S. Washington in the Town & Country Mall**. Clothing, furniture, household items and a variety of miscellaneous items make shopping fun at the Home Place. New or like new items at low prices. Affordable shopping for everyone.

Donations are always appreciated. All donations are tax deductible, stay in the community and benefit individuals in the Grand Forks community. The Home Place Thrift Store picks up donations of clothes, furniture, working appliances, computer equipment less than 3 years old, books, household items, etc. at no cost. Also accept ripped, stained or torn cotton/cotton blend clothing for the Prairie Harvest Mental Health work program.

Due to the COVID-19 pandemic, all donations are accepted during business hours. Place your boxed or bagged donations in the back of The Home Place truck parked in front of the store. Accepting furniture donations, please call 701-795-9143 to schedule time to drop off donation.

The Home Place is in need of volunteers to work in the thrift store. Volunteering provides an excellent opportunity to give back to the Grand Forks community. Any time you can give is appreciated.

Thrift Store Hours

Monday - Friday: 10:00 AM—6:00 PM

Saturday: 10:00 AM - 5:00 PM

Sunday: Closed



Board of Directors

Nicole Amsbaugh, MPAS, PA-C - Grand Forks, ND

Irene Dybwad - Grand Forks, ND - Retired - Grand Forks County Family Service Supervisor

Thomasine Heitkamp - Grand Forks, ND - UND - Chair of Department of Social Work

Kate Kenna—Grand Forks, ND - Retired - Licenser/Recruiter at PATH

Bill Lund - Grand Forks, ND - Retired RN

Kristi Magnuson-Nelson - Grand Forks, ND - Owner - Hugo's/Hugo's Wine & Spirits

Jeremy Moe—Grand Forks, ND— Grand Forks Police Department

Vicki Morrissette - Grand Forks, ND - UND Dean of Students Office - Director of Judicial Affairs & Crisis Program

Eric Scheffer - Grand Forks, ND - Bremer Bank - Assistant Vice President of Banking

Sue Shirek - Arvilla, ND - Northlands Rescue Mission - Executive Director

Dolly Stennes - Grand Forks, ND - Retired - Northeast Human Service Center

Paul Stenseth - Grand Forks, ND - Retired - Alerus Financial Senior Trust Officer

Sonia Zimmerman - Grand Forks, ND - UND - Associate Professor Occupational Therapy

Client Advisory Board

The Client Advisory Board is a client run entity with a Prairie Harvest Mental Health staff coordinator that reports directly to the Prairie Harvest Mental Health Board of Directors about the needs and wishes of the clients. It will be a way for the voice of the client to be heard as well as a way to better involve Prairie Harvest Mental Health clients in the workings and activities of Prairie Harvest Mental Health. The Client Advisory Board representatives will consist of 1 representative from Harvest Homes, 1 representative from Stern Place, 1 representative from Siewert Plains, 2 representatives from Supported Residential, 1 representative from Prairie Lodge and 1 representative from Harvest Lodge. Meetings will be held on the last Tuesday of the month.

Updated 7/1/2020

United Way

Testimony #2714
House Bill 1012
House Appropriations Human Resources Division
Rep. Jon Nelson, Chairman
January 25, 2021

Chairman Nelson, members of the House Appropriations Human Resources Division, I am Heather Simonich, Operations Director of Nexus-PATH. Nexus-PATH is a member of Nexus Family Healing, providing child welfare and behavioral health services from nine office locations in North Dakota. I am here today to provide input on HB1012, more specifically the Behavioral Health Division budget, relating to implementation of 1915(i) services.

Your committee is familiar with the Department's work in securing legislative and federal CMS approval to develop a 1915(i) state plan amendment. We fully support the Department's vision and believe the 1915(i) state plan provides opportunity to offer robust community-based services and supports previously unavailable in North Dakota.

Much progress has been made and yet many challenges remain. Timing is critical as our children and families need us now more than ever. You heard from Superintendent Baesler on Friday morning regarding the growing behavioral health needs of our students – the "multipliers" as she put it. You are also aware of the Department's goal and strategic efforts to avoid placing children in foster care or congregate care settings whenever possible. To achieve this goal, it is critical that we build and improve access to intensive family services in our ND communities.

We understand that there is significant federal rule that makes rolling 1915(i) services out in a rural state with a limited workforce very challenging. Today, I would like to speak briefly to concerns about the current eligibility requirement in the area of functional capacity.

- **A WHODAS score of 50 indicates an individual ranks in the 95th percentile of functional impairment. This is a level of functioning**

comparable to those that are home-bound, have significant physical limitations, or reside in institutional care settings.

- **The WHODAS was developed to assess functional impairment in adults and although it is a reliable and well-validated measure for use with adults – it was not designed for children. We have concerns regarding the application of this tool and its scoring algorithm to children. A score of 50 is simply too restrictive and will severely limit access to these essential 1915(i) services.**
- **We currently use the WHODAS to determine eligibility for our school case management services because a score of 25 is required for eligibility under the ND SED-TCM state plan. To date, we have not had a child score near 50 yet these are students that our schools have identified as having the highest needs and would certainly benefit from 1915(i) services. Many of them have experienced significant trauma, are on the verge of out of home placement, and require substantial one-on-one supports in school to function.**

We understand the Department will work with CMS to make amendments to the eligibility criteria if needed and we urge them to begin conversations now or in the very near future. We have shared our data with both Medical Services and Behavioral Health Division staff. Without careful reconsideration of this eligibility requirement and more assurance of eligible children, providers will struggle to establish these critical services – especially in our rural communities.

In closing, I can't help but return to Superintendent Baesler's words, "We cannot do this alone". I know our schools are depending on providers like Nexus-PATH to be part of the solution here. To meet our ND families where they are at – to provide person-centered services in ways they have never been delivered before. It will take all of us working in tandem and, together, I believe we can bend the curve. We are proud to live in a state chasing bold behavioral health and child welfare goals – goals aimed to reduce congregate and foster care placement, invest in families and early childhood, and build robust community services that span the entire

behavioral health continuum. These are goals that we all agree are in the best interest of children and families and will ultimately build a better North Dakota. The collaborative leadership demonstrated at the state level is applauded and has set an effective tone for leadership amongst providers, Human Service Zones, and local school districts.

Thank you for the opportunity to testify before your committee today. I am happy to answer any questions you may have.

Testimony #2604
House Bill 1012 (DHS Appropriation)
House Appropriations- Human Resources Division
Representative Nelson, Chairman
January 25, 2021

Chairman Nelson, Members of the House Appropriations Committee, I am Stacey Hunt, Licensed Clinical Psychologist in the state of North Dakota and Chief Executive Officer of St. Thomas Counseling Center, PLLC, in Jamestown. I am here today to provide information on House Bill 1012.

House Bill 1012 is a bill for an Act providing an appropriation for defraying the expenses of the Department of Human Services. This bill provides funds for the ND Behavioral Health Division's Substance Use Disorder Voucher program. I am here today in support of the SUD Voucher program.

St. Thomas Counseling Center, PLLC, is a mental health and addiction counseling center in Jamestown. We employ a Licensed Addiction Counselor and are licensed by the ND Department of Human Services Behavioral Health Division for Adult Level 2.1 (Intensive Outpatient Program) and Level 1 (Individual and Aftercare) treatment services. We accept commercial insurances and are approved providers for the Behavioral Health Division SUD Voucher program, which provides a funding source for substance use disorder treatment for people who do not have insurance and cannot afford treatment. Potential clients are generally referred to us from Parole and Probation, district court, local clinics, or from South Central Human Service Center.

The Behavioral Health Division SUD Voucher program was created to allow less chronic substance users seeking treatment to access services

at a community provider so the human service centers could focus on serving the high-risk, chronically addicted population. During the current biennium, St. Thomas Counseling Center has treated 101 clients who used the SUD Voucher to pay for services. These clients did not have private insurance and could not qualify for ND Medicaid or Sanford Expansion insurances. Without the SUD Voucher program to pay for services, these clients would have had to go to the Human Service Centers to receive services; thus taking resources away from the chronic, core population the HSCs are intended to serve. Unfortunately, the appropriations for the SUD Voucher were exhausted as of June 30, 2020, and we had to start turning clients away. These last six months have been difficult for not only our business, but also for potential clients who may have lost their jobs because of COVID related reasons, or are realizing that their use of substances during COVID quarantines is problematic and want to seek treatment. Because the SUD Voucher is exhausted, these ND citizens have to attempt to find treatment at the Human Service Centers.

The people we see at St. Thomas Counseling Center are typically individuals whose use of drugs or alcohol has caused some significant concern in their life, but can usually get back on track after addressing their addiction issues. For instance, a DUI may cause the person to lose their job, and with it their health insurance. They are ordered by the court to have a chemical dependency evaluation, but cannot pay the out of pocket fee. Without their evaluation, they cannot regain their license, cannot regain their job, and likely will continue a cycle of using drugs or alcohol to cope with stress. However, if the person can access the Behavioral Health Division SUD Voucher funding for their evaluation and any subsequent services needed; the person can complete their court

requirements, regain their driver's license, find a job, and change the trajectory of their life.

Additionally, the SUD Voucher provides transportation assistance, so citizens who live in rural areas can access services. Approximately 60% of our Voucher clients live in Jamestown, leaving 40% who travel from other towns in South Central ND, including Valley City, Oakes, LaMoure, Napoleon, Carrington, Cooperstown, and Edgeley. There are no substance use treatment providers in those areas, which means without the Voucher's transportation assistance, approximately 45 clients would not have been able to access services with us this biennium.

Funding for the SUD Voucher is included in the Behavioral Health Division budget appropriation. Testimony from the BHD indicates that Voucher funding will be exhausted prior to the end of the biennium. I feel that this program is a needed and valuable resource to the citizens of North Dakota and now advocate for the funding to not only be continued, but to be increased for the 2021-2023 biennium, so we can continue to provide a continuum of SUD treatment options among private and public providers.

Thank you for allowing me to speak on this issue. This concludes my testimony and I would be happy to answer any questions you may have.

#2311

January 3, 2021

To Whom it May Concern,

It has come to my attention that funding cuts are having a drastically amount of the needed funding being considered for the ND Brain Injury Network.

I have had the impacts of several different types of head injuries in my 70 years. In the beginning of my injuries at the age of 15 or 16 it has been a psychological nightmare to live with. The struggles I had growing through the different injuries and not having any type of help for healing and recovering. There are still struggles I live with daily, for instance trying to write this letter so that you can understand or realize how greatly this funding is needed to be able to continue its guiding me with resources that are not available. Especially in this rural western part of the state, on our reservations and to reach other people who have no knowledge of what life has been or is like for me or others who live with this.

I am telling you about how their programs help support me. I am one of North Dakota's American Indians who uses their online support groups, and the webinars of their education for people who have experienced, lived through and struggle living with these very difficult traumatic brain injuries(concussions) that people, doctors, hospitals, educators, legal systems, schools and a whole list of other offices, programs that haven't any knowledge of how to help us. I have been a part of this Brain Injury Network since it has begun. Since Rebecca Quinn has been in the office I have seen this program expand enormously and hoping for it to continue for me and it's reaching onto the reservations and other American Indians that live off the reservations, including the educating of all the legal and legislative systems.

I am asking for your consideration of the greatly needed funding of this Brain Injury Network.

Sincerely,

Skipp Miller

Still alive and functional

1.14.2021

North Dakota Legislators,

My name is Carma Hanson and I am the Coordinator of Safe Kids Grand Forks, an injury prevention coalition based out of Altru Health System in Grand Forks. Our mission is to reduce the number of unintentional injuries and deaths to children under age 19 – their leading cause of death. Safe Kids Grand Forks has a coverage area that includes northeast North Dakota and northwest Minnesota and through our efforts, we partner with many agencies that conduct like-type work. Together, we have over 250 parents and colleagues that assist in our work to keep kids safe at home, at school, at play and on the way.

The North Dakota Brain Injury Network (NDBIN) is one of our partner agencies and together, we collaborate on many projects related to brain injuries. As you can imagine, brain injuries in children can occur in a number of ways, including preventable injuries such as sports concussions, falls from playground equipment or bike and car crashes. Our work as Safe Kids Grand Forks is to prevent those injuries from happening and we share that mission with the NDBIN. Once an injury has occurred, they then take over with the wonderful work that they do to assist clients with services, provide support for living with a brain injury, assist with support for the caregivers of those with brain injuries and connect the client with support and resources to help them in their recovery process.

The work that this group does is outstanding and I would encourage you to reconsider the funding allocation that has been presented in the DHS Funding Bill 1012. This proposal suggests a 50% reduction in funding for the NDBIN. While we are in a time when all funding needs to be carefully considered, I would caution that this drastic cut could have significant impacts on those suffering from brain injuries. This type of injury is complicated and careful intervention and rehabilitation is critical to those inflicted with this type of trauma. Safe Kids Grand Forks and our team have benefited greatly from the work of the NDBIN as they educate providers on concussion and brain injury management and help set protocols for coaches, teachers, athletic trainers and others involved with kids with TBI's. They also provide direct services to clients across the state as they navigate the very complicated world of living with a brain injury.

Rebecca Quinn, the Program Director for the NDBIN can speak eloquently about the services that are provided from kids – adults in their program. She has established a network of care and resources across the state that assists people of all ages, injury severities and income levels. The impact of a financial cut to the extent suggested would significantly impact their programming abilities and I would challenge you to reconsider that proposal.

I thank you for your time to read this letter of support for the North Dakota Brain Injury Network. Please do not hesitate to reach out to me should you have further questions that I can address.

Sincerely,

Carma Hanson

Carma Hanson, MS, RN

Coordinator – Safe Kids Grand Forks

It is great to have such a wealth of resources and your work in coordinating all of it is much appreciated!

Amy Brossart-Robinson, M.S., CCC-SLP
Clinical Assistant Professor
Department of Communication Sciences & Disorders
University of North Dakota (UND)

Thank you! I also wanted to thank you for all the work you are doing across our state for those with brain injury and providers. Really helpful and impressive, thanks so much!!~ It has been crazy. We are still seeing everyone by telemedicine, which has proven quite effective. Also great to be able to address initiation, planning and really all areas of cognitive and executive functioning in patients natural environments. Anyway, we are fortunate to be able to carry one, even in this bizarre times. Have a happy and healthy Holiday!! Thanks,

Janet Grove, MS CCC-SLP, CBIS
Licensed Speech-Language Pathologist
Certified Brain Injury Specialist
Progressive Therapy Associates

During these trying COVID times of stress and negativity, the Pollyanna in me wants to spread cheer!

Thank you for all that you do to elevate the lives of those with BI. Each time I am on calls with you I am SO impressed. You show genuine compassion, insight and kindness to those you talk to. I have wondered if people treat me kindly because I'm "brain damaged", but I truly believe that you treat everyone kind because that is who you are.

Thank you,

Sandi

I continue to see how active NDBIN is in this crazy time. I keep hoping that hospital admissions will slow down but like the entire State of ND hospitals, we are overrun. I was still working last night and already know today will be no different. You continue to have great topics and meetings. I just have not been able to attend. Just wanted you to know it is not due to lack of interest or support.

Marie Brekken, PA-C
Physical Medicine & Rehabilitation
Sanford Health Fargo

67th Legislative Session #2312

House Appropriations-Human Resources Division

Chairman Nelson and other members of the Committee. I am Rebecca Quinn and serve as program director at the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. The Center for Rural Health is contracted by the Department of Human Services to operate the North Dakota Brain Injury Network. My testimony today is on behalf of all the individuals and families impacted by brain injury in North Dakota.

A 2016 North Dakota Brain Injury Needs Assessment found that for people with brain injury in North Dakota, services and supports for the condition are **few, are disparate, and are disjointed.** Among the primary needs identified were a **lack of awareness, lack of training, and a lack of coordination across existing services.** The North Dakota Brain Injury Network meets these needs by providing a centralized, statewide source of information regarding brain injury and delivers resource facilitation services to individuals with brain injury. Resource facilitation for brain injury is an evidenced based service that assists individuals along the path of recovery and increasing independence. This vital service has been adopted by over 40 states and is seen as a core for state brain injury service development by the Federal TBI grant program. In order to continue to serve as the central source of information and support for brain injury in the state I ask that you please restore the funding for NDBIN.

I know there has been a lot of discussion about the future possibility of 1915i and how services can be shifted to be provided under these programs. I would like to address some concerns regarding how this would impact the services for individuals with brain injury.

First, is concerns over the **diagnosis eligibility 1915i.** In order to access the 1915i an individual must have a Diagnostic and Statistical Manual diagnosis of Neurocognitive Disorder Due to Traumatic Brain Injury. This is a psychological diagnosis, not a medical diagnosis and many individuals with brain injury do not currently receive this correct diagnosis and it is exclusive of non-traumatic injuries. This was something raised during the comment period for 1915i and DHS went above and beyond to try to find an easier solution. We were unable to find one and instead the discussion was that NDBIN could serve as a resource helping individuals understand the proper diagnosis needed and help with attaining it. A concern is that if NDBIN funding is reduced, no longer being able to serve in the role to assist with accessing 1915i for brain injury, this could mean less individuals able to receiving needed services.

A second concern is regarding the **financial eligibility** for 1915i. Majority of the individuals that NDBIN works with are not receiving Medicaid or Medicaid expansion, but are on private insurance or Medicare. For many of these individuals the very reason they utilize NDBIN is it is an opportunity to get support and understanding no matter their financial status. Many of these individuals are working, in school, lead active lives, but still need information, support, and navigation help that is not tied to Medicaid eligibility.

Third concern is regarding the **functional eligibility and service needs**. Depending on the age of the individual, financial eligibility, level of impairment, and functional need there are numerous different service options and combinations that can be tailored to meet an individual with brain injuries' needs. While 1915i may be a newly available service, it is not the only service available and, in many cases, may not be the best fit for an individual. NDBIN services to provide guidance and navigation to help access various service types, programs, services, treatments, and supports.

The final and ultimate concern is the **role of NDBIN**. Throughout the development of North Dakota's brain injury services, there has been identified the need for a centralized brain injury hub to provide information, support, and training. Over the last ten years this has been developed in NDBIN. Currently, NDBIN provides information and resource referral, informal supports, outreach, and training. All of these are indispensable services and none of them are billable under 1915i. In fact, a crucial component in 1915i being successful for individuals with brain injury is the existence of NDBIN. Training for direct care providers in understanding brain injury and how to effectively help provide the proper supports and available treatments will need to be an ongoing process. NDBIN will be able to serve to assist individuals navigate the application process and understand how to get the proper diagnosis and documentation of injury, we will be available to provide routine training for providers, but also able to provide case by case technical assistance and understanding of each individuals' unique options. And most importantly, NDBIN will continue to advocate for providers to serve individuals with brain injury. The complexity of the brain injury population means these individuals are often misunderstood, feel lost in the service system, and are often forgotten.

I am excited and hopeful about the potential 1915i holds for those with traumatic brain injury, but I am equally as excited and hopeful about the impact of the new residential habilitation services under HCBS, and the new options for tele-medicine therapy services under Medicaid. 1915i may be able meet the needs of one individual, another individual may have needs that cannot be met by it or they may not qualify. However, we would be remiss to think these services will meet the needs of individuals with brain injury without the ongoing training, guidance, and support of NDBIN.

Respectfully submitted

Rebecca Quinn
Center for Rural Health
University of North Dakota, School of Medicine and Health Sciences

NDBIN Activities July 2019-January 2021 #2312

- Resource Facilitation
  - Resource facilitation for brain injury is an evidenced based service that assists individuals along the path of recovery and increasing independence. This vital service has been adopted by over 40 states and is seen as a core for state brain injury service development by the Federal TBI grant program.
  - This biennium NDBIN has provided resource facilitation to a total of 266 individuals, received 92 new referrals, and had contacts with more than of 1,600 individual or family members
  - A few quotes from our satisfaction survey:
    - *Felt supported and understood.*
    - *Always prompt in answering questions and providing support and assist.*
    - *Keep on Keepin on with how you are doing your work! Thank you for all your support for those who need and are searching for others to help them in their daily lives.*
    - *I had no problem whenever I called Rebecca to ask a question. She always got back to me and either asked further questions to clarify or gave me answers to what I was seeking.*
    - *You do I & R services and help individuals get connected to a service. This is a great need.*

- Mind Matters Conference
  - Unfortunately, had to cancel in 2020, but plan to host a 2-day virtual event: March 25&26th
  - Past conference attendee quotes:
    - *I like having the information to share with clients that struggle with TBI*
    - *Love the Mind Matter conferences*
    - *We are fortunate to have such an important conference in ND.*
    - *Oh my-all speakers were amazing! Connecting with everyone and sharing what works-what does not.*
    - *Well organized-good job and thank you!*
    - *I thought the conference was great. I enjoyed all the speakers-nice variety and topics and good information.*

- Online Brain Injury Training
  - June of 2019 NDBIN launched 5 online training courses
  - Courses included:
    - Introduction to Brain Injury
    - Cognitive and Behavioral Consequences of TBI in Adults
    - Primary Care and TBI
    - Pediatric TBI
    - Substance Use and TBI
  - 1,287 individuals enrolled, 625 having completed, 412 evaluations

- Certified Brain Injury Specialist (CBIS) Training
    - Nationally recognized credential for professionals working in brain injury services. This certification is administered by the Brain Injury Association of America and involves formal coursework and a written examination.
    - NDBIN provided CBIS training in ND in July of 2019, Dec 2019, June 2020, Dec 2020
    - Total of 65 officially certified CBIS in ND as of 1/19/2021.
    - NDBIN hosts a quarterly call for all CBIS to share information and collaborate.

- Webinar Wednesdays
    - These FREE webinars cover a range of brain injury topics and are designed to meet the needs whether you are a brain injury/stroke survivor, caregiver, or provider. Variety of continuing education credits are offered and they are archived online.
    - Total of 26 webinars, 251 total evaluations.

- Virtual Support Groups
    - Facilitated 22 support groups, including 15 virtual.
    - Began partnership with University of Mary Occupational Therapy program to have students co-lead groups.

- Adapted the REAP for ND
    - This is an evidenced based return to learn guide developed by CO and adapted to over 20 states.
    - What is REAP?
        - R = Remove/Reduce physical and cognitive demands
        - E = Educate the student athlete families, educators, coaches, and medical teams of the potential symptoms
        - A = Adjust/Accommodate for the student athlete academically
        - P = Pace the student athlete back to learning, activity, and play
- Virtual Concussion Symposium
    - Hosted a Concussion Symposium with over 100 attendees
    - Keynote by the author of REAP

- Website
    - Maintained a comprehensive website with over 34,780 unique page views
    - Searchable online resource guide, maintained events calendar
    - Developed new content regarding caregivers, special education, and related services

- North Dakota Brain Injury Guide
    - Partnered with the North Dakota Stroke Association to publish a new North Dakota Brain Injury Guide for new survivors. In process of being distributed to hospitals, clinics and private providers.

Upcoming Programs:

- Survivor Connections
    - New program to be launched spring of 2021.
    - Phone based program for new individuals with brain injury to connect them with trained volunteers to provide support for those new to the injury.
    - So far have developed program, recruited & trained 3 survivor volunteers.

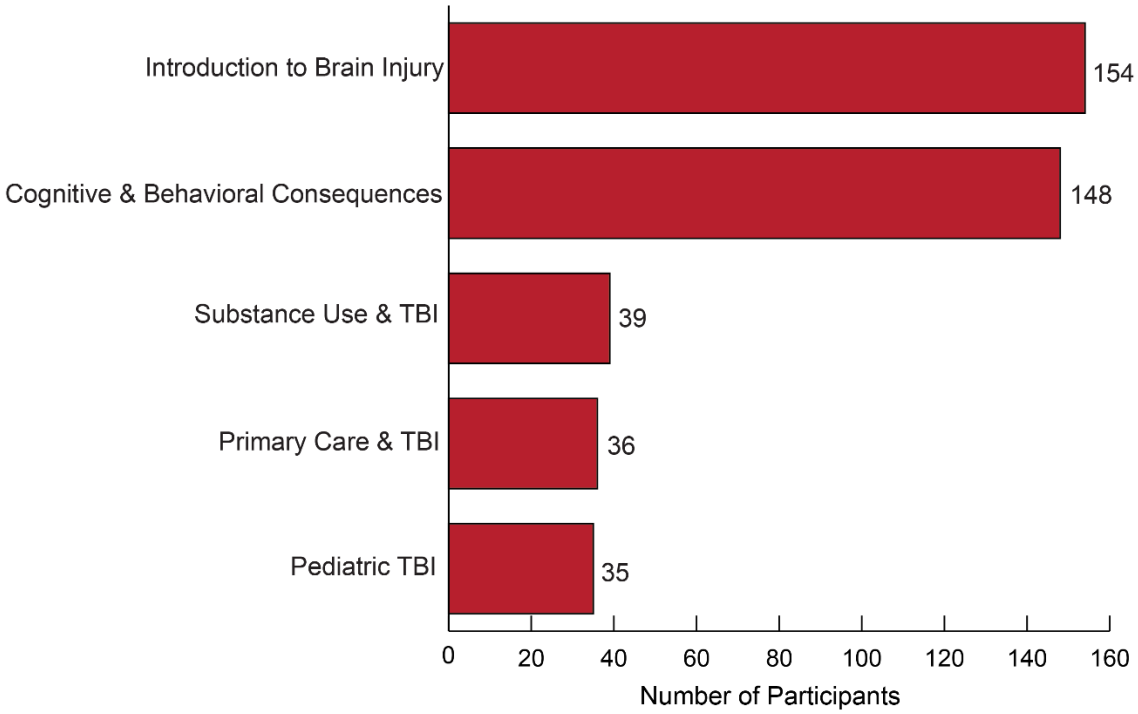
- Brain Injury Basics Training
    - 1st training to be held February 19th, 2021.
    - New training developed to be less intensive than the Certified Brain Injury Specialist, but more engaging than the online courses.
    - This training is based on an interactive approach and will provide direct care staff, peer support specialists and caregivers of individuals with brain injury a general knowledge of brain injury and what that means for the individuals they serve, practical techniques for handling difficult behaviors of individuals with brain injury, as well as building rapport for the individuals within their care.

- Book Club
    - Launched January 2021.
    - A virtual brain injury book club on the first Thursday of every month.

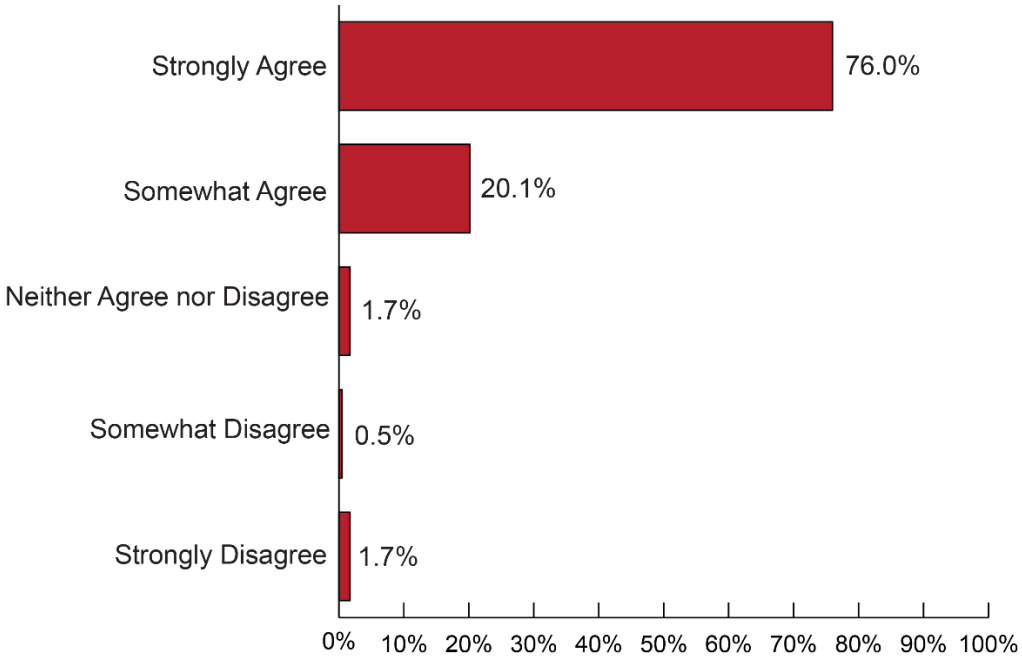
- Virtual Office Hours
    - Launching February 2021.
    - Anyone with questions or needs related to brain injury can join NDBIN for these virtual office hours.

Online Brain Injury Courses-412 total evaluations completed

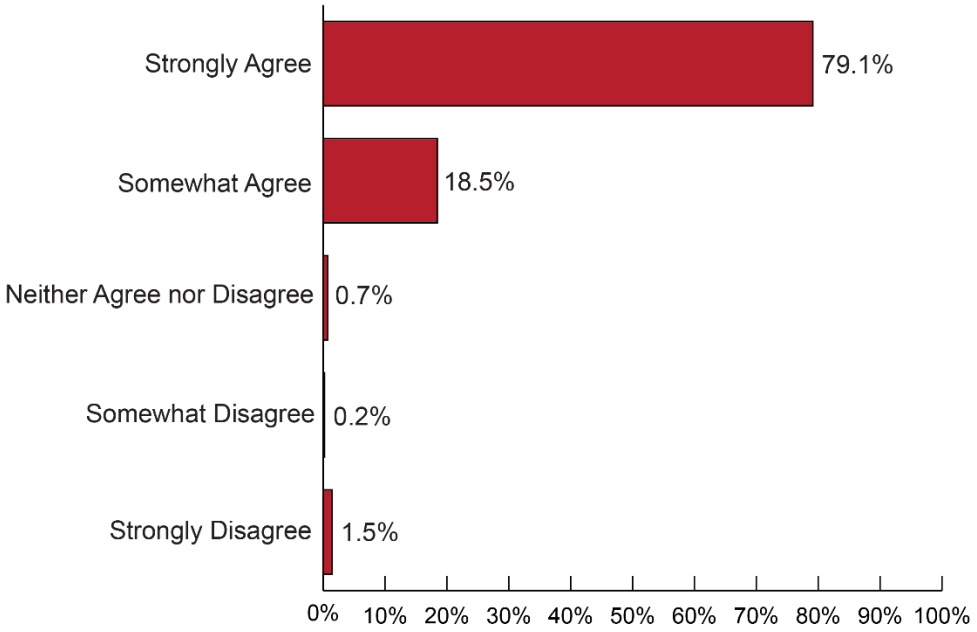
Course Attended:



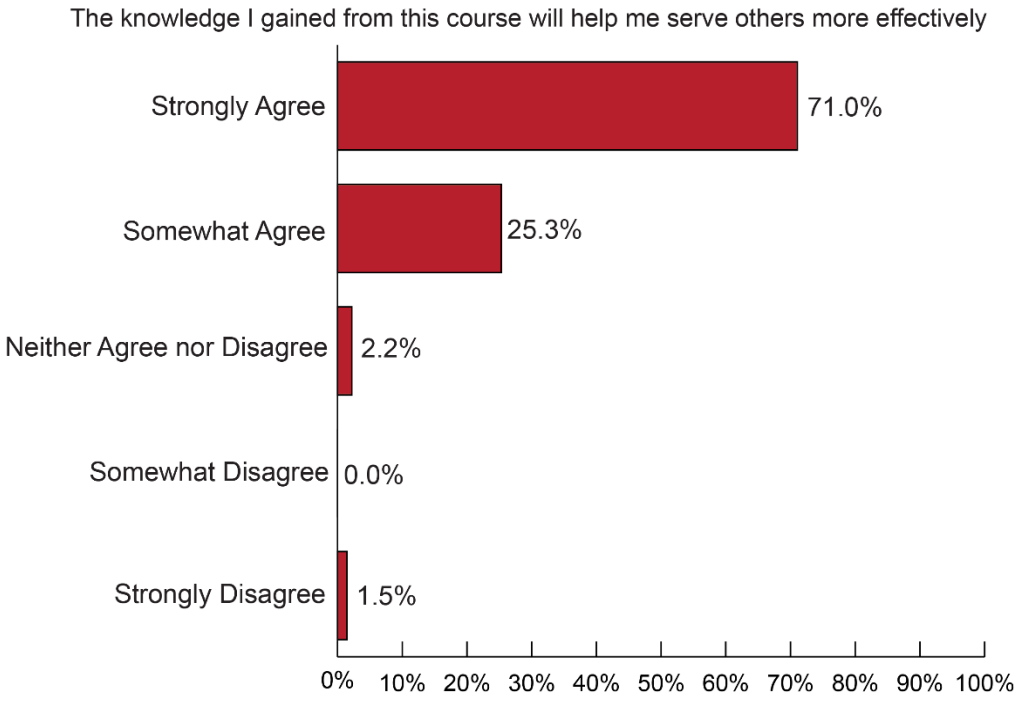
I found the course information to be helpful:



The material presented was appropriate for the intended audience:



The knowledge I gained from this course will help me serve others more effectively:



Webinar Wednesdays-26 total webinars, there were 251 total evaluations completed

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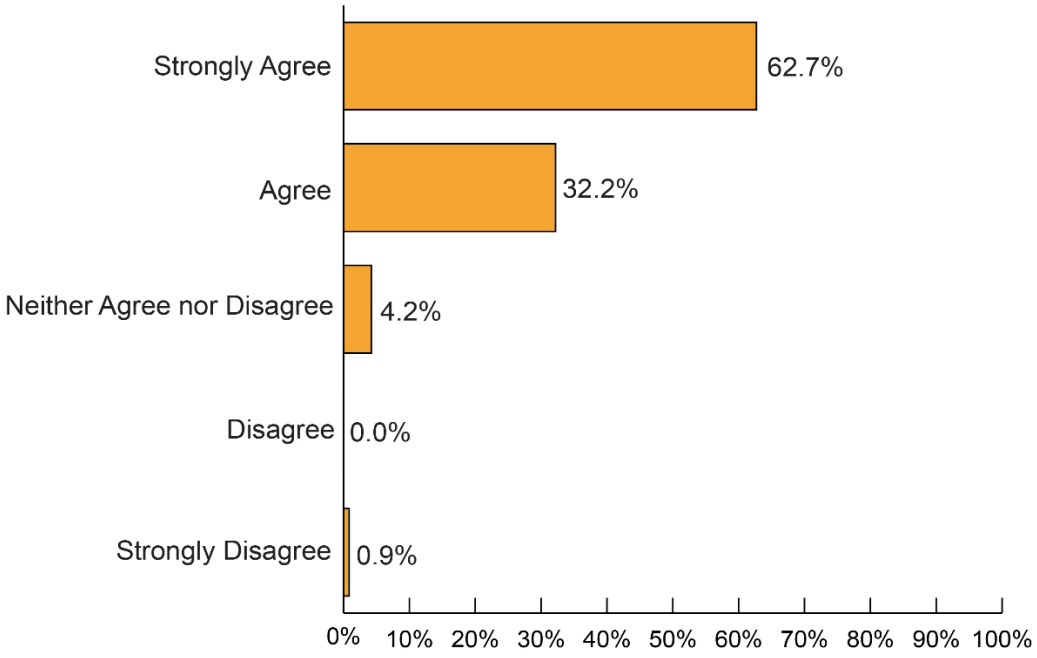
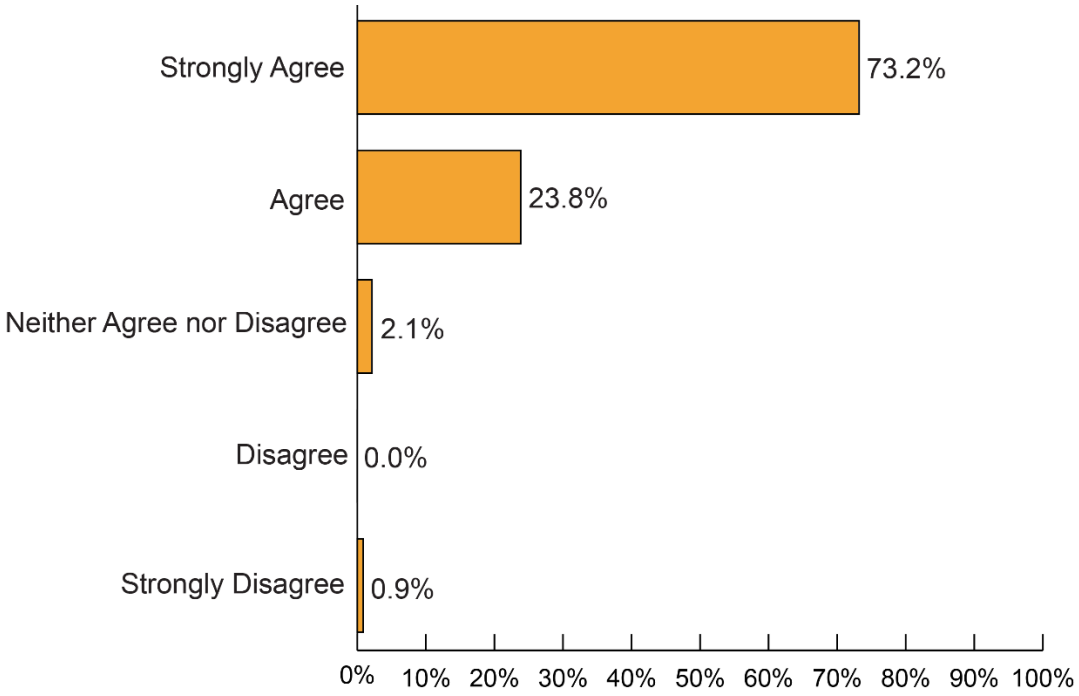
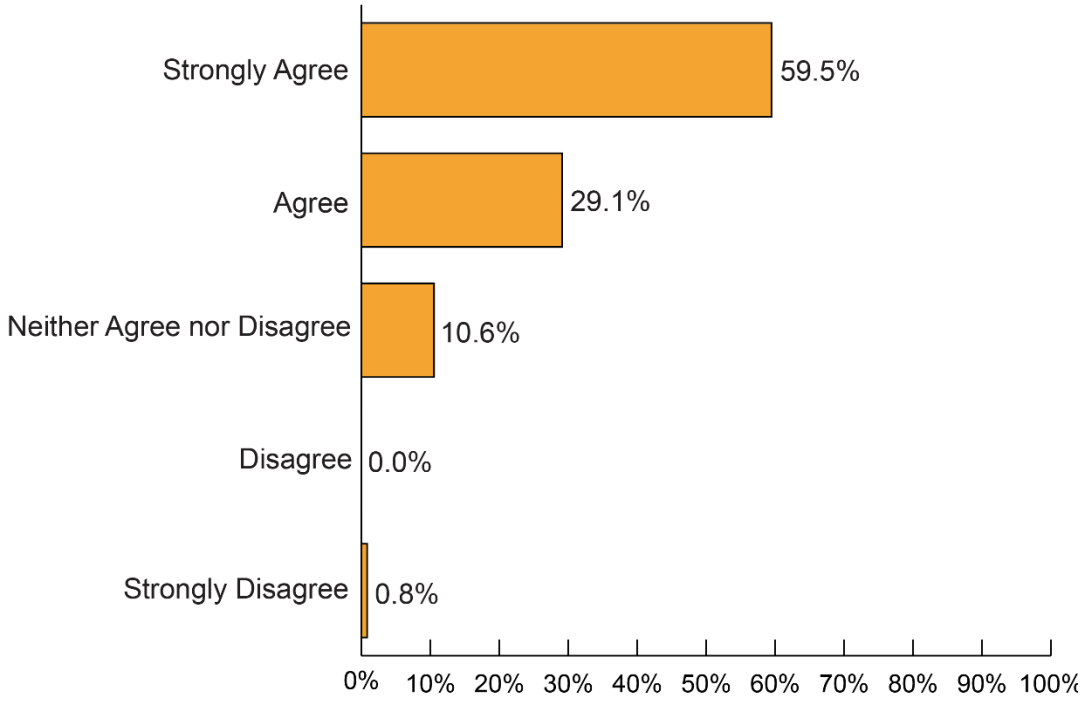
The training objectives were met:

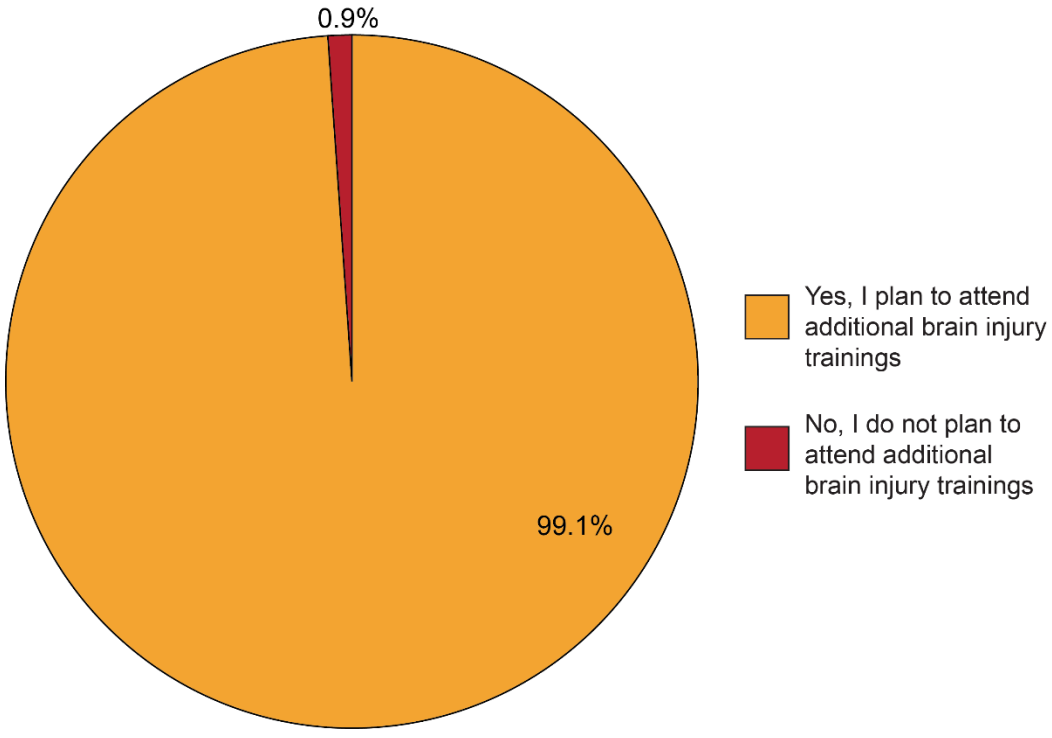


The trainers were knowledgeable about the topics:



The training will be useful in my work:





NORTH DAKOTA BRAIN INJURY NETWORK

House Bill 1012
#2313 House Appropriations

Rebecca Quinn, MSW, LCSW, CBIST

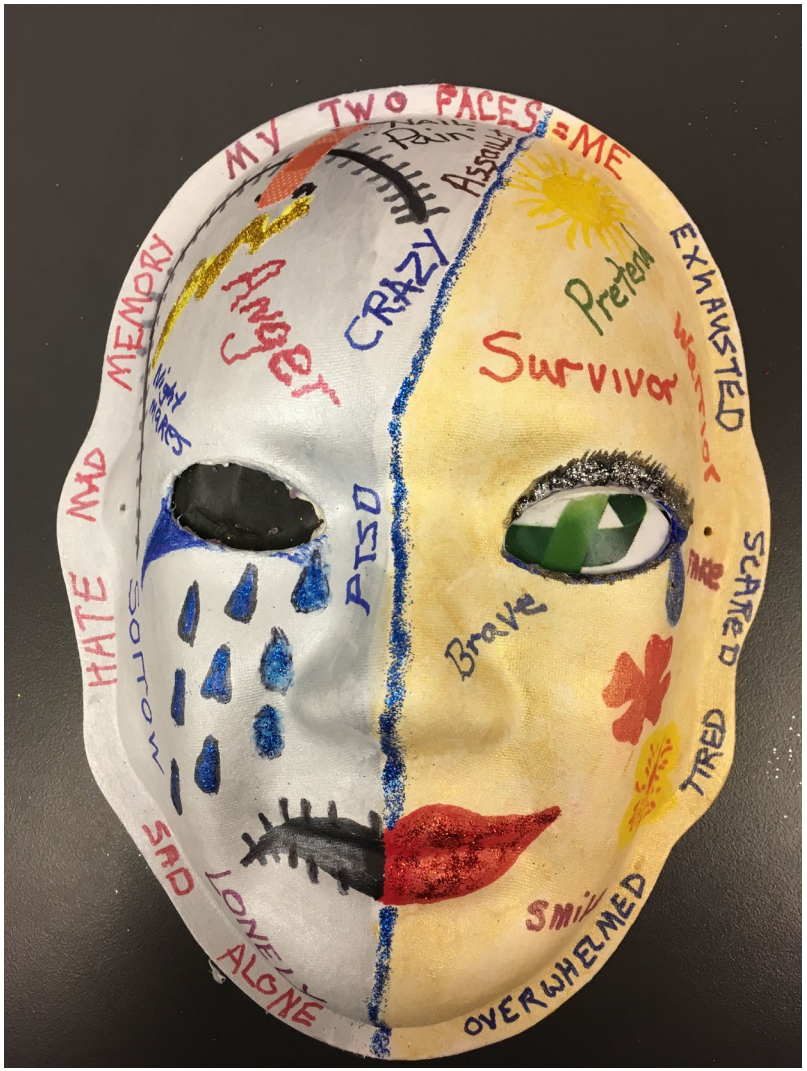
rebecca.quinn@und.edu

701-777-5200

Help for Today,
Hope for Tomorrow.

North Dakota Brain Injury Network

- Free service to individuals, family members and professionals
- The central source of brain injury support, information, and education for ND



Why NDBIN?

- NDBIN was developed because there had been identified a **lack of awareness, lack of training, and a lack of coordination across existing services.**
- NDBIN meets these needs by providing:
  - Outreach
  - Toll-free number, website with searchable directory
  - Informal supports and resource facilitation
  - Education and training for individuals, family, and providers

Need to Fully Restore Funding

- Have slowly built over 10 years to have this base infrastructure.
- NDBIN is complementary of newly developing services, not duplicative or able to be shifted.



Concerns about Replacing with 1915i

Diagnosis Eligibility	• Neurocognitive Disorder Due to Traumatic Brain Injury • Excludes those with acquired
Financial Eligibility	• Majority of individuals utilizing NDBIN are not on Medicaid • For most NDBIN is there only service option because they are over the limits to qualify for other programs
Level of Care and Service Needs	• Variety of brain injury presentation requires various avenues for support • NDBIN provides navigation across all systems
Role of NDBIN	• Hub for support and training • Vital to maintain NDBIN as the resource to support the development of providers and individuals navigate the available services.



Greg is a 45-year-old male from Fargo who sustained several TBIs as a child.

He was never identified as having a brain injury, or provided treatment, but has stuggled with attention, memory, impulse control, and addiction.

He was screened for brain injury by his Free Through Recovery provider and was referred to NDBIN for assistance.

How NDBIN helped:

- Provided education to Greg about his brain injury and learning to manage his symptoms.
- Training to his providers about high incidence in the criminal justice system and how to modify services to be more supportive
- Began attending brain injury support group and now “doesn’t feel alone or in a fog”



Melissa is a freshman in high school in a rural ND town.

She sustained a severe TBI in an ATV accident 2 years ago.

She received inpatient rehabilitation, but was discharged to her rural ND home with little support.

Her special education teacher reached out to NDBIN for assistance.

How NDBIN helped:

- Education and support to parents regarding understanding of brain injury and disability acceptance.
- Explained possible available services and eligibility.
- Provided TBI education to teachers and TBI prevention education to fellow students
- Provided materials for special ed teacher to utilize and technical assistance in developing individualized education plan.



Heather is a working mother of two. She sustained a brain injury last year when she was rear-ended.

She broke her nose as well as was unconscious for 20 minutes. She was treated in the emergency room, but was discharged with no information or follow up.

Since her injury she has been feeling forgetful, disorganized, short tempered with her kids, and feels isolated. Heather found NDBIN via a google search and called the toll-free number.

How NDBIN helped:

- Education and support to parents regarding understanding of brain injury and disability acceptance.
- Explained available services and eligibility
- TBI training for teachers and fellow students
- Technical assistance in developing individualized education plan and supportive materials

Staff

- Rebecca Quinn-Director
- Carly Endres-Outreach Coordinator
- Nickie Livedalen-Resource Facilitator
- Michelle Graba-Admin



NORTH DAKOTA BRAIN INJURY NETWORK

NORTH DAKOTA BRAIN INJURY NETWORK

Contact us today!

855.866.1884

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67th Legislative Session #2510 January 25, 2021

House Appropriations-Human Resources Division

Chairman Nelson and other members of the Committee,

Thank you for the opportunity to testify today. My name is Nan Kennelly. I am a speech-language pathologist and certified brain injury specialist from Fargo, and a provider for cognitive and communication disorders related to brain injury. I currently serve as the Chair of the North Dakota Brain Injury Advisory Council.

I am providing testimony on behalf of the Brain Injury Advisory Council, a statutory-defined (NDCC 50-06.4-10) and Governor-appointed state advisory council. The Mission of the North Dakota Brain Injury Advisory Council is to improve the quality of life for all individuals with brain injury and their families through brain injury identification, awareness, prevention, research, education, collaboration, support services and advocacy.

A 2016 North Dakota Brain Injury Needs Assessment found that for people with brain injury in North Dakota, services and supports for the condition **are few, are disparate, and are disjointed.**

The Brain Injury Advisory Council has serious concerns about the proposed budget reductions for brain injury in the Department of Human Services budget. These programs have been slowly built over the last 10 years and represent the *only state funded programs exclusively dedicated to brain injury* in the state. With services for this complex population being *already so limited,* it would be a disservice to ND residents and families living with brain injury.

It is particularly concerning that the DHS budget reductions appear to be made with the mistaken assumption that the programing could shift to federally funded programs, with an expectation that the Medicaid 1915(i) program will provide offsetting benefits.

Members expressed concern for these shifting DHS budget priorities, including:

- The restrictive definition of brain injury within the Medicaid 1915(i) program, requiring a "neuro-cognitive disorder related to traumatic brain injury" diagnosis. This would eliminate other types of brain injury diagnoses and needs, and limit brain injury services to a select few individuals.

- Since Medicaid 1915(i) services requires financial eligibility for Medicaid, economic means testing will greatly restrict the number of individuals eligible for brain injury services, compared to current practices.

- The reduction of NDBIN program funding will limit the level of technical assistance support and service coordination statewide, compared to current service levels.

- The NDBIN is not a direct service agency and should not be conflated within discussions concerning Medicaid 1915(i) service programming.

- The reduction of technical and facilitative support to the operations of the ND Brain Injury Advisory Council.

- The reduction of education and training available to providers in ND, currently provided by NDBIN.

In summary, the ND Brain Injury Advisory Council has serious concerns about proposed budget cuts to existing programming, as well as the mistaken rationale that the 1915i services will duplicate NDBIN, which they do not. The Advisory Council feels these budget cuts and reduction of service go against our mission to improve the quality of life for all individuals with brain injury and their families.

Thank you for your time and I welcome any questions.

Respectfully submitted,

Nan Kennelly
Chair, ND Brain Injury Advisory Council

onword THERAPY

onwordtherapy.com

4450-31st Ave S. Suite 103, Fargo, ND 58104

P 701.364.5433
F 701.364.5431

67th Legislative Session #2512 January 25, 2021

House Appropriations-Human Resources Division

Dear Representative Nelson and members of the House Appropriations Committee, Chairman Nelson and other members of the Committee. Thank you for the opportunity to testify today. My name is Nan Kennelly. I am a speech-language pathologist and certified brain injury specialist from Fargo, and a provider for cognitive and communication disorders related to brain injury. I serve as the current Chair of the North Dakota Brain Injury Advisory Council. I own a private practice in Fargo, ND, Onword Therapy. I lead a support group for individuals and families living with brain injury, and I am a vendor for the Social and Recreation program through the Department of Human Services.

I am providing testimony today as a provider who serves ND residents and families living with brain injury, and to object to proposed budget cuts for brain injury programming in ND and to the North Dakota Brain Injury Network (NDBIN). Over the last 10 years, ND has slowly built brain injury programming for education, support, and service. To reduce funding that would sustain and develop this programming would be a giant step backward for ND, and would have negative consequences for ND residents and families living with brain injury.

Many of our patients attend our support group, Webinar Wednesdays and participate in the Social and Recreation program funded by DHS. Our patients utilize the modules available on the NDBIN website for education and support. The benefit of these program runs deep. The Social and Recreation program has been especially beneficial, as social engagement is one of the biggest changes after brain injury. Our staff participated in training put on by NDBIN to become Certified Brain Injury Specialists, improving the quality of care we provide at our clinic. Additionally, our staff and many patients attend the ND Brain Injury Conference put on by NDBIN each year for professional continuing education and supportive education for our patients. I repeatedly see firsthand the benefit that ND brain injury programming has on those I serve. It is my opinion that cutting funding to serve ND residents living with brain injury would be a devastating loss.

I am especially concerned with a justification provided to me for budget reductions for brain injury programming. I have been told that since 1915i was approved for ND, the budget cuts were hoping to avoid duplication of service. I am here to tell you that this is a misconception. To qualify for 1915i services, an individual must first qualify for Medicaid, and then have the specific diagnosis of Neurocognitive Disorder related to Traumatic Brain Injury. These requirements alone exclude most ND residents living with brain injury. In my 15 years of private practice, I can count on one hand the number of brain injury patients we served that qualified for Medicaid. That is a very small percentage compared to the thousands of patients I have treated with brain injury. In my experience, the majority of ND residents living with

brain injury have commercial insurance, Medicare or Workforce Safety. Additionally, the definition for brain injury for 1915i varies from the ND definition of brain injury, leaving out a large percentage of people that would otherwise qualify for service and support. And in an ironic twist, many individuals would find the services of 1915i through NDBIN. If funding is cut to NDBIN, it is likely that fewer individuals will know about and/or benefit from 1915i services and qualification requirements. While the 1915i is a victory to add to services that were lacking for Medicaid recipients, it is absolutely not a duplication of service, and will not benefit most of ND residents living with brain injury who are currently being served through DHS and NDBIN funding.

Please consider this testimony a request to **fully restore the brain injury funding in HB 1012 including the proposed 50% reduction in funding the North Dakota Brain Injury Network.** This reduction would have detrimental effects on our patients, the programming my practice can offer, the support available through NDBIN, and the overall progress we have made in recent years in ND brain injury programming and support.

Thank you for your time and I welcome any questions.

Respectfully,

Nan Kennelly, MS CCC-SLP, CBIST
Licensed Speech-Language Pathologist
Owner | Onword Therapy

Date: 1/22/2021

Dear Members of the Budget Committee: #2307

Prior to knowing about my head injury life was:
I was scared to death. I couldn't remember things. I missed appointments they tested me for dementia. Then I had testing and they said you have a brain injury

Since learning about my brain injury life is:
I wake up and it is foggy. Knowing is helpful. I am learning new tools. It is scary, but at least I know.

North Dakota Brain Injury Network is important to me because: I love them. Without them I would be lost. I am starting to feel better. I am feeling human not like a freak.

I feel that the state of North Dakota needs to know this about brain injury: We think different. We are the same but completely different we need different services then typical brain injuries.

Sincerely,

1/22/2021 Maureen E Spath

Date: 1/22/2021

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
good. I had a full time job, I did not have pain, confusion, or other symptoms of a TBI. After my TBI, I was mis-diagnosed.

Since learning about my brain injury life is:
After my brain injury, I feel miserable because of my mis-diagnosis and constantly being in pain. I also feel fatigue much of the time.

North Dakota Brain Injury Network is important to me because:
I can have an agency like NDBIN to help me with things like doing my paperwork, going to doctor appointments and advocating for me. Sometimes when I go to the doctor they don't listen to me

I feel that the state of North Dakota needs to know this about brain injury:
The care people with brain injuries need is different than mental health care.

Sincerely,

Date: 1-22-21

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:

A strugel, not knowing why I felt different and out of place. Upset more often the not. Trusting is hard. Taking responably for my self was Hard.

Since learning about my brain injury life is:

I still strugel but now I have some sence of self worth, and hope. Life is not all Bad. I feel better about choices I make.

North Dakota Brain Injury Network is important to me because: the help I get is worked at my needs and pace, Because N.D.B.I.N [redacted] offers me help I did not know was out there.

I feel that the state of North Dakota needs to know this about brain injury:

That no person is the same as a nother. So [redacted] progress is never the same as a nother.

Sincerely, Bruce Owens

Thanks for being There For us.

Date:

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
My life felt scattered, very confusing and I was self destructive.

Since learning about my brain injury life is:
a little bit better because I am learning to deal with which help me cope better.

North Dakota Brain Injury Network is important to me because: They keep me grounded. They educated me. I know I can reach out anytime.

I feel that the state of North Dakota needs to know this about brain injury: We need comprehensive care, beyond mental health. We help communicating with others.

Sincerely,

[illegible]

January 22, 2021

To the members of the budget committee:

I would like to express my support towards the North Dakota Brain Injury Network, NDBIN. As a guardian working in North Dakota I see the growing need for the services provided by NDBIN. There are many individuals including the several I serve as guardian who are not able to get services through current the mental health system. This is very frustrating as a guardian. Often the services they do get are often one sided focusing on their mental health and not addressing the brain injury only the mental health or substance abuse. This strikes me odd as without the brain injury being addressed, I see a gap in their ability to utilize the services they are given. Either they cannot communicate effectively with their providers or cognitively they cannot take in the information provided by their providers and the cycle of mental health and or substance abuse continues.

My interactions with NDBIN have assisted me as far as education, consultation, and collaboration going as far as attending meetings involving my individuals with head injuries. My concern is that without this service I will not have the information I need to effectively assist my wards to be as independent as possible. I have genuinely enjoyed the education provided by this organization. Not only has it been an excellent source of a device volume of topics but it as allowed me to obtain the CEUs to retain my National Guardianship status. I look forward to continued opportunities to engage with NDBIN and hope that you will allow them the funding necessary to provide the level of education, consultation and support they currently offer.

Thank you very much for allowing me to voice my support on this matter. I feel that it is the duty of all of us especially the legislature to provide services to all North Dakotans especially those lives we can impact so significantly.

Sincerely,

Veronica Miller, guardian

Veronica Miller

Buffalo ND

701-840-5207

Thursday 2-

To whomever it may concern,

This is a letter about my care at NAMI and its benefits.

I have been with NAMI for about 1 year. I go to groups there and receive help from their wonderful staff. Tori McCarthy is my case manager there and she is very good at what she does.

I also have a TBI and have a short memory span as a result of my TBI.

Since I have been with NAMI - they have helped me stay connected and also helped me live independently. It has made a difference in my life.

Thank you again.

Joanne Savage

Date: 1/21/2021

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
My life was confusing. I felt fearful of being taken advantage of but didn't understand why. I had a hard time communicating with people. My life felt disorganized.

Since Learning about my brain injury life is:
I feel better about myself and I feel improved. It is good to connect with others and learn and share things. I no longer feel like I am just surviving I think that I can own these.

North Dakota Brain Injury Network with important to me because: They have educated me about my injury and through that I am coping better. They have advocated for me. They helped me to find NDM Brain Injury Services who are very supportive of me.

I feel that the state of North Dakota needs to know this about brain injury: That people with Brain Injuries want to get better. And that they need different services than more traditional mental health services.

Sincerely,

Andrea Heath

Date: 1-22-2021

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
I struggled with many aspects of my life for a long time.

Since learning about my brain injury life is:
I am better equipped to be self-aware and am more apt to function within my abilities.

North Dakota Brain Injury Network is important to me because:
People need education and support to recognize and understand ALL the conditions of their lives.

I feel that the state of North Dakota needs to know this about brain injury:
Many people are suffering because of this issue not even knowing that they are among others with similar needs and can recover more effectively with support and understanding.

Sincerely,

Nicole Lacey

Date: 1/22/2021

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
Hectic, confusing and scattered and disorganized I didn't always understand why things went the way they did.

Since learning about my brain injury life is:
My life was more manageable. I still not under control by better I understand myself better.

North Dakota Brain Injury Network is important to me because: I like having a place where I can get facts and answers. Nice to know that there is an advocate out there.

I feel that the state of North Dakota needs to know this about brain injury:
That I'm not invisible any more. That brain injuries are a real ~~thing~~ issue and not the same as mental health. I hope we won't be overlooked anymore.

Sincerely,

John Butt

Date: 1-22-21

Dear Members of the Budget Committee:

Prior to knowing about my head injury life was:
very difficult for me. I had a hard time controlling my emotions and understanding what was happening to me and why.

Since Learning about my brain injury life is:
I now understand what is happening and now I'm not feeling alone anymore. There is a family at NIAM that is wonderful.

North Dakota Brain Injury Network with important to me because: The support has been incredible that I have received and I do not know what I would do without it. NIAM has been indispensible. Their support and knowledge is vital to Brain Injury clients.

I feel that the state of North Dakota needs to know this about brain injury:
It's a very important issue that needs funding and needs to be addressed. This is an invisible illness worthy of attention!

Sincerely,

Chelsea E. McNair

Toni & Christie are one of the brightest lights in my work to work living and I am grateful to be one of their clients.

I am processing as time goes on and now I realize I would be so lost without them. These guys are so special and dedicated that I feel my life is becoming a replection of some of my dreams and they have restored a lot of my faith back into me. These guys are amazing to me. Thanks for letting me share my thoughts & sentiments.

God Bless

Tony Gus

Testimony on HB 1012
House Appropriations Committee - Human Resources Division
January 26, 2021 #2849

Good afternoon Chairman Nelson and members of the House Appropriations - Human Resources Division Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 211 assisted living, basic care, and skilled nursing facilities in North Dakota. I am here in support of HB 1012 and ask for your support of basic care and nursing facility funding.

HB 1012
First, just a quick recap of the numbers – see the attachments for assisted living, basic care, and nursing facilities.

Second, I want to address basic care funding as the DHS budget proposes a decrease in basic care funding as shown on Attachment A.

The reduction of $7.3 million to basic care is catastrophic, and if left intact many basic care facilities will be unable to stay in business.

Before the pandemic hit basic care utilization was growing, more people needing basic care assistance were seeking this living arrangement with services. However, as you can see, basic care occupancy has dropped because of COVID-19, so the money for the increase in caseload/utilization is probably not necessary, (3.3 million). But the cost changes to continue, as well as at least a 2% inflator is absolutely necessary. This type of reduction will forever destroy care to individuals in need of this type of care.

What is basic care and why is it important? Basic care is a congregated residential setting with private and semi-private rooms, providing 24 hour staffing. Basic care provides an all-inclusive rate providing room, meals, personal care services, supervision, activities, transportation, medication administration, nursing assessment and interventions and care planning. Residents range in age from late 30's to over 100 years old, with the average age in the mid 80's. Almost two-thirds of residents living in basic care need assistance to pay for their care. The average basic care assistance rate on July 1, 2020 was $129.69, what a bargain! Twenty-four hour care, all-inclusive rate that covers all of your needs. An independent study commissioned by DHS in 2014 stated in their report, (Myers & Stauffer), "It is therefore in the state's best interest to proactively invest additional resources to further develop it's non-institutional resources, (HCBS, basic care and assisted living) that promote the ability of the elderly and disabled to "Age in place" and be served for as long as possible in their own home or another community residential setting.". This cut to basic care is doing just the opposite and serves to harm this entire service option in North Dakota. Please take a look at Attachment B labeled Basic Care Rates Effective July 1,2020, the average rate is $129.69. North Dakota has a real gem, called basic care and I would ask the committee to not accept the Governor's Budget reduction.

The next budget item I would like to address is Adult Residential Care. These are licensed basic care providers specializing in head injury services, (two) and in dementia care, (thirteen). These facilities are funded under the Medicaid waiver and the clients they serve screen in need of skilled nursing care. Adult Residential Care is a more independent integrated setting with 24 hour access to staff to support their independence.

Below is the list of the 15 Adult Residential Care facilities and their daily Medicaid rate, their licensed bed capacity and their occupancy as shared on the 1-14-21 HC Standard report.

FACILITY NAME	CITY	DAILY RATE	LICENSED BEDS	OCCUPIED
Maple View	Bismarck	$112.08	36	31
Edgewood Senior Living	Fargo	$108.93	35	33
Maple View Memory Care	Minot	$103.22	43	32
Edgewood Senior Living	Mandan	$107.08	73	48
Maple View Fargo	Fargo	$108.26	36	30
Ecumen – Evergreens	Fargo	$114.72	54	32
Edgewood Senior Living	Minot	$123.77	22	18
Edgewood Senior Living	Minot	$126.38	133	97
Roseadele	Jamestown	$127.47	20	20
Edgewood Senior Living	Bismarck	$133.13	44	36
Maple View	Grand Forks	$125.62	36	25
Edgewood Senior Living	Jamestown	$127.35	61	39
Lakewood Landing	Mandan	$154.94	38	32
Open Door Center	Valley City	$173.00	10	10
Dakota Pointe – HIT INC	Mandan	$198.24	10	10

Besides the daily rate above, a room and board rate of $758.00 per month is allowed. These providers are also in need of at least a two percent rate adjustment per year. The Governor's Budget allows only a one percent adjustment.

Interestingly that brings me to the next budget item, skilled nursing facilities. That budget needs an enhancement of $7.2 million for reforming the Nursing Facility Payment System. What we need for nursing facilities $7.2 million is almost identical to the basic care reduction of $7.3 million. Although we are on board and support the changes to the Nursing Facility Payment System, we can not in good faith ask for that money at the expense of basic care. Options to restore basic care funding:

1) Take the $3.3 million funded for the bed buy-out and give it to basic care.
2) Take the $5.6 million funded for the nursing facility 1% inflator and give it to basic care, (nursing facility inflator is already funded at the Skilled Market Basket in another part of the budget). As well as use that money to increase the inflator to at least two percent for all basic care providers.

3) Look at nursing facilities and basic care utilization, as budget savings may be found, as the pandemic has negatively impacted occupancy.
4) If money cannot be found in the above three options, then delay implementation of the new Nursing Facility Payment System. I hate to even suggest that option as we have worked hard to gain consensus with members and the department, any delay might damper the spirit of reform. However, we can not and will not support the reform at the expense of basic care.

That being said, I would now like to transition into the new Nursing Facility Payment System funded in this budget and ask you to support this reform.

The study of the payment system was a long grueling process and it challenged us to think differently. The study was mandated in the 2019 legislative session and you directed a revised payment methodology be developed. Not a tweaking of the old system but the creation of a new methodology. That took us awhile to grasp. I believe for the first few meetings, someone in the group would ask, "Are you sure this is necessary? Wouldn't it be better to change our current system and improve it to incentivize efficiency?" Then we would go back, read the legislative language you approved and said no, we need to change the entire payment methodology and thus we did! Many times, during our months of meetings I did not think we would arrive at consensus, but we stuck with the process and in the end at our September 2020 membership meeting, approved the new payment system by a vote of 99-1. At the end we did not get everything we advocated for and neither did the state, but we believe this system can achieve better efficiency of state resources and a quality service that delivers on our promise of assuring the elderly get quality care at the end of their life.

We could never had completed this study without the knowledge and expertise of two payment experts. Joe Lubarsky, President of Eljay, LLC and Brad DeJong, Senior Partner with Eide Bailly. Brad is an expert in North Dakota's nursing facility payment system and Joe is a national expert in the development and modification of nursing facility payment systems. He has assisted in the design of payment systems in 30 states. Without their expert knowledge this project would have never been successful. Brad DeJong is with us today and he will testify on the details for the new proposed fair rental system.

As you are aware, HB 1090 contains all the policy language to implement the new payment system and HB 1012 contains the money to implement. It is impossible to just talk about the money without talking about the new policy behind it. We are still working out the policy issues, (HB 1090), with House Human Services. All policies are based upon a long and sometimes challenging negotiation process. Each detail impacts one another. They are all related and entwined to the overall success of the new payment system. We know you have final approval the as legislature determines policy and the budget. I am hoping you see the value and can support all changes we are bringing to you. To trust the state and national experts who know complex payment systems. There are key components that are vital to the implementation and success of the new system.

Key Features of the New Pricing Model

1. Moves to a hybrid pricing model verses our current cost-based system with limits.

2. Set price levels as a percentage of median, with direct care and other direct care at 120% of median and indirect at 110% of median.
3. The indirect price will be established separately for small nursing facilities, 55 beds and under, and large facilities, greater than 55 beds. Small nursing facilities will have a higher price of approximately $4 dollars in the indirect cost category.

4. The margin cap in all cost centers will be 3.46% of the price. Please do not confuse this with an operating margin under our current system. In our current system, everyone gets an operating margin, that will not be true in our new system. Every facility will have the opportunity to receive a margin, but it will be based on where they are operating relative to the Price Point.

- Facilities that are 3.46% or more under the Price Point will receive the facility specific allowed cost plus the margin.
- Facilities that are within 3.46% of the Price Point will receive the Price.
- Facilities that are at or over the Price Point will only receive the Price, no margin.

5. The new pricing model, (not the property component), would implement on 1-1-22 and the 6-30-21 cost report will be used to set the initial prices.

6. We are proposing a hold harmless provision for two years on the operating side. For the initial year starting 1-1-22 nursing facilities

will be able to select to operate under the existing cost based methodology or the new pricing model. All nursing facilities will receive two sets of rates and they will decide and select the one they want. This two year hold harmless is very important and will help those who may experience rate decreases under the new pricing model to transition more slowly into the new payment model.

7. In the second year of implementation, 2023, the hold harmless provision continues. A nursing facility can continue to stay under the existing cost based system or convert to the new payment system. In year three, all must convert to the new pricing model.

8. Rebasing will occur every two years for the first four years and will be examined after that period.

9. The Medicare Skilled Nursing Facility Market Basket will be utilized to increase rates in the non-rebasing years. Item 8 & 9 are really important because we are losing a key component on the payment system. That is called annual rebasing. Under annual rebasing today, if your costs are <u>under</u> the cost limit and your costs increase substantially, you get that full increase in your rate up to the limit. This feature has saved many facilities and has been vital. But we are giving it up. In giving this "annual rebasing up", it is important to get the annual Skilled Market Basket and rebasing of the price every two years.
10. A process has been developed to address atypical cost increases in a non-rebasing year. (i.e., pandemic – national minimum wage) and that will be outlined through the rule promulgation process.

11. Equalization of Rates continues.

12. When the two year transitional hold harmless ends, we would like to see the development of a new quality incentives payment. This is not part of the legislation before you today but something I would like to bring back in 2023 for implementation in 2024.

    Based upon a statistical analysis of costs there is <u>one</u> driver of why it costs more in some North Dakota nursing facilities and that is the number of staff they have. Lower cost facilities have less staff, high cost facilities have more. Under this new system some high staff facilities may need to reduce staffing to be successful under this model. An analysis of cost and quality data in North Dakota shows those with higher costs, (higher staffing), have better overall quality outcomes. We would like to see a system that rewards quality and allows all nursing facilities to earn back dollars in the form of a quality payment to help support the cost of their higher staffing. Today we need the two year hold harmless transition payment, but in the future, we would love to see this as a quality payment. (See two charts on quality)

13. Implement a Fair Rental Value System as the property component on 1-1-23. Implementing this component of the new system is going to take time because to establish your Fair Rental Value the state will need to collect square footage and cost of additions and renovations made on all nursing facilities over their lifetime. This also needs a hold harmless provision, and this provision will be needed until everyone crosses over into the fair rental system. The hold harmless provision is to help those that have recently undertaken a major construction project or to help those that are planning a major

construction project if the financing of the project was in place by 12-31-21. The majority of the new money here are for those nursing facilities that have a low property rate to transition to a higher property value.

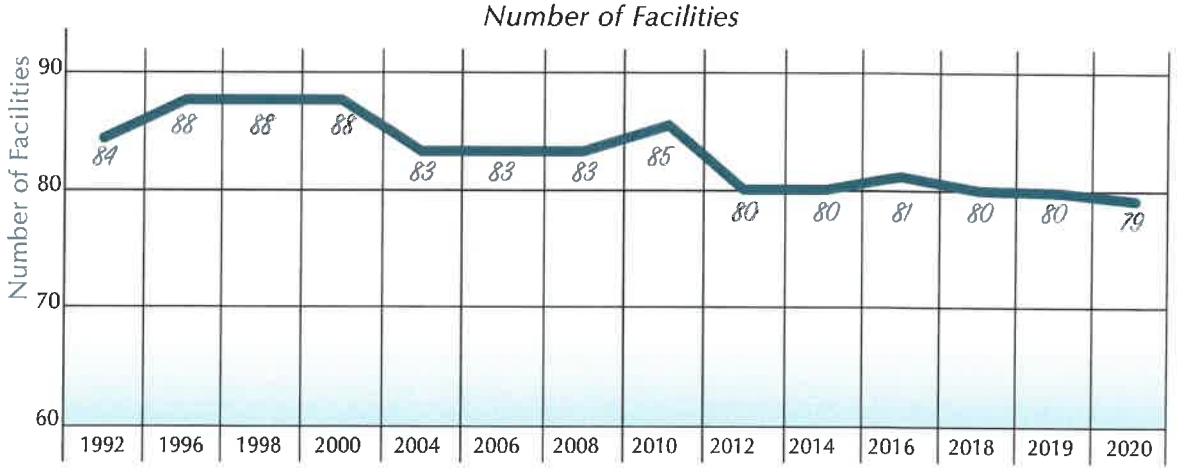
Brad DeJong is going to address in detail the fair rental system so I would like to defer any question on that topic to him. After Brad, I have asked Reier Thompson, CEO of Missouri Slope in Bismarck, to talk about his skilled nursing facility the impact of the pandemic and a little bit about a new construction project in progress today.

This concludes my testimony and I welcome your questions. Would you like to hear from Brad and Reier before you ask questions?

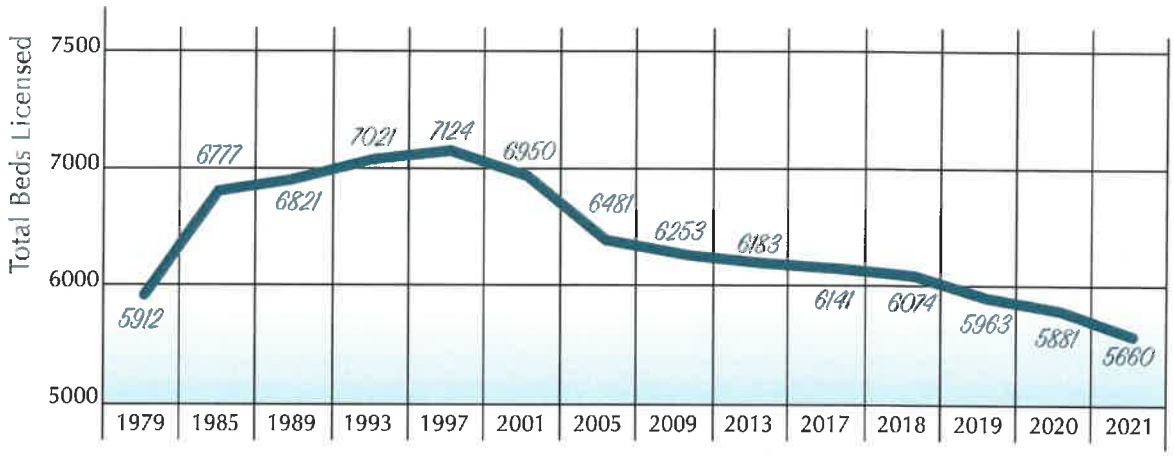
Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

Nursing Facilities

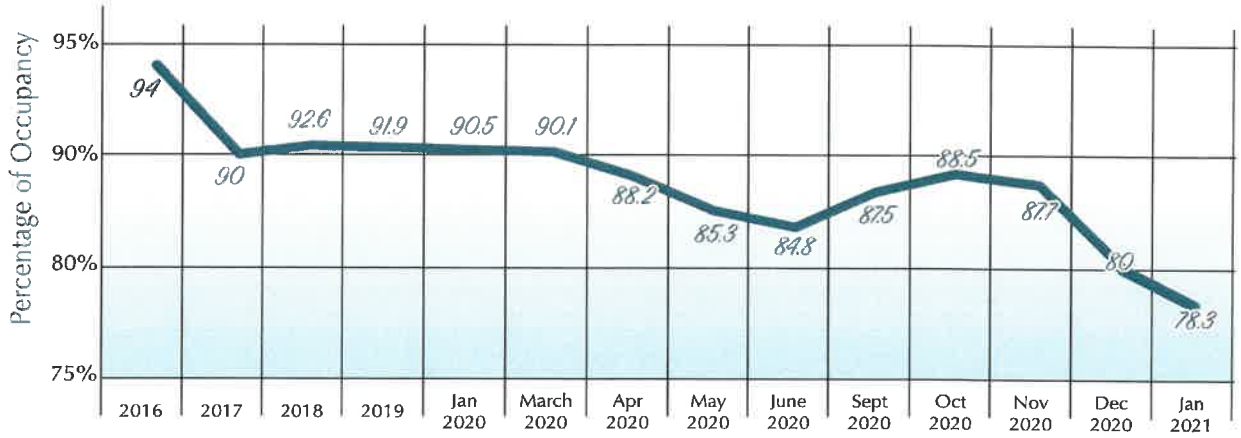
Number of Facilities



Licensed Beds



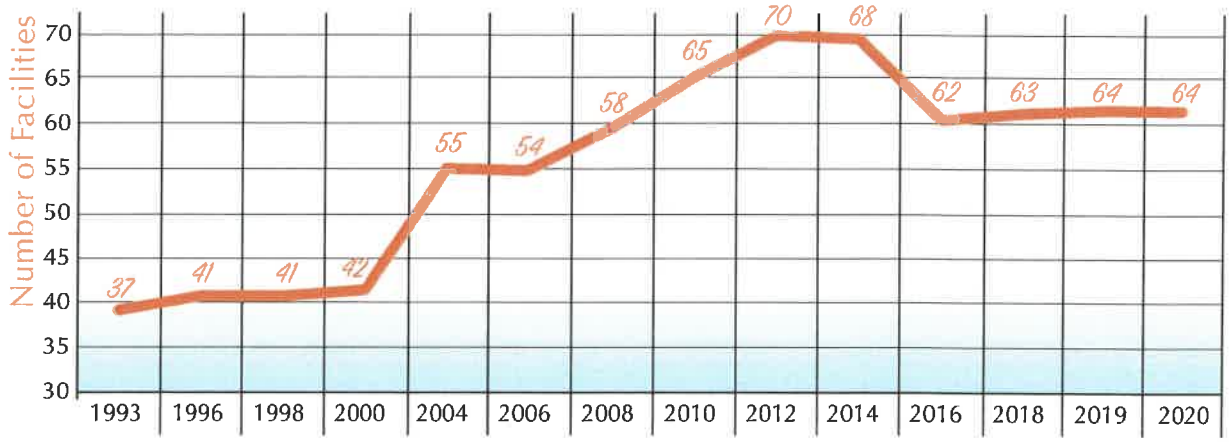
Occupancy



January - June 2020 Based on NDLTCA Survey
September 2020 Based on HC Standard Report on September 10, 2020
October 2020 Based on HC Standard Report on October 2, 2020
November 2020 Based on HC Standard Report on November 2, 2020
December 2020 Based on HC Standard Report on November 30, 2020
January 2020 Based on HC Standard Report on January 11, 2021

Basic Care

Number of Facilities



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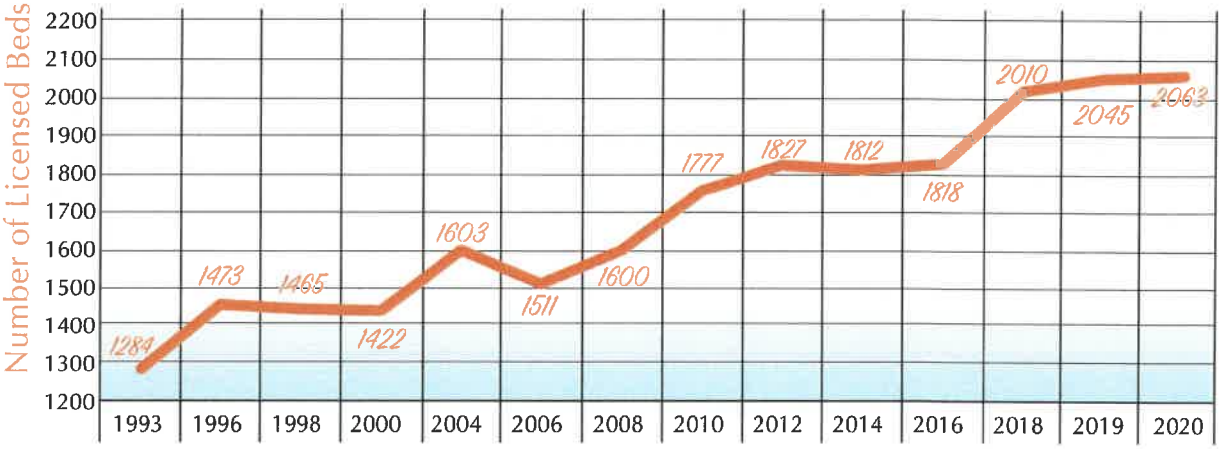
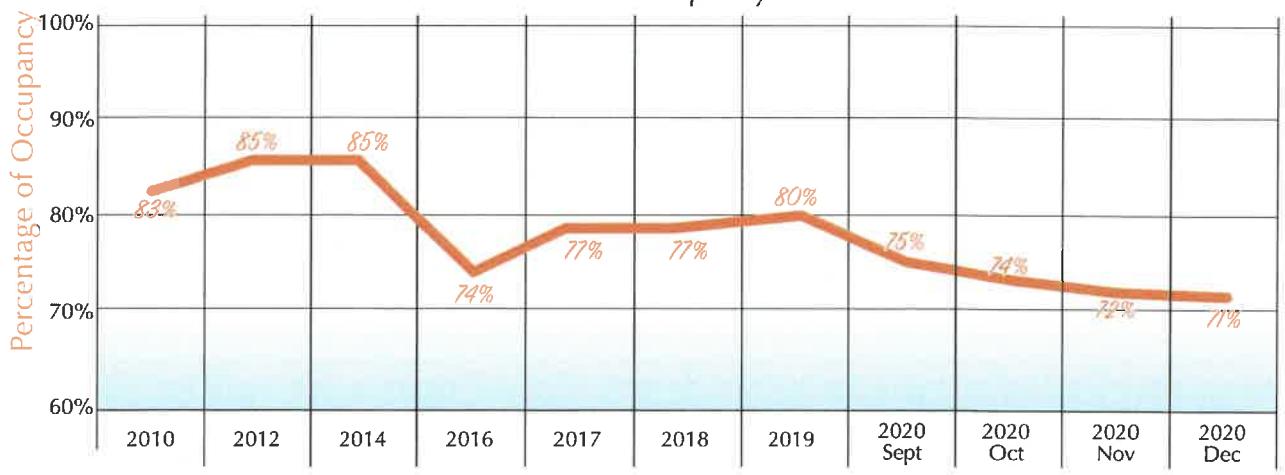


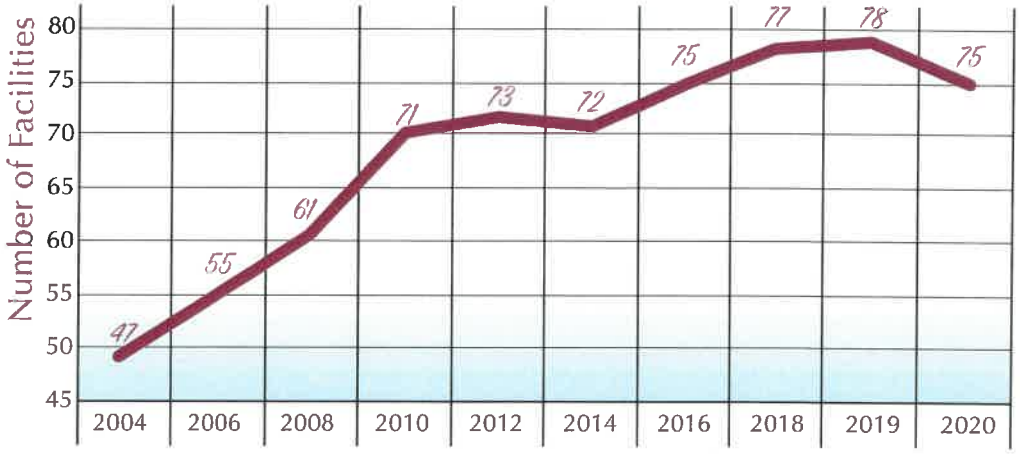
Occupancy



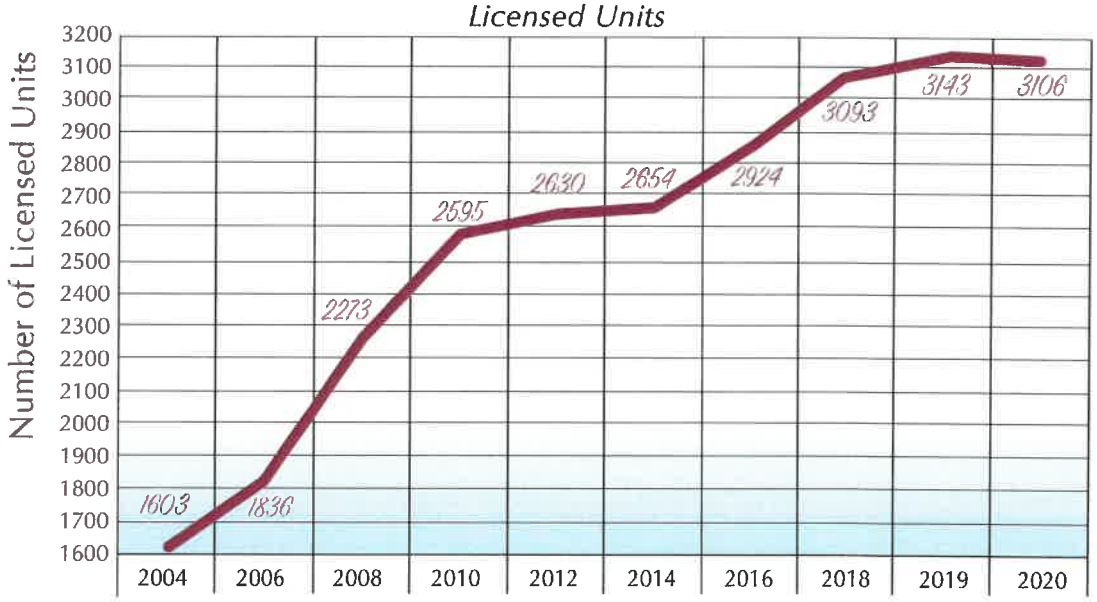
The occupancy for 2020 is based upon the 9-10-20, 10-2-20, 11-2-20 and 11-30-20 data submitted by basic care facilities (n=61) and HC Standard/Covid Reporting

Assisted Living

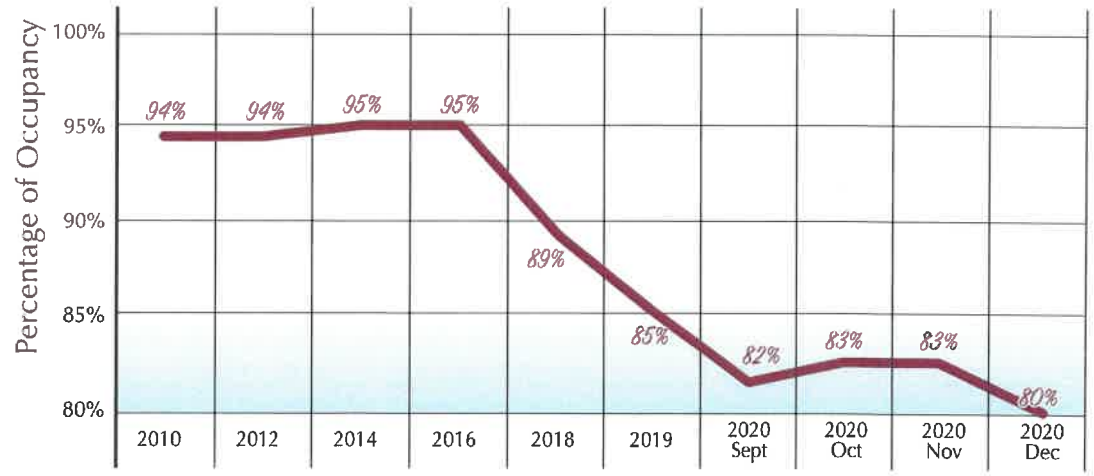
Number of Facilities



Licensed Units



Occupancy



The occupancy for 2020 is based upon the 9-10-20, 10-2-20, 11-2-20, and 11-30-20 data submitted by assisted living facilities (n=69) and HC Standard/Covid Reporting

North Dakota Department of Human Services
Changes in Long Term Care (LTC) from 2019-2021 Appropriation to the 2021-2023 ExecutiveBudget Recommendation

Service Description	Legislatively Approved Budget 2019 - 2021	Funding Shift	Cost Changes	Caseload / Utilization Changes	Cost to Continue	Medicaid FMAP	Take Autism Voucher Funds and move them into Autism Waiver	Basic Care Savings Plan	Eliminate Tech Dependent Waiver	PACE Rate Adjustment and Decrease Enrollment	Total Changes	2021-2023 Budget To OMB	1% & 1% Provider Inflationary Increases	Nursing Home Payment Reform	Medicaid Underfunding	Total Governor Changes	2021-2023 Budget To House
Nursing Facilities	582,849,867		33,767,833	5,908,804	39,676,637						39,676,637	622,526,504	5,646,947	7,200,000		12,846,947	635,373,451
Underfunding	(20,000,000)			20,000,000	20,000,000						20,000,000						
Total Nursing Facilities	**562,849,867**		**33,767,833**	**25,908,804**	**59,676,637**						**59,676,637**	**622,526,504**	**5,646,947**	**7,200,000**		**12,846,947**	**635,373,451**
Basic Care	40,555,981		2,393,813	3,323,952	5,717,765			(7,300,000)			(1,582,235)	47,973,746	439,126			439,126	46,412,872
Home & Community Based Services	**124,104,683**		**(5,929,850)**	**18,234,160**	**12,304,310**		**(645,673)**		**(596,112)**	**(1,914,734)**	**9,147,791**	**133,252,474**	**2,032,976**		**(330,000)**	**1,702,976**	**134,955,450**
SPED	17,799,841		(889,472)	2,909,951	2,020,479						2,020,479	19,820,320	298,683			298,683	20,119,003
Ex-SPED	1,844,963		(43,909)	33,836	(10,073)						(10,073)	1,834,890	27,782			27,782	1,862,672
Personal Care Services	34,483,377		1,721,255	(4,926,192)	(3,206,937)						(3,206,937)	31,276,440	470,710			470,710	31,747,150
Targeted Case Management	1,917,742		73,903	(1,837,109)	(1,763,206)						(1,763,206)	154,536	2,326			2,326	156,862
Home & Comm Based Service Waiver	30,104,751		(3,139,230)	17,632,007	14,492,777						14,492,777	44,597,528	683,836		(330,000)	353,836	44,951,164
Children's Medically Fragile Waiver	544,416		(154,680)		(154,680)						(154,680)	389,736	5,866			5,866	395,602
Technology Dependent Waiver	591,288		4,824		4,824				(596,112)		(591,288)						
PACE	32,866,676		(2,477,105)	4,423,667	1,946,562					(1,914,734)	31,828	32,898,504	509,262			509,262	33,407,766
Children's Hospice Waiver	61,848		10,224		10,224						10,224	72,072	1,085			1,085	73,157
Autism Waiver	2,564,772		(1,068,804)		(1,068,804)		712,480				(356,324)	2,208,448	33,626			33,626	2,242,074
Autism Voucher	1,325,009		33,144		33,144		(1,358,153)				(1,325,009)						
Excess Federal Authority																	
Total	**736,510,531**		**30,231,796**	**47,466,916**	**77,698,712**		**(645,673)**	**(7,300,000)**	**(596,112)**	**(1,914,734)**	**67,242,193**	**803,752,724**	**8,119,049**	**7,200,000**	**(330,000)**	**14,989,049**	**818,741,773**
General Fund	**376,714,731**	**1,000,000**	**14,638,993**	**25,380,980**	**40,219,973**	**(17,377,698)**	**(1,026,852)**	**(5,015,638)**	**(277,552)**	**(891,831)**	**16,630,402**	**393,345,133**	**3,994,328**	**3,348,000**	**(330,000)**	**7,012,328**	**400,357,461**

NORTH Dakota | Human Services
Be Legendary.

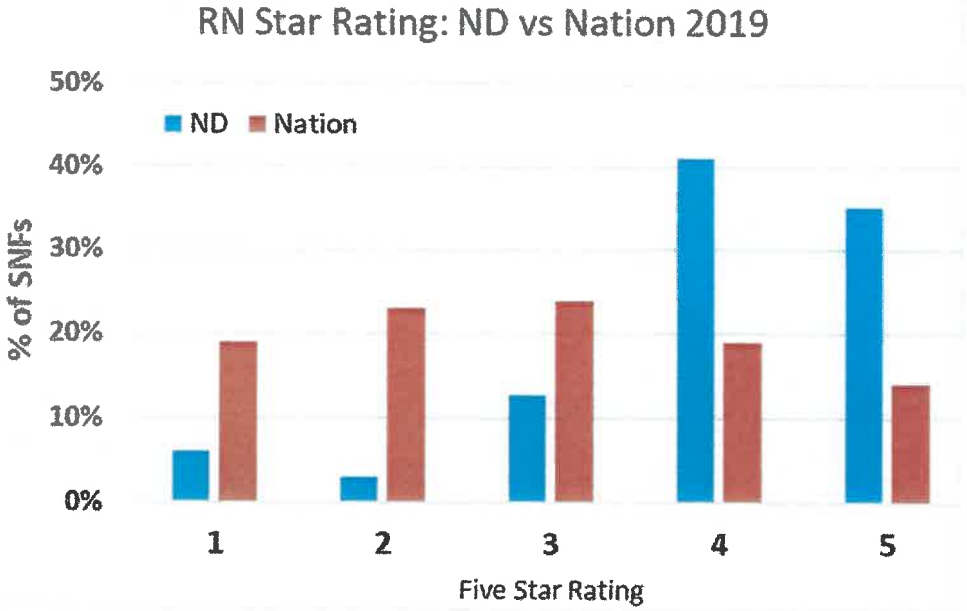
Basic Care Rates Effective July 1, 2020

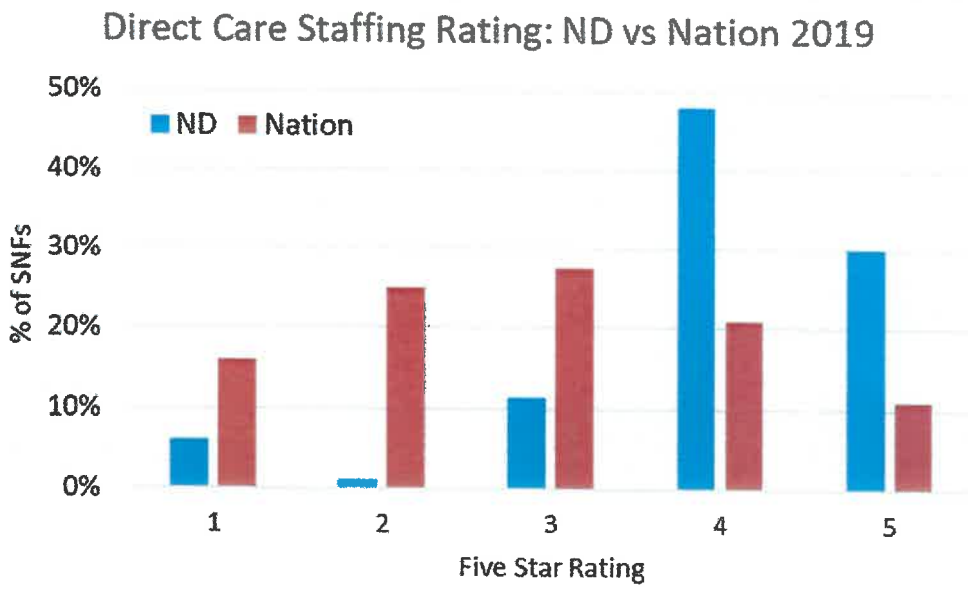
Faciltiy	City	Personal Care Rate	Room & Board Rate	Total Rate
Prairie Villa	Arthur	$77.99	$68.99	$146.98
Augusta Place	Bismarck	$53.56	$84.42	$137.98
Edgewood Bismarck Senior Living	Bismarck	$64.87	$40.81	$105.68
Edgewood Vista at Edgewood Village	Bismarck	$63.64	$63.51	$127.15
Prairie Pointe	Bismarck	$99.88	$80.57	$180.45
St. Gabriel's Community	Bismarck	$73.77	$112.91	$186.68
The Terrace	Bismarck	$72.37	$57.95	$130.32
St. Francis Residence	Cando	$48.98	$84.91	$133.89
St. Luke's Sunrise Care Center	Crosby	$59.64	$96.81	$156.45
Eventide - Lake Country Manor	Devils Lake	$45.69	$71.01	$116.70
Odd Fellows Home	Devils Lake	$50.65	$59.44	$110.09
Evergreen Dickinson	Dickinson	$45.85	$68.70	$114.55
Manor St. Joseph	Edgeley	$65.06	$43.80	$108.86
Edmore Rest Home	Edmore	$93.49	$39.92	$133.41
Dakota Hill Housing	Elgin	$60.29	$39.85	$100.14
Evergreen Place	Ellendale	$59.58	$64.81	$124.39
Bethany Towers	Fargo	$68.63	$59.88	$128.51
Edgewood Fargo Senior Living	Fargo	$64.94	$61.17	$126.11
Evergreens of Fargo - 1401	Fargo	$77.00	$59.53	$136.53
Evergreens of Fargo - 1411	Fargo	$77.47	$59.34	$136.81
Good Samaritan Society - Fargo	Fargo	$49.39	$59.44	$108.83
Gackle Care Center	Gackle	$71.27	$58.46	$129.73
Edgewood Parkwood Place	Grand Forks	$50.59	$43.16	$93.75
St. Anne's Guest Home	Grand Forks	$59.27	$67.71	$126.98
Tufte Manor	Grand Forks	$55.08	$65.41	$120.49
Senior Suites at Sakakawea	Hazen	$85.82	$65.25	$151.07
Edgewood Jamestown	Jamestown	$74.17	$77.79	$151.96
Rock of Ages Home, Inc.	Jamestown	$62.71	$46.29	$109.00
Hill Top Home of Comfort	Killdeer	$77.53	$88.38	$165.91
Good Samaritan Society - Lakota	Lakota	$78.54	$90.80	$169.34
Good Samaritan Society - Larimore	Larimore	$44.43	$97.07	$141.50
Parkside Lutheran Home	Lisbon	$79.16	$87.02	$166.18
Maddock Memorial Home	Maddock	$61.00	$65.90	$126.90

Basic Care Rates Effective July 1, 2020

Faciltiy	City	Personal Care Rate	Room & Board Rate	Total Rate
Edgewood Mandan	Mandan	$51.26	$58.11	$109.37
Lakewood Landing	Mandan	$46.48	$67.13	$113.61
Sheridan Memorial Home	McClusky	$52.22	$42.38	$94.60
Edgewood Minot Senior Living	Minot	$42.18	$36.45	$78.63
Borg Pioneer Memorial Home	Mountain	$57.26	$46.34	$103.60
Napoleon Care Center	Napoleon	$60.15	$61.65	$121.80
Lutheran Home of the Good Shepherd	New Rockford	$58.18	$94.73	$152.91
Osnabrock Community Basic Care	Osnabrock	$57.19	$42.81	$100.00
Good Samaritan Society - Park River	Park River	$36.38	$68.76	$105.14
Harold S. Haaland Home	Rugby	$67.29	$66.96	$134.25
Golden Manor	Steele	$63.47	$63.34	$126.81
Siena Court	Wahpeton	$79.62	$82.21	$161.83
The Leach Home	Wahpeton	$54.77	$77.23	$132.00
Bethel Lutheran Home	Williston	$62.95	$79.96	$142.91
Redwood Village	Wilton	$79.19	$65.09	$144.28

ND vs Nation: Staffing Star Rating 2019





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Staffing Association with Quality ND Facilities 2019



FINDING: As staffing Star Rating increases so does the average Quality Measure Star Rating

Note: 1 star facilities (n=5) were assigned 1 star by CMS due to staffing data errors; not because of low staffing levels; and were excluded

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EideBailly®

CPAs & BUSINESS ADVISORS

HO PROPRIATIONS PRESENTATION

House Bill 1090, Fair Rental Value

HISTORICAL PROPERTY RATE SETTING

- Current property rates are set based on accounting standards based depreciation on allowable capital assets and debt financing costs
- Building and fixed equipment capital assets are subject to a per bed maximum allowable cost which limits what a facility can spend
- Depreciation on capital assets is calculated based on a straight-line method over an estimated useful life set based on AHA guidelines
- Interest expense is based on the payment terms of the allowable debt and includes the amortization of debt financing costs
- The allowable depreciation and interest are divided by actual cost report year days or 90% occupancy days, whichever is higher, to get to the rate per day

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HISTORICAL PROPERTY RATE SETTING

- Current system provides for high rates in the earlier years after a major project, and decreasing rates as it ages
- Current system only repays facilities for cost of capital projects over future years which discourages renovations as it will always require debt
- Current system does not provide funding to build reserves for future projects which leads to large projects having to be funded with debt which increases overall cost

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PROPOSED FAIR RENTAL VALUE (FRV)

- Property rate would be based on a % return on the fair value of all allowable capital assets to determine the Fair Rent
- Building and fixed equipment costs are still subject to a per bed limit that is based on RS Means cost per square foot multiplied by an allowable square footage per bed license (entire facility space)
- Equipment is limited to $15,000 per bed license and land and land improvements are limited to 10% of the building limits
- FRV is adjusted annually for based on the effective age and a replacement factor
- Effective age decreases annually, but can be limited by capital renovations made which encourages ongoing maintenance
- The Fair Rent is then divided by actual cost report year days or 90% occupancy days, whichever is higher, to get to the rate per day

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PROPOSED FAIR RENTAL VALUE (FRV)

- FRV will provide a more stable property rate
  - Early year rates will not be as high as current system, estimated cap is $62.14 vs $86 currently the high rate
  - Rate will remain consistent over time as long as the facility maintains the buildings
- FRV will provide revenue streams that will help facilities reserve for future projects and encourages renovations over time without having to utilize debt to fund the entire project
- See Attachment 3 for calculation examples of new projects

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FRV FOUR YEAR PHASE IN

- 71 facilities are estimated to see an increase in their property rates due to the transition from historical property rate setting to FRV
- These 71 facilities will see an average estimated impact of $7 per day increase in total on their rates that will increase the estimated Medicaid spending by $8,619,000
- FRV proposed rate setting will phase this increase in over 4 years at an estimated cost of $2,155,000 in each of the fiscal years 2023-2026
- Information is included as Attachment 1

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FRV HOLD HARMLESS

- 8 existing facilities are estimated to have property rates as set under the current property rate rules that will exceed the 1/1/23 FRV rates based on 2020 rate data
- The Medicaid cost for these facilities is already included in the current DHS budget, there is no new money needed to keep them under the current property rate system
- If these 8 facilities were forced to move their rates down to FRV on 1/1/23, it would reduce revenues by an estimated $1,500,000 based on the estimated FRV vs current 2021 property rates
  - This could lead to debt obligation issues
- Of these 8, 3 will transition to FRV in year 1 with all but 1 transitioning by year 8
- Missouri Slope will be new in 2021 and is also not expected to transition to FRV as the interest rate on the debt is too high
- See information provided in Attachment 2 and 3

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QUESTIONS?

Thank you for the opportunity to share this information with you.

Bradley W DeJong, CPA
Partner, Director of Senior Living Services
Eide Bailly LLP
Fargo, ND

EideBailly

#3732

Attachement 1

Facility Name	2019 Licensed Beds Per Survey or Ortherwise 2018 Beds per State	2020 Census	Lower Of Actual or Maximum Sq Feet Per Bed	FRV/PPD adjusted for 90% occupancy (fair rent/patient days)	Current Property Rate per Day	Difference per Day		Increase Rate change Medicaid Impact	Property Rate Increases Capped at 25%	Annual Impact
Aneta Parkview Health Center	39	12,604	600.00	$ 30.59	$ 25.88	$ 4.71		$ 51,739	$ 1.18	$ 12,935
Ashley Medical Center	40	10,884	421.13	$ 16.58	$ 10.44	$ 6.14		$ 45,558	$ 1.54	$ 11,390
Augusta Place - a Prospera Commur	48	17,332	848.19	$ 48.05	$ 44.95	$ 3.10		$ 31,714	$ 0.78	$ 7,929
Ave Maria Village	100	35,494	588.85	$ 27.83	$ 22.68	$ 5.15		$ 100,360	$ 1.29	$ 25,090
Baptist Health Care Center	140	50,517	950.00	$ 50.51	$ 38.88	$ 11.63		$ 324,039	$ 2.91	$ 81,010
Benedictine Living Center of Garriso	52	18,262	388.65	$ 16.91	$ 16.34	$ 0.57		$ 5,246	$ 0.14	$ 1,311
Bethany on 42nd	116	42,053	950.00	$ 55.89	$ 46.52	$ 9.37		$ 209,355	$ 2.34	$ 52,339
Bethany on University	172	60,599	891.84	$ 51.62	$ 41.32	$ 10.30		$ 238,460	$ 2.58	$ 59,615
Bethel Lutheran Nursing & Rehabilit	150	42,625	600.00	$ 22.85	$ 10.58	$ 12.27		$ 281,841	$ 3.07	$ 70,460
Dunseith Community Nursing Home	30	9,218	730.53	$ 22.79	$ 8.46	$ 14.33		$ 126,587	$ 3.58	$ 31,647
Elim Care Center	136	40,873	600.00	$ 22.85	$ 11.07	$ 11.78		$ 201,302	$ 2.94	$ 50,325
Elm Crest Manor	68	24,543	950.00	$ 43.47	$ 21.09	$ 22.38		$ 296,482	$ 5.60	$ 74,121
Eventide Heartland	82	28,561	600.00	$ 33.25	$ 29.67	$ 3.58		$ 62,096	$ 0.90	$ 15,524
Eventide Jamestown	115	35,832	600.00	$ 30.59	$ 22.41	$ 8.18		$ 177,334	$ 2.04	$ 44,334
Fargo Nursing and Rehab Center, LL	110	23,989	700.00	$ 34.46	$ 33.59	$ 0.87		$ 12,147	$ 0.22	$ 3,037
Four Seasons Health Care Center	37	12,421	690.51	$ 29.77	$ 19.77	$ 10.00		$ 62,830	$ 2.50	$ 15,707
Garrison Memorial Hospital Nursing	28	8,064	291.96	$ 12.06	$ 10.86	$ 1.20		$ 5,953	$ 0.30	$ 1,488
Golden Acres Manor	64	21,959	502.25	$ 15.44	$ 8.17	$ 7.27		$ 88,342	$ 1.82	$ 22,086
Good Samaritan Society Bottineau	52	15,037	826.69	$ 30.79	$ 13.43	$ 17.36		$ 136,549	$ 4.34	$ 34,137
Eventide Devils Lake Care Center	48	16,573	600.00	$ 14.38	$ 6.64	$ 7.74		$ 88,146	$ 1.93	$ 22,037
Good Samaritan Society Lakota	38	11,959	812.32	$ 30.29	$ 14.73	$ 15.56		$ 123,747	$ 3.89	$ 30,937
Good Samaritan Society Larimore	42	13,310	667.07	$ 29.46	$ 17.24	$ 12.22		$ 67,782	$ 3.05	$ 16,946
Good Samaritan Society Mohall	57	16,703	597.12	$ 26.60	$ 17.14	$ 9.46		$ 88,009	$ 2.37	$ 22,002
Good Samaritan Society Mott	42	13,543	654.50	$ 24.76	$ 14.26	$ 10.50		$ 78,455	$ 2.62	$ 19,614
Good Samaritan Society Oakes	59	19,173	716.51	$ 26.93	$ 12.52	$ 14.41		$ 151,489	$ 3.60	$ 37,872
Good Samaritan Society Park River	54	17,272	522.91	$ 20.15	$ 14.77	$ 5.38		$ 45,066	$ 1.34	$ 11,266
Griggs County Care Center	44	13,390	600.00	$ 30.59	$ 26.22	$ 4.37		$ 35,150	$ 1.09	$ 8,787
Heart of America Care Center	55	16,943	600.00	$ 26.72	$ 19.71	$ 7.01		$ 67,297	$ 1.75	$ 16,824
Hill Top Home of Comfort	58	20,474	559.91	$ 23.34	$ 19.09	$ 4.25		$ 48,724	$ 1.06	$ 12,181
Knife River Care Center	86	30,888	702.29	$ 32.35	$ 29.68	$ 2.67		$ 52,549	$ 0.67	$ 13,137
Luther Memorial Home	99	30,694	600.00	$ 18.98	$ 7.85	$ 11.13		$ 153,425	$ 2.78	$ 38,356
Lutheran Home of the Good Shephe	75	20,152	533.33	$ 27.47	$ 25.19	$ 2.28		$ 22,090	$ 0.57	$ 5,523
Lutheran Sunset Home	91	31,344	614.45	$ 22.27	$ 11.25	$ 11.02		$ 178,033	$ 2.76	$ 44,508

Maple Manor Care Center	63	16,102	800.00	$	44.16	$ 41.53	$ 2.63	$	20,028	$	0.66	$ 5,007
Marian Manor Healthcare Center	72	23,307	822.83	$	25.49	$ 9.59	$ 15.90	$	205,823	$	3.97	$ 51,456
Maryhill Manor	48	15,672	676.29	$	34.15	$ 23.41	$ 10.74	$	109,634	$	2.69	$ 27,408
Missouri Slope Lutheran Care Cente	250	84,253	675.94	$	33.27	$ 20.98	$ 12.29	$	585,208	$	3.07	$ 146,302
Mountrail Bethel Home	48	10,681	600.00	$	30.59	$ 22.36	$ 8.23	$	29,527	$	2.06	$ 7,382
Napoleon Care Center	36	11,249	641.72	$	32.54	$ 29.04	$ 3.50	$	20,019	$	0.87	$ 5,005
Nelson County Health System Care (	39	13,388	513.21	$	15.74	$ 8.36	$ 7.38	$	60,399	$	1.84	$ 15,100
North Dakota Veterans Home	52	17,540	700.00	$	33.56	$ 31.64	$ 1.92	$	14,495	$	0.48	$ 3,624
Northwood Deaconess Health Cente	45	13,566	600.00	$	30.59	$ 22.55	$ 8.04	$	62,110	$	2.01	$ 15,527
Parkside Lutheran Home	38	12,742	881.34	$	42.84	$ 21.24	$ 21.60	$	148,747	$	5.40	$ 37,187
Prince of Peace Care Center	53	12,910	457.36	$	11.78	$ 6.50	$ 5.28	$	44,613	$	1.32	$ 11,153
Rolette Community Care Center	40	14,092	800.00	$	46.63	$ 43.39	$ 3.24	$	39,843	$	0.81	$ 9,961
Rosewood on Broadway	125	43,152	786.24	$	42.10	$ 37.88	$ 4.22	$	92,978	$	1.06	$ 23,245
Sanford Hillsboro	30	10,915	691.47	$	39.43	$ 39.00	$ 0.43	$	3,258	$	0.11	$ 814
Sheyenne Care Center	170	48,628	807.52	$	40.28	$ 27.76	$ 12.52	$	400,220	$	3.13	$ 100,055
Sheyenne Crossings Care Center/TC	64	22,510	700.00	$	37.09	$ 36.47	$ 0.62	$	4,355	$	0.16	$ 1,089
Souris Valley Care Center	50	14,377	417.28	$	16.45	$ 10.41	$ 6.04	$	47,818	$	1.51	$ 11,955
Southwest Healthcare Services	40	12,962	600.00	$	30.59	$ 20.34	$ 10.25	$	72,651	$	2.56	$ 18,163
St Vincent's - a Prospera Community	101	36,141	762.68	$	30.63	$ 16.89	$ 13.74	$	287,690	$	3.44	$ 71,923
St. Aloisius Medical Center	80	25,038	786.11	$	44.24	$ 38.94	$ 5.30	$	85,351	$	1.32	$ 21,338
St. Benedict's Health Center	124	40,005	529.27	$	20.37	$ 10.49	$ 9.88	$	209,721	$	2.47	$ 52,430
St. Catherine's Living Center	52	16,565	766.77	$	38.38	$ 20.43	$ 17.95	$	161,477	$	4.49	$ 40,369
St. Gerard's Nursing Home	35	11,172	950.00	$	36.86	$ 10.43	$ 26.43	$	139,888	$	6.61	$ 34,972
St. Luke's Home	88	30,805	950.00	$	57.88	$ 47.29	$ 10.59	$	162,301	$	2.65	$ 40,575
St. Luke's Sunrise Care Center	40	11,435	600.00	$	26.72	$ 15.06	$ 11.66	$	50,526	$	2.91	$ 12,631
St. Rose Care Center	44	13,758	410.84	$	10.69	$ 6.43	$ 4.26	$	28,337	$	1.07	$ 7,084
Strasburg Nursing Home	55	17,924	754.00	$	23.48	$ 7.37	$ 16.11	$	191,537	$	4.03	$ 47,884
Sunset Drive - a Prospera Communit	128	44,785	633.05	$	30.17	$ 25.20	$ 4.97	$	144,758	$	1.24	$ 36,189
Tioga Medical Center LTC	30	9,380	417.03	$	22.04	$ 22.03	$ 0.01	$	132	$	0.00	$ 33
Towner County LivingCenter	30	9,837	600.00	$	30.59	$ 24.35	$ 6.24	$	21,848	$	1.56	$ 5,462
Tri-County Reitrement and Nursing	39	12,991	950.00	$	48.07	$ 21.05	$ 27.02	$	184,594	$	6.76	$ 46,148
Trinity Homes	230	69,416	811.07	$	30.24	$ 12.23	$ 18.01	$	800,091	$	4.50	$ 200,023
Villa Maria Health Care	120	43,701	632.32	$	25.62	$ 15.92	$ 9.70	$	228,689	$	2.43	$ 57,172
Wedgewood Manor	50	13,619	600.00	$	22.85	$ 12.31	$ 10.54	$	70,421	$	2.63	$ 17,605
Western Horizons Care Center	45	14,732	592.38	$	22.58	$ 10.45	$ 12.13	$	112,389	$	3.03	$ 28,097
Wishek Living Center	60	18,784	600.00	$	18.98	$ 7.72	$ 11.26	$	99,019	$	2.81	$ 24,755
Woodside Village	138	48,887	674.29	$	35.57	$ 34.61	$ 0.96	$	21,549	$	0.24	$ 5,387
	5,891	1,897,153		**$**	**33.08**	**$ 25.64**	**$ 7.44**	**$**	**8,619,942**			$ 2,154,985

Attachment 2

Facility Name	2019 Licensed Beds Per Survey or Ortherwise 2018 Beds per State	2020 Census	Lower Of Actual or Maximum Sq Feet Per Bed	FRV/PPD adjusted for 90% occupancy (fair rent/patient days)	Current Property Rate per Day	Difference per Day		Annual Hold Harmless Medicaid Impact (difference/day times medicaid days)
Eventide Fargo	98	34,282	950.00	$ 61.42	$ 67.60	$ (6.18)		$ (90,775)
McKenzie County Healthcare Systen	47	13,887	782.55	$ 51.95	$ 80.00	$ (28.05)		$ (169,360)
Miller Pointe - a Prospera Communi	120	42,592	841.49	$ 48.52	$ 54.25	$ (5.73)		$ (159,141)
Minot Health and Rehab LLC	114	21,904	377.72	$ 20.20	$ 27.09	$ (6.89)		$ (69,891)
Pembilier Nursing Center	37	12,996	600.97	$ 32.27	$ 37.97	$ (5.70)		$ (30,087)
Richardton Health Center Inc	28	9,590	584.46	$ 38.06	$ 65.54	$ (27.48)		$ (182,092)
St. Gabriel's Community	72	25,544	800.00	$ 46.30	$ 49.05	$ (2.75)		$ (34,972)
Valley Eldercare Center	196	66,052	661.89	$ 36.76	$ 38.33	$ (1.57)		$ (62,870)
	5,891	1,897,153						**$ (799,188)**

Attachment 3
NDLTCA
HB 1090
Fair Rental Value Calculations
- Hold Harmless Impacts

Estimated New Project with Full Replacement of a 100 Bed Facility

Year	2.5% Project Loan at 100% of Cost		5% Project Loan at 100% of Cost		6.5% Project Loan at 100% of Cost	
	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 54.21	$ 62.14	$ 75.94	$ 62.14	$ 89.03	$ 62.14
2	53.71	62.20	75.29	62.20	88.38	62.20
3	53.20	62.23	74.59	62.23	87.68	62.23
4	52.05	62.24	73.24	62.24	86.31	62.24
5	51.51	62.23	72.48	62.23	85.52	62.23
6	48.32	62.19	69.04	62.19	82.04	62.19
7	47.76	62.13	68.20	62.13	81.14	62.13
8	47.18	62.03	67.31	62.03	80.17	62.03
9	46.58	61.91	66.37	61.91	79.15	61.91
10	45.97	61.76	65.39	61.76	78.05	61.76
11	39.47	61.58	58.49	61.58	71.01	61.58
12	38.83	61.36	57.41	61.36	69.76	61.36
13	38.17	61.12	56.27	61.12	68.43	61.12
14	37.50	60.84	55.07	60.84	67.01	60.84
15	36.81	60.52	53.81	60.52	65.49	60.52

Year	2.5% Project Loan at 95% of Cost		5% Project Loan at 95% of Cost		6.5% Project Loan at 95% of Cost	
	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 53.13	$ 62.14	$ 73.78	$ 62.14	$ 86.21	$ 62.14
2	52.66	62.20	73.15	62.20	85.59	62.20
3	52.17	62.23	72.50	62.23	84.93	62.23
4	51.05	62.24	71.18	62.24	83.60	62.24
5	50.53	62.23	70.45	62.23	82.84	62.23
6	47.38	62.19	67.06	62.19	79.41	62.19
7	46.84	62.13	66.25	62.13	78.55	62.13
8	46.29	62.03	65.41	62.03	77.63	62.03
9	45.72	61.91	64.52	61.91	76.66	61.91
10	45.14	61.76	63.59	61.76	75.62	61.76
11	38.67	61.58	56.74	61.58	68.63	61.58
12	38.06	61.36	55.71	61.36	67.45	61.36
13	37.44	61.12	54.63	61.12	66.18	61.12
14	36.80	60.84	53.49	60.84	64.83	60.84
15	36.14	60.52	52.29	60.52	63.39	60.52

Specific Facility Holdharmless Estimates

- assumes zero new capital expenditure for both sides of the calculation

Missouri Slope, 6.625% Int Rate

Year	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 109.42	$ 62.43
2	109.28	62.49
3	108.67	62.54
4	107.12	62.55
5	106.43	62.54
6	101.93	62.51
7	101.14	62.45
8	100.30	62.37
9	99.40	62.25
10	98.43	62.11
11	89.72	61.93
12	88.62	61.73
13	87.45	61.49
14	86.20	61.21
15	84.87	60.90

Richardton, 3.5% Int Rate

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 61.71	$ 36.04
60.77	36.00
60.04	35.95
59.29	35.88
58.17	35.79
37.93	35.69
37.09	35.57
35.31	35.42
34.53	35.26
33.79	35.08
29.83	34.88
29.07	34.65
28.26	34.40
27.44	34.13
26.60	33.83

Miller Point, 3.0% Int Rate

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 50.01	$ 50.53
40.76	50.48
39.51	50.41
39.01	50.32
38.40	50.20
37.71	50.06
33.86	49.89
33.07	49.69
32.55	49.47
32.07	49.22
25.23	48.94
24.16	48.63
23.66	48.28
23.15	47.90
22.62	47.49

St Gabriel's,

Year	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 47.26	$ 40.36
2	46.13	40.24
3	44.53	40.11
4	42.62	39.95
5	41.42	39.77
6	38.72	39.57
7	37.23	39.34
8	31.29	39.09
9	29.75	38.81
10	27.49	38.50
11	25.68	38.17
12	24.21	37.81
13	22.66	37.42
14	21.04	37.00
15	19.33	36.54

Eventide

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 55.81	$ 56.62
54.16	56.57
52.98	56.49
50.95	56.38
46.01	56.25
44.75	56.09
43.27	55.91
42.05	55.69
39.90	55.44
35.06	55.16
33.72	54.85
32.28	54.50
30.78	54.11
29.11	53.69
26.90	53.23

McKenzie County

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 86.10	47.60
85.59	47.57
79.56	47.53
79.02	47.46
78.41	47.37
76.12	47.26
75.55	47.12
62.59	46.96
61.99	46.78
59.35	46.57
58.72	46.33
58.08	46.07
49.48	45.77
48.81	45.45
48.13	45.09

Valley Senior

Year	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 33.89	$ 39.55
2	29.70	39.49
3	24.02	39.42
4	21.44	39.32
5	19.36	39.21
6	16.81	39.07
7	15.47	38.92
8	13.96	38.74
9	12.48	38.55
10	9.89	38.32
11	8.37	38.08
12	7.68	37.80
13	6.56	37.51
14	4.98	37.18
15	3.36	36.83

Reier Thompson Testimony In Support of HB 1012 #3728
January 26, 2021
House Appropriations Committee – Human Resources Division
Harvest Room
Chairman Jon Nelson

Chairman Nelson and members of the Committee, my name is Reier Thompson and I am the President/CEO of Missouri Slope in Bismarck. I am testifying in support of HB1012.

Missouri Slope opened its doors 54 years ago as a retirement home. At this time, the residents were very capable of most of their needs. About one in ten residents required a wheelchair. Fast forward to today, one in ten do not require a wheelchair. In addition to wheelchairs, many of our residents need the help of mechanical lifts which we are required to operate with two caregivers. Residents are now using oxygen concentrators, electric lift recliners, electric lift beds, walkers, CPaps, BiPaps, IV and feeding pumps. All of these items compete for physical space in the resident rooms. Rooms that were not designed to handle this amount of equipment. It has gotten to the breaking point of becoming unsafe working conditions from overcrowding.

Our Skilled Nursing Facility is currently licensed for 250 beds and has approximately 170,000 square feet in total (attachment A). When divided this equate to 680 square feet per bed. The single resident rooms are approximately 214 square feet + another 27 square feet in the bathrooms. The double occupancy rooms are approximately 282 square feet + another 27 square feet in the bathrooms (attachment B). Unfortunately, residents who require the use of a mechanical lift are often unable to use their own bathrooms as they are too small to safely maneuver. These residents end up using a commode in their room or a larger bathroom in another part of the facility. This is not a good situation and is not what our seniors deserve.

The current pandemic has put a magnifying glass on Infection Control within Skilled Nursing Facilities. Having double occupancy rooms creates additional risk and has forced us to create safe spaces to isolate people when they are COVID pending, doing certain treatments, or even collecting COVID test specimens. This is a terribly inefficient use of space and our occupancy is artificially limited because of it. Additionally, the double occupancy rooms create uncomfortable situations for residents, families, physicians, and caregivers wanting to have private conversations. Even more uncomfortable and sad is during end of life situations for a roommate wanting to allow for and give extra space to the dying resident and their family members. The rooms are just too small.

Moving forward, we have designed a new campus with 192 private/single rooms and a total square footage of 224,000 square feet (attachment C). When divided this equate to 1,167 square feet per bed. The rooms will all be approximately 263 square feet + another 105 square feet in the bathrooms (attachment D). Bathrooms of this size will

allow residents and caregivers to safely maneuver as well as have a shower in their own room. The space in the room will allow residents to feel comfortable and have room for a visitor or two.

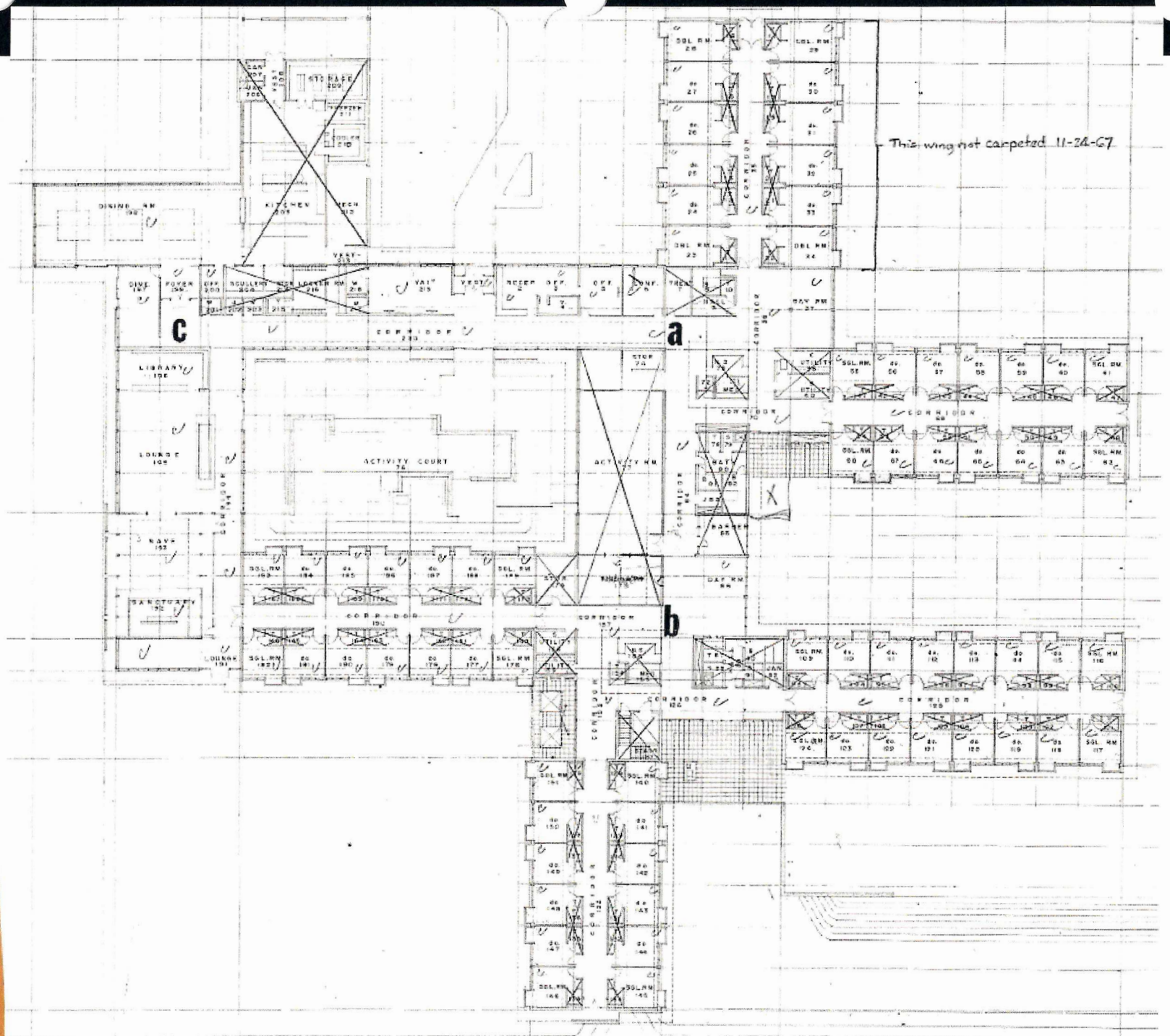
Not only are the rooms and bathrooms larger, more space has been planned for storage of emergency supplies, food, and equipment. We struggle to find space for important supplies at our current location. Additionally, our residents and families desire space outside their room. Our new campus will offer shared spaces attached to the households (nursing units). Sunrooms, living rooms, and a chapel are helpful in meeting the social, emotional, and spiritual needs of our residents. Meeting all our residents needs is required by CMS.

Our new campus has been slightly oversized in ancillary areas including the kitchen, laundry, maintenance, and supplies departments to accommodate future phases including basic care and independent living buildings. Had we not built these spaces this large, we would be closer to the 950 square foot target that is the subject of discussion. At any rate, we have learned over the past 54 years what works, what is required, and what is expected. Our new campus is being built to accomplish all of this and with a focus on safety and efficiency. For instance, bringing services to our residents such as showers and dining, rather than bringing our residents out to services will help keep our direct staffing levels in check. We will have more to clean and maintain, but the cost of doing so versus hiring more direct care staff to move residents around is less. We feel our new campus will be a model for the future of long term care in terms of efficient design and will help bend the cost curve.

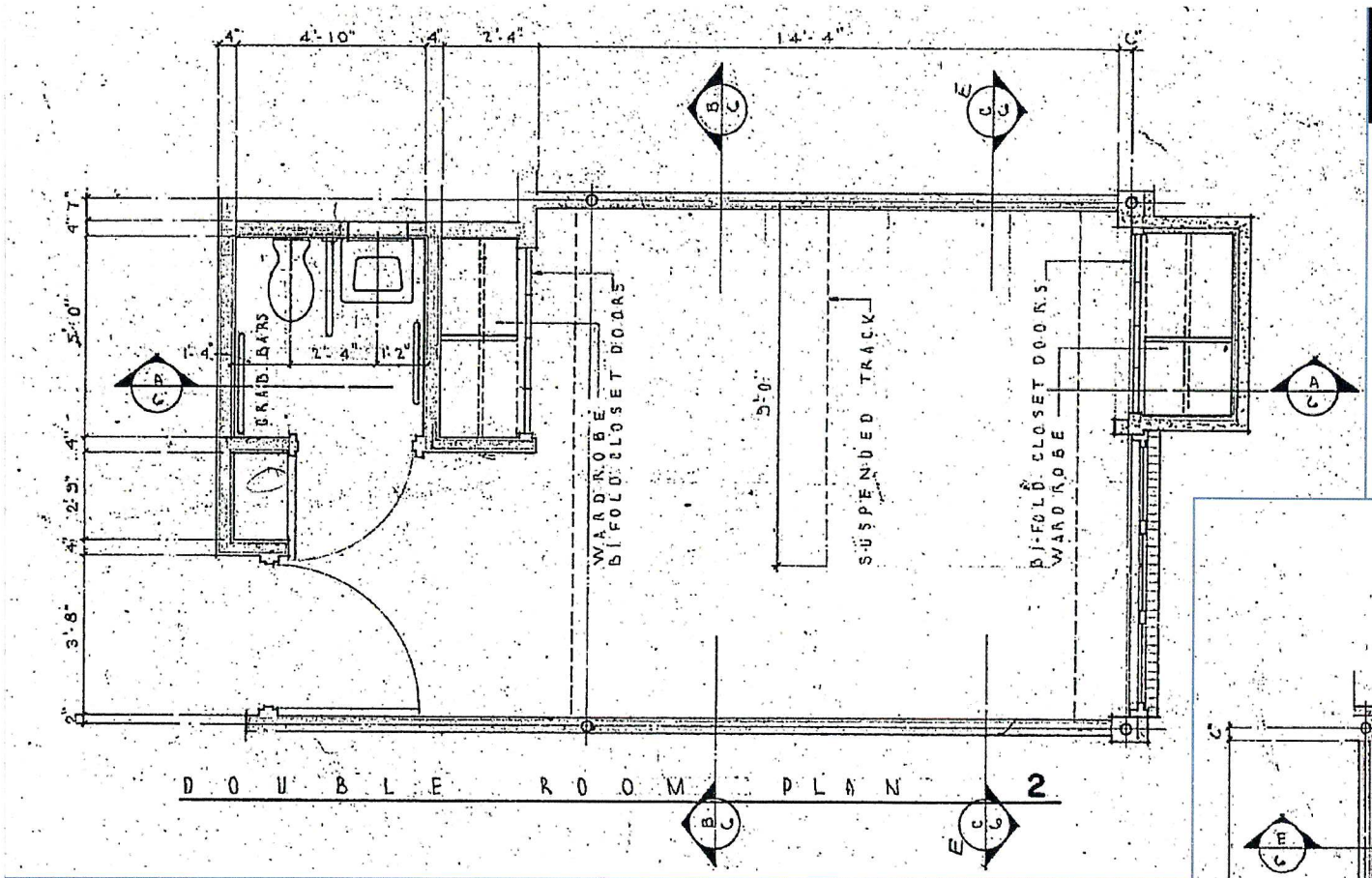
Thank you for the opportunity to testify on behalf of my organization and the North Dakota Long Term Care Association.

Respectfully,

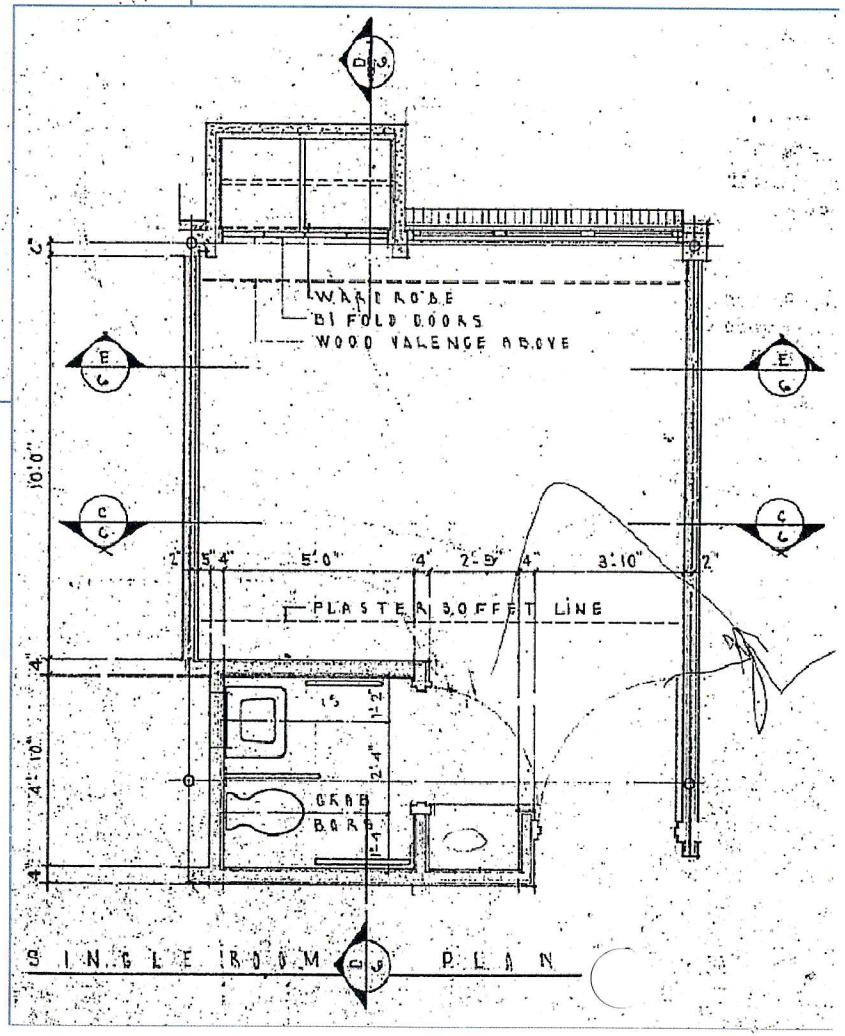
Reier Thompson, President/CEO



Attachment A: 1967 SNF Floorplan

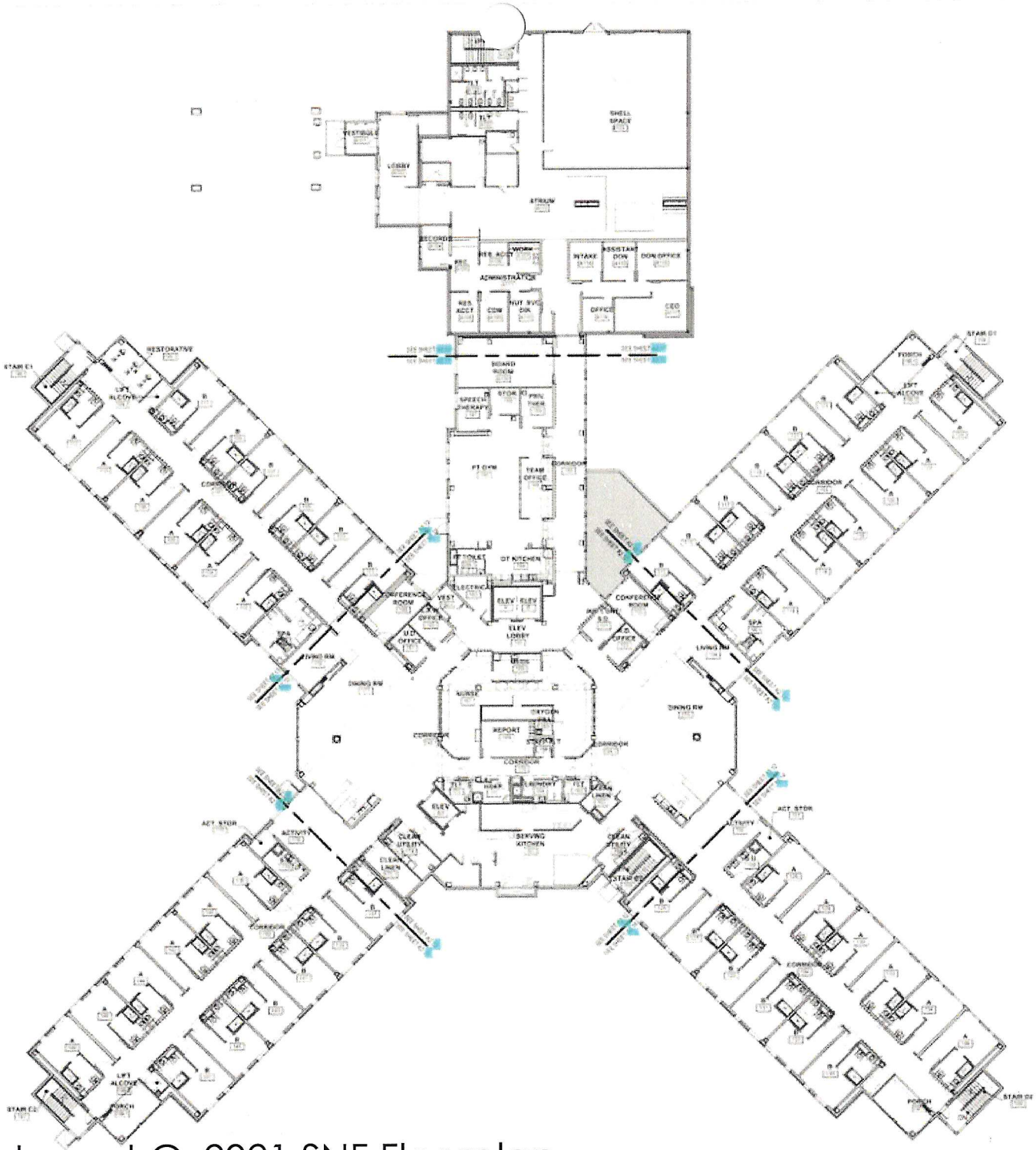


Single Room Size: ~214 sq/ft
Bathroom: ~27 sq/ft

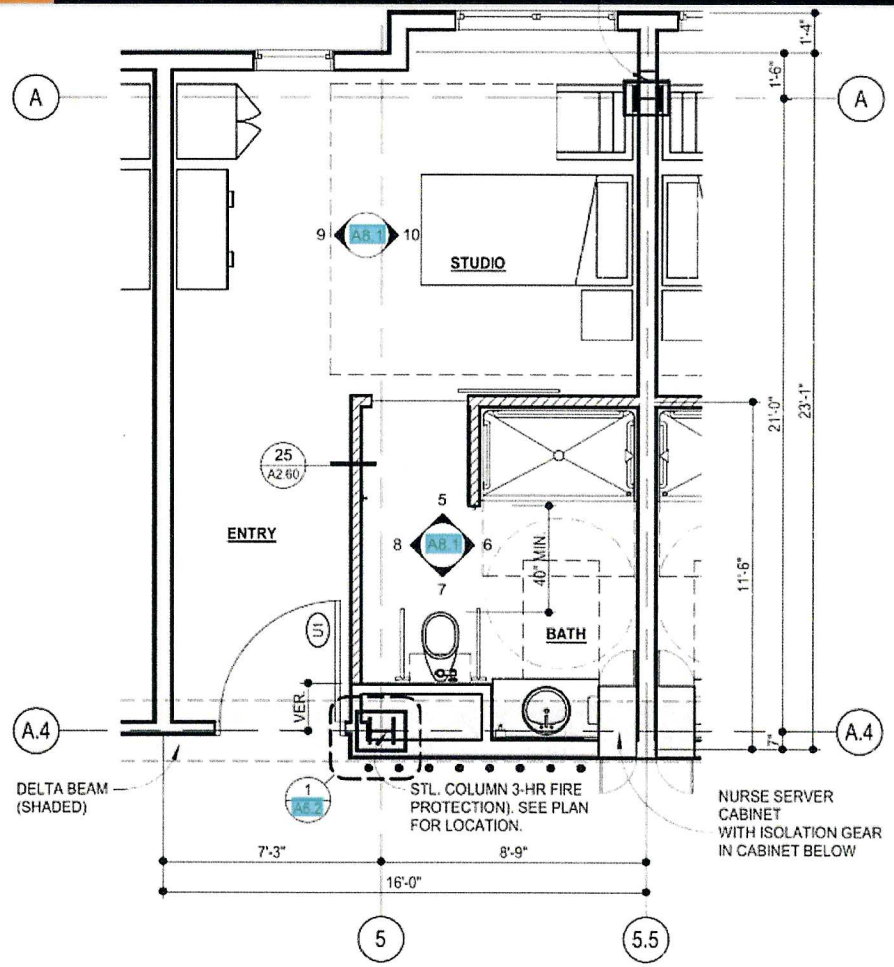


Double Room Size: ~282 sq/ft
Bathroom: ~27 sq/ft

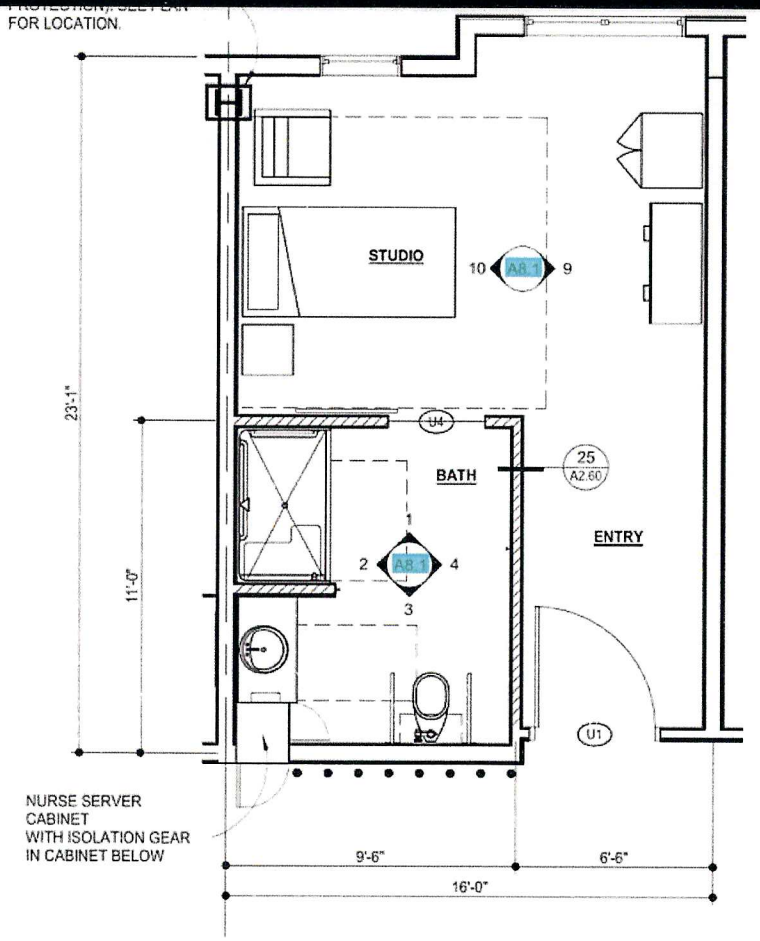
Attachment B: 1967 Room Design



Attachment C: 2021 SNF Floorplan



4 A2.60 UNIT PLAN B.1 (BEAM LINE)
1/4" = 1'-0"



3 A2.60 UNIT PLAN A.1
1/4" = 1'-0"

Room Size: ~263 sq/ft
Bathroom: ~105 sq/ft

Attachment D: 2021 Room Design

NORTHLAND PACE
Senior Care Services
Program of All-Inclusive Care for the Elderly

ND House Bill 1012

Ryan Bosch Executive Director

#3481 Lynn Grimm Chief Financial Officer

NORTHLAND HEALTHCARE ALLIANCE
a new direction in healthcare excellence

Northland PACE Statement

- In response to North Dakota HB 1012, specific to budget detail for PACE Program payment rate reductions, Northland PACE opposes the proposed HB 1012 budget detail specific to the PACE program and would like to further propose alternative appropriations

NORTHLAND HEALTHCARE ALLIANCE
a new direction in healthcare excellence

Problem Statement

- ND Department of Human Services proposes under HB 1012 a cost-based reduction payment change to the PACE program of 4.0% during 2021-2023 biennium
- Reduction change based on previous year profit margin at the time of reporting to DHS
- Cumulative sustained earnings not considered in determining rate change.

NORTHLAND HEALTHCARE ALLIANCE
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Problem Statement

- PACE program payment model is much different than that of long-term care.
- PACE receives capitated payment to manage and coordinate healthcare services to those needing nursing home level of care in their homes and in the community
- PACE does not receive payment/funding for property/facilities

NORTHLAND HEALTHCARE ALLIANCE
a new direction in healthcare excellence

Problem Statement

- Proposed cost-based payment change and normalization plan jeopardizes operational and PACE program growth and expansion
- PACE program is responsible for building financial reserve to self-fund expansion and investments
- Directly negates goals to expand healthcare options for those that wish to receive care at home

NORTHLAND HEALTHCARE ALLIANCE
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Proposed Alternative

- Northland PACE proposes the alternative to the currently proposed DHS cost-based payment rate reflective of profit margin to be rather based on MDS assessment model.
- Each enrolled participant is nursing home level of care screened, each with unique measurable and defined care needs.

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Proposed Alternative

- Proposed alternatives could include:
  - PACE specific MDS rates or
  - Establish % of average 40 rates per facility in particular zip codes
  - Northland PACE and DHS to partner in establishing MDS assessed model

NORTHLAND PACE
Senior Care Services
Program of All-Inclusive Care for the Elderly

January 26, 2021 #3482

North Dakota 67th Legislative Assembly
House of Appropriations Committee

RE: Northland PACE Program and HB 1012

Representative Jon Nelson and members of the House Appropriations Committee,

The Northland PACE Program has been supported by legislation and the state of North Dakota since opening in 2008. House Bill 1012 provides detail to the proposed budget changes under the Department of Human Services (DHS), to include the services of Northland PACE, also associated with long-term care payment reform. Testimony has been provided by members of DHS outlining details of these changes which involves a change reduction in payment rate to Northland PACE of 4.0% over the 2021-2023 biennium. These changes are based on the proposed cost-based payment methodology by DHS and to seek an optimal profit margin. Under the cost-based payment model, the premise is that the Medicaid rate will be adjusted (decrease as stated) and then monitored. If costs for services and/or operations are observed to increase, the rates may be increased to compensate. If costs for services and/or Northland PACE becomes more efficient operating, rates will be decreased but not to exceed the established minimum set by DHS. This proposed cost-based rate setting may be highly variable creating financial volatility. A meeting was held between Northland PACE leadership and members of DHS when it was announced these changes would be implemented January 1, 2021 and were based on current and previous year Northland PACE financial reports, specifically our profit margin. Cumulative sustained earnings over time were not reviewed to account for the cost-based rate change and rate setting into the future.

While the Northland PACE Program, long-term care facilities, and Home and Community Based Services (HCBS) do have similarities in the fact that they are supported and funded under the DHS budget, the Northland PACE Program is unique and considerably different than that of these other programs. The Northland PACE Program receives payment based on a risk adjusted capitated payment rate from both the state as well as CMS. The Northland PACE Program receives payment based on the level of care need for each participant and the PACE program then manages and coordinates the healthcare needs of the participant to ensure optimal health outcomes and reduced care costs. The more successfully we achieve these goals the more financially solvent we are which allows us to reinvest in the Northland PACE Program and further save state financial resources and increase access to those throughout North Dakota meeting nursing home level of care needs.

Given the capitated payment model, the Northland PACE Program incurs all financial risk associated with providing care services and operating as a PACE program which also serves as incentive for optimizing care outcomes and efficiencies of operating. Furthermore, the Northland PACE Program does not receive funding, like long-term care facilities, for property. These details demonstrate the rationale of why seeking an adjusted optimal profit margin by way of the cost based payment model do not fit the model in which the PACE program is designed to operate nor does the cost-based payment model adjustment allow for the PACE program to achieve growth and expansion. The cost-based payment model changes provide financial risk to the Northland PACE Program given care needs change rapidly for enrolled participants. Maintaining a financial reserve allows us to deliver all necessary services while focusing on opportunities for growth, expansion, and further investing in service improvement.

Additionally, funding reduction for the PACE program is also being proposed based on enrollment reduction goals. During previous testimony by DHS, it was stated that enrollment goals have historically not been met and therefore funding can be reduced as a result. Given the settlement between the state of North Dakota and Department of Justice and the strategies in place by DHS, Northland PACE is a program, among all other options under DHS, that is being provided as an option for all people of ND that screen for nursing home level of care. As Northland PACE is included in the Informed Choices and ADRL strategy along with additional internal growth measures, Northland PACE is positioned for continued growth into the future. The detail for the proposed budget accounting for enrollment should be proposed with the expectation that growth be realized thus assessing and appropriating budget support in response to enrollment growth.

The Northland PACE Program provides access to all-inclusive healthcare for adults 55 years of age and older, meet nursing home level of care, and to those that are able to and wish to remain living at home. Since July 2019, Northland PACE has undergone leadership change as well as significant operational and structural changes resulting in financial success in building financial reserves to invest in existing and projected future capital to include expansion to additional service areas. Reducing payment rates associated with the cost-based payment adjustment plan jeopardizes the ability for Northland PACE to provide adequate services, expand services to additional service areas (communities) throughout North Dakota. It further jeopardizes the ability for the PACE program to assist the state in being a viable option for North Dakotans to receive healthcare in their homes versus placement in long-term care facility options.

For consideration of the ND House Appropriations committee and DHS, Northland PACE leadership would like to propose alternative options for payment adjustment consistent with the PACE program model. In order to enroll in PACE, a potential participant is required to screen as “Nursing Home Eligible”. Considering this requirement, it only makes sense that PACE rates determined in a similar methodology to the MDS assessment model. Whether PACE Programs have their own set of MDS rates or are a % of average 40 rates per facility in the particular zip code, the MDS model would be a more objective and fair value approach to setting the payment structure for PACE Programs. Similarly, to a certain degree, Medicare rates are established

based on the frailty of participants which is determined by the diagnosis of each participant. This change in the method of payment at the Medicaid level would require a joint effort between the PACE Program and Department of Human Services in order to establish a concrete structure.

Developing an MDS payment model for PACE Programs in ND would not only provide an objective approach to rate setting, it would also assist in providing an objective tool to determine those individuals best suited for the PACE Program or other care options. It would provide means to the SNF to refer those residents who are on the cusp of institutionalization but are still eligible for independence to receive the care necessary to stay in their homes

Submitted respectfully,

_____	_____
Ryan Bosch, CEO	Lynn Grimm, CFO
_____	_____
Date	Date

Testimony on HB 1012
2021 Legislative Session
January 26, 2021
Rep. Nelson, House Appropriations Chairperson

Chairman Nelson and Members of the Committee, #3436

My name is Lynne Ostrem. I wear numerous hats with concerns of HB 1012.

- I have an adult son, David, with a Traumatic Brain Injury.
- I have been David's Guardian and Conservator and responsible for completing the applications for services with DHS since 2012.
- I worked with Senator Mathern, Royce Schultze (DCLI), Representative Anderson and Stacie Dailey (DHS) to set up By Laws and legislation for the ND Brain Injury Council.
- I worked with Representative Anderson to pass legislation to study the use of Hyperbaric Oxygen Therapy for individuals with Traumatic Brain Injury.
- I started a QSP Agency to provide services to Brain Injured individuals.
- I worked with others to form the "North Dakota Brain Injury Advocates" a Non-profit organization.

A common statement in the Brain Injury World is "No 2 brain injuries are alike". There are a number of medical studies, journals and papers where you can find evidence that brain injured individuals can make gains with rehabilitation years after their injury. The gains may not be as dramatic as the initial year but functional gains are noted.

Brain Injury Association of America – March 21, 2017 "Brain Injury Rehabilitation Outcomes"
The National Association of Insurance Commissioners defines rehabilitation as:
"Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."

Although earlier access to post-acute rehabilitation is associated with greater gains and overall cost reduction, later rehabilitation also results in significant functional treatment gains and reduced costs, even many years after injury or for those patients who have an overlay of psychiatric or behavioral issues.

BrainLine; Institute of Medicine. 2011 and Reviewed July 26, 2018
Cognitive rehabilitation therapy may be like the proverbial elephant — it feels different to different people depending on their circumstances and perspective. But, as patients and families will attest, CRT is as fundamental a need in TBI recovery as physical rehabilitation — and for some, even more essential to their quality of life.

David's disability necessitates the use of many services. Most of those services are in different silos within DHS. We have used North Central Human Services, Medicaid, Behavioral Health, Aging Services, Vocational Rehabilitation, and Economic Assistance.

Each one of these services involves a different application and verification of all expenses. Since 2012, I have filled two - 18 gallon totes with files of DHS related paperwork with applications, appeals and legal action that needed to be taken for David to receive the services that are valid and available according to the DHS manuals and the North Dakota Administrative Code.

I have been listening online to DHS personnel testimony this session concerning HB 1012. I have heard several times that some departments have funds still remaining. When I hear that comment, from a consumer/advocate standpoint, my question is, "Why are there remaining funds?"

I can tell you from my son's experiences and trying to access services, it has not been an easy adventure.

When we tried to access services with North Central Human Services we were told there was no one that specialized with brain injury. When we tried accessing services with Vocational Rehabilitation, I found the "job" for David, but there were no consistent options for job coaches that would work with a brain injured individual so between the employer and David we turned it into a volunteer position and I made sure someone was with him and supervised him.

I have requested various services for David and told either he was not eligible for services, or there were no services in ND so "DHS" will not list it on the Care Plan.

David and I met last week with his case manager and requested cognitive therapy or behavioral therapy added to his Care Plan. It was not added. The case manager said she would check on it and let us know. DHS only wants services that you are actually using put on the Care Plan. Every time you add or take something off the Care Plan, there is a Case Management Charge of $131.42 in David's case.

There are a number of cases like this that I could point out but I don't think we have the time. From past experiences, it is not very easy to access the services you as a Committee are allocating money for. The current system is not very "user friendly" and I would venture to say that most people give up. I on the other hand, am part Polish – (no offense meant).

I understand that there may be some that label me and others that advocate for loved one as “problem people”. Please understand, we are human and we are struggling to get services for our loved ones in a system that is very difficult to navigate. Many times the first response we receive from DHS personnel is “No”. We are forced to take the next step to continue to find a way to receive services. I feel it is only through this process of giving our personal testimony that we can change the system to hopefully make it more user-friendly.

There are limited residential options for the brain injured population in North Dakota. The 2 specialized skilled nursing homes are always full along with a wait list. The Nursing homes are not interested in admitting a young “mobile” brain injured client because the rate of reimbursement does not allow for the specialized care required.

Brain Injured individuals can access Transitional Living Services through the HCBS waiver. This service has to be provided by a licensed QSP agency.

In 2016 I believe there were only 3 QSP Agency that offered this service. All 3 of them had limited staff and were not willing to take on an additional client. This put me in a position where I felt like there was no other option but to start a QSP agency to provide transitional living services for my son. I have found barriers for QSP agencies to provide quality care with the rate of reimbursement is almost parallel to the barriers for consumers looking for services. QSP agencies are required to have employees complete a Document of Competency and training. These expenses are bore by the Agency without reimbursement. It is recommended that new employees “shadow” a seasoned employee that understands the client to ensure the best possible care. Those costs are not reimbursable. My average costs to “train” an individual are approximately $3,000.00. That amount is not reimbursable. I have questioned Nancy Meier about the possibility of QSP Agencies being reimbursed for administrative costs or training but was told that it was not possible, DHS is only allowed to reimburse for “face-to-face” units.

Another financial hindrance is the unit rate of pay for Transitional is reimbursable only when there is “face-to-face” engagement with the client. If I have overnight staff at his house, my billable units stop when he goes in his bedroom at night. I continue to pay staff at an overnight rate that I cannot get reimbursed for.

For overnight staff to be reimbursable I would have to add Supervision on to the Care Plan and the agency rate of pay drops to $9.96/hour with the condition the staff is required to stay awake. I will admit, I didn't try to add that to the Care Plan.

From my understanding, the December 2021 DOJ agreement with DHS has a timeline where individuals are suppose to be transferring out of the institutional setting and into community. There are already limited QSP Agencies in the state. I have talked with many of them and it is a reoccurring problem – lack of employees to meet the workload. From my perspective, the current program that is set up for licensing QSP agencies is going to make it very difficult to meet the increasing needs of individuals looking for Home and Community Based Services because of the DOJ settlement.

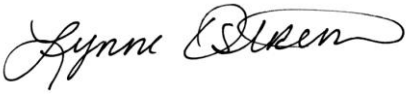
I'm not sure what the process would be to get help to cover some of the QSP Agencies' administrative costs, training costs or increase the rate of pay. I have reached out to North Dakota Association of Community Providers for assistance. The Director, Bruce Murry, has been very helpful and has reassured me that I am not the only one with this dilemma.

This past year, I have found 2 great organizations that I have relied on for resources. Family Voices have hosted several informational Zoom meetings that have been very beneficial for me and my son. There are resources and supports on their website that can be used for a wide variety of consumers.

The other is Protection and Advocacy. Teresa Larsen has done an outstanding job keeping those of us informed as to the legislative happenings and any updates. I have needed to use the Advocacy services in the past and it is helpful to know they are there.

I respectfully submit that you reconsider and replace the funds that were cut from their budget. The support and guidance they offer to all families dealing within this system is something we need to rely on to help us.

Thank you for your time and your consideration in these matters. If you have any questions I would be happy to try and answer them.



Lynne Ostrem
(701) 208-1051

Testimony Prepared for the
House Appropriations – Human Resource Division
January 26, 2021
By: Kim Jacobson, Agassiz Valley Human Service Zone Director
#3222

RE: House Bill 1012 – DHS Budget related to Human Service Zones

Chairman Nelson and committee members, my name is Kim Jacobson. I am the Agassiz Valley Human Service Zone Director, serving the service area of Traill and Steele Counties, a member of the North Dakota Social Service Director Association, and a member of the North Dakota Association of Counties Board of Directors. Please consider my testimony in support of HB 1012 and the amendment brought forth by the department.

The last two years have brought many changes for the local human service delivery system. At the end of the 66th Legislative Assembly, county social service agencies and the department together began a fast-paced path towards the formation of human service zones. The teamwork and collaboration leading up to the 66th assembly provided groundwork for system redesign, visioning, and goal setting. However, planning and doing are two very different things.

Today, I am pleased to report that we have together transitioned to 19 human service zones. We have accomplished many great things, including: developing, negotiating, and entering into human service zone agreements and operational plans; combining county-based workforces into human service zone teams; leading the transition to human service zone board structure; developing innovative service and management collaborations between zones; transitioning locally administered services allowing zones to still meet the unique needs of local communities; developing and launching unified human service zone personnel policy which supports merit system/federal/state law compliance while providing opportunity for locally unique policy when appropriate; transitioning the legal custody of all foster children to the human service zone director; and restructuring to a consistent fiscal coding, management and budgeting system. As alluded to last week during the department's testimony, we have created many elements of a well-designed and even frosted cake.

It is recognized that the transition to effective and efficient state/human service zone team will take at least eight years. While we have accomplished a lot of initial and visual steps, it is important to note that we are just **one year** into the human service zone and state team system during a time we have also been dealing with COVID19. Our team-based approach is a strong example of government innovation. However, the operational side of service delivery is very complex. Building a responsive state/zone team system is unchartered territory. Working as one with shared decision-making and accountability while demonstrating local responsiveness is hard work that requires time, attention, and nurture. This is critical to continued success and for responsive services for citizens. However, as you know, adequate funding is key to providing service.

Last session's SB 2124 was a comprehensive and sizable bill. I am very grateful for the support of the legislative body from both an appropriations and policy perspective and the investment in local human service delivery. I also express appreciation for the support of the vision - *a state and local team* - working together in a hybrid model of structure. This allows for unique local need to be met, voices to be heard, and a nimble, local response as we work together to provide system effectiveness, efficiency, and quality.

With any system's change it takes time. It was anticipated that there would be need for technical changes, intent clarifications, and parameters for next steps. Therefore, as expected through this year's legislative budgeting process we have learned many lessons. We have learned that there are some financial issues that need to be addressed so that human service zones can continue to effectively serve the entire state. It is important to address the budgetary issues now or the cake that we have worked so hard to prepare will be missing big pieces and there will not be enough to serve those in need across the state.

Our Lessons Learned:

Initial base funding shortfall:

The approved appropriation for human service zones in 2019 biennium was ~$10 M short of necessary levels to support local human services. Efforts to redesign programs, especially economic assistance programs, was delayed because of the COVID19 pandemic. The benchmark of 985 FTEs for human service zones was not an accurate projection to base funding for our current system and the phase of the redesign process. As prior biennium

approved budget levels are used to base the next budget, we face a critical and concerning trajectory.

HB 1012 compounds this budgeting concern as it was built off the 2019 biennial budget. We started in with a $10M deficit. Luckily, when human service zones formed on January 1, 2020, most zones had a reserve fund balance. However, the department projects that 100% of the reserve funds statewide will be depleted by July 2022.

The department's amendment for $9M in uncovered need and $3.4M in 2/2 salary adjustments will not erase the impact of the $10M shortfall in 2019 and the impact of this shortfall on 2021 budget base. The amendment also will not prevent full depletion of all human service zones reserve fund balances.

Human service zones provide critical safety net services to North Dakotans. In essence, no human service zone reserve fund balance means the safety net will no longer have a financial safety net. The department has reassured us that they are legally and morally committed to ensuring adequate funding of human service zone services. However, even with this reassurance, it is very concerning especially as we are so early in our new structural model and will soon have no reserve fund balances. Due to this trajectory, we are faced with uncertainty about how current and future needs will be met and how local access points and services will be preserved to meet the needs our vulnerable citizens.

Looking forward, it is important for the legislative body to understand that unless the budget is passed as requested with the addition of the department's amendment plus additional funds to offset the full depletion of human service zone reserve balance funds, the 2023 budget request will be significantly higher than the 2021 request. If not, critical services may be lost. Simply said, there will not be enough cake to go around. Plus, the 2023 cake will need to be much larger and/or prepared as a multi-layer cake.

Salaries, Benefits, and Equity:

For 2021, 89% of the approved Agassiz Valley Human Service Zone budget is salary and benefits. For many years, social service employee salaries have been subject to the state classified merit system and salary ranges. The only real changes now are the legislative body determines our annual salary adjustment and the department authorizes any new or vacant position fills and agrees upon salary set points. Salary adjustments for most human service zone team members equaled 0% in 2020 and up to 2.5% in 2021.

We learned through the introduction of HB 1012, that there was not a mechanism to include human service zone team members with the state employee salary requests in the OMB budget. One of the reasons for this omission was a lack of clarity on how human service zone team member salary adjustments should be requested within the state budgetary request system. The amendment introduced by the department, aims to correct this omission. I urge you to adopt this amendment. Also, I encourage legislative intent to address the process for requesting and bringing forward human service zone team member legislatively authorized salary increases to prevent future inadvertent omissions.

Another lesson learned is the scope and impact of health insurance package disparity within the human service zone system. For example, a family health insurance policy for Agassiz Valley Human Service Zone team members costs employees over $1000 per month out-of-pocket. Meanwhile, our neighboring zones and state agency, who we compete with for hiring and retention, have much more robust benefit packages. As we move forward, we realize that both salary and benefits need to be looked at in a comprehensive manner to provide a level of equity but also to prevent service deserts. Adequate base funding is necessary for the system to work as one. Budgetary flexibility is also key so that funds, upon availability can be redirected to meet identified need.

During this legislative assembly, *SB 2086* – a policy bill – seeks to address policy points and clarify legislative intent regarding a variety of items including equity, indirect costs, roles and responsibilities, county "*skin in the game*", and other items. There is a current workgroup, in which I am a member, that is working on amendments to provide critical policy clarifications. This is also an important piece of the cake.

Today, I respectfully ask you to ensure adequate funding for local human service zone services and to support our workforce in the provision of those services. Adequate funding is critical in meeting the needs of our citizens and to support the property tax relief efforts gains through our systems change. Also, funding is key to support the ongoing redesign efforts as we work together to achieve additional system improvements. With adequate funding and solid policy, our cake will be large enough and designed well to serve those in need.

Thank you for this opportunity to provide testimony regarding HB 1012. Questions from the committee are welcomed.

Testimony for Senate HB 1012

Senate Human Services Committee #3171

January 26, 2021

Chairman Nelson and members of the House Human Resource Division of the Appropriation Committee, I am Steven Reiser, Director of Dakota Central Human Service Zone. I am also a member of the North Dakota Human Service Zone Association. Please accept this testimony in favor of HB 1012.

The counties of McLean, Mercer, Oliver and Sheridan formed a social service district in 2006 and started operating as district on January 1, 2007. The mission of the district was to provide a better service to the county residents and when possible lower costs. In 2007 Dakota Central employed 36 staff. At the end of 2019 Dakota Central employed 31 staff. There can be cost savings and efficiencies found when counties join together but it takes time. Even though caseloads have grown from 2007 Dakota Central is able to employ fewer staff. If you look at 2020 staff numbers Dakota Central is down to 25 staff because of 4 staff transferring to state employment and reducing two more staff.

Zones have done a lot in one year and are working hard to improve services and find efficiencies but there has to be financial stability to the achieve kind of improvements we all hope for.

I support the amendments that the Department of Human Services has proposed. Using all of the reserve funds that zones have now to replace the dollars that the zone budget is short for the last biennium and not fully funding zones this biennium could cause a reduction in service and make good thoughtful cost savings very difficult.

Zones want to improve the services they provide at the grass roots level and they are willing to work together to be more efficient in this delivery. They need the funding requested by the Department of Human Services to make it happen.

Thank you for allowing me to testify and I would answer any questions you might have.

Testimony Prepared for the
House Appropriations – Human Resources Division
Tuesday, January 26, 2021
By: Terry Traynor, NDACo Executive Director #3144

RE: House Bill 1012 – DHS Budget/Zones

Chairman Nelson and committee members, thank you for the opportunity to briefly address you regarding the ongoing process of social service redesign and the budget to support the Human Service Zones across the state. Zones, and particularly zone employees, are very literally the boots on the ground for delivering so many of the state funded services critical to our most vulnerable North Dakotans.

I want to preface my testimony on the bill by thanking this Committee and the Legislature for passing the redesign enabling legislation, and funding, last session, as well as DHS staff and the many county officials – zone directors, county auditors, state's attorneys, and commissioners – that have devoted so many hours to implementing this monumental change. My conclusion is that the transition, thus far, has gone well considering the short amount of time that we have been at this, but it is not without its difficulties. Some of which are fiscal and will ultimately be addressed by HB1012.

First and foremost, counties very clearly support the funding requested for Zones in the base budget and the critical additions identified by the Department. I think it is important to note that these funds support not just zone employees, but also all former county and zone employees transferred to state employment through the various redesign initiatives – all of which became, and continues to be, property tax relief. As proposed, this will be the third biennium that the Legislature has set aside $200 Million in oil tax revenue specifically to make this redesign successful, and thus far, significantly less has been requested and appropriated.

While efforts have been made since formal zone formation, barely a year ago, to achieve some degree of compensation equity, for many employees this goal has not been met. As some zones require much greater employee share for benefits, it has been, and will continue to be, challenging. Obviously, if the Department is not

provided with sufficient funds to address inflationary costs of salaries and benefits – treating zone budgets similarly to DHS division budgets – this concept collapses.

Because the Property Tax Relief Fund transfer as proposed in HB1012 is insufficient for fully funding the zones, the budget anticipates spending over $15 million in zone reserves (exhausting all reserve accounts in one biennium). These reserves were largely built up over many years. They, very honestly, include some state reimbursement, however, they are largely dedicated social service property tax levy funds. We are a team – state and county – working together and pooling our resources to make human service redesign work, but the perception that property taxes (although clearly collected specifically for human service purposes) will be used as a one-time harvest to offset state general fund dollars is difficult for many zone board and county commission members to accept.

I recognize that reserve funds should not sit unused indefinitely, and the legislature has mandated that DHS fund the human service delivery needs – by transfers from other divisions if necessary – many local officials are (after barely a year) unsure about the potential emergency needs that DHS may not be able to fund, or fund immediately. I also recognize that not utilizing those reserve funds would make your job significantly more difficult, but I must raise this issue as those perceptions exist. Possibly consideration could be giving to reserving a small amount in each Zone, as we gain more experience as to its need.

A final point I wish to address is the meager offset to the property taxes supporting the indirect costs of human service zone support. I thank the Department for budgeting to continue the partial funding at the same level as 2016, but only wish to point out that the costs of space, utilities, janitorial, insurance, IT support, state's attorney salaries and benefits, and all the rest are not stagnant. Over the past five years the property tax burden for these costs has continued to erode the "relief" you as a legislature have provided. This is becoming critical for the counties that have reached their 60-mill general fund limit. DHS, zones and counties are working to analyze and hopefully better standardize how these indirect costs are identified and I sincerely hope we can present a better picture of this property tax supported piece of the puzzle before you adjourn.

Thank you again for the opportunity to address this important bill.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/27/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 8:31 a.m.

Discussion Topics:

- Health Policy Consortium
- Altru Health Systems
- Bismarck Mandan Chamber EDC
- Older Individuals Who Are Blind (OIB) Program Appropriation

Tim Blasl, President of the North Dakota Hospital Association (8:32 am) testified about NDHA #3478 #3479

Michael LeBeau, M.D (8:47 am) testified about the Health Policy Consortium, a healthcare advocacy group that includes Trinity Health in Minot, Altru in Grand Forks and Sanford Health in Fargo and Bismarck #3261

Mike Delfs, President/Chief Executive Officer (9:15 am) testified about the Jamestown Regional Medical Center #3366

Dave Molmen, CEO (9:28 am) testified about Altru Health Systems #3420

Courtney Koebele, Executive Director of the North Dakota Medical Association (9:58 am) testified about the North Dakota Medical Association #3491

Kurt Snyder, Exec. Dir (10:01 am) testified about the Heartview Foundation #3480

Brian Ritter, President the Bismarck Mandan Chamber EDC (10:12 am) testified about the President the Bismarck Mandan Chamber EDC #3341

Jack Mcdonald, AHIP(10:15 am) testified about health insurance, oral testimony

Lorena Poppe, Owner, Poppe's Promise (10:18 am) testified about Poppe's Promise #2499

Allan Peterson, OIB (10:28 am) testified about the Older Individuals Who Are Blind (OIB) Program Appropriation within HB1012. #3458 #3459

Heather Simonich, Operations Director of Nexus-PATH (10:33 am) testified about the Medical Services budget, relating to the equalization of Targeted Case Management (TCM) rates #3274

Dr. Rosalie Etherington, Chief Clinic Dir, NDSH Superintendent (10:56 am) testified about the state hospital #3828 #3829

Chair Nelson closed the meeting at 12:01 p.m.

Cole Fleck, Committee Clerk

Senate Bill 1012

House Appropriations
Human Resources
Division#3478

NDHA
North Dakota
Hospital Association
Est. 1934

Overview Today

- **Medicaid Expansion**
  - Hospitals support HB 1012

HB 1012

- Thank you for supporting Medicaid Expansion
  - Reauthorizing the program every session
  - Supporting the current reimbursement rates

HB 1012

- **Benefits of Medicaid Expansion**
  - 24,000 individuals receive health care coverage
  - Health outcomes improve
    - individuals receive care on a regular basis
    - chronic conditions are managed
      - Ex. diabetes

HB 1012

- **Benefits of Medicaid Expansion**
  - Uncompensated Care
    - reduced by nearing 50% ($150 million per year)
  - Prevents cost shifting to other payers
  - Maintains access to health care in rural communities

Medicaid Expansion

- **Governor's Executive Budget 2021 – 2023**
- Reduces hospital/physician Expansion payment rates to traditional Medicaid rates
- Payment rates reduced by 40% - 50%
- Annual negative impact = <u>$100 million per year</u>

Medicaid Expansion

- **Rural Hospitals**
  - Medicaid Expansion payments $31 million
  - Proposed Cut $12 million
- **Urban Hospitals**
  - Medicaid Expansion payments $165 million
  - Proposed Cut $88 million
- **Total Reduction** **$100 million**
- Includes physicians

Medicaid Expansion

- **Impact of removing $100 million per year from provider payments.**
  - Reduced services
  - Job reductions
  - Access to care – hospital closures
  - Cost shift – increase insurance premiums

Conclusion

- **Why current Medicaid Expansion rates are good for ND?**
  - Maintains stability in our healthcare system
  - 90% federally funded/10% state funded
  - Traditional Medicaid rates don't cover the cost of providing care.
  - Provides access to care
  - Limits cost shift to other programs/payers (commercial)

Questions

- Tim Blasl, President
- North Dakota Hospital Association
- tblasl@ndha.org

2021 HB 1012
House Appropriations Human Resources Division
Representative Jon Nelson, Chairman
January 26, 2021

Chairman Nelson and members of the House Appropriations Human Resources Division, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to testify in support of House Bill 1012. I ask that you give this bill a **Do Pass** recommendation.

Medicaid (Traditional)

Medicaid payments play an important role in hospitals' finances, which can affect beneficiaries' access to care. Like other public payers, Medicaid payments do not cover the cost to the hospital of providing the care, resulting in payment shortfalls. Adequate provider payment rates help to ensure improved outcomes and access to necessary medical services for the people who rely on Medicaid to get their health care.

Medicaid Expansion

Medicaid Expansion was designed to significantly reduce the number of uninsured and improve their health by providing access to routine health care and preventive screenings. Covering about 24,000 North Dakotans, Medicaid Expansion has been very good not only for patients, but North Dakota communities and health care providers as well. The federal government pays 90% of the cost. This requires the state to pay only 10% – considerably less than the 50% the state pays for traditional Medicaid enrollees. Before the program was authorized, North Dakota hospitals' bad debt and charity care rose from $102 million in 2008 to $274 million in 2014—a nearly threefold increase. Thanks to Medicaid Expansion, hospital bad debt has dropped by nearly 50 percent. This significant decrease in uncompensated care has contributed to positive operating margins for a number of our hospitals.

We support reauthorization of Medicaid Expansion at the rates that were appropriated last session. We are not asking for an increase. We are simply asking that current rates – rates that have been in place with no increase since 2014 – be maintained. The cut being proposed by the Department of Human Services (Department) represents a reduction of $100 million annually to hospitals (acute care hospitals). It makes little fiscal sense to cut $10 million in general funds and lose the corresponding $90 million in federal funds which amounts to an approximately 45 percent cut in hospital reimbursement.

The federal share for Medicaid Expansion is a nine to one return on investment. It provides dollars that flow directly into local communities, supporting wages, employment, consumer spending, and state tax revenue. It is critical to covering operating costs at our hospitals and clinics, the loss of which will result in staff cuts and closed facilities.

It has also been proposed to move administration of the Medicaid expansion program away from a private carrier and to the Department. We feel the administration of the Medicaid expansion program by a private carrier has worked well and our members would like to see that continue. Hospitals are concerned with the ability of the Medicaid Management Information System (MMIS) to handle this change. We are also concerned with the FTEs that the Department is requesting to add in order to administer Medicaid Expansion and that they will not be sufficient to provide the strong managed care being provided by the current private carrier.

Medicaid – Value-Based Purchasing

NDHA supports a collaboration between the State and hospitals to design a Value-Based Purchasing model that will create incentives that encourage enrollees to take personal responsibility for their health, provide program cost certainty, and support practice innovations that further the objectives of efficient, patient-centered care delivery.

Conclusion

In summary, hospitals treat and care for the citizens of North Dakota in a variety of settings and at a number of locations. Services must be provided 24 hours a day, seven days a week, 365 days a year, and the competition for employees has been raised to a new level. I ask that you support reauthorizing Medicaid Expansion at current reimbursement rates, maintain

administration by a private carrier, and providing for a partnership model between the State and provider organizations to implement a Value- Based Purchasing model.

For these reasons, we support HB 1012 and ask that you give it a Do Pass recommendation. Thank you. I would be happy to address any questions you may have.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

SANFORD HEALTH

House Appropriations Human Resources Division Committee
Rep. Jon Nelson, Chair
Jan. 26, 2021
HB 1012 #3261

Good afternoon, Chairman Nelson and members of the committee. My name is Michael LeBeau, M.D., and I serve as President for Sanford Health's western North Dakota region.

I am here today representing the Health Policy Consortium, a healthcare advocacy group that includes Trinity Health in Minot, Altru in Grand Forks and Sanford Health in Fargo and Bismarck. Collectively we provide 80 percent of the acute healthcare services in North Dakota.

Let me begin by thanking each of you for your support and your leadership. North Dakota's lawmakers are a frontrunner in making decisions important to providing uninterrupted care for the patients we serve. I raise up your decision to leverage federal funding for North Dakota's Medicaid Expansion program. While other states struggle through hospital closures and shrinking access to care, North Dakota's hospitals are supported by sound policy decisions and innovative financial investments.

As you know, North Dakota's healthcare system has the unique challenge of delivering care in one of the most rural parts of the country. We provide the same advanced medical services offered in urban areas, competing for the same medical professionals and investing in the same technology—the two biggest drivers of healthcare costs—all while serving a much smaller population. While we lack the advantage of economies of scale in urban areas, you have helped us maintain a healthy healthcare ecosystem necessary to keep healthcare services close to home.

It is what prepared us for the healthcare emergency that has tested healthcare systems across the country. While we are still working our way through the COVID pandemic, it's important to recognize North Dakota's healthcare system has been strong from day one and has successfully handled COVID-19 patient surges arguably better than other states who have had to ration services. By working together, North Dakota hospitals created access to safe,

high-quality hospital care for more than 3,700 critically ill COVID-positive North Dakota. During the last surge, when every available hospital bed in the state was being used, we found new beds and staffing by leasing additional space and hiring every contract nurse we could find. We leveraged our system affiliations to acquire necessary personal protective equipment (PPE), invested in testing equipment and supplies when the State Lab's productivity was bottlenecked and we redesigned the way we provide care, increasing the use of telemedicine by nearly 1000%.

Today we are leading the country by treating high-risk COVID-positive patients with outpatient antibody infusions that help reduce hospital admissions and save lives. We are also leading the country in administering COVID vaccinations.

I'm sharing this information to both thank you for helping us meet the challenge and to frame my comments regarding Medicaid Expansion. The decisions you have made to support North Dakota's healthcare system by making fair policy decisions and by leveraging federal dollars for sustainable Medicaid Expansion rates are key to maintaining our rural delivery system. Medicaid Expansion has helped us recruit and retain workforce, provide innovative behavioral health community services, invest in critically needed capital improvements and stand ready in the face of worldwide pandemic. We could not do this without your leadership and support.

Before I wrap up, I'd like to briefly discuss the Governor's proposal to reduce Medicaid Expansion rates. It has been suggested that paying North Dakota healthcare providers a different rate for those covered by traditional and those covered by Expansion is not fair to healthcare providers. That statement is false.

Different reimbursement rates for the same service is a standard practice in healthcare, not the exception. Hospitals receive many different payment rates from many different payors. Some pay more, some pay less. The only point that matters is at the end of the day is that the collective rates equal more than the cost of the care. Traditional Medicaid does not nearly cover the cost of care. Medicaid Expansion rates do. Collectively, Traditional and Expansion payments are still slightly less than the cost of care, but expansion payments – which have a 90% federal match rate – are tremendously helpful in offsetting costs that would otherwise be shifted to private health

insurance. Lowering Medicaid Expansion rates to Traditional Medicaid rates does not fix a problem for healthcare providers, it creates one.

In closing, I cannot overstate the stability Medicaid Expansion in its current form has provided. Leveraging Medicaid Expansion's 90 percent federal match to offset underpayments from Traditional Medicaid is both innovative and strategic. Without it, hospitals will need to reduce services, reduce staffing and, in some cases, close their doors. And businesses will be left to bear cost-shifting that will inevitably increase insurance premiums. HPC supports HB 1012 and encourages you, our state's policy leaders, to engage North Dakota's healthcare leadership in your work to ensure access to affordable, high-quality care for your constituents. We could not continue to enhance healthcare in North Dakota without your leadership and support, and we are pleased to support you.

I would be happy to answer any questions. Thank you.

Mike LeBeau, M.D.
Sanford Health Bismarck President
Health Policy Consortium Board Member
Michael.LeBeau@SanfordHealth.org
701-323-6104

House Appropriations Testimony #3366

Medicaid Expansion

January 26, 2021

INTRODUCTION:

Name: Mike Delfs

Position: President/Chief Executive Officer

Organization: Jamestown Regional Medical Center

Chairman Nelson and members of the Committee,

I appreciate the challenging and important work all of you are doing for North Dakota and I'm thankful for your willingness to serve. The legislature and the ND Hospital Association have accomplished some amazing things to positively impact the health of North Dakotans and provide coverage for at-risk individuals, particularly those who fall within the confines of the Medicaid Expansion program.

Thank you for the time to today to present information on what Medicaid Expansion means to Healthcare across the state, to the communities we serve and most importantly, to the people whose healthcare needs we serve.

As stated previously, but certainly worth repeating; there are few programs that can boast a 10% state contribution to access an additional 90% from the federal government. While some may assert the payment rate is too high, I would remind everyone that the rate was set high by design. To mitigate cost shifting to other programs and payers, the healthcare providers and state worked together to establish a rate that could stand on its own and not produce the unintended consequence of cost shifting.

The positive impact of the Medicaid Expansion dollars simply can't be overstated. Aside from the obvious positive influence of decreased bad debt, more patients qualifying for coverage and therefore seeking out care, the secondary but equally important economic impact for our communities is vital across the state. Economically, these dollars flow through to communities

and end up as money spend at the local hardware store, grocery story, car dealership, or spent on a new home and countless other ways.

Primarily, the Medicaid Expansion program has improved health of our citizens who receive care on a regular, consistent basis, with properly managed chronic conditions (such as hypertension and diabetes), and now receive much needed screenings that mitigate potential life threatening conditions and expensive treatment.

While providing medical care to an at-risk population, the Medicaid Expansion reimbursement has also provided a safety net to North Dakota's hospitals by reducing the amount of uncompensated care, commonly known as bad debt. For decades, segments of our population without medical coverage or with poor coverage, have used the emergency room as their healthcare option when their conditions became so bad they had no choice but to seek emergency assistance. As you may know, emergency room fees can run as much as ten times the fees of a primary care visit which further exacerbates the problem.

Consider the primary impact to hospitals and healthcare providers of losing these dollars. The patients who fall within the Medicaid Expansion rates do not simply "go away" if the reimbursement is reduced down to traditional Medicaid Rates. They continue to need services while the costs associated with providing care for them i.e. salaries of nurses, doctors, technicians, people to keep the facility germ free etc. do not change and in fact most often go up year-over-year to meet the increased cost of living. Similarly, the cost of medical (and nonmedical) supplies, drugs, equipment etc. continue to increase every year. Unfortunately, the fact remains; there are very few services that break even at traditional Medicaid rates and in fact, most services are reimbursed at a significant loss at traditional Medicaid rates. These losses range from 30% up to 60% or more on every dollar spent. This is true at all hospitals and healthcare providers across the U.S.

What could this mean for your local hospital? For example, at Jamestown Regional Medical Center, decreasing payment down to traditional Medicaid rates would result in a loss between $900,000 and $1 million dollars per year. Hospitals, including Jamestown Regional Medical Center, and the communities we serve, will be faced with some extremely hard choices. Are there services that the community needs but we can no longer provide? Will patients have to drive hundreds of miles to get the same services they are receiving locally today? Will your hospital be there in the future if they are no longer paid at the current rate for these patients? This is not an overly dramatic question to ask.

As I am working on this testimony, new information has just come out from CHPQR (Center for Healthcare Quality and Payment Reform) a national association dedicated to improving quality and exploring payment reform. They have assessed how many rural hospitals in each state are at immediate and high risk for closing. In ND, 9 rural hospitals are at immediate risk for closing with another 7 at high risk for closing. While some of this is due to the COVID-19 crisis, it illustrates that hospitals in ND do not have exorbitant bottom lines or that Medicaid Expansion dollars are reimbursement revenue that is the proverbial cherry on top. This reimbursement is vital for all hospitals to continue providing services locally.

I asking, on behalf of hospitals across the state that you continue all elements of the Medicaid Expansion program as-is. It helps patients, helps healthcare in maintaining the ability to serve our communities and it is good for the communities we serve. In short, it is good for North Dakota.

Thank you.

Chairman Nelson and members of the committee, thank you for the opportunity to appear before you today. My name is Dave Molmen and it is my privilege to serve as CEO of Altru Health System. I am here to offer comments in support of HB.

You've heard testimony by several of my colleagues today, and to save the committee's time, I want to go directly to the issue of payments under Medicaid Expansion. This committee has heard testimony asserting that payments under this program are higher than other states, and as such, should be reduced to be more "in line" with those other states. While on the surface, that argument may have some appeal, it does not hold up to even a cursory review.

I would like to briefly walk you through an understanding of how North Dakota came to expand Medicaid to explain why we feel the issue has been wrongly framed, and why it would not be wise to implement those reductions.

When the Affordable Care Act was signed into law in 2010, it created the Medicaid Expansion program wherein, if states determined to extend Medicaid eligibility to those with incomes of up to 138% of federal poverty level, the federal government would provide 100% of the funding to do so in 2014, phasing down to 90% in 2020.

The question of Medicaid Expansion was debated vigorously in the North Dakota legislature in 2013. Although the program held the promise of making care available to low-income families with a large federal match, there was concern, both about the long-term sustainability of the program and whether the federal share of funding would remain true to the initial representations. There was additional apprehension about standing up a program with required state funding, even if it was only a minority share.

Ultimately, the Legislature recognized the high benefit of this program to over 20,000 North Dakota citizens and moved ahead with plans to implement. It was the right thing to do for the health and well-being of North Dakotans, and in the succeeding years Legislators' wisdom would be borne out.

It's important to recognize that, after authorization, a parallel debate was taking place among our state's health care providers. Hospitals in the US had $160 billion cut from their Medicare payments to pay for Medicaid Expansion and other components of the Affordable Care Act. On one hand, participation in this program was a way to get some of that money back, but providers had severe concerns about the stability and funding of the program and for taking on a new category of care that may pose new risks, especially the risk of cost shifting. For a time, it appeared as though we might not be able to get enough contracts with providers to cover the state for care.

Now here's the important part, and I'm going to call this the North Dakota way.

I'm sure you're all aware of many situations in which North Dakota gets treated unfairly under Federal programs in comparison to many more populous, more urban states. Medicaid

Expansion is an example where North Dakota used skill in negotiating our unique position to achieve something very good for our state.

The Obama administration had, to the time of our negotiation with them, not been successful in getting Expansion authorized and implemented in any "red states". It was highly motivated and willing to do so, and willing to do what was needed to get it going in North Dakota. In these negotiations, they agreed to terms that would provide a rate of payment for services that would not have to be cross subsidized by other patients, as they do in other states. This was a huge success and it leveraged our position as a small rural state to get terms that worked our state. As I said, we can find plenty of examples where it hasn't worked that way for North Dakota, but this is something that over the years has delivered huge benefits to our people. Nearly a decade into the program, the federal government continues to pay 90% of the cost.

Mr. Chairman and members, should the state reverse this position on the misconception that a reduction of rates is better for North Dakota's citizens, health care systems will be put at great risk. That move would result in only a small relative benefit (10%) to our state, while turning away over $100 million from our economy every year. $100 million dollars *every year.* Over $50 million of that $100 million goes to directly pay nurses, doctors, and other workers, who provide the care to our people, pay taxes, build houses, and buy groceries. $50 million dollars *every year*. That's nearly 1,000 jobs across our state. Jobs in Hettinger, and Harvey, Bismarck and Grand Forks, Mayville and Jamestown; those are jobs of people caring for their neighbors in every community, your community and mine.

I want to emphasize that this is an issue that impacts all providers of care and does so equally in every community in our state, those in our rural areas and larger cities alike. As I did last week, I would encourage you; I would ask you, to inquire of leaders of the hospitals and institutions in your local area as to its impact. I'm confident that they will tell you exactly the same thing as Mr. Delfs and Dr. Lebeau have told you today. It would be a devastating blow. For many of our institutions, the reduction would be larger than their entire bottom line.

Returning once more to the assertion that North Dakota should be more like other states, superficially that might sound appealing, but study after study after study has shown that in those other states *the payment for services under their Medicaid programs are less than the providers' costs to deliver them*. This means that in those states the burden must be shifted to commercial payors or other sources. The tab has to be picked up by their Blue Cross Blue Shield plans, other payment sources, or somehow cut out of services delivered.

Emulating other states' model does not strike me as a formula for success.

Although I do not have access to the figures for the whole state, I would speculate that, in our state, implementation of the proposed reimbursement reductions would cut payments by nearly half.

I hear actuaries and economists throw around a lot of numbers, formulas, and jargon about the costs and margins for hospital services, and I think they mostly just confuse people and cloud the issue. So here's the back-of-the-envelope way that I think about it, and it works exactly the same way as any farmer or business person would think about it for their own operation. It goes like this: operating margins for hospitals in the State of North Dakota have generally ranged between -5% and 3% over the past several years. In the case of a 3% operating margin, that means the revenue a hospital brings in would be 3 cents more on the dollar than the expenses they incur to deliver the services. Three cents. And in the case of hospitals with negative operating margins, it means they would lose several cents on every dollar of service.

With margins like that, it doesn't take any complex actuarial formula to get the idea that if you reduce the payment for any type of service by 50%, as has been suggested by some, that service would now have to now have to be subsidized by other services or payments from other sources. And I would say that for any form of payment, whether it was Medicaid, commercial insurance, or any other form of payment.

My question is, why would you do that? Why would you severely cut the payments to support the program only to send the money that could pay for it out of the State of North Dakota to Washington DC? Why would we purposely underpay services and turn away $9 to at best save 1?

The North Dakota Legislature was wise to expand our Medicaid program. It's done immeasurable good for our citizens and our state. We negotiated well and effectively to ensure the program's sustainability. Mr. Chairman and members of the committee, I ask that in your wisdom you act to protect our success and see that it not be undone

House Appropriations
Human Resources
Division

HB 1012 #3491
January 26, 2021

Chairman Nelson and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

NDMA supports keeping Medicaid Expansion at current rates through a private carrier. Reducing Medicaid Expansion at this point would have a devastating effect on North Dakota's healthcare system.

As the committee knows, Medicaid Expansion is 90% funded by the federal government. Therefore, moving Medicaid Expansion in house would provide a cost savings of $10.7 million, with a loss of $85.9 million to North Dakota's healthcare systems and private providers. There is no doubt that this would have a massive impact on all providers, not just hospitals.

The 2016 allotment was particularly harsh on physicians. Physicians did not receive a 4% cut, or even a 10% cut. According to our calculations, the Department cut traditional Medicaid physician payments by 33%. With reduction of Medicaid rate and the elimination of the budgeted 3% inflationary increase, the total reduction to health care

providers was $30.5 million. The North Dakota Medical Association had serious concerns about these cuts. In short, the already small operating margins of many systems and providers were eliminated.

Medicaid expansion helped cushion the blow of these cuts. Medicaid expansion is a program that is working well for the patients and the providers. NDMA urges this committee to keep the program as it is today.

Expanding Medicaid provided the much-needed coverage to our low-income patients, improved access to care, improved the health and well-being of the newly insured, and improved the financial stability of our clinics and hospitals. Medicaid expansion is not simply a budget issue. You must also consider the real human effects of this decision, including the health and well-being of those who gain coverage under expansion. Medicaid expansion provided coverage to a population who never before had coverage – including behavioral health coverage.

Our physicians provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from the services we are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state. Our capital needs continue to grow, with aging facilities, technology and equipment. Our costs for medical

equipment, new technology and supplies continue to increase. We must pay the same rates for physicians, nurses and other health care personnel as the rest of the country.

NDMA is very concerned that going back to the trend of poor payment will not bode well for the future of health care in North Dakota. In time, the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met. We need to work together on all avenues that provide resources to sustain our health care system.

Physicians in North Dakota continue to do their part in providing good access to quality medical care for Medicaid beneficiaries and showing their ongoing commitment to the long-term sustainability of the Medicaid program. We look forward to working with the Committee in addressing the future needs for Medicaid medical services. Thank you for the opportunity to address this committee. I would be happy to answer any questions.

North Dakota Practicing Physicians by Specialty

Specialty - Primary Care

Of the 1695 total physicians, 34% or 581 physicians are in primary care. For this purpose, we define primary care as family medicine, internal medicine, obstetrics, and pediatrics (first self-designated specialty only).

Specialty	Count	%	Specialty	Count	%
Allergy and Immunology	6	0.35%	Ophthalmology	40	2.36%
Anatomic or Clinical Pathology	34	2.01%	Orthopaedic Adult Reconstruction	1	0.06%
Anesthesiology	84	4.96%	Orthopedic Surgery	54	3.19%
Cardiac Electrophysiology	3	0.18%	Orthopedic Trauma	2	0.12%
Cardiothoracic Surgery	1	0.06%	Otolaryngology	22	1.30%
Cardiovascular Disease	29	1.71%	Pain Medicine	1	0.06%
Cardiovascular Surgery	7	0.41%	Pain Medicine-Anesthesiology	6	0.35%
Child Abuse Pediatrics	1	0.06%	Pain Medicine-Physical Med & Rehab	1	0.06%
Child and Adolescent Psychiatry	8	0.47%	Palliative Medicine	1	0.06%
Child Neurology	1	0.06%	Pathology	1	0.06%
Clinical Pathology	2	0.12%	Pediatric Allergy	1	0.06%
Colon and Rectal Surgery	5	0.29%	Pediatric Anesthesiology	1	0.06%
Critical Care Medicine	20	1.18%	Pediatric Cardiology	6	0.35%
Dermatology	21	1.24%	Pediatric Critical Care	5	0.29%
Dermatopathology	2	0.12%	Pediatric Gastroenterology	1	0.06%
Diagnostic Radiology	57	3.36%	Pediatric Hematology/Oncology	5	0.29%
Emergency Medicine	85	5.01%	Pediatric Infectious Disease	1	0.06%
Endocrinology, Diabetes & Metabolism	11	0.65%	Pediatric Nephrology	1	0.06%
Family Medicine	326	19.23%	Pediatric Ophthalmology	1	0.06%
Forensic Pathology	1	0.06%	Pediatric Orthopedics	1	0.06%
Gastroenterology	21	1.24%	Pediatric Pulmonology	1	0.06%
General Surgery	58	3.42%	Pediatric Radiology	1	0.06%
Geriatric Medicine (Family Medicine)	1	0.06%	Pediatric Rehabilitation Medicine	1	0.06%
Geriatrics	2	0.12%	Pediatric Rheumatology	2	0.12%
Hand Surgery	6	0.35%	Pediatric Surgery	2	0.12%
Hematology	20	1.18%	Pediatrics	91	5.37%
Hematology (Internal Medicine)	1	0.06%	Phlebology	1	0.06%
Hematopathology	1	0.06%	Physical Medicine & Rehabilitation	2	0.12%
Hospital Medicine	115	6.78%	Physical Medicine and Rehabilitation	12	0.71%
Infectious Disease	13	0.77%	Plastic Surgery	15	0.88%
Internal Medicine	93	5.49%	Psychiatry	67	3.95%
Interventional Cardiology	9	0.53%	Pulmonary Disease	13	0.77%
Interventional Radiology	11	0.65%	Radiation Oncology	13	0.77%
Maternal and Fetal Medicine	3	0.18%	Radiology	14	0.83%
Maxillofacial Surgery	11	0.65%	Reconstructive	1	0.06%
Medical Genetics	2	0.12%	Reproductive Endocrinology & Infertility	3	0.18%
Musculoskeletal Radiology	1	0.06%	Rheumatology	12	0.71%
Neonatal-Perinatal Medicine	17	1.00%	Sleep Medicine-Internal Medicine	2	0.12%
Nephrology	21	1.24%	Sleep Medicine-Psychiatry and Neurology	2	0.12%
Neurological Surgery	21	1.24%	Sport Medicine-Family Medicine	5	0.29%
Neurology	28	1.65%	Sports Medicine (Family Medicine)	2	0.12%
Neuropysiology	1	0.06%	Surgical Critical Care	4	0.24%
NeuroRadiology	2	0.12%	Surgical Oncology	2	0.12%
Nuclear Radiology	2	0.12%	Thoracic Surgery	2	0.12%
Obstetrics and Gynecology	71	4.19%	Trauma Surgery	1	0.06%
Occupational Medicine	2	0.12%	Urology	19	1.12%
Oncology	11	0.65%	Vascular Surgery	5	0.29%

North Dakota Practicing Physicians by City

City	Count	%	City	Count	%	City	Count	%
Belcourt	5	0.29%	Garrison	1	0.06%	New Town	2	0.12%
Beulah	5	0.29%	Grafton	3	0.18%	Northwood	1	0.06%
Bismarck	367	21.65%	Grand Forks	218	12.86%	Oakes	4	0.24%
Bottineau	2	0.12%	Harvey	4	0.24%	Park River	3	0.18%
Bowman	2	0.12%	Hazen	2	0.12%	Rolette	1	0.06%
Carrington	1	0.06%	Hettinger	9	0.53%	Rolla	3	0.18%
Casselton	1	0.06%	Hillsboro	2	0.12%	Rugby	5	0.29%
Cavalier	3	0.18%	Horace	1	0.06%	Stanley	2	0.12%
Crosby	1	0.06%	Jamestown	35	2.06%	Tioga	1	0.06%
Devils Lake	13	0.77%	Langdon	1	0.06%	Trenton	1	0.06%
Dickinson	35	2.06%	Linton	1	0.06%	Valley City	6	0.35%
Dunseith	2	0.12%	Lisbon	1	0.06%	Wahpeton	12	0.71%
Elgin	2	0.12%	Mandan	10	0.59%	Watford City	6	0.35%
Fargo	716	42.24%	Mayville	3	0.18%	West Fargo	16	0.94%
Fort Totten	1	0.06%	McVille	2	0.12%	Williston	38	2.24%
Fort Yates	5	0.29%	Minot	138	8.14%			
Gackle	1	0.06%	Minot AFB	1	0.06%		1695	

Chairman Nelson and members of the House Appropriations Human Services Division: #3480

My name is Kurt Snyder, and I am the Executive Director of the Heartview Foundation. Heartview is currently offering Medication Assisted Treatment (MAT) to 291 individuals including some at North Dakota State Penitentiary in Bismarck and Dakota Women's Correctional in New England. At any given time, we have over 400 individuals in our care. We employ a psychiatrist, medical providers, psychologists, nurses, addiction counselors, mental health counselors, social workers, peer support specialists, case managers, and residential technicians. Last year we served individuals from 38 of the 53 counties of ND. Of our patient population, over 65% are Medicaid or Medicaid Expansion. (20% Medicaid and 47% ME).

I am here today to voice our support for the re-authorization of Medicaid Expansion. More specifically we support:

Removing the Sunset Clause

- I have a number for you, 47. 47% of our patient population is Medicaid Expansion. Almost ½ of our patient population is covered for only 2 years at a time. How can treatment providers plan expansion efforts into rural or underserved communities with such a vulnerable funding base? How can we be expected to meet the needs and demands of the opioid epidemic without confidence in our funding streams? Please remove the sunset clause!

Retain Medicaid Expansion with a Private Insurance Carrier

We strongly oppose moving Medicaid Expansion under Medicaid for these main reasons:

- First, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was meant to prevent health insurance plans from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical surgical benefits. Medicaid Expansion fully complies with MHPAEA. ND Medicaid does not. MHPAEA specifically restricts annual limits. ND Medicaid has annual restrictions on Intensive Outpatient, Partial Hospitalization and High Intensity Residential. Parity also insures that "Medical Necessity" be the standard for authorizing services. Again, ND Medicaid does not follow parity in this respect. ND Medicaid does not utilize accepted clinical standards for authorizations but instead providers must request additional days of coverage that sometimes takes months for approval. If Expansion is moved under ND Medicaid over 67% of our patients would not have the important protections of this federal parity law. The law that prevents discrimination and stigma.

- I have another number for you, 67. 67% of our patient population would be ND Medicaid if Expansion is moved under the Medicaid umbrella. 67% of our patient population would be subject to ND Medicaid's claims processing. This terrifies me! ND Medicaid has testified on many

occasions that clean claims are paid in a timely manner, which we agree upon. The problem, however, is that ND Medicaid denies 33% of Heartview claims, while other commercial payers average under 9%. Furthermore, reprocessing denied claims is extremely difficult with ND Medicaid. We often experience wait times of weeks, and sometimes months to even get a response from Medicaid on a single claim. In January 2019 ND Medicaid gave us a $450,000 cash advance because we were having cash flow issues due to overwhelming outstanding Medicaid claims. As of today, 55% of outstanding claims with ND Medicaid are over 6 months old. In comparison, only 4% of Medicaid Expansion outstanding claims are over 6 months old.

We Support Implementation and Continuation of Commercial Rates

- Finally, I need to address reimbursement rates. Last session there was an amendment that was intended to provide consistent reimbursement rates across providers. However, it turned out that reimbursement rates within substance use providers were not established equitably. A level of care called Partial Hospitalization Program or PHP, (which makes up over 50% of our revenue) was given a higher reimbursement rate to hospital-based programs. Community based programs were given a lower rate which is inherently unfair. I would argue that our quality of care exceeds hospital-based programs because we offer all 3 FDA approved medications for opioid use disorder. Even within the ND Medicaid reimbursement rate structure there is no difference between hospital-based programs and community-based PHP programs.

- According to the American Hospital Association, 18.5% of the payer mix in hospitals is attributed to Medicaid. Most Medicaid Expansion enrollees are childless adults working one or more jobs and in much-needed access to chronic disease management, mental health services and addiction treatment programs. As a result of the needs of this population they are overrepresented in our services. Substance use providers need commercial rates to offset the disproportionate number of patients (67%) within our service structure.

This concludes my testimony, and I would stand for any questions.

Kurt A. Snyder, MMGT/LSW/LAC
Executive Director
Heartview Foundation
kurt@heartview.org
Cell: 426-8677

House Appropriations Committee, Human Resources Division - HB 1012

Representative Jon O. Nelson, Chair #3341

January 26, 2021

Chairman Nelson, Members of the Committee:

My name is Brian Ritter and I'm President the Bismarck Mandan Chamber EDC. I am here today on behalf of our organization's approximately 1,200 members in support of HB 1012.

While it may seem out of place for a business organization to offer its support for the Department of Human Services appropriations bill, our 2021 Legislative Agenda specifically states, "*Support efforts to sustain Medicaid Expansion to ensure access to services and to mitigate increased expense to businesses."* And make no mistake, Medicaid Expansion is critically important to the Bismarck-Mandan business community.

One reason why is because Bismarck-Mandan's two largest private employers are healthcare providers. Thousands of employees in our community are employed in an industry directly impacted by Medicaid Expansion; the rates of which cover the cost of care. As not-for-profit entities, reducing those rates can directly impact their viability and in turn their ability to employ Bismarck-Mandan residents.

Additionally, if those rates are reduced, the cost of care will be shifted to private insurance carriers who may pass those costs on to the business community in the form of increased premiums. Once again, this is a direct impact on the business community and why we're here today supporting this legislation.

And finally, Medicaid Expansion becomes a business community concern because most Medicaid Expansion enrollees work in jobs that do not provide health insurance. In an economy that already has nearly 2,400 open jobs, any employee not able to participate in the workforce because of a health concern left untreated is a detriment to the business community.

In short, maintaining Medicaid Expansion rates at their current levels is a good thing for our providers, our employees and our community. As such, I respectfully ask the Committee for a DO PASS recommendation on HB 1012.

Thank you for the opportunity to testify and should you have any questions, I would happy to address them.

Testimony
House Bill 1012 – Department of Human Services Budget
House Appropriations – Human Resources Division
Representative Jon Nelson, Chairman

January 25, 2021 #2499

Chairman Nelson and Members of the House Appropriations Committee – Human Resources Division:

My name is Lorena Poppe. I am the owner and executive director of Poppy's Promise, a Bismarck-based provider of In-Home Support services through the Developmental Disabilities traditional Home and Community Based Waiver. I am testifying today in support of the Department of Human Services budget, particularly that of the Developmental Disabilities Division, with amendments.

I started Poppy's Promise in the Fall of 2017 in response to families of kids with disabilities expressing there was a shortage of providers to be available to meet the needs of their children and families. My goals were to 1) be another option as families seek out services that will best meet the needs of their children, and 2) meet kids and families where they are at on their unique journeys to full inclusion and participation in home and community life. We believe strongly in designing supports that will help to keep kids in their family homes and communities and minimize the need for institutionalization in a place that is unfamiliar to the child. In our short existence, we have seen the difference a small provider organization can make and are proud that we have been part of keeping families together in their home communities.

I am the sole owner of Poppy's Promise. I started my business by getting a Small Business Administration loan and taking a leap of faith. I knew there was a need, but understand now more than ever, 3 ½ years later, how critical it is that DD providers be supported to do the important work of helping people with disabilities achieve maximum health, happiness and freedom of choice across their lifetimes. At Poppy's Promise, we operate on a month-to-month basis without having a large financial reserve to fall back on. Since opening the doors at Poppy's Promise, I have been excited to see other new provider organizations popping up across the state. This is an exciting thing for North Dakota and I believe there is definitely a place for new organizations that can work together with longstanding providers to assure gaps in services are filled and people can receive supports and services in the least restrictive setting.

In listening to the budget detail of the DD Division of the Department of Human Services, I am concerned that new providers and those that are smaller and more specialized are not being fully considered. Specifically regarding the In-Home Supports program, you heard testimony from the Department indicating that program had the largest drop in utilization over the course of the Covid-19 pandemic (27%). And yet, In-Home Supports was left out of the Appendix K option to receive retainer payments to help providers stay in business during the pandemic. For providers of services that were eligible to receive retainer payments, those payments were an important part of keeping the doors of those businesses open. With the current extension of the Appendix K, there is an opportunity for the Department to extend the retainer payment option to those providers most in need and help to assure the services families rely upon don't disappear.

Another area of concern for all providers of DD services, but especially small providers, is the intention of the Department of Human Services to require providers to absorb the cost of accreditation necessary to maintain DD licensure. Because DHS contracts with one organization for accreditation, the Council on Quality and Leadership (CQL), providers would be forced to pay several thousands of dollars toward the accreditation process. This includes travel and lodging expenses of CQL reviewers coming to North Dakota from across the country. There is no reimbursement for accreditation built into the DHS budget. Poppy's Promise does not have the ability to cover that cost. I believe strongly in review processes being in place to assure quality of services, but also know the reality of trying to maintain a business that does not have the ability to set aside thousands of dollars for unreimbursed licensure requirements.

I come before you today to ask that you consider the current state of services for people with disabilities during an ongoing pandemic, the financial vulnerability of new and small providers, and the addition or preservation of funds to assure all providers who are relied on heavily by the citizens of North Dakota are able to survive and stand strong in continuing to provide supports and services.

Thank you for your time today, and I would be happy to answer any questions you may have.

NDAB Resolution 2021-03:

State 2021 – 2023 Appropriation for the Older Individuals Who Are Blind (OIB) Program

Whereas, demographically, North Dakota is among the states which has the highest proportion of people per capita who are 55 years of age and older, and this is the subpopulation of people who have the highest incidence of significant sight loss that is not medically correctable; and,

Whereas, seniors who receive blindness rehabilitation skills training to adjust to sight loss can postpone or avoid institutionalized care and live more productive and fulfilling lives; and,

Whereas, the appropriation that's made for the older Individuals Who Are blind (OIB) program in the state's budget is critical to meet the costs that this program realizes because, (1) the federal government funds the program in North Dakota at a minimal base level due to the size of our population compared to other states, and (2) travel costs are significant because the vision specialists employed in the program need to meet in the client's home setting to make a proper evaluation to assess the skills training needed for that individual person;

Now, Therefore, be it resolved by the Board of the North Dakota Association of the Blind at its meeting on this Sunday, January 10, 2021, that given the increasing demand for vision rehabilitation skills services available through the Older Individuals Who Are Blind Program, that we,

(1) Strongly Urge the Governor and the 67th State Legislature that convened on January 5, 2021, to maintain and increase the state appropriation that is allocated in the 2021-2023 biennial budget within the HB1012 Human Services budget for the Older Individuals Who Are Blind Program and that our state appropriation for this program would be increased to a 25% match of the federal appropriation that North Dakota receives for this program; And,

(2) urge our federal congressional delegation, Senators Hoeven and Cramer, and Congressman Armstrong, to work to maintain and increase the federal appropriation for the Older Blind Program in the federal budget and that they would work to have the formula for the federal appropriation be based, not only on the state's population size, but also on a state's per capita percentage of people who are 55 years of age and older.

Testimony for the Older Individuals Who Are Blind (OIB) Program Appropriation within HB1012.

To: Chair John Nelson, and Members of the House Appropriations Human Services subcommittee, North Dakota 67th Legislative Assembly.

From: Allan Peterson, Legislative Committee, North Dakota Association of the Blind (NDAB).
Home address: 7009 Horseshoe Bend, Horace, ND 58047.
Home: (701) 282-4644; cell: (701) 429-7209; Email address: allan.c.peterson@gmail.com

Re: Testimony in support of the state Appropriation for the Older Individuals Who Are Blind (OIB) Program within the Division of Vocational Rehabilitation, North Dakota Department of Human Services

Greetings Chairman Nelson, and members of the House Appropriations Human Services Subcommittee,

We are testifying on our own behalf, as well as to help represent the advocacy goals of the North Dakota Association of the Blind (NDAB). Our testimony is directed in support of the Appropriation for the Older Individuals Who Are Blind Program within the Division of Vocational Rehabilitation for its operation during the next biennium of 2021 - 2023.

In North Dakota, the Older Individuals Who Are Blind Program is administrated by the Division of Vocational Rehabilitation within the Department of Human Services. Funding for the program is generated through a 90% grant from the federal government which requires a minimum state appropriation of 10%. Federal funding for the program is authorized under the U.S. Rehabilitation Act.

Federal funding for the Older Individuals Who Are Blind program is allocated to the states on the basis of population size. Because North Dakota's population base is small in comparison to other more populated states, it receives what is termed a minimal allocation. Minimal federal funding is a problem for the program here in North Dakota because our state is geographically large in relation to its population size, which necessitates a lot of travel to meet with clients in their homes. Also, our state has a higher proportion of people in the older age ranges, which experience a much higher incidence of sight loss. The Older Individuals Who Are Blind Program is specifically directed to serve individuals who are 55 years of age and older.

Although there have been many significant advances in eye care, sight problems such as macular degeneration, diabetic retinopathy, glaucoma, and cataracts continue to be primary sources of vision impairments and blindness, particularly, for persons who are 55 and older.

The professional staff which are trained to provide the services for the Older Blind Program are classified as vision rehabilitation specialists. In North Dakota there are 6 vision rehabilitation specialists assigned to work in each of the state's 8 defined Human Service regions. Vision specialists, employed in the older blind program, travel to a client's home to do an assessment of needs and provide the services and counseling that is needed in that person's home environment and is individualized to meet client needs. The services of this program have helped thousands of our older citizens who have experienced severe sight impairments to become more independent and enjoy a more productive and fulfilled life in spite of having lost some or all of their eyesight.

The skills and aids that the vision rehabilitation specialists provide to older citizens with sight loss, is often quite an (pardon the pun) "an eye opener" which does much to help them stay in their own homes and postpone or avoid institutionalized nursing home care. The cost savings that are gained by postponing or avoiding institutionalized care and the increased sense of wellbeing and dignity that are realized by being more independent are compelling reasons for the state to provide the appropriation needed for this program in North Dakota. In most instances, the clients served are elderly and live on very fixed incomes so for them to purchase a vision aid that would help them is difficult or impossible.

The rural character of our state and limitations on access to public transportation can mean those who experience severe sight loss are isolated and very dependent on others.

You might ask, among us in ND, **how many today have a loss of eyesight**? The U.S. Senses Bureau estimates that presently there are approximately 762,062 residents in North Dakota. Many credible studies have demonstrated that, conservatively, that **3.3%** among the general population, will have conditions that mildly, moderately, or severely medically compromise their eyesight – this means that more than 20,000 individuals in North Dakota are affected by uncorrectable sight loss - a quarter of whom (5,000) have significant sight loss and/or are "legally blind".

About North Dakota Association of the Blind (**NDAB**): You could say that NDAB is an organization of and for people who are blind or sight impaired. We are a statewide membership organization founded 85 years ago in 1936, a majority of our members are blind or sight impaired.

Testimony
House Bill 1012
House Appropriations Human Resources Division
Rep. Jon Nelson, Chairman
January 26, 2021 #3274

Chairman Nelson, members of the House Appropriations Human Resources Division, I am Heather Simonich, Operations Director of Nexus-PATH. Nexus-PATH is a member of Nexus Family Healing, providing child welfare and behavioral health services in ND. I am here today to provide input on HB1012, specifically the Medical Services budget, relating to the equalization of Targeted Case Management (TCM) rates.

We understand the Department's effort to equalize Targeted Case Management rates within and across state plans. However, as a provider charged with supporting our schools and communities with much needed community-based services now more than ever – we have significant concerns regarding the established targeted case management rate.

Recently, Nexus-PATH creatively partnered with six North Dakota school districts to deliver intensive case management services to students and their families. This is a formal partnership with a signed MOU that places a Nexus-PATH school case manager within the school building. This individual works as a member of the school team serving students with the highest needs as identified by school staff. This partnership offers school professionals and students access to an intensive service not available through traditional school supports.

The Nexus-PATH case manager serves as a bridge between school, home, and the community. An individualized care plan based on a comprehensive assessment of student and family needs and strengths guides service delivery. The case manager routinely visits the family home, assists with transportation, connects the family to services available in the community, assists with student behavior at school, and works intensively with the student and family to build the skills necessary to overcome their challenges. Importantly, this service is provided throughout the summer and provides the family with access to a 24/7 on-call service staffed by a licensed social worker. Initial feedback from school professionals, students, and families has been overwhelmingly positive.

Currently, the cost of this service is funded by Medicaid Targeted Case Management or BCBSND billing, the school district, and various grants/donations. The cost of this service, particularly in our rural communities, is not sustainable without a significant contribution by the school district and sustained grant funding. As a provider, it is an ongoing challenge to rely heavily on unstable grant and school funding from one year to the next. The challenges in our rural areas related to the behavioral health workforce shortage and serving clients across expansive geography necessitates a targeted case management rate be established based on true service costs. The service referenced here is an excellent example of the type of service required to meet our most vulnerable families where they are at, build trust, and begin healing while at the same time supporting our educators and improving academic success.

I will close today just as I did yesterday – reminding us of Superintendent Baesler's statement on Friday, "We cannot do this alone". These words weigh heavy on me. I have provided you with an example of one innovative and successful private-public partnership to better meet the needs of our students and their families. North Dakota service providers can do this. It will take all of us, and your full support, but I believe we can answer the call. Our children's lives depend on it.

Thank you for the opportunity to testify before your committee today. I am happy to answer any questions you may have.

The individuals below provided permission to list their name, email, and school district (agency) in support of this testimony and welcome questions you may have regarding their partnership with Nexus-PATH to deliver School Case Management service.

Missy Eidsness
Fargo Public School District
eidsnem@fargo.k12.nd.us

Michael Kaiser
Ellendale Public School District
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Tyler Hanson
Edgeley Public School District
Tyler.Hanson1@k12.nd.us

Luke Shaefer
Central Region Education Cooperative (CREA)
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Dr. Mark Vollmer
Minot Public School District
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Dr. Rachael Agre
West Fargo Public School District
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Andrew Jordan
Wilton Public School District
Andrew.Jordan@k12.nd.us

#3828



HOUSE BILL 1012

HOUSE APPROPRIATIONS | HUMAN RESOURCES DIVISION

REPRESENTATIVE JON NELSON, CHAIRMAN

NORTH Dakota | Human Services

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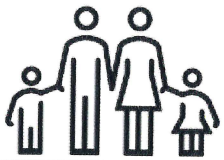
STATE HOSPITAL

Rosalie Etherington, Chief Clinic Director/NDSH Superintendent



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being

SPECIALIZED SERVICES

- Psychiatric Inpatient Services
- Substance Use Disorders Residential Services
- Sex Offender Residential Services
- Transitional Residential Services

PRIMARY PSYCHIATRIC HOSPITAL

- Jamestown Region
- Devils Lake Region



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

EFFICIENT AND HIGH QUALITY

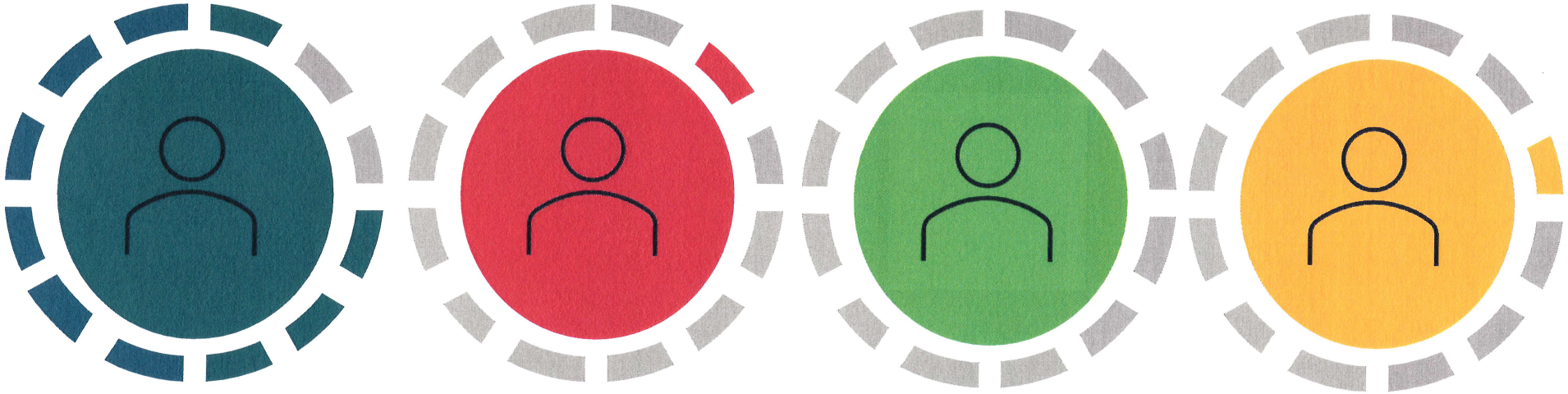
- Award Winning Hospital for Quality Redesign
- 20 Years of Efficiencies Meet a Limit
- New Hospital Improves Efficiency and Quality



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service

STATE HOSPITAL ADMISSIONS
Acute, Subacute, Rehabilitative, Residential



83% Inpatient Hospital Admissions

16% Residential Substance Use Disorder (SUD) Admissions

.5% Residential Sexual Offender Admissions

4% Transitional Living Facility Admissions

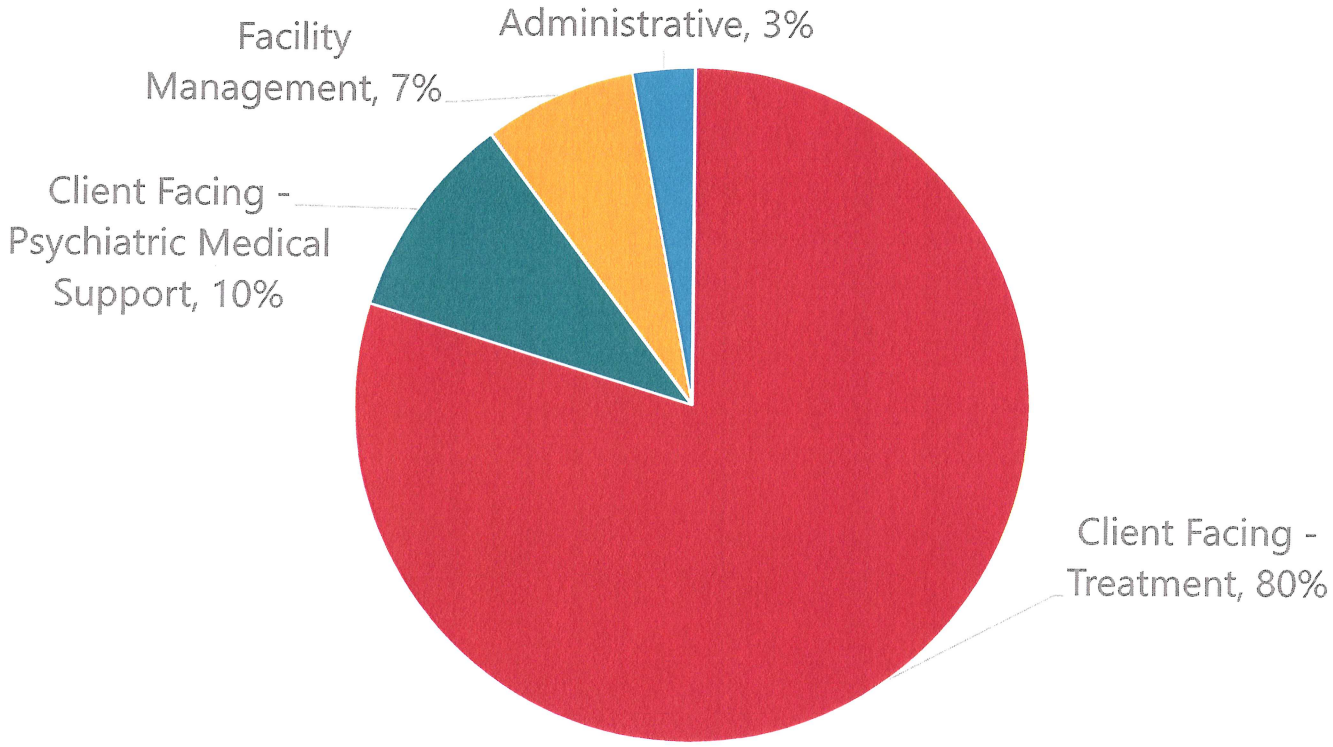
STATE HOSPITAL FTE BREAKDOWN

TRADITIONAL TREATMENT BUDGET = T
SEX OFFENDER TREATMENT BUDGET = S

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
339.52 (T) 68.5 (S)	331.62 (T) 67.5 (S)	314.52 (T) 67.5 (S)	68.8	80%	Client Facing	303
				10%	Patient Medical and Support Services	39
				7%	Facility Management	27
				3%	Administrative	12

Telework Headcount	
Pre-COVID	Current
0	1

STATE HOSPITAL EMPLOYEES BY TYPE



STATE HOSPITAL VACANCIES

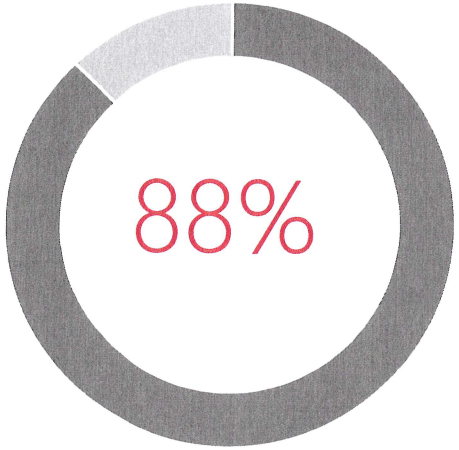
55 of 68.8 vacancies are nursing staff

Job Classification	Vacant FTE	Job Classification	Vacant FTE
Activity Therapist	1.0	Industries Specialist	1.0
Applied Behavior Analyst	1.0	Licensed Practical Nurse (LPN)	6.0
Direct Care Associate I, II, III	32.9	Occupational Therapist	1.0
Direct Care Supervisor	2.0	Psychiatrist	1.0
Human Service Program Administrator	2.0	Psychology Resident	1.0
Heating Plant Supervisor	1.0	Registered Nurse (RN)	15.9
Human Relations Counselor	2.0	Social Worker	1.0

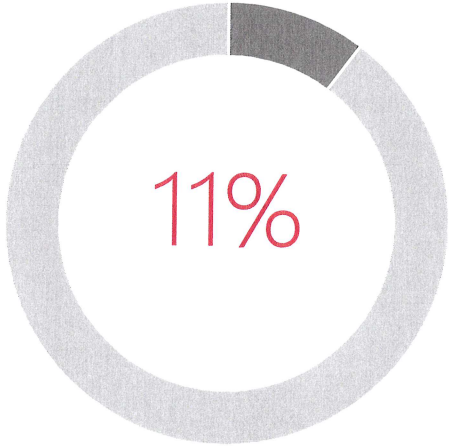
Total Vacant FTE: 68.8 (effective 12.31.2020)

SALARY BUDGET DISTRIBUTION

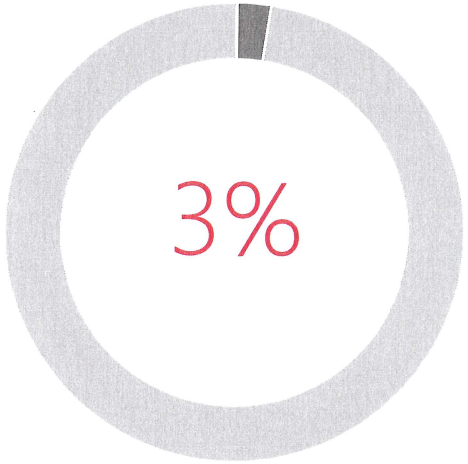
VACANCIES AREN'T EQUAL TO EMPTY POSITION



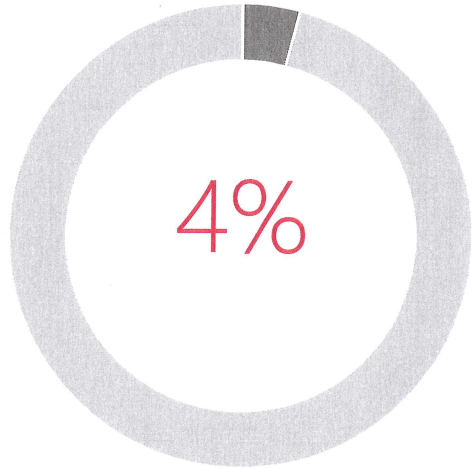
Filled FTE



Overtime FTE Equivalent

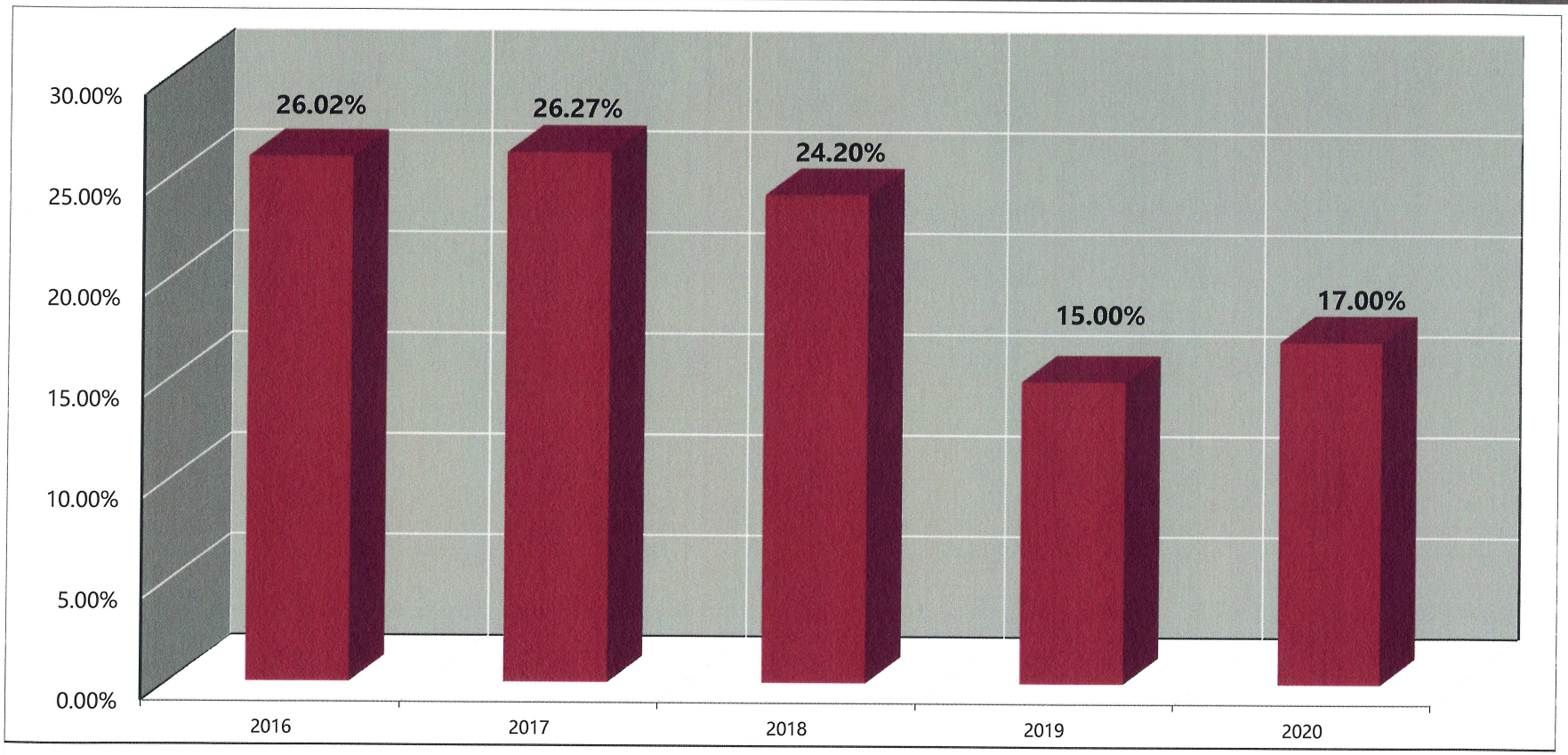


Agency Nurses



Underfunding FTE Equivalent

STATE HOSPITAL TURNOVER RATE





Budget Recommendations

BUILD NEW HOSPITAL

- Eliminate $148M of Deferred Maintenance
- Finance Construction Without Upfront Capital
- Make Annual Payment Through $5M Savings
- $1.7M Gap Payment Requires Funding

Improve care and save costs

FTE AND UNIT REDUCTIONS

- Close 25 bed Inpatient Unit
  - ✓Reduce 14 FTE
- Close 30 bed Tompkins Unit
  - ✓Reduce 10 FTE Budget
- Operational Efficiencies
  - ✓Reduce 3 FTE

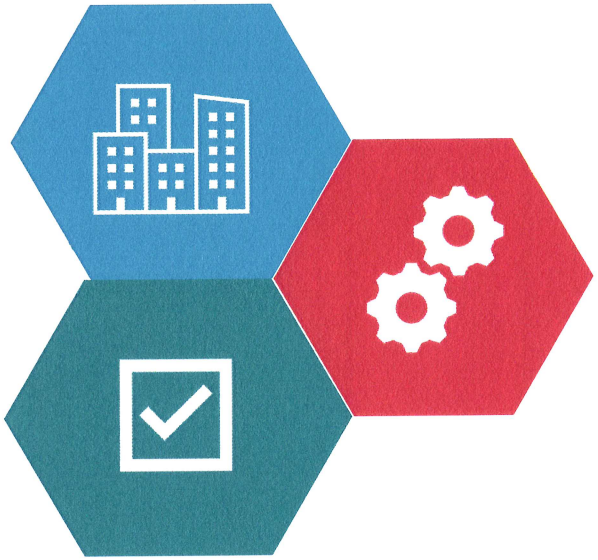
What We Need to Accomplish Budget Reduction

PRE-CONDITIONS TO CLOSE INPATIENT UNIT

NEGOTIATING

Western Beds

Partner with private hospital for 6-10 hospital beds



Close Inpatient Unit

Reduce State Hospital to 75 Beds
Reduce Staff and Operating Costs

Failed

Authority to Say No

SB 2084 to give authority to decline admission when full





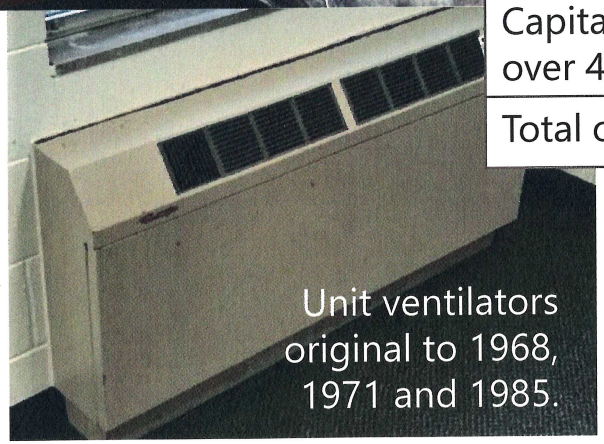
RETAIN 14 FTE AND KEEP UNIT OPEN

To Build or Not to Build

IMPROVE CARE AND REDUCE COSTS

NEW STATE HOSPITAL ESTIMATED COSTS


Steam and condensate piping throughout facility (original to 1956)


Unit ventilators original to 1968, 1971 and 1985.

	Stay in Place / Renovate	Bond	Lease
Lease payment (principal and interest)	$0	$170,915,156	$287,400,000
Facility operations cost over 40 years	$64,091,103	$60,689,847	$0
Additional Hospital FTE costs over 40 years	$161,877,332	$30,986,482	$0
Capital reinvestment costs over 40 years	$327,118,000	$91,841,146	$0
Total cost over 40 years	$**553,086,435**	$**354,432,631**	$**286,400,000**

NEW STATE HOSPITAL ESTIMATED SAVINGS

Patient depression and anxiety levels are reduced in environments built with an intent to heal.



	Stay in Place / Renovate	Bond	Lease
Facility operations cost savings over 40 years	$0	($3,401,256)	($64,091,103)
FTE Savings over 40 years	$0	($130,890,850)	$161,877,332)
Capital reinvestment savings over 40 years	$0	($235,276,854)	($327,118,000)
Total savings over 40 years	**$0**	($**369,568,960**)	($**553,086,435**)



MAKE ONGOING REPAIRS OR BUILD: THREE OPTIONS FOR STATE HOSPITAL

Current Situation: Make On-Going Repairs

Requires immediate General Funds

- State secures General Funds
- State procures an architectural design
- State procures contractors to renovate facility
- State maintains facility with reoccurring costs
- State pays the bond/loan over time

No operational savings

New State Hospital via Bond (Loan) Option

Requires no up-front funds

- State secures funds
- State procures an architectural design
- State procures contractors to build facility
- State maintains facility with reoccurring costs
- State pays the bond/loan over time

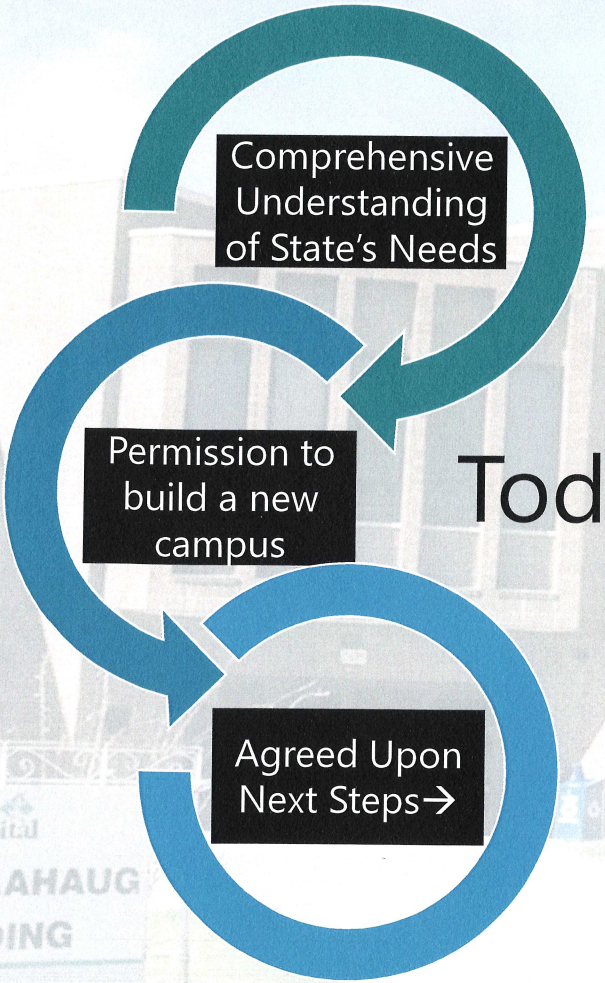
Operational savings

New State Hospital via Public/Private Partnership (Lease)

Requires no up-front funds

- State procures private partner
- Private partner procures an architectural design
- Private partner builds facility
- Private partner operates and maintains facility
- State makes annual payment over life of lease
- State retains ownership of hospital
- Private partner returns asset at 85% new

Operational savings



Today, We Are Seeking Authorization



INPATIENT AND RESIDENTIAL SERVICES BUDGET DETAIL

NORTH Dakota

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DETAIL BUDGET CHANGES BY EXPENSE CATEGORY

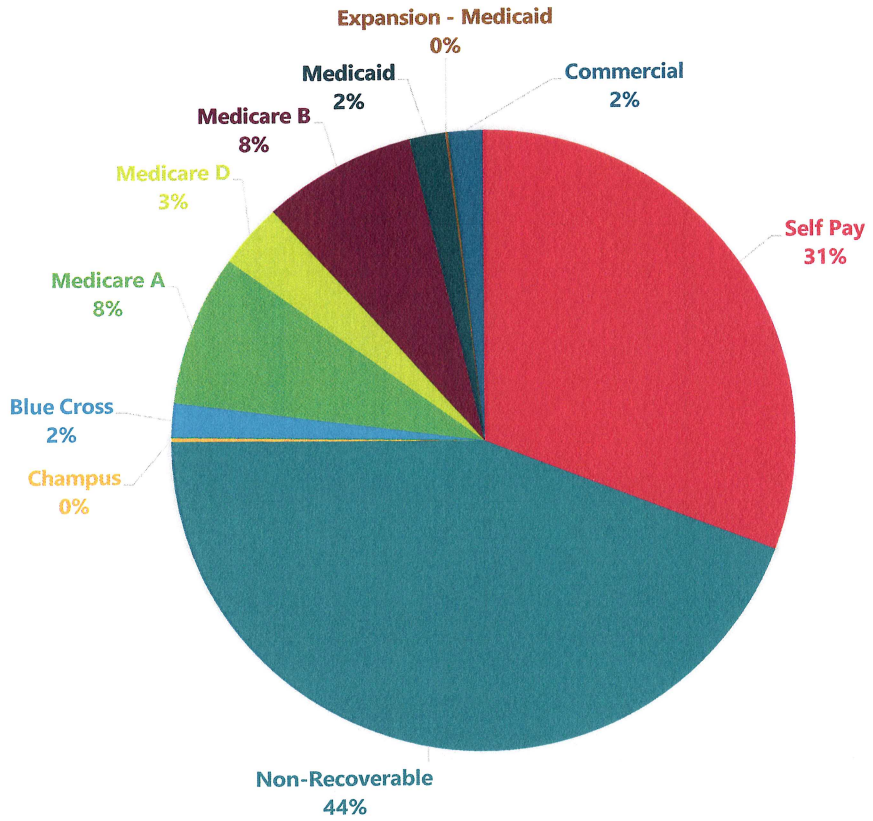
Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	32,042,056	31,798,985	15,547,397	1,384,672	33,183,657
512x Salaries - Other	584,621	564,220	266,760	(85,026)	479,194
513x Salaries - Temp	2,164,328	2,142,408	935,744	(1,430,665)	711,743
514x Salaries - Over Time	4,264,810	4,620,146	2,093,134	(3,469,246)	1,150,900
516x Salaries - Benefits	16,452,967	15,974,913	8,370,549	2,429,440	18,404,353
Total Salaries & Benefits	55,508,782	55,100,672	27,213,584	(1,170,825)	53,929,847
52x Travel	417,226	408,892	176,226	(39,602)	369,290
53x Supply	2,574,219	2,852,549	1,090,934	(367,017)	2,485,532
54x Postage & Printing	51,521	55,830	9,244	(17,115)	38,715
55x Equipment Under $5,000	85,522	96,092	60,481	(3,625)	92,467
56x Utilities	7,052,175	1,099,014	801,771	275,062	1,374,076
57x Insurance	79,337	93,047	44,260	45,406	138,453
58x Rent/Leases - Bldg./Equip	32,327	45,676	23,013	4,320	49,996
59x Repairs	513,129	394,588	165,697	(8,627)	385,961
61x Professional Development	104,553	176,492	73,699	134,692	311,184
62x Fees - Operating & Professional	5,357,657	6,937,613	2,723,190	(1,244,038)	5,693,575
60x IT Expenses	226,611	207,675	102,911	24,853	232,528
Total Operating	16,494,277	12,367,468	5,271,426	(1,195,691)	11,171,777
68x Land, Building, Other Capital	1,873,925	1,231,699	3,349,096	60,800	1,292,499
69x Equipment Over $5,000	347,714	101,650	75,467	(40,850)	60,800
Total Capital/Equipment over 5,000	2,221,639	1,333,349	3,424,563	19,950	1,353,299
Total	74,227,395	68,801,489	35,909,573	(2,346,566)	66,454,923

FEES – OPERATING/PROFESSIONAL/MEDICAL

State Hospital - 2021-23 Biennium Budget

		$ 6,937,613	$ 5,693,575	$ 5,693,575
Vendor	**Comments / Description**	**2019-21 Biennium Amount**	**2021-23 Biennium Amount**	**General Fund**
Various	Service Award, Background Check, License & Certification Fees required for employees	86,605	82,202	82,202
Worldwide	Travel Nurses		611,520	611,520
Stutsman County	Special Assessments, Commissary & Sales Tax	74,064	260,966	260,966
Lutheran Social Services	Interpreters	19,000	19,500	19,500
Guardian Pest Solutions/ Trane/ Otis Elevator	Pest Extermination Services/ Chiller System contract/Elevator contract	170,654	170,654	170,654
Various	Delivery of Supplies and Materials to NDSH and Destruction of PHI	28,146	26,064	26,064
Northern Plains	Lab Services	87,000	87,000	87,000
Jamestown Regional Medical Center	Contracts for PT/OT/Xray/Speech	144,344	144,344	144,344
Waste Healthcare Environmental Services	Infectious Disease Control	29,011	29,011	29,011
UND	Residency Contract with UND		100,000	100,000
Various	Guardianships	118,641	118,641	118,641
Contract with Bascilia of St. James	Catholic Chaplain	18,980	31,480	31,480
Contract with Progress Enterprises	Progress Enterprises Contract	300,000	300,000	300,000
Various	Medical, Dental and Optical	2,118,942	2,201,982	2,201,982
Various	Legal services for patient hearings	111,982	111,982	111,982
Various	Patient Medical Services from external healthcare providers and testing	1,377,266	1,398,229	1,398,229
	Operating expense for 25 bed unit	2,252,978	-	

PAYOR MIX - STATE FISCAL YEAR 2020



	Payment Received	Amount Adjusted
Blue Cross	215,313	214,305
Champus	4,119	-
Commercial	65,883	118,612
Expansion - Medicaid	-	3,051
Medicaid	883,862	71,990
Medicare A	1,669,330	230,328
Medicare B	79,318	295,334
Medicare D	189,447	930,342
Non-Recoverable	18,916	12,652,982
Self Pay	86,061	236,540
Total	3,212,249	14,753,485



SEX OFFENDER TREATMENT AND EVALUATION PROGRAM
BUDGET DETAIL

NORTH Dakota
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DETAIL BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	5,408,400	5,090,007	2,535,146	838,380	5,928,387
512x Salaries - Other	110,103	110,876	53,339	(4,198)	106,678
513x Salaries - Temp	258,558	257,040	99,740	(56,448)	200,592
514x Salaries - Over Time	490,056	452,846	225,324	(376,942)	75,904
516x Salaries - Benefits	2,862,823	3,590,302	1,398,671	146,365	3,736,667
Total Salaries & Benefits	9,129,940	9,501,071	4,312,220	547,157	10,048,228
52x Travel	57,413	55,187	20,161	(2,917)	52,270
53x Supply	282,190	303,955	65,971	(125,076)	178,879
54x Postage & Printing	7,594	13,922	3,736	(6,197)	7,725
55x Equipment Under $5,000	8,232	13,250	5,101	-	13,250
56x Utilities	97,958	141,624	10,474	(45,698)	95,926
57x Insurance	14	8,109	-	8,720	16,829
58x Rent/Leases - Bldg./Equip	6,404	7,767	3,954	(1,381)	6,386
59x Repairs	7,407	4,460	1,689	(1,791)	2,669
61x Professional Development	12,207	23,153	3,877	(8,703)	14,450
62x Fees - Operating & Professional	1,097,007	656,164	578,311	484,823	1,140,987
60x IT Expenses	38,795	38,700	17,569	1,114	39,814
Total Operating	1,615,221	1,266,291	710,843	302,894	1,569,185
69x Equipment Over $5,000	10,308	19,950	-	(19,950)	-
Total Capital/Equipment over 5,000	10,308	19,950	-	(19,950)	-
Total	10,755,469	10,787,312	5,023,063	830,101	11,617,413

FEES – OPERATING/PROFESSIONAL/MEDICAL

Sex Offender Treatment & Evaluation Program - 2021 - 23 Biennium Budget

62X- Fees Operating, Professional & Medical/Dental/Optical

$ 656,164	$ 1,140,987	$ 1,140,987	$ -	$ -	

Vendor (Please put "VC" in front of the vendor name if it is a contract and "OTH" in front of the vendor if it is not a contract)	Comments / Description	2019-21 Biennium Amount	2021-23 Biennium Amount2	General Fund	Federal Funds	Other Funds
OTH - License Fees for staff	Years of Service/ License & Certification Fees required for job duties	12,612	12,612	12,612		
OTH - Various	Additional amount needed to contract out vacant services of forensic psychologist		423,916	423,916		
OTH - Stutsman County	Special Assessments		11,709	11,709		
OTH - Freight and Express	Delivery of Supplies and Materials to NDSH	13,204	13,204	13,204		
Legal services & Consulting Fees for patient hearings		42,286	64,000	64,000		
Outside Medical Costs		326,298	356,178	356,178		
Pharmacy Costs		261,764	259,368	259,368		



STATE HOSPITAL

NORTH Dakota | State Hospital
Be Legendary.™ HUMAN SERVICES

Rosalie Etherington, PhD,
Superintendent/Chief Clinics Officer
Email: retherngton@nd.gov
(701) 253-3650

NORTH DAKOTA STATE HOSPITAL #3829

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 4, after line 16, insert:

"**SECTION 9. CAPITAL PROJECTS AND PAYMENTS.** During the period beginning with the effective date of this Act, and ending June 30, 2023, the department of human services is authorized to expend funds for the following capital projects and payments:

1. The payment of special assessments at the state hospital and life skills and transition center; and
2. The demolition of the chapel and employee building and associated tunnels at the state hospital.

Notwithstanding sections 54-16-04 and 54-27-12, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services for the department to expend funds on the demolition of the identified buildings and associated tunnels and for emergency capital projects. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department of human services shall report to the budget section after June 30, 2022, any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 10. STATE HOSPITAL BUILDING PROJECTS. The department of human services is authorized to construct a new state hospital on the property owned by the state of North Dakota, in Stutsman County, near or on state hospital's current campus. The new state hospital may include space for the operation of the regional human service center. The department of human services shall utilize chapter 48-02.1 and have a private operator to build, transfer, and operate the facility through a development agreement on leased property owned by the state of North Dakota. The continuing cost to support the new state hospital through a development agreement must be included in the department of human services' 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 11. LEGISLATIVE INTENT – CONVEYANCE OF LAND. It is the intent of the sixty-seventh legislative assembly that the department of human services and national guard enter into an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to build a new training and storage center.

SECTION 12. EMERGENCY. Sections 9 and 10 of this Act are declared to be an emergency measure."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/27/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 2:17 p.m.

Discussion Topics:

- Children and Family Services
- Long term care
- ASD Waivers
- Budget Changes
- Executive request

Cody Pederson, Division Director, Children and Family Services (2:18 pm) testified about children and family services #3677

Dr. Caprice Knapp, Medicaid Dir (2:56 pm) testified about long term care #3887

Christa Fleming (3:16 pm) testified about ASD Waivers #3887

Chair Nelson closed the meeting at 3:36 p.m.

Cole Fleck, Committee Clerk

HOUSE BILL 1012 #3677
HOUSE APPROPRIATIONS
HUMAN RESOURCES DIVISION
REPRESENTATIVE JON NELSON, CHAIRMAN

Children and Family Services

Cory Pedersen, Division Director

NORTH Dakota | Human Services
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CHILDREN AND FAMILY SERVICES
Program Purpose

The purpose of the Children and Family Services division is to help families who are struggling avoid disruption by having access to the help they need to build stability and well-being together.



Department of Human Services

Children & Family Services

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
18.50	41.60	41.60	0	41%	Permanency	17
				25%	Safety	10.3
				16%	Wellbeing	6.8
				10%	Admin	4
				8%	Criminal Background Checks	3.5

COVID INFO

CFS has implemented workflow automation solutions which allow staff to work from home, both during COVID and into the future.

Telework Headcount	
Pre-COVID	Current
0	40

CHILDREN AND FAMILY SERVICES

In ND child welfare services are delivered by local, state, tribal and private providers using both federal and state funds

Dept of Human Services

- **Human Service Centers**
  - Crisis teams
  - Intensive In-home services (therapy & treatment, skills training, behavior mod)
  - Targeted case management
- **Children & Family Services**
  - Training and coaching of field staff
  - Oversee quality service delivery
  - Administration of policy

Private Human Service Providers

- Safe shelter for crisis
- Human trafficking supports and safe beds
- Unaccompanied minor services
- Foster homes, including therapeutic
- Targeted case management

Tribal Social Services

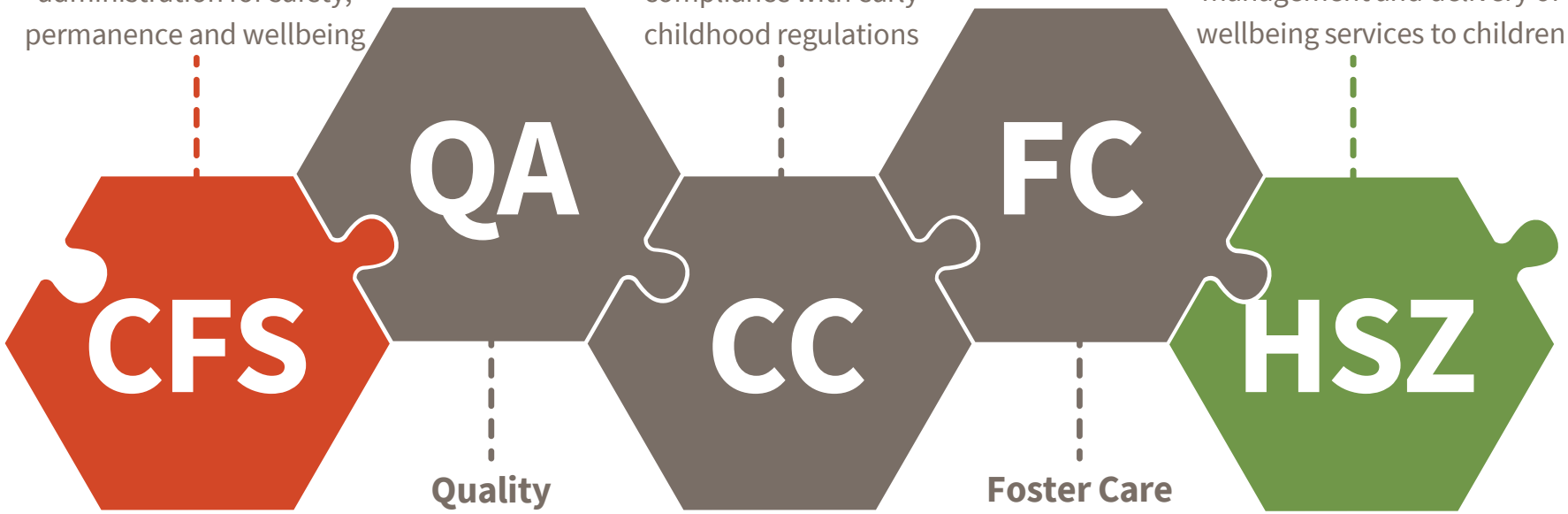
- FRAME entry and foster eligibility determinations
- Joint practice model and ICWA training
- Native American Training Institute supports (training, billing, svc delivery)
- New FMAP service contracting
- IV-E agreements boost access to funding

Human Service Zones

- Assess present and impending danger
- Safety planning
- Case management
- Assess and build parent capacities
- Provide safe supports for children and families
- Refer and broker services needed for families
- In home supports
- Parent aides
- License foster homes
- Intake for child abuse and neglect reports

A Focus on Quality, Fidelity & Consistency

Connector teams link program and policy with client services



Program & Policy

41.5 employees in CFS budget;
Policy planning and administration for safety, permanence and wellbeing

Child Care Licensing

24 FTE in HSZ budget
Oversee licensing and compliance with early childhood regulations

Client Services

≈300 HSZ employees
Assess safety; case management and delivery of wellbeing services to children

Quality Assurance

10 FTE in HSZ budget
Monitor quality across child welfare system; provide coaching/training

Foster Care Licensing

16 FTE in HSZ budget
Assure quality and efficient delivery of support services to families

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	**General Fund**	**Other Funds**	**Total**
Children and Family Services				
Continued program changes		3,172,228	(394,323)	2,777,905
Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Subtotal Children and Family Services	**-**	**(15,206,926)**	**(2,097,345)**	**(17,304,271)**



Our goals

- Reduce Foster Care Numbers
- Reduce Institutional Placements
- Reduce Out of State Placements
- Reduce Substance Abuse as Abuse/Neglect factor
- Increase Kids receiving evidence-based supports
- Reduce severity of school-based behaviors



"North Dakota's Child Welfare System is focusing on efforts to **ensure availability and access** to a broad, flexible array of **effective community-based services and supports**

for children and their families

that address their emotional, social, educational and physical needs,

including traditional and nontraditional services as well as natural and informal supports."

ND 2020-2024 Title IV-E Prevention Services and Programs Plan

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	5,153,639	5,377,650	2,492,452	201,240	5,578,890
512x Salaries - Other	-	-	-	-	-
513x Salaries - Temp	170,393	182,132	137,295	150,085	332,217
514x Salaries - Over Time	87,237	37,458	35,769	(18,942)	18,516
516x Salaries - Benefits	2,290,725	2,749,399	1,152,752	(178,751)	2,570,648
Total Salaries & Benefits	**7,701,994**	**8,346,639**	**3,818,268**	**153,632**	**8,500,271**
52x Travel	172,677	240,835	62,175	(77,385)	163,450
53x Supply	13,992	30,549	12,223	6,501	37,050
54x Postage & Printing	29,798	32,296	10,331	(4,652)	27,644
55x Equipment Under $5,000	208	150	131	-	150
57x Insurance	7,000	10,000	5,273	-	10,000
58x Rent/Leases - Bldg./Equip	83,994	35,116	27,641	(1,750)	33,366
59x Repairs	106	800	-	-	800
61x Professional Development	103,950	102,825	37,576	(14,515)	88,310
62x Fees - Operating & Professional	7,785,077	6,077,342	3,791,066	488,571	6,565,913
60x IT Expenses	4,743	1,814	1,814	-	1,814
Total Operating	**8,201,545**	**6,531,727**	**3,948,230**	**396,770**	**6,928,497**
71x Grants, Benefits, & Claims	139,368,973	166,292,675	59,792,854	(16,083,723)	150,208,952
Total Grants	**139,368,973**	**166,292,675**	**59,792,854**	**(16,083,723)**	**150,208,952**
Total	**155,272,512**	**181,171,041**	**67,559,352**	**(15,533,321)**	**165,637,720**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	66,151,962	87,651,918	29,531,281	(15,698,254)	71,953,664
Federal	83,762,041	88,707,220	35,916,129	1,028,817	89,736,037
Other	5,358,509	4,811,903	2,111,942	(863,884)	3,948,019
Total	155,272,512	181,171,041	67,559,352	(15,533,321)	165,637,720

OVERVIEW OF BUDGET CHANGES IN GRANTS: **FOSTER CARE & FFPSA**

Service Description	**2019-2021 Appropriation**	Continued Program Changes	Grants to Cost to Continue	FMAP Changes	Savings	Total Changes	2021-2023 Total Budget To OMB	Inflation 1%/1%	Executive Budget Recommend
Child Care Licensing Payments to Counties			-			-	-		-
Child Abuse/Neglect Assessment Payments to Counties			-			-	-		-
Subsidized Adoption Grants	42,764,596		11,364,852	-	(2,250,303)	9,114,549	51,879,145	662,295	52,541,440
Foster Care Maintenance/Services	91,251,091		(15,187,273)	-	(14,933,247)	(30,120,520)	61,130,571	855,621	61,986,192
Foster Care Therapeutic	8,819,466		(3,185,930)	-	(2,363,809)	(5,549,739)	3,269,727	48,260	3,317,987
Subsidized Guardianship Grants	1,030,115		376,521	-	-	376,521	1,406,636	13,709	1,420,345
Family First	-		6,469,069			6,469,069	6,469,069		6,469,069
Total	143,865,268		(162,761)	-	(19,547,359)	(19,710,120)	124,155,148	1,579,884	125,735,032
General Fund	70,941,489		(6,187,819)	(1,745,739)	(11,843,851)	(19,777,409)	51,164,080	992,570	52,156,650

Also included in the grants line are other Children & Family Services grants for which cost and caseload data is not computed. These grants include:

Child Abuse and Prevention Grants	2,967,556	32,500	-	-	(238,056)	(205,556)	2,762,000		2,762,000
Independent Living Programs	1,031,278	141,946	-	-	-	141,946	1,173,224		1,173,224
Refugee Payments	3,740,000	192,000	-	-	-	192,000	3,932,000		3,932,000
Child Care Quality Grants	6,617,392	-	-	-	-	-	6,617,392		6,617,392
Tribal Grants IV-E Reimbursement	1,273,732	2,567,455	-	-	-	2,567,455	3,841,187	37,434	3,878,621
Family Preservation Grants	2,183,786	-	-	-	-	-	2,183,786		2,183,786
Training Child Welfare Professionals and Foster Parents	2,110,392	(150,000)	-	-	-	(150,000)	1,960,392		1,960,392
Foster Care Administration Grants to Tribes & DOCR	1,114,012	(100,012)	-	-	-	(100,012)	1,014,000		1,014,000
Other CFS Grants	1,389,259	(336,754)	-	-	(100,000)	(436,754)	952,505		952,505
Total Other Grants	22,427,407	2,347,135	-		(338,056)	2,009,079	24,436,486	37,434	24,473,920
General Other Grants	9,448,177	2,942,563	-	-	(338,055)	2,604,508	12,052,685	37,433	12,090,118

Total CFS Grants	166,292,675	2,347,135	(162,761)	-	(19,885,415)	(17,701,041)	148,591,634	1,617,318	150,208,952
General Fund	80,389,666	2,942,563	(6,187,819)	(1,745,739)	(12,181,906)	(17,172,901)	63,216,765	1,030,003	64,246,768

CHILDREN AND FAMILY SERVICES

Foster Care and Residential Placements & Prevention Services

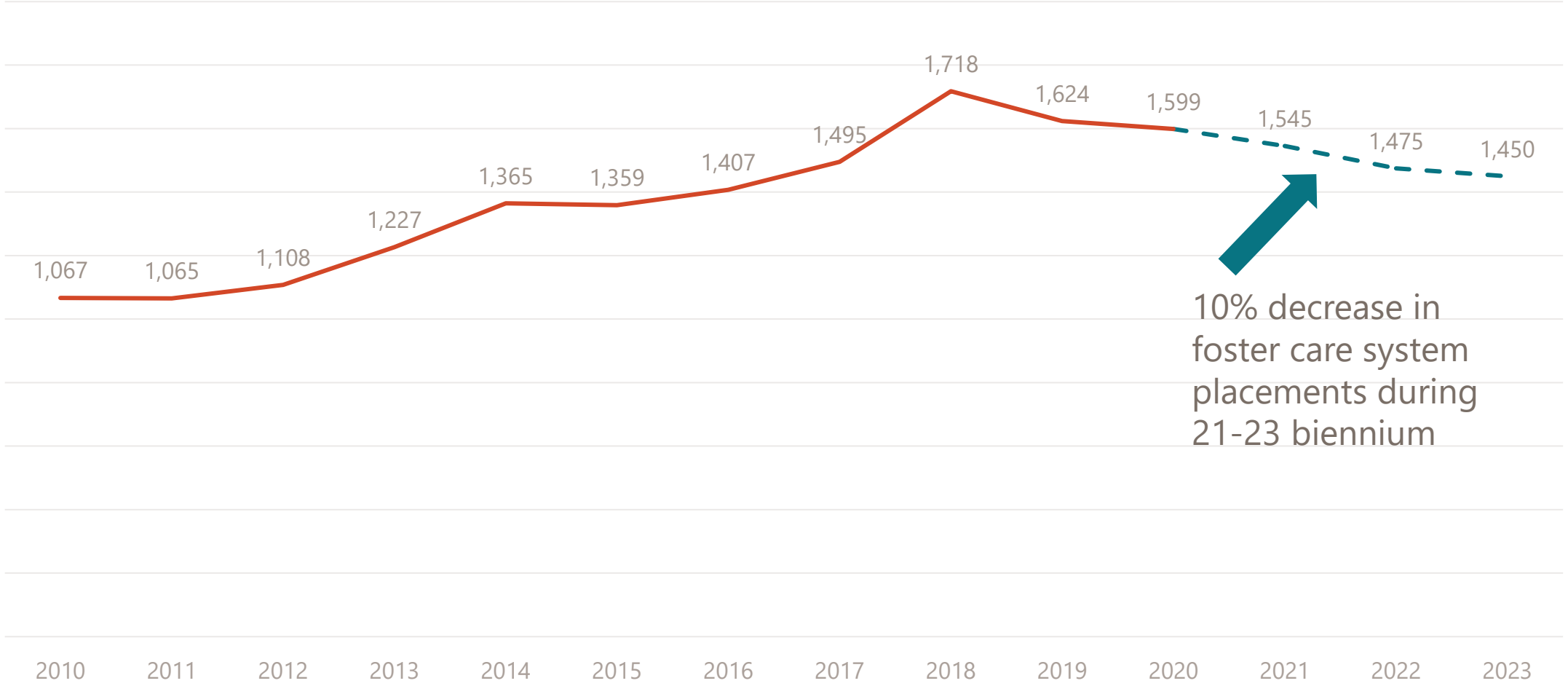
- 10% reduction in foster care system placements
- Increase in prevention services as outlined in the Family First Prevention plan

Foster Care & Residential Placements / FFPSA				
	Total	**Federal**	**State**	**Other**
Foster Care Maint Pmt	$(30,120,520)	$(5,552,595)	$(24,194,873)	$(373,052)
Therapeutic Foster Care	$(5,549,739)	$(2,660,429)	$(2,889,310)	-
Family First Prevention	$6,469,069	$4,358,048	$2,111,021	-

Estimated Total Potential Savings **$29,201,190**

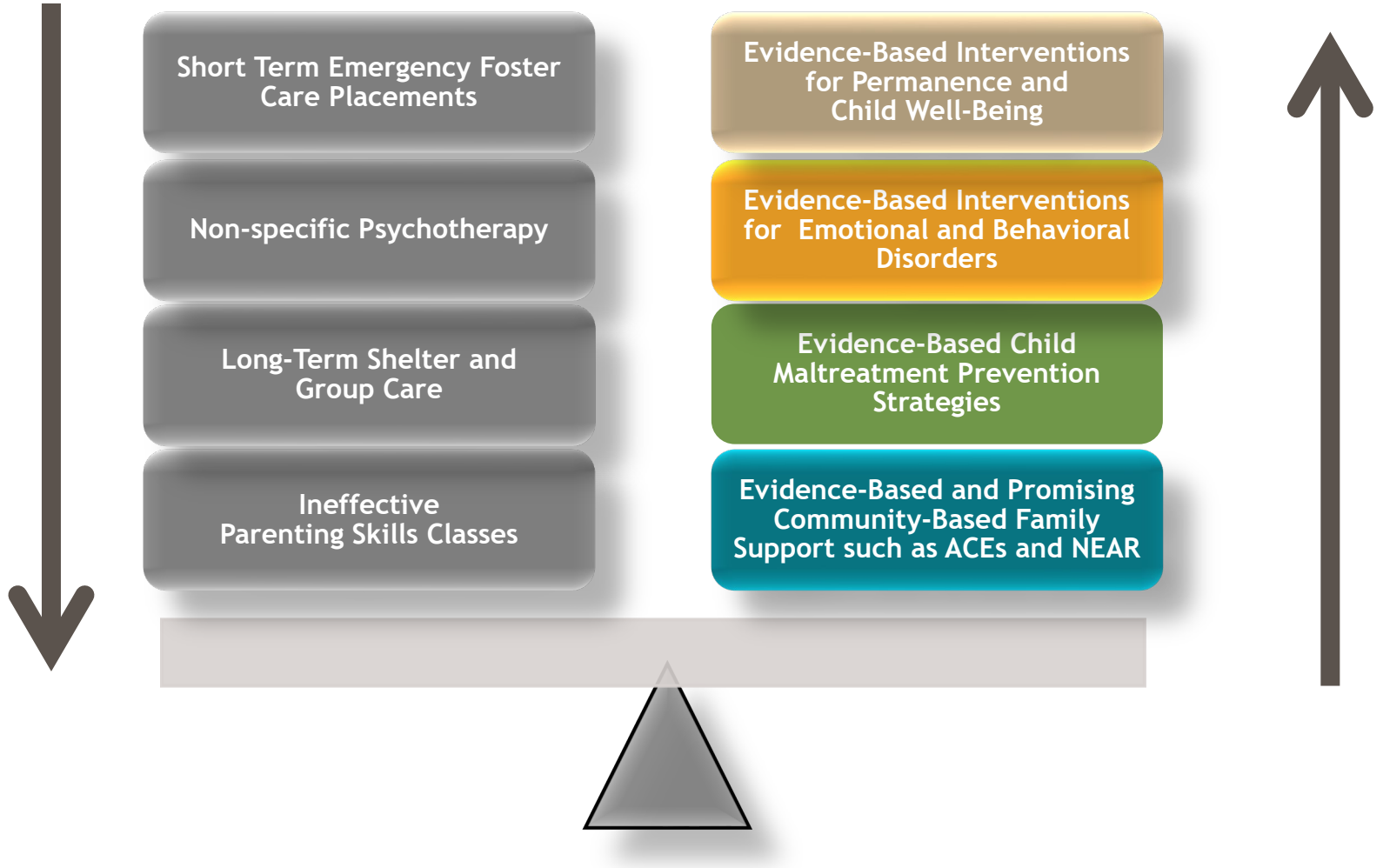
CHILDREN AND FAMILY SERVICES

The 21-23 budget anticipates a modest but steady reduction in foster care and residential placements



SHIFTING RESOURCES TO SUPPORT WHAT RESEARCH INDICATES WILL WORK FOR CHILDREN AND FAMILIES

De-scale investment in **approaches** that are **not proven effective**



Invest in approaches with **proven results** for the populations being served

OVERVIEW OF BUDGET CHANGES: **GRANTS, CONTRACTS & OP SVC**

Service Description	**2019-2021 Appropriation**	Continued Program Changes	Grants to Cost to Continue	FMAP Changes	Savings	Total Changes	2021-2023 Total Budget To OMB	Inflation 1%/1%	Executive Budget Recommend
Child Care Licensing Payments to Counties			-			-	-		-
Child Abuse/Neglect Assessment Payments to Counties			-			-	-		-
Subsidized Adoption Grants	42,764,596		11,364,852	-	(2,250,303)	9,114,549	51,879,145	662,295	52,541,440
Foster Care Maintenance/Services	91,251,091		(15,187,273)	-	(14,933,247)	(30,120,520)	61,130,571	855,621	61,986,192
Foster Care Therapeutic	8,819,466		(3,185,930)	-	(2,363,809)	(5,549,739)	3,269,727	48,260	3,317,987
Subsidized Guardianship Grants	1,030,115		376,521	-	-	376,521	1,406,636	13,709	1,420,345
Family First	-		6,469,069			6,469,069	6,469,069		6,469,069
Total	143,865,268		(162,761)	-	(19,547,359)	(19,710,120)	124,155,148	1,579,884	125,735,032
General Fund	70,941,489		(6,187,819)	(1,745,739)	(11,843,851)	(19,777,409)	51,164,080	992,570	52,156,650

Also included in the grants line are other Children & Family Services grants for which cost and caseload data is not computed. These grants include:

Child Abuse and Prevention Grants	2,967,556	32,500	-	-	(238,056)	(205,556)	2,762,000		2,762,000
Independent Living Programs	1,031,278	141,946	-	-	-	141,946	1,173,224		1,173,224
Refugee Payments	3,740,000	192,000	-	-	-	192,000	3,932,000		3,932,000
Child Care Quality Grants	6,617,392	-	-	-	-	-	6,617,392		6,617,392
Tribal Grants IV-E Reimbursement	1,273,732	2,567,455	-	-	-	2,567,455	3,841,187	37,434	3,878,621
Family Preservation Grants	2,183,786	-	-	-	-	-	2,183,786		2,183,786
Training Child Welfare Professionals and Foster Parents	2,110,392	(150,000)	-	-	-	(150,000)	1,960,392		1,960,392
Foster Care Administration Grants to Tribes & DOCR	1,114,012	(100,012)	-	-	-	(100,012)	1,014,000		1,014,000
Other CFS Grants	1,389,259	(336,754)	-	-	(100,000)	(436,754)	952,505		952,505
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Total CFS Grants	166,292,675	2,347,135	(162,761)	-	(19,885,415)	(17,701,041)	148,591,634	1,617,318	150,208,952
General Fund	80,389,666	2,942,563	(6,187,819)	(1,745,739)	(12,181,906)	(17,172,901)	63,216,765	1,030,003	64,246,768

CHILDREN AND FAMILY SERVICES
1915i Payment Re-alignment & Evidence based practice

- Begin transitioning parent and family peer support services to 1915i payment structure
- Shift investments related to parent education to evidence based models that are targeted to families most urgently in need

Grants & Contracts			
	Total	**Federal**	**State**
Peer to Peer / Family Voices	$(100,000)	$(1)	$(99,999)
Nurturing Parent / NDSU	$(238,056)	$(0)	$(238,056)

Estimated Total Potential Savings **$338,056**

OVERVIEW OF BUDGET CHANGES IN GRANTS: **RATE ALIGNMENT**

Service Description	**2019-2021 Appropriation**	Continued Program Changes	Grants to Cost to Continue	FMAP Changes	Savings	Total Changes	2021-2023 Total Budget To OMB	Inflation 1%/1%	Executive Budget Recommend
Child Care Licensing Payments to Counties			-			-	-		-
Child Abuse/Neglect Assessment Payments to Counties			-			-	-		-
Subsidized Adoption Grants	42,764,596		11,364,852	-	(2,250,303)	9,114,549	51,879,145	662,295	52,541,440
Foster Care Maintenance/Services	91,251,091		(15,187,273)	-	(14,933,247)	(30,120,520)	61,130,571	855,621	61,986,192
Foster Care Therapeutic	8,819,466		(3,185,930)	-	(2,363,809)	(5,549,739)	3,269,727	48,260	3,317,987
Subsidized Guardianship Grants	1,030,115		376,521	-	-	376,521	1,406,636	13,709	1,420,345
Family First	-		6,469,069			6,469,069	6,469,069		6,469,069
Total	143,865,268		(162,761)	-	(19,547,359)	(19,710,120)	124,155,148	1,579,884	125,735,032
General Fund	70,941,489		(6,187,819)	(1,745,739)	(11,843,851)	(19,777,409)	51,164,080	992,570	52,156,650

Also included in the grants line are other Children & Family Services grants for which cost and caseload data is not computed. These grants include:

Child Abuse and Prevention Grants	2,967,556	32,500	-	-	(238,056)	(205,556)	2,762,000		2,762,000
Independent Living Programs	1,031,278	141,946	-	-	-	141,946	1,173,224		1,173,224
Refugee Payments	3,740,000	192,000	-	-	-	192,000	3,932,000		3,932,000
Child Care Quality Grants	6,617,392	-	-	-	-	-	6,617,392		6,617,392
Tribal Grants IV-E Reimbursement	1,273,732	2,567,455	-	-	-	2,567,455	3,841,187	37,434	3,878,621
Family Preservation Grants	2,183,786	-	-	-	-	-	2,183,786		2,183,786
Training Child Welfare Professionals and Foster Parents	2,110,392	(150,000)	-	-	-	(150,000)	1,960,392		1,960,392
Foster Care Administration Grants to Tribes & DOCR	1,114,012	(100,012)	-	-	-	(100,012)	1,014,000		1,014,000
Other CFS Grants	1,389,259	(336,754)	-	-	(100,000)	(436,754)	952,505		952,505
Total Other Grants	22,427,407	2,347,135	-		(338,056)	2,009,079	24,436,486	37,434	24,473,920
General Other Grants	9,448,177	2,942,563	-	-	(338,055)	2,604,508	12,052,685	37,433	12,090,118

Total CFS Grants	166,292,675	2,347,135	(162,761)	-	(19,885,415)	(17,701,041)	148,591,634	1,617,318	150,208,952
General Fund	80,389,666	2,942,563	(6,187,819)	(1,745,739)	(12,181,906)	(17,172,901)	63,216,765	1,030,003	64,246,768

CHILDREN AND FAMILY SERVICES
Rate Alignment – Targeted Case Management

- Provide equity of rates for Targeted Case Management Services
- Rates will be consistent with TCM for Individuals with SMI/SED
- Services are consistent for
  - TCM – Child Welfare
  - TCM – For Individuals with SMI/SED

Standardize TCM Rate for Child Welfare			
	Total	**Federal**	**State**
Targeted Case Management	$(2,363,809)	$(1,264,638)	$(1,099,171)
Estimated Total Potential Savings **$2,363,809**			

CHILDREN AND FAMILY SERVICES
Rate Alignment – Subsidized Adoption

- Centralized foster care and subsidized adoption eligibility team will help assure consistency in future rate establishment
- Not applied retroactively

Standardize Subsidized Adoption Rates			
	Total	**Federal**	**State**
Subsidized Adoption	$(2,250,303)	$(1,093,984)	$(1,156,319)
Estimated Total Potential Savings **$2,250,303**			

CHILDREN AND FAMILY SERVICES

Replacement of FRAME/CCWIPS

BUDGET AMOUNT

$30,000,000

- $15 M general fund
- $15 M federal funds

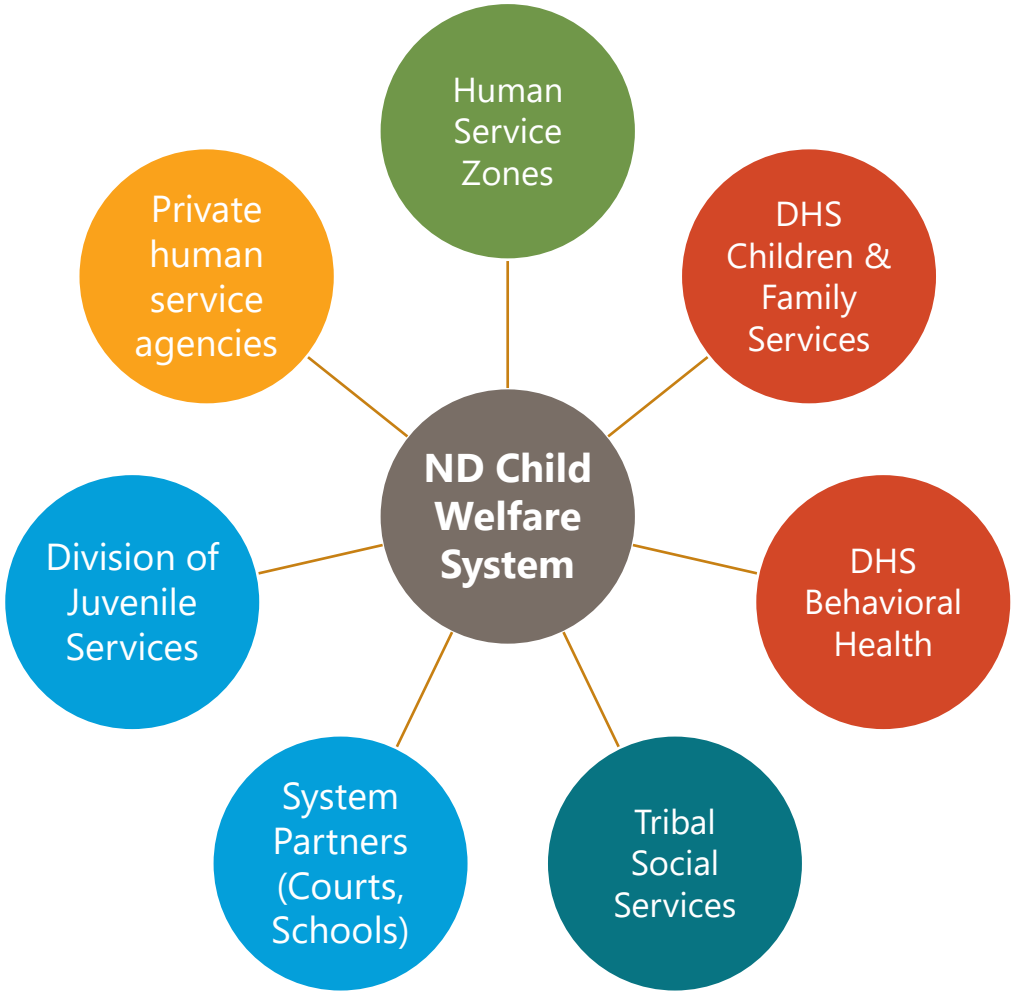
PURPOSE

Develop and deploy system to manage child protection, foster care, in-home supports to families, and adoption

Supports administrative efficiencies, retirement of mainframe, and requirements for continued federal program compliance



The replacement of FRAME/CCWIPS affects all parties involves in the ND Child Welfare System



The mission of the child welfare system in North Dakota

Safe Children
Strong Families

CHILDREN AND FAMILY SERVICES

Early Childhood Integrated Data System (ECIDS)

BUDGET AMOUNT

$500,000

- $500k general fund
- $0 federal funds

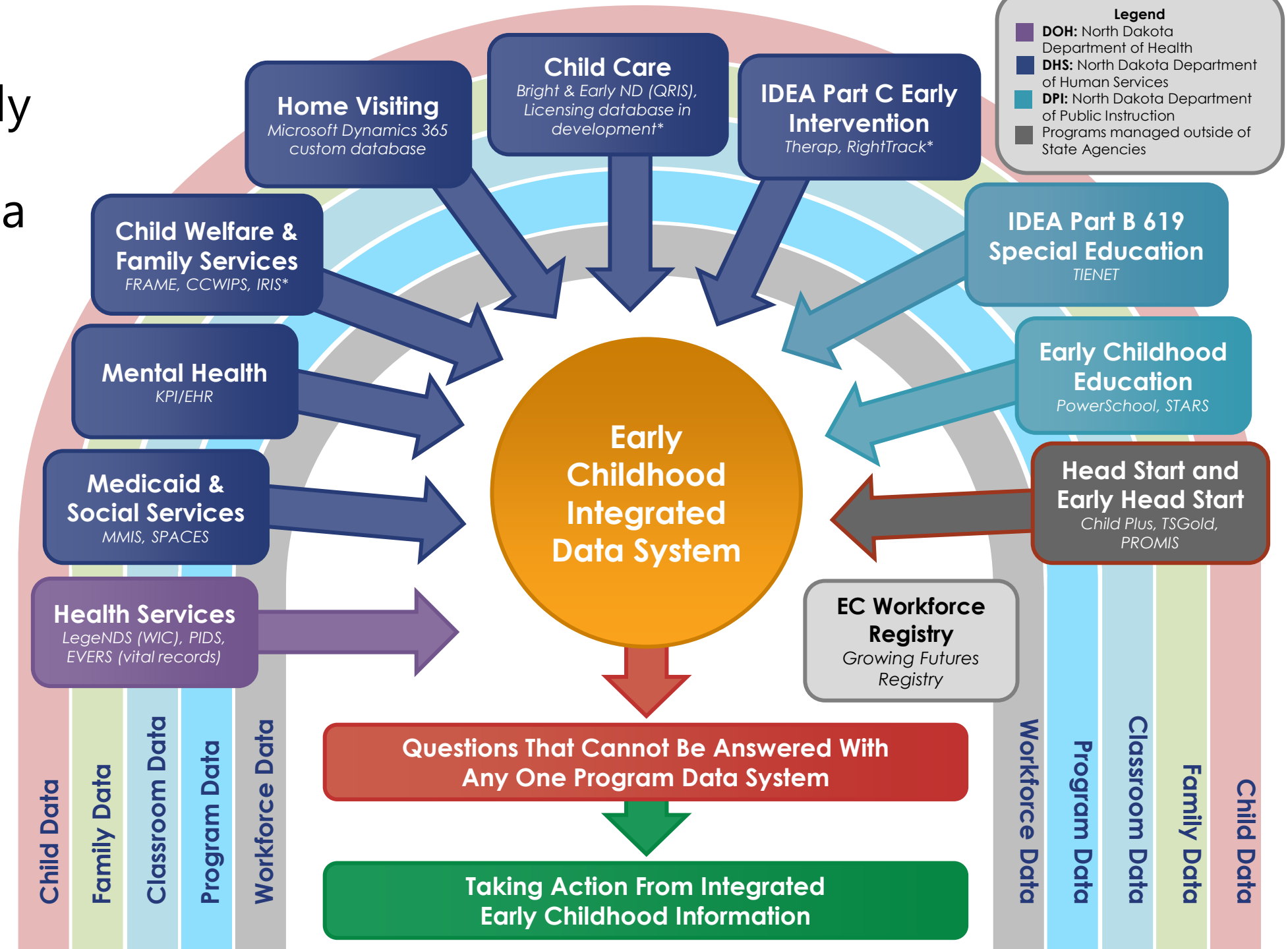
PURPOSE

Build a data model that connects information from existing databases in ways that allow policy makers to better understand how early childhood programs intersect with families' lives.

Improve ability to measure the outcomes of the investments made in early childhood.



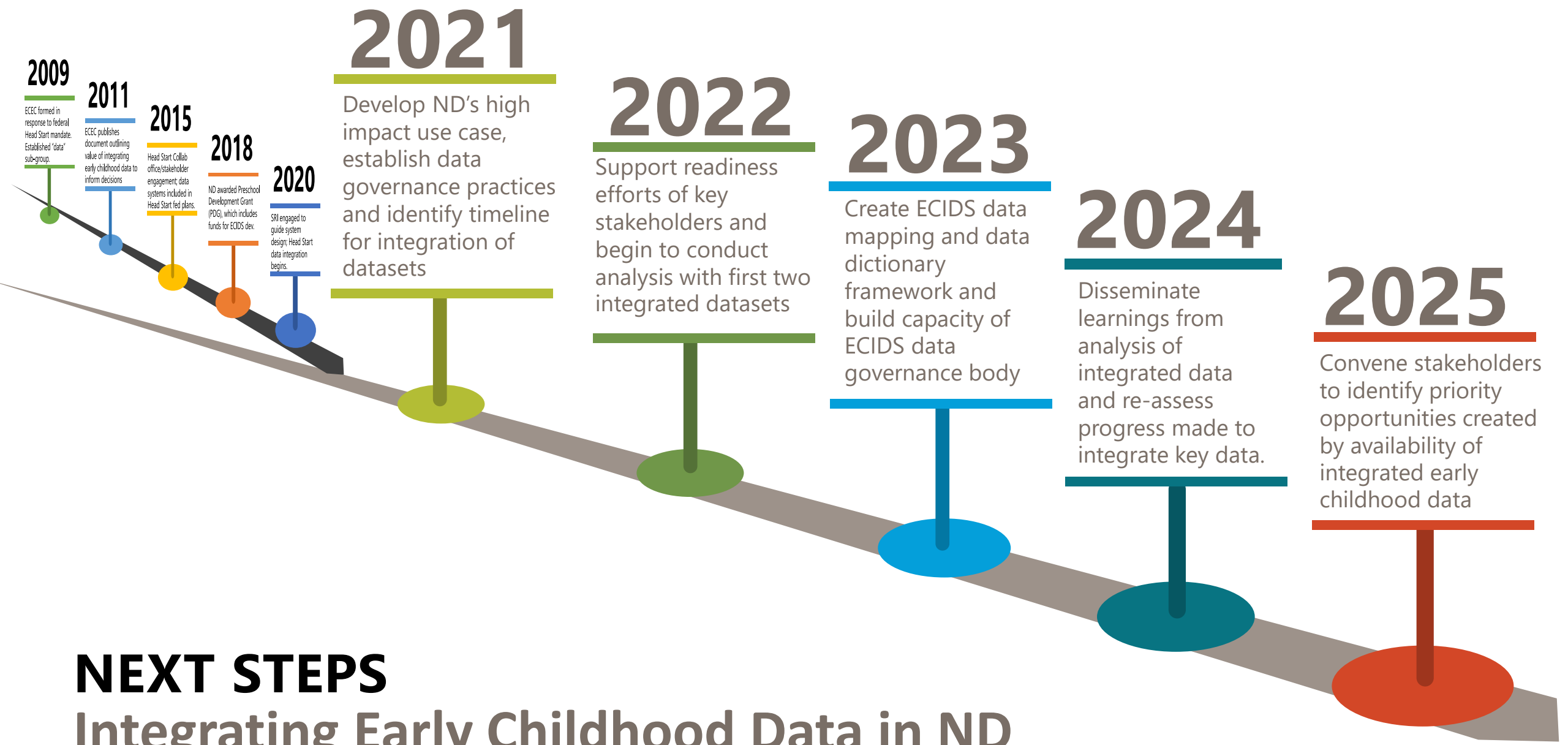
What is an Early Childhood Integrated Data System?



EARLY CHILDHOOD INTEGRATED DATA SYSTEM

Creating an ECIDS in North Dakota will

Integrate	Integrate data from various early childhood programs and services
Enable	Enable decision making to improve the coordination among and quality of services
Support	Support collaborative thinking between service providers, state agencies and policymakers
Improve	Improve efficiency of data management and reporting for stakeholders
Maximize	Maximize return on resources invested in collecting quality data
Inform	Inform policies and practices that support better outcomes for children and families.



NEXT STEPS

Integrating Early Childhood Data in ND

The evolution of an idea that could help us better serve families



House Bill 1012 #3887
Long-Term Care Services and Supports

House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD, Medical Services Director
Nancy Nikolas-Maier, Aging Services Director

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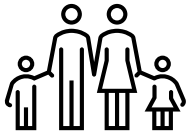
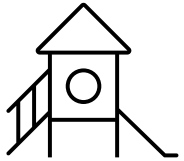
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



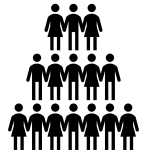
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Medicaid Long-Term Care Eligibility Unit

- Long Term Care Unit was formed in February 2020. The unit consists of 15 Eligibility Workers and One Supervisor.
- The LTC unit members are dispersed throughout the State and are home based employees.
- They are supported by several other State entities such as NDIT, Medicaid Policy and System Support, Medical Services, Economic Assistance, and the Legal Advisory Unit.
- The LTC unit utilizes MS Teams, and has a Call Center that is staffed Monday – Friday 8:00 am to 5:00 pm CST.

Client Support

The LTC Unit processes Medicaid Applications in which the client falls into one of the following categories:

- Resides in Skilled Nursing facility
- Resides in a Memory Care facility
- Resides in a Basic Care Facility
- Resides in a Medical facility with a Swing Bed Level of Care
- Is in receipt of Nursing Care Services or HCBS services and has a Spouse
- Is in receipt of the HCBS – 1915c Medical Waiver for Elderly or Physically Disabled individuals
- Asset assessments prior to Medicaid application for spouses who enter a nursing home – Spousal Impoverishment

Contact the Long-Term Care Unit

Online Self-Service Portal:
https://www.nd.gov/dhs/eligibility/index.html

Email: dhsmedicaidltc@nd.gov

Phone: 701-328-1180 or Toll Free 1-833-755-0235

Fax: 701-328-5020

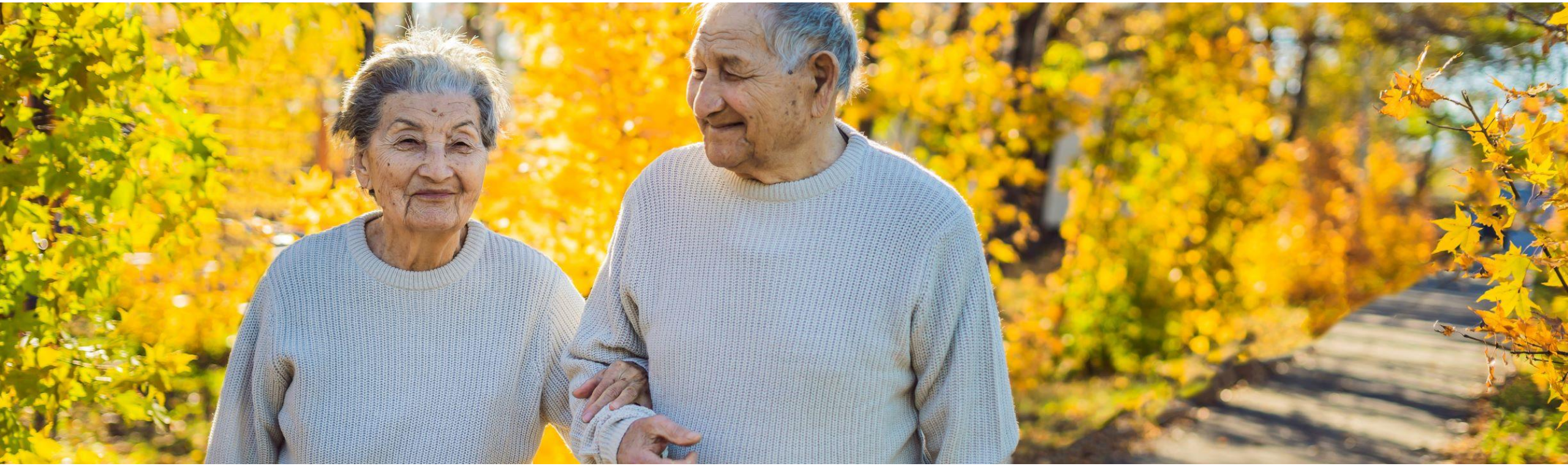
Mail: NDDHS – LTC Unit
600 East Boulevard Ave, Dept 325
Bismarck, ND 58505



AGENDA

- **Detail for Long-Term Care Services: Institutions**
- **Detail for Long-Term Care Services: PACE**
- **Detail for Long-Term Care Services: Autism and Other Waivers**
- **Review Executive Request for 2021-2023**

Detail for Long-Term Care Services: Institutions



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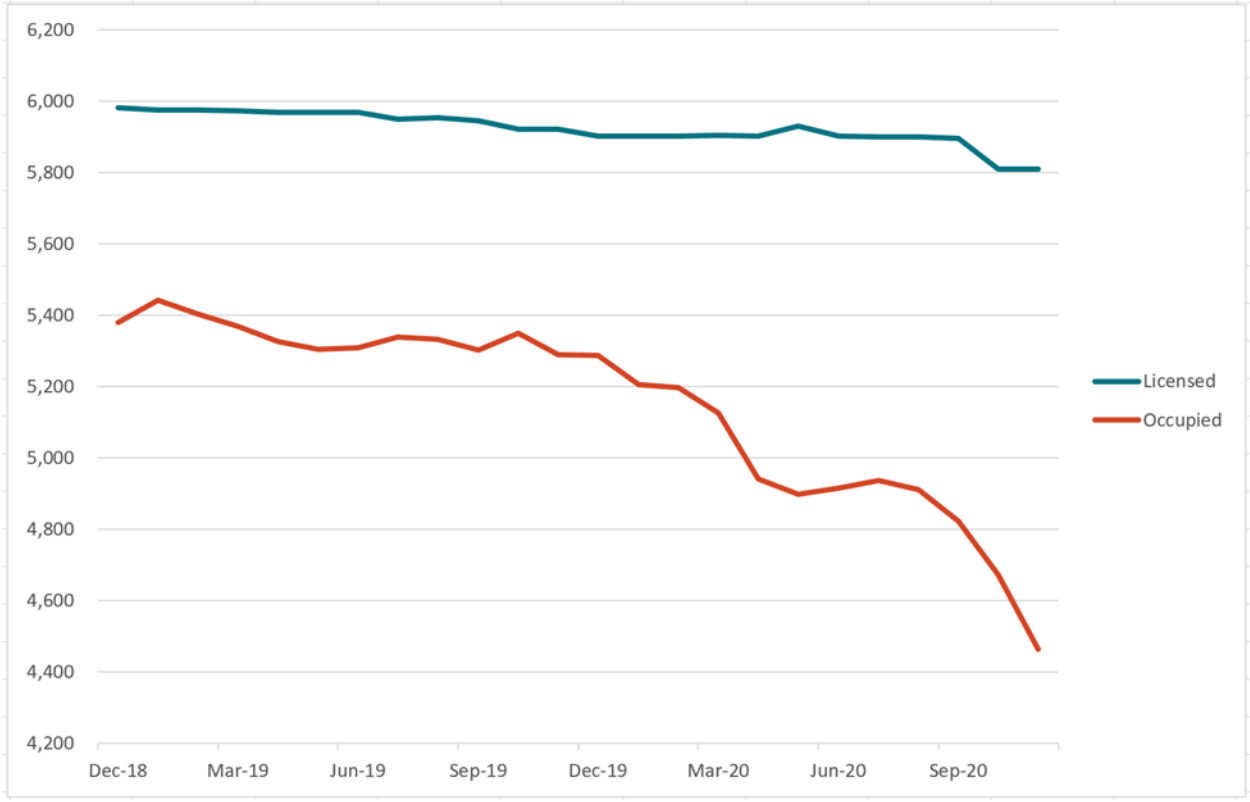
Bed Occupancy For Nursing Home Facilities

Nursing Facility Occupancy

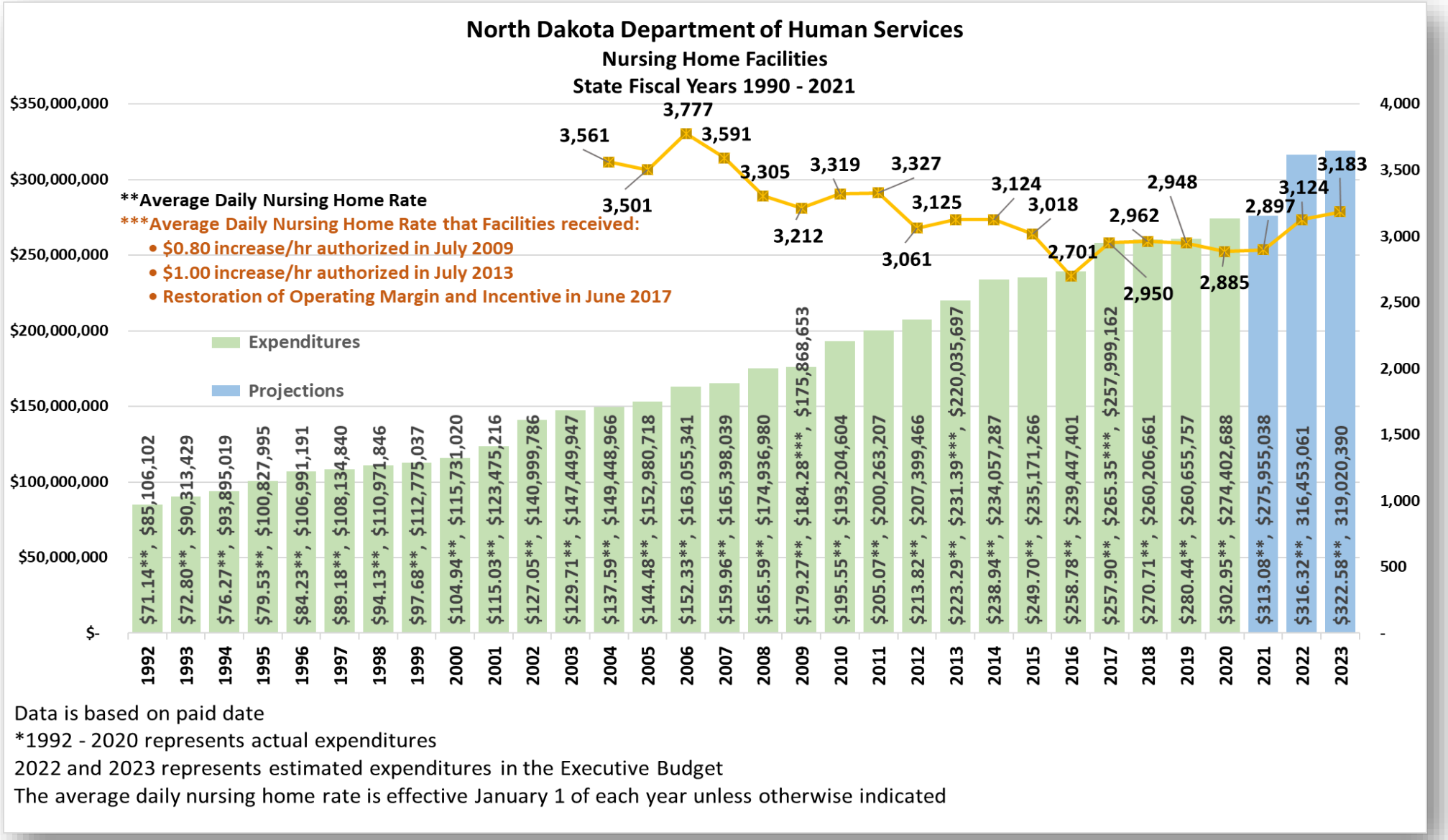


Nursing Facility Medicaid Occupancy



Nursing Home Facilities

State Fiscal Years 1990 - 2023



Data is based on paid date

*1992 - 2020 represents actual expenditures

2022 and 2023 represents estimated expenditures in the Executive Budget

The average daily nursing home rate is effective January 1 of each year unless otherwise indicated

Funding Request

Nursing Home Payment Reform

- Reform of both care and property rate methodology
- Interim report submitted October 1, 2020
- Testimony will be presented in **Human Services Committee**
- DHS sponsored bill
- $7.2 million ($3.3m General; $3.8m Federal)



Care Rate

Hold Harmless $4.1 million ($2.5 million year 1, $1.6 million in year 2)

- Facilities can choose old cost rate or new price rate
- 14 will likely choose old cost rate
- In year 1 (2022), the 14 choosing old cost rate would be inflated by 2.3%= $2.5 million
- In year 2 (2023) the 14 choosing the old cost rate would get 1.8% inflation (0.5% less than those choosing the new rate or 2.3%)=$1.6 million
- **At the end of year 2 there is no more hold harmless for care**



Services Closer to Home

Create pathways that help people access the right service at the right time

Engage proactively with providers to expand access to services

Property Rate

$2.1 million for increases to lower rate facilities

- 4-year phase in
- Year 1 (2023) $2.1 million
- Year 2 (2024) $4.2 million
- Year 3 (2025) $6.3 million
- Year 4 (2026) $8.4 million, annual amount expected



Property Rate

$1 million for Hold Harmless

14 facilities where cost>FRV

- By year 1, 8 cross over
- By year 2, 9 (cumulative) cross over
- By year 6, 10 cross over
- By year 8, 11 cross over
- By year 9, 12 cross over

Missouri Slope nor McKenzie County do not cross over even at year 15



Property Rate

Future Hold Harmless Estimate Depends on 12/31/2021

- So, if most cross over by year 9 why not predict how the $1 million per year decreases?
- Because the deadline to submit new construction or major renovation projects is 12/31/2021 and those would be considered in the future hold harmless amount
- Note prior testimony that lower interest rates cause facilities to cross over quicker (2.5% would cross in year 1; 5% would cross around year 11)



Funding Request

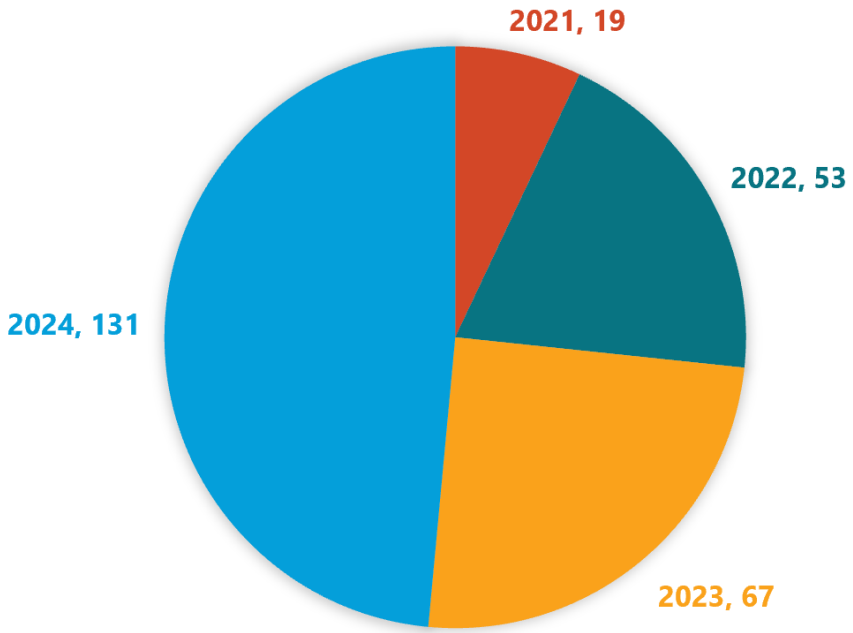
Nursing Home Bed Buy Back

- Request to purchase beds out of the current nursing home system and layaway
- State plans to pay between $12,000-$15,000 per bed
- Taking beds out of the system reduces future State liability
- $3.3m in General Funds



Nursing Home Bed Buy Back

EXPIRATION OF BEDS IN LAYAWAY
270 TOTAL



Services Closer to Home

Create pathways that help people access the right service at the right time

Engage proactively with providers to expand access to services

Burleigh/Morton

224

Medicaid beds

Cass

264

Medicaid beds

Grand Forks

163

Medicaid beds

Ward

25

Medicaid beds

Basic Care Facilities











Basic Care Rates

- Rates are effective July 1
- Cost reports are submitted annually
- Limits for Direct Care and Indirect Care
- No Rate Equalization
- One daily rate for all residents in the facility regardless of care needs
- Rates range from $78.63 - $186.68 per day
  - **Personal Care rate range**
    $36.37 - $99.88 per day
  - **Room and Board rate range**
    $36.45 - $112.91 per day

Reduce Basic Care Appropriation



Basic Care is a **state-funded program** that was created in the 1990s when home and community-based services were not as well developed

- North Dakota is the **only** state with Basic Care
- Medicaid **pays for personal care services** for Medicaid-eligible Basic Care residents
- The State **pays for room and board** for Medicaid-eligible Basic Care residents
- Basic Care **is not a CMS recognized institutional setting** and CMS will only allow payment for room and board in an institutional setting.

There is currently private pay differential in the Basic Care program, unlike Nursing Homes which charge a private pay room differential to Medicaid clients

LTCA survey showed that:

- 26 facilities charge >$10 per day (average is $9)
- Range is $1 to $26
- Room and board rates have no limit unlike nursing home rates that have limits
- Room and board ranges from $36 to $112 across Basic Care facilities

BASIC CARE REDUCTION



Estimated Total Potential Savings **$7,300,000**

Basic Care Reduction			
	Total	**Federal**	**State**
Basic Care	$ (7,300,000)	$ (0)	$ (7,300,000)

Detail for Long-Term Care Services: PACE



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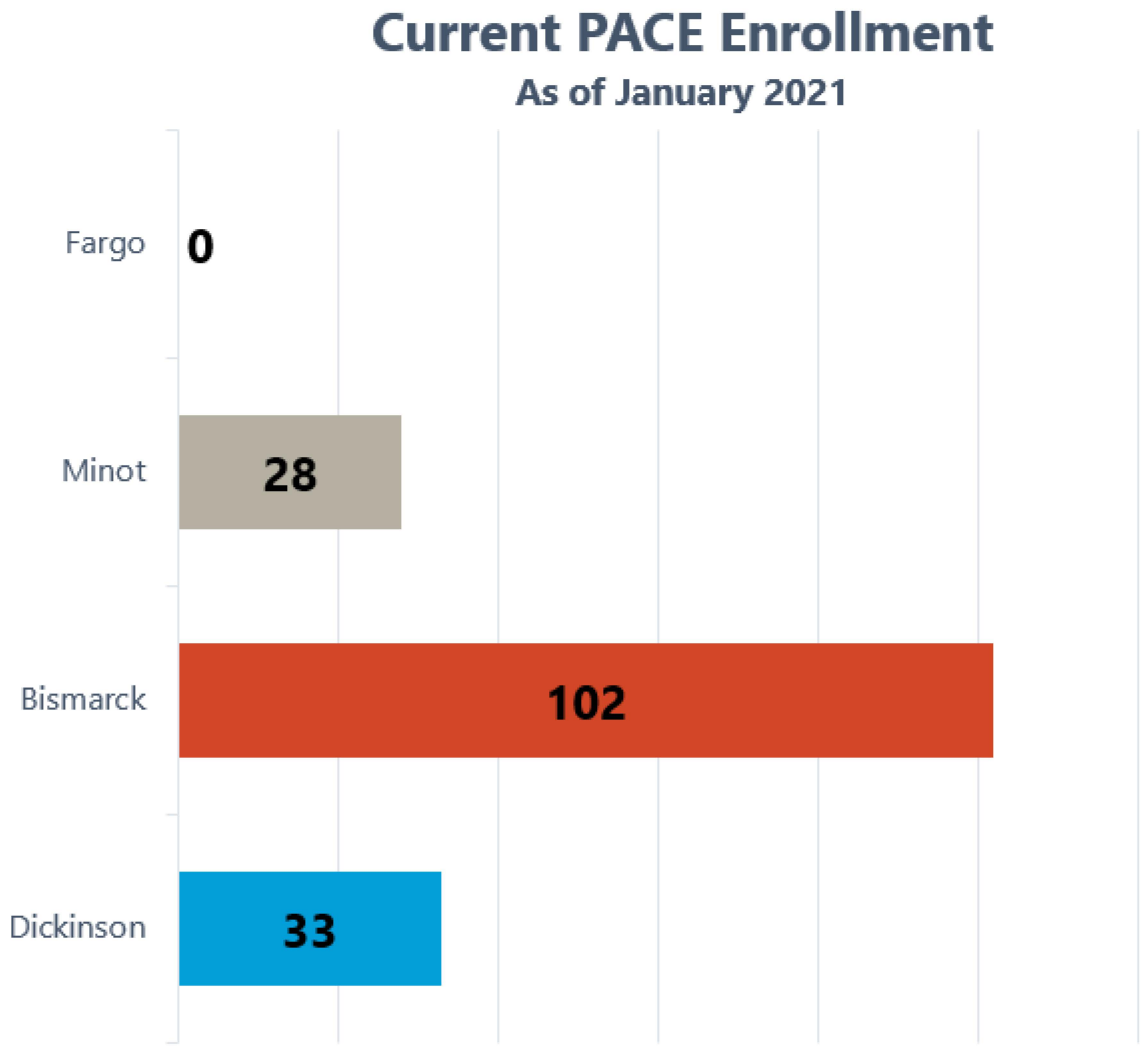
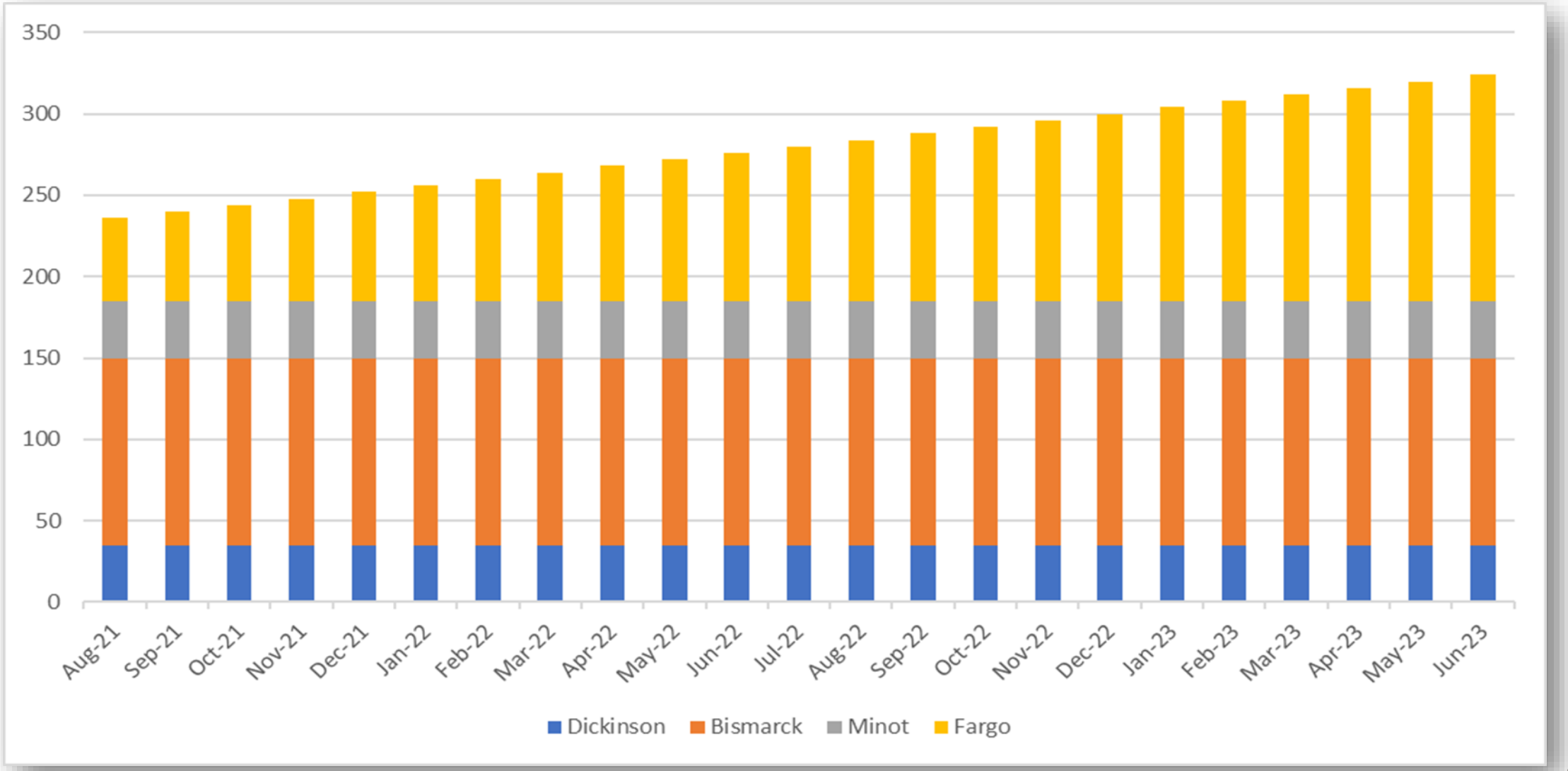
PACE ENROLLMENT



Total Enrollment: 163

PACE ENROLLMENT PROJECTIONS

2019-2021 Biennium



Reduce PACE Rates and Enrollment



- Based on the latest audited 9-months of financials from July 2019 through March 2020, Northland PACE experienced a **10.7 percent profit**. Our goal is to bring profits more in line with PACE programs in other states.

- The rate decrease was calculated by the State's actuaries using a Dual allocation methodology model. This approach analyzed the three most recent years of financial experience and allocates expenses for the Dual population between Medicaid and Medicare, and builds the rates up using the financial experience.

- Starting January 1, 2021, the monthly PACE capitation rates will be **decreased by 3.98%**.

REDUCE PACE RATES & ENROLLMENT



Estimated Total Potential Savings **$1,914,734**

Reduce PACE Rates & Enrollment			
	Total	**Federal**	**State**
PACE Capitated Rate Reduction	$ (1,385,545)	$ (740,194)	$ (645,351)
PACE Enrollment Reduction	$ (529,189)	$ (282,709)	$ (246,480)
TOTAL POTENTIAL SAVINGS	**$ (1,914,734)**	**$ (1,022,903)**	**$ (891,831)**

Detail for Long-Term Care Services: Autism and Other Waivers







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AUTISM SPECTRUM DISORDER (ASD) WAIVER

ASD Wavier

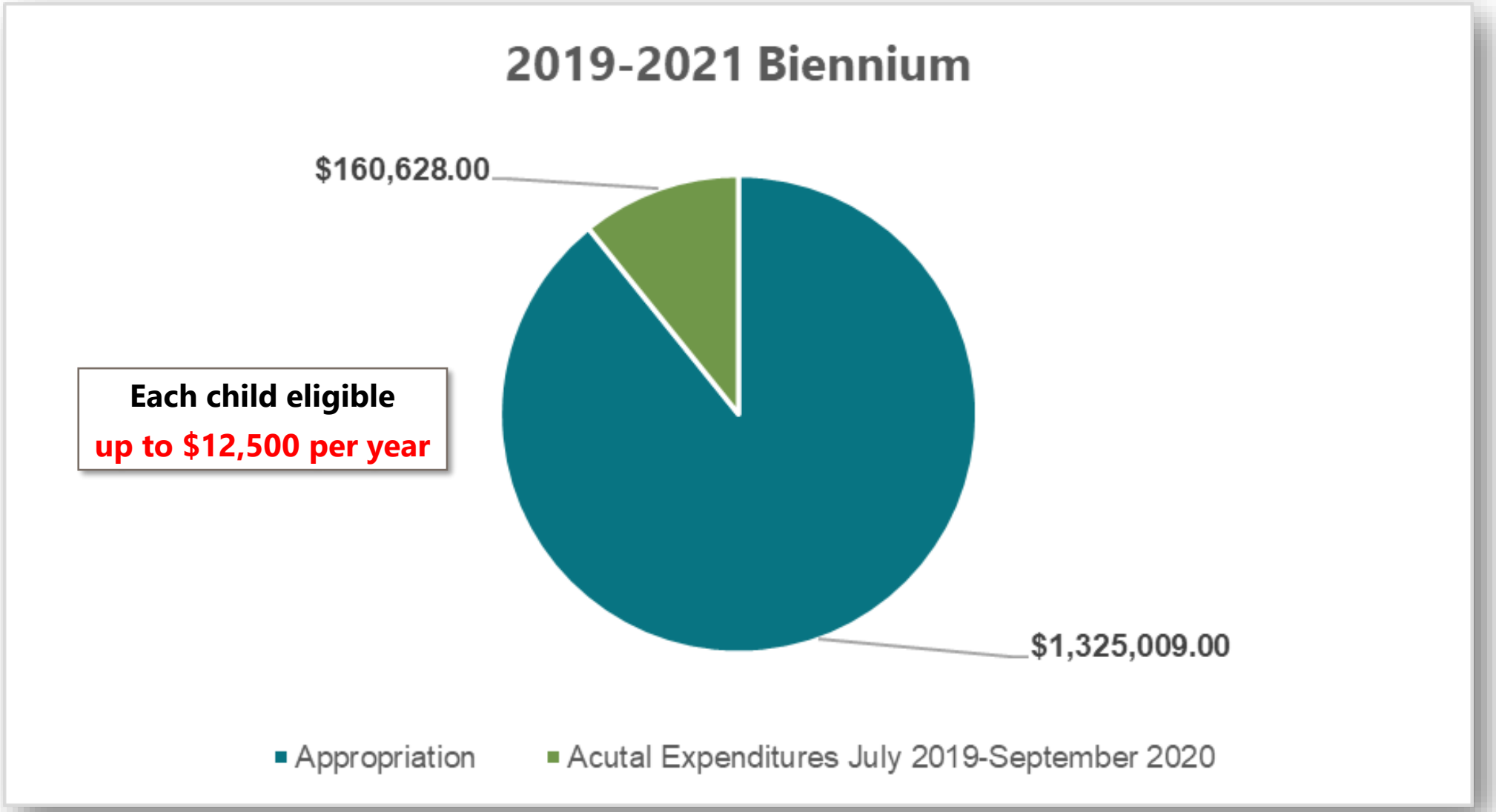
- **96 slots** per year
- **56 children on waitlist** as of 1/20/2021

- **$395,577 spent** in 2019-2021 on waiver
- **$2,077,632 spent** on state plan services in 2019-2021

  (96 children*$10,821 per child*2 years = $2,077,632)

- **$2,473,209** total spent on waiver & state plan in 2019-2021

ASD VOUCHER


2019-2021 Biennium
$160,628.00
$1,325,009.00
Each child eligible
up to $12,500 per year
Appropriation
Acutal Expenditures July 2019-September 2020

Re-Investment of the Autism Voucher



- Age 3 years through age 17
- Family gross income is 200% below Federal Poverty Level (FPL)
- Must have an Autism Spectrum Disorder diagnosis
- Not be on any Medicaid 1915c waivers
- Child must reside with parents, legal guardian or custodian
- Must have lived in ND for at least 6 months

- Helps pay for assistive technology, training and other approved support services such as respite, that enhance the quality of life of children with autism spectrum disorder.
- ASD Voucher = maximum of $12,500 per year, per child.
- Early intervention and therapy services are not covered.

Autism Voucher Statistics

Year	Total Number of Children Enrolled	Total Number of Children with Voucher Purchases	Total Number of Children with No Voucher Purchases	Average Spending Per Year
2017-18	52	45	7	$4,974.45
2018-19	39	30	9	$4,866.84
2019-20	48	43	5	$3,186.88
2020-21	42	-	-	-

Autism Voucher Purchases

- Swings/playsets
- Arts and craft items/puzzles/flashcards/magnetic letters
- Toys to support socialization – doll house, kitchen sets, fidgets
- Respite/tutoring
- Adaptive swimming lessons/adaptive activities/adaptive horseback riding
- Weighted blankets/bean bag chairs/iPads, sensory items

Autism Voucher Requested – Not Purchased

- Fishing poles and tackle
- Pools
- Workout equipment that is not age appropriate
- Stuffed animals
- Kayaks and trailers
- Home Meal Delivery
- Cable TV, air conditioner, internet
- Car
- Entire kitchen sets, appliances, knives, plates, etc.

Re-Investing in Waiver Instead of Voucher

Voucher

- Only families with ASD who are 200% below FPL are eligible
- Limited to purchases of items and non-therapy services
- Does not qualify child for Medicaid
- Does not provide a service manager
- All general fund budget
- No federal matching funds

Waiver

- All North Dakota families with ASD are eligible
- Receives traditional Medicaid coverage and benefits
- Receives a service manager to assist family with planning and services
- Has assistive technology to purchase items of need
- Receive federal matching funds for all services

Eliminating the voucher and **re-investing** in the **waiver** will result in **50 new slots**

Summary of Autism Changes

Estimated Total Potential General Fund Savings

$623,000

Elimination of Autism Voucher = **$1.358 million** general fund savings

Re-investing in Autism Waiver = **$830,000** in general funds for of **50 slots** and state plan services

Elimination of Autism Training funds = **$93,000** in general fund savings

ELIMINATION OF TECHNOLOGY DEPENDENT WAIVER

Estimated Total Potential Savings **$596,112**

Elimination of TECH DEPENDENT WAIVER			
	Total	**Federal**	**State**
Tech Dependent Waiver	**$ (596,112)**	$ (318,560)	$ (277,552)

SUMMARY OF BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Grants	853,200	(330,000)	523,200
Medical Grants	736,510,531	85,531,242	822,041,773
Total	**737,363,731**	**85,201,242**	**822,564,973**
General Fund	377,567,931	26,612,730	404,180,661
Federal Funds	356,199,438	61,872,874	418,072,312
Other Funds	3,596,362	(3,284,362)	312,000
Total	**737,363,731**	**85,201,242**	**822,564,973**
Full Time Equivalent (FTE)	**0.00**	**0.00**	**0.00**

GREEN SHEET WALKTHROUGH GF/FTE

Executive Budget Request

	FTE Positions	General Fund	Other Funds	Total
Long-Term Care				
Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)
Grant cost and caseload changes		40,219,972	37,478,740	77,698,712
Other funds reprioritization		0	(2,284,362)	(2,284,362)
Funding source change - Health care trust fund		1,000,000	(1,000,000.00)	-
Subtotal Long Term Care		**33,348,100**	**33,234,093**	**66,582,193**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY AND FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
71x Grants, Benefits, & Claims	647,482,878	737,363,731	307,772,030	85,201,242	822,564,973
Total Grants	647,482,878	737,363,731	307,772,030	85,201,242	822,564,973
Total	647,482,878	737,363,731	307,772,030	85,201,242	822,564,973

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	338,341,273	377,567,931	161,713,605	26,612,730	404,180,661
Federal	306,998,114	356,199,438	146,058,425	61,872,874	418,072,312
Other	2,143,491	3,596,362	-	(3,284,362)	312,000
Total	647,482,878	737,363,731	307,772,030	85,201,242	822,564,973

GRANTS NOT ON WALKTHROUGH

Long Term Care

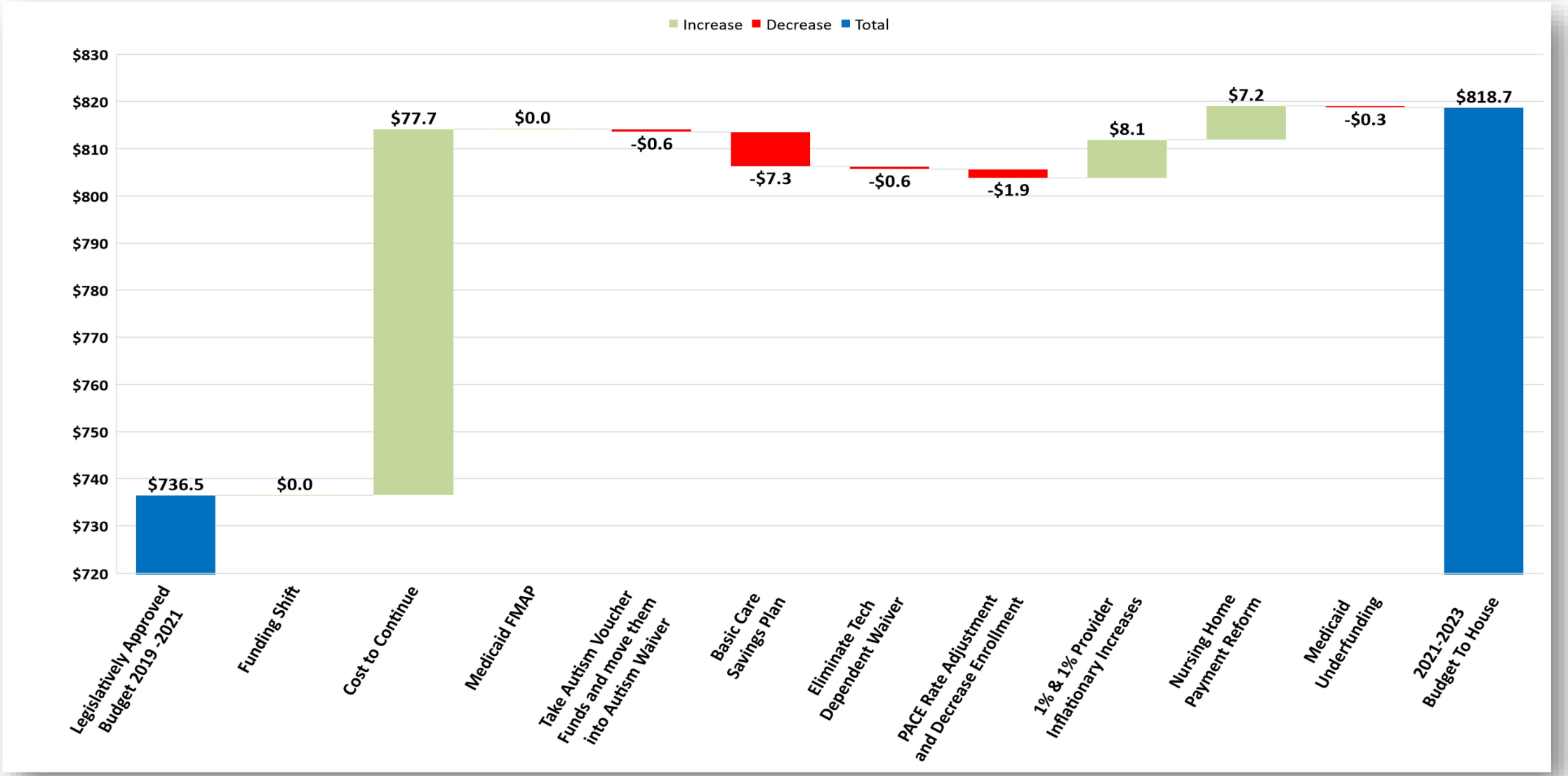
Budget Account Code 712000 - Grants, Benefits, and Claims	**$ 853,200**	**$ 523,200**	**$ 523,200**	**$ -**	**$ -**

Vendor	Description	2019-21 Biennium Amount	2021-23 Biennium Amount	General Fund	Federal Funds	Other Funds
Community of Care		660,000	330,000	330,000		
Personal Needs Allowance		193,200	193,200	193,200		

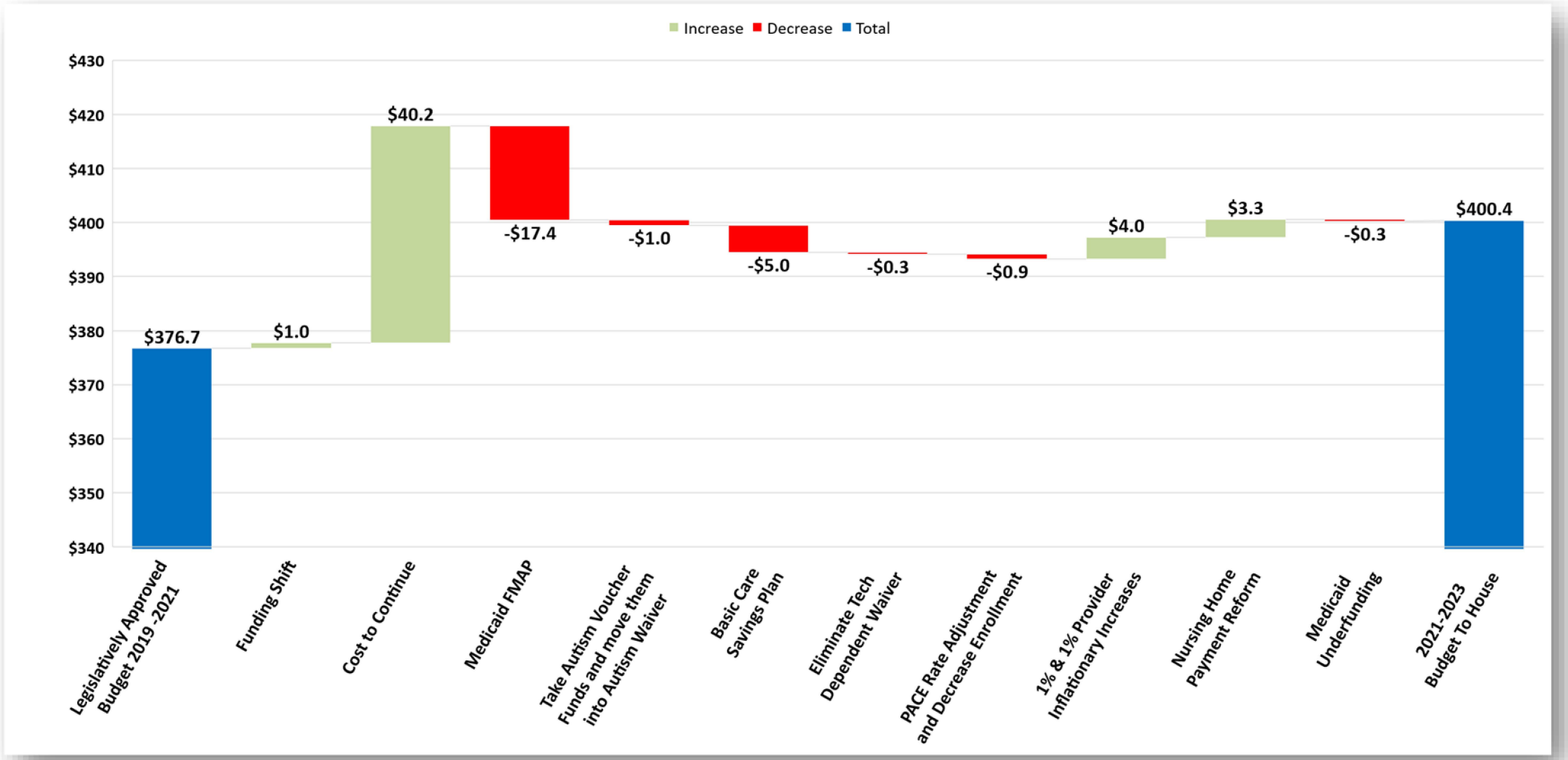
LONG TERM CARE WALKTHROUGH

Service Description	Legislatively Approved Budget 2019 - 2021	Funding Shift	Cost to Continue	Medicaid FMAP	Take Autism Voucher Funds and move them into Autism Waiver	Basic Care Savings Plan	Eliminate Tech Dependent Waiver	PACE Rate Adjustment and Decrease Enrollment	Total Changes	2021-2023 Budget To OMB	1% & 1% Provider Inflationary Increases	Nursing Home Payment Reform	Medicaid Underfunding	Total Governor Changes	2021-2023 Budget To House
Nursing Facilities	582,849,867		39,676,637						39,676,637	622,526,504	5,646,947	7,200,000		12,846,947	635,373,451
Underfunding	(20,000,000)		20,000,000						20,000,000	0			(330,000)	(330,000)	(330,000)
Total Nursing Facilities	**562,849,867**	**0**	**59,676,637**	**0**	**0**	**0**	**0**	**0**	**59,676,637**	**622,526,504**	**5,646,947**	**7,200,000**	**(330,000)**	**12,516,947**	**635,043,451**
Basic Care	49,555,981		5,717,765			(7,300,000)			(1,582,235)	47,973,746	439,126			439,126	48,412,872
Home & Community Based Services	**124,104,683**	**0**	**12,304,310**	**0**	**(645,673)**	**0**	**(596,112)**	**(1,914,734)**	**9,147,791**	**133,252,474**	**2,032,976**	**0**	**0**	**2,032,976**	**135,285,450**
SPED	17,799,841		2,020,479			0			2,020,479	19,820,320	298,683			298,683	20,119,003
Ex-SPED	1,844,963		(10,073)			0			(10,073)	1,834,890	27,782			27,782	1,862,672
Personal Care Services	34,483,377		(3,206,937)			0			(3,206,937)	31,276,440	470,710			470,710	31,747,150
Targeted Case Management	1,917,742		(1,763,206)			0			(1,763,206)	154,536	2,326			2,326	156,862
Home & Comm Based Service Waiver	30,104,751		14,492,777			0			14,492,777	44,597,528	683,636			683,636	45,281,164
Children's Medically Fragile Waiver	544,416		(154,680)			0			(154,680)	389,736	5,866			5,866	395,602
Technology Dependent Waiver	591,288		4,824			0	(596,112)		(591,288)	0	0			0	0
PACE	32,866,676		1,946,562			0		(1,914,734)	31,828	32,898,504	509,262			509,262	33,407,766
Children's Hospice Waiver	61,848		10,224			0			10,224	72,072	1,085			1,085	73,157
Autism Waiver	2,564,772		(1,068,804)		712,480				(356,324)	2,208,448	33,626			33,626	2,242,074
Autism Voucher	1,325,009		33,144		(1,358,153)				(1,325,009)	0				0	0
	0		0												
Excess Federal Authority	0		0						0	0				0	0.00
Total	**736,510,531**	**0**	**77,698,712**	**0**	**(645,673)**	**(7,300,000)**	**(596,112)**	**(1,914,734)**	**67,242,193**	**803,752,724**	**8,119,049**	**7,200,000**	**(330,000)**	**14,989,049**	**818,741,773**
General Fund	**376,714,731**	**1,000,000**	**40,219,973**	**(17,377,698)**	**(1,026,852)**	**(5,015,638)**	**(277,552)**	**(891,831)**	**16,630,402**	**393,345,133**	**3,994,328**	**3,348,000**	**(330,000)**	**7,012,328**	**400,357,461**

LONG-TERM CARE TOTAL FUND CHANGE (IN MILLIONS)



LONG-TERM CARE GENERAL FUND CHANGE (IN MILLIONS)



Thank You!

Caprice Knapp, PhD
Division Director

Phone: (701) 328-1603
E-Mail: cknapp@nd.gov

Nancy Nikolas-Maier
Aging Services Director

Phone: (701) 328-4607
E-Mail: nmaier@nd.gov

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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/28/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 8:30 a.m.

Discussion Topics:

- Key Priorities
- Overview of Medical Services
- Overview of Budget
- Executive Request
- Medicaid Expansion
- MMIS Modernization

Caprice Knapp, Medicaid Dir (8:31 am) testified about medical services #4046

Tory Brabent, DHS, Medical Services(9:10 am) testified about MMIS #4046

Caprice Knapp, Medicaid Dir (9:46 am) testified about Executive Budget #4046

Caprice Knapp, Medicaid Dir (10:50 am) testified about Medicaid Expansion #4071

Chair Nelson closed the meeting at 11:10 a.m.

Cole Fleck, Committee Clerk



House Bill 1012 #4046
Medical Services Budget- Traditional

House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD **Medical Services Director**

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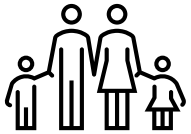
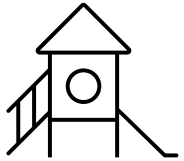
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



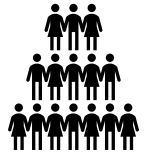
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



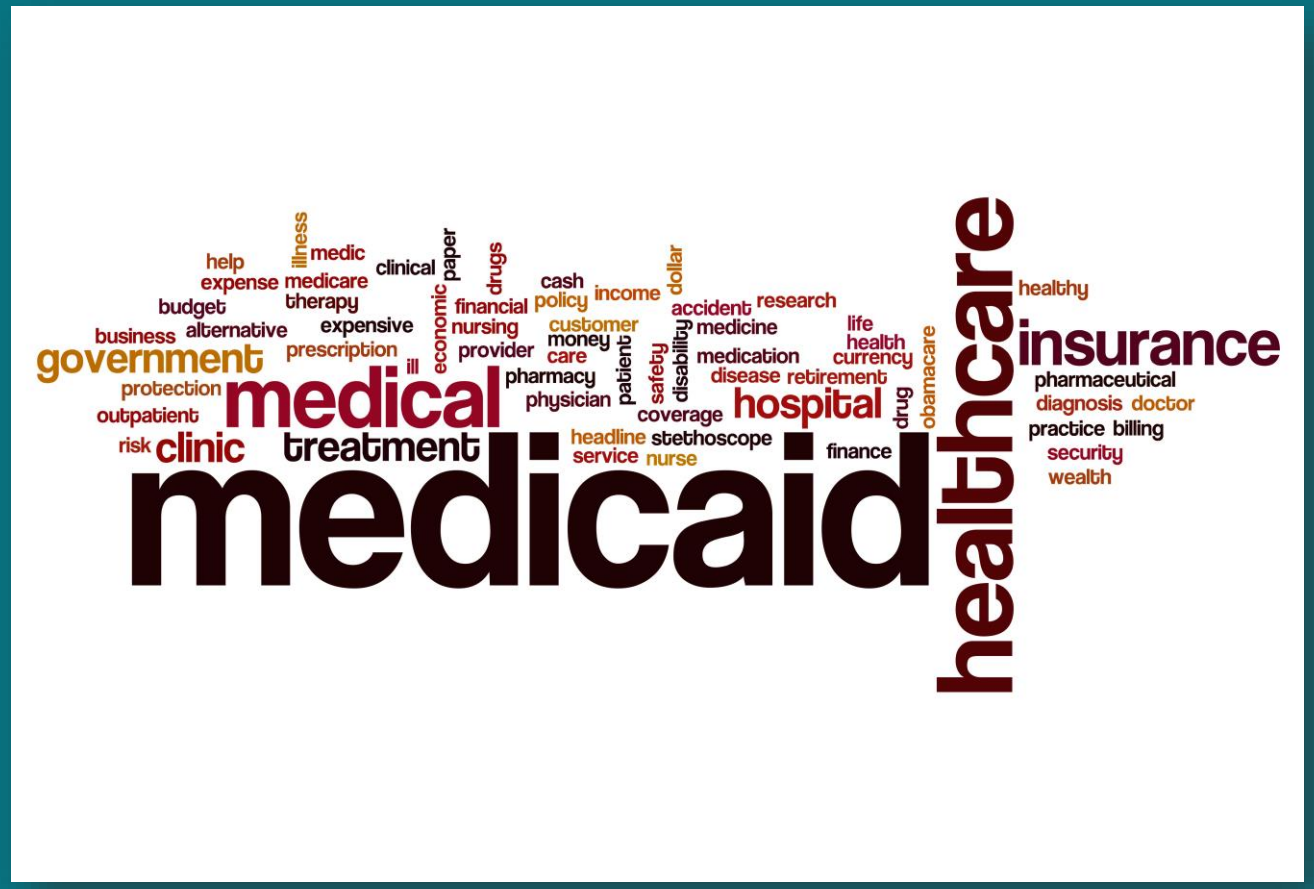
We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.



AGENDA

- Overview of Medical Services
- Overview of Budget
- 2021-2023 Executive Request
  - Funding Request Item
  - Budget Savings Items
- Review Executive Request for 2021-2023

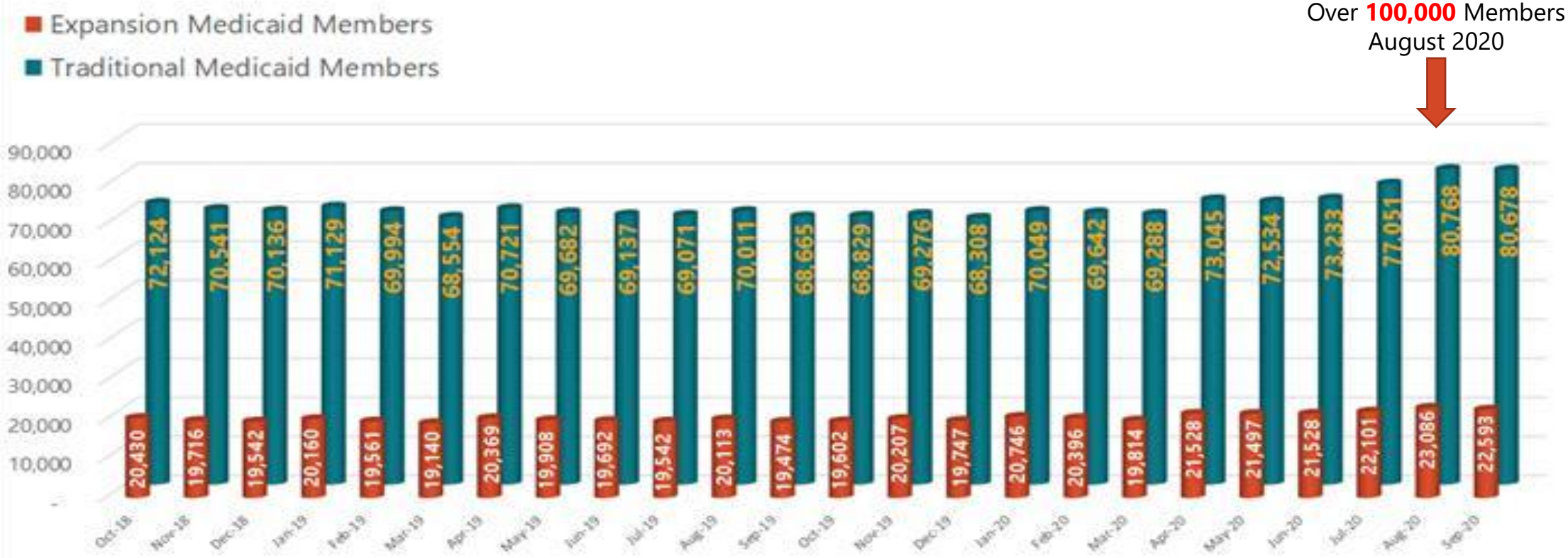
MEDICAL SERVICES DIVISION

Who We Serve

Traditional and Expansion Medicaid Members

24 Month Period

October 2018 - September 2020



Note: Children's Health Insurance Program numbers prior to January 1, 2020 are included in the Traditional Medicaid Members count. Effective January 1, 2020, Healthy Steps children transitioned to Traditional Medicaid and are included in the Traditional Medicaid Members count.

MEDICAL SERVICES DIVISION

How We Pay

Traditional Medicaid

Payments:

- Fee-For-Service
- Payment rate for most professional services is about 100% of Medicare's reimbursement
- Some providers are paid according to their cost like nursing homes, critical access hospitals, and Human Service Centers
- Some provider payment rules are set by the feds IHS, FQHC

Fee Schedules: http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html

Children's Health Insurance Program Interim Changes

CHIP Savings (1Q20-3Q20)

- Expected CHIP cost = $6,706,332
  - Average 2,378 kids per month x Average $313.38 premium per month
- Actual CHIP cost = $1,932,582
  - Actual Provider Payments = $2,872,734
  - Drug rebates = $940,152
- Savings = $4,773,750
- % reduction = 71.18%

EXECUTIVE REQUEST 2021-2023



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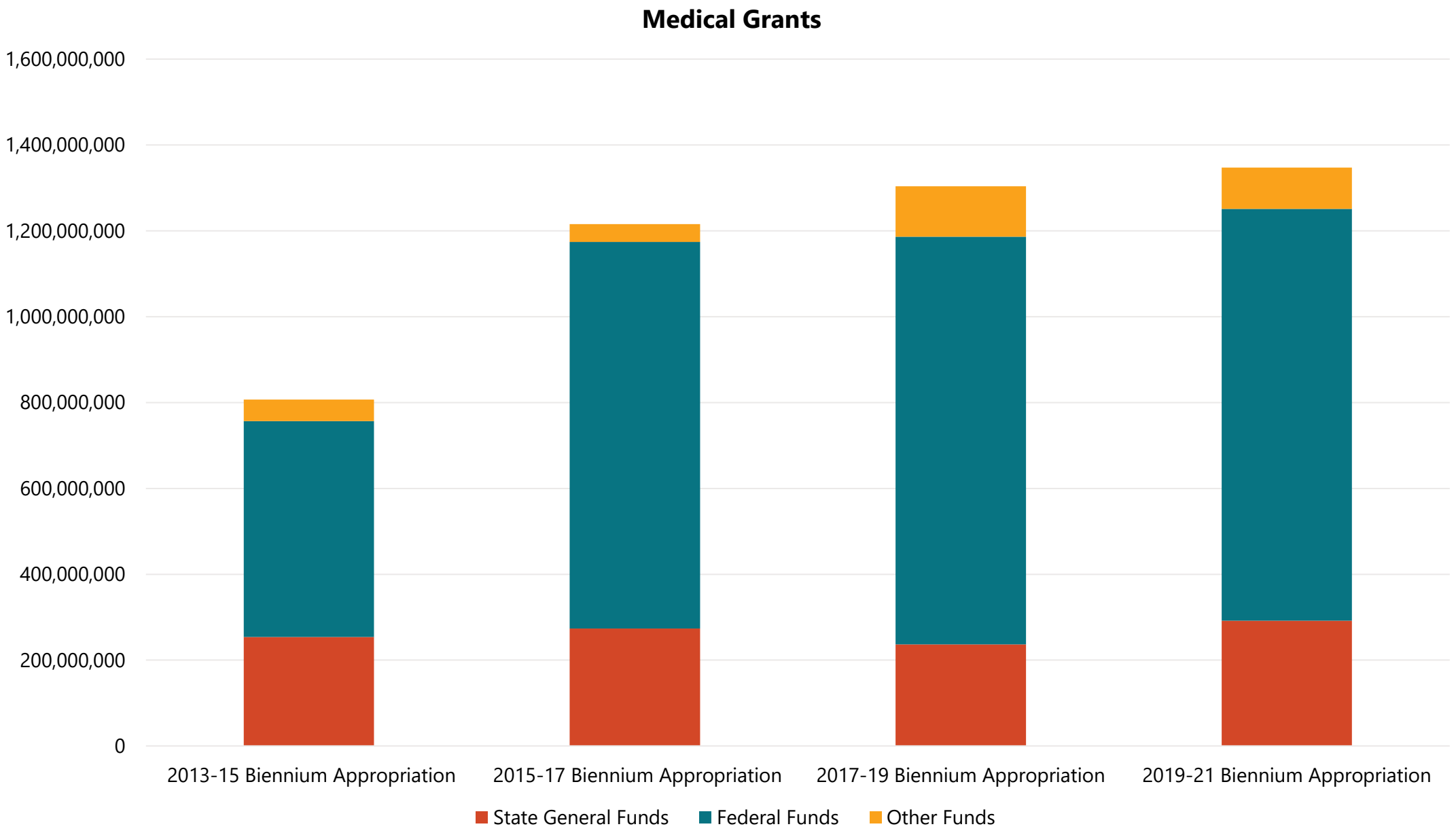
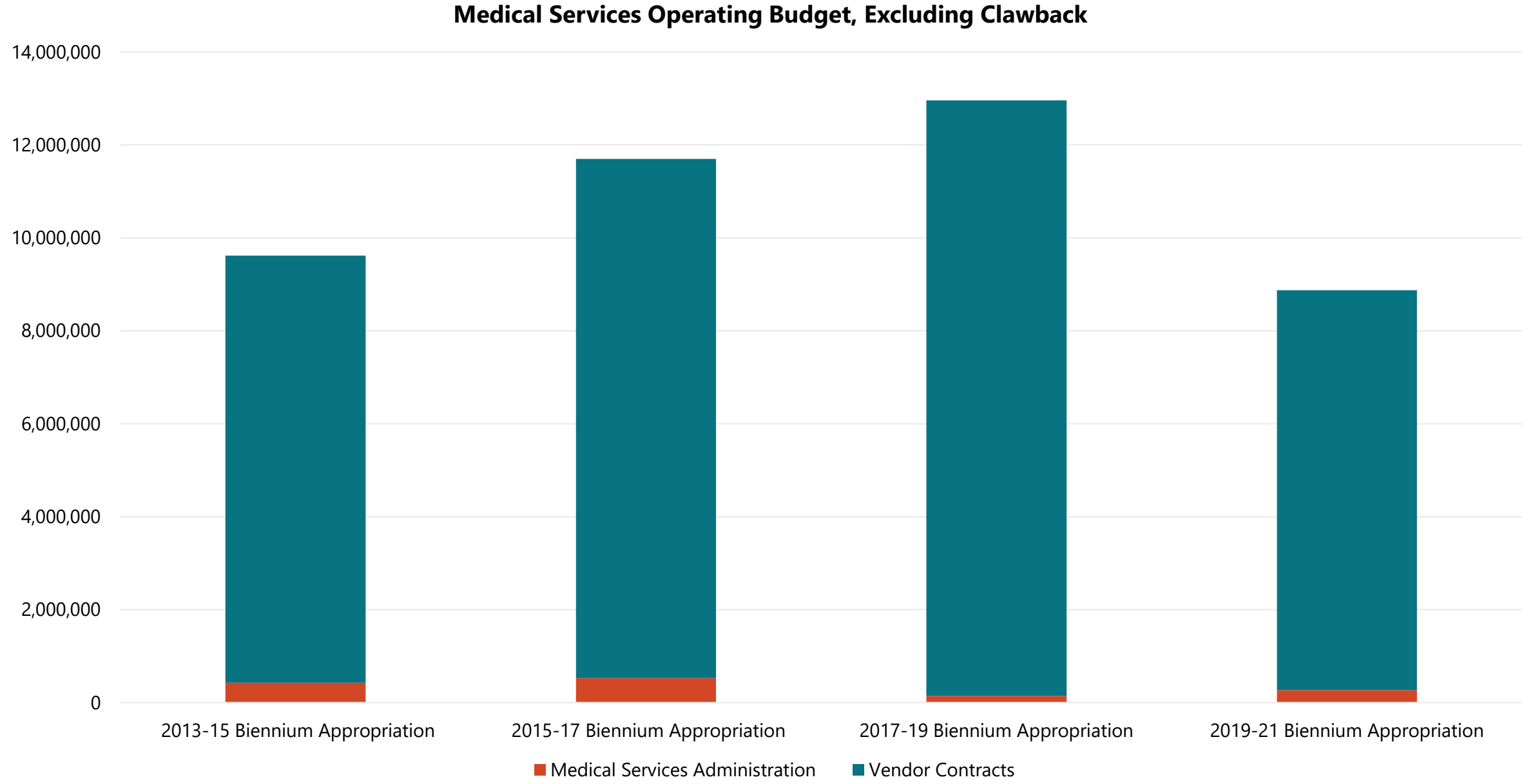
OVERVIEW OF BUDGET

Description	2013-2015 Appropriation	2015-2017 Appropriation	2017-2019 Appropriation	2019-2021 Appropriation	Changes	2021-2023 Executive Budget
Salary and Wages	9,361,167	11,006,399	9,217,240	17,623,821	839,862	18,471,683
Operating	39,355,085	44,241,160	53,320,237	48,290,789	8,712,126	57,002,915
Grants						
Medical Grants	806,717,552	1,215,896,867	1,303,690,959	1,352,417,879	49,551,425	1,401,969,304
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**59,111,413**	**1,477,443,902**
General Fund	289,891,636	313,547,595	284,162,440	342,465,788	42,758,835	385,224,623
Federal Funds	514,107,184	914,467,704	962,268,730	977,292,683	30,619,126	1,007,911,809
Other Funds	51,434,984	43,129,127	119,797,266	98,574,018	(14,266,548)	84,307,470
Total	**855,433,804**	**1,271,144,426**	**1,366,228,436**	**1,418,332,489**	**59,111,413**	**1,477,443,902**
Full Time Equivalent (FTE)	**59.50**	**59.50**	**48.00**	**86.50**	**12.00**	**98.50**

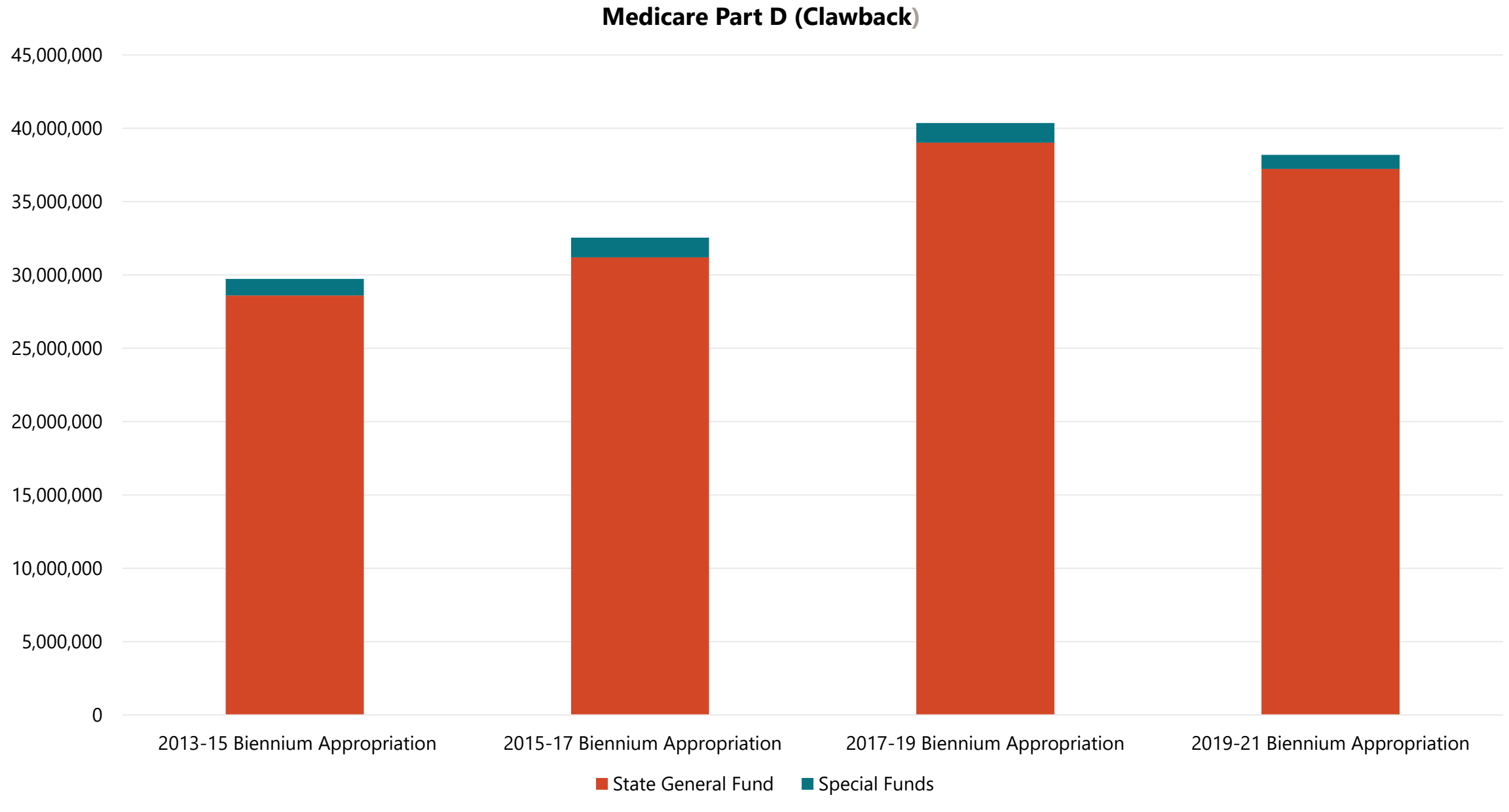
HISTORY OF MEDICAL GRANTS BUDGET CHANGES BY FUND



HISTORY OF OPERATING BUDGET, EXCLUDING CLAWBACK



HISTORY OF MEDICARE PART D (CLAWBACK) BUDGET



Department of Human Services

Medical Services

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
86.50	86.50	98.50	2	40%	Operations (Claims/TPL/Program Integrity)	39
				19%	Pharmacy/Utilization Review/Quality	19
				16%	Programs (Managed Care/Health Tracks/HCBS)	16
				12%	Administration	12
				8%	Medicaid Policy	7.5
				5%	Rate Setting/Compliance	5

COVID INFO

Medical Services is actually processing more claims on medical and pharmacy due to FMAP MOE, our cost avoidance for TPL recovery has increase $1.2 million post-COVID, we track prior authorizations each month as well

Telework Headcount	
Pre-COVID	Current
14	87

GREEN SHEET WALKTHROUGH

	Executive Budget Request			
	FTE Positions	General Fund	Other Funds	Total
Medical Services				
Continued program changes		2,493,060	5,504,976	7,998,036
Agency savings plan, including adjustments to Medicaid Expansion administration and rates	12.00	(11,725,352)	(80,633,115)	(92,358,467)
Grant cost and caseload changes		55,976,251	100,813,594	156,789,845
Other fund reprioritization			(40,000)	(40,000)
Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-
Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Subtotal Medical Services	**12.00**	**51,563,046**	**1,289,530**	**52,852,576**

OVERVIEW OF BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	8,289,724	9,706,660	4,656,019	2,496,860	12,203,520
513x Salaries - Temp	1,214,610	2,110,752	441,191	(1,628,113)	482,639
514x Salaries - Over Time	334,296	467,424	84,452	(467,424)	-
516x Salaries - Benefits	4,132,220	5,338,985	2,298,437	446,541	5,785,526
Total Salaries & Benefits	**13,970,850**	**17,623,821**	**7,480,099**	**847,864**	**18,471,685**
52x Travel	50,139	47,413	33,609	-	47,413
53x Supply	33,461	30,962	14,273	-	30,962
54x Postage & Printing	159,914	102,218	72,293	-	102,218
55x Equipment Under $5,000	2,697	2,100	1,826	-	2,100
58x Rent/Leases - Bldg./Equip	111,859	119,244	48,320	(107,208)	12,036
61x Professional Development	69,745	77,192	26,474	-	77,192
62x Fees - Operating & Professional	41,363,713	47,907,663	22,022,018	8,819,334	56,726,997
60x IT Expenses	3,406	3,997	1,744	-	3,997
Total Operating	**41,794,934**	**48,290,789**	**22,220,557**	**8,712,126**	**57,002,915**
71x Grants, Benefits, & Claims	1,156,014,751	1,352,417,879	569,360,205	49,551,424	1,401,969,303
72x Transfers	2,269,057	-	-	-	-
Total Grants	**1,158,283,808**	**1,352,417,879**	**569,360,205**	**49,551,424**	**1,401,969,303**
Total	**1,214,049,592**	**1,418,332,489**	**599,060,861**	**59,111,414**	**1,477,443,903**

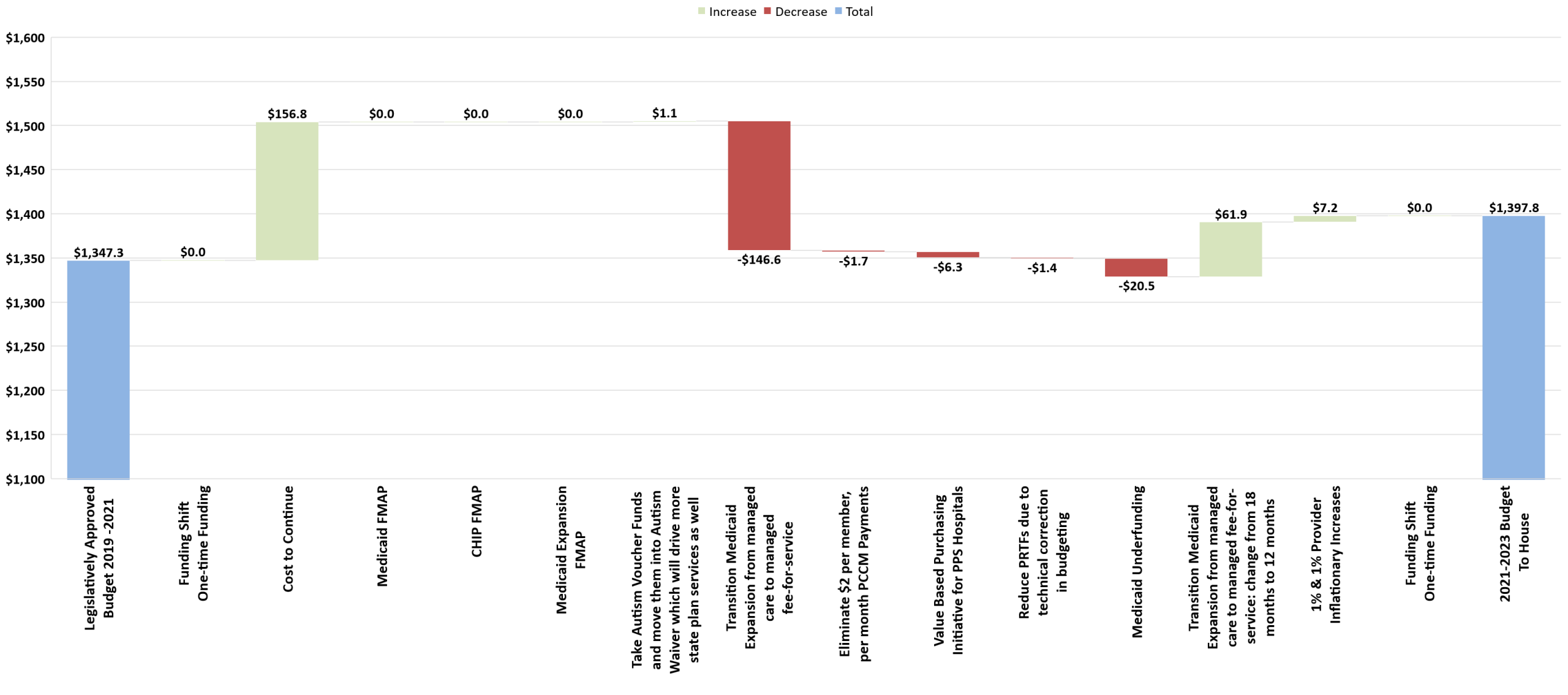
GRANTS NOT ON A WALKTHROUGH

Medical Services - 2021-23 Biennium Budget

Budget Account Code 712000 - Grants, Benefits, and Claims

		$ 5,136,590	$ 4,205,938	$ 63,902	$ 3,142,036	$ 1,000,000
Vendor	**Description**	**2019-21 Biennium Amount2**	**2021-23 Biennium Amount**	**General Fund**	**Federal Funds**	**Other Funds**
	Remedial Eye	5,000	-			
Lutheran Social Services	Medical Refugee Screening	335,780	335,780		335,780	
	County Jail Claims	1,500,000	1,000,000			1,000,000
Rolette County Public Health	Health Tracks Services		127,804	63,902	63,902	
Department of Health	Nursing Home Surveys	2,963,456	2,450,000		2,450,000	
Department of Health	Nurse Aide Registry	170,504	170,504		170,504	
	Dental Access Project	40,000	-			
Department of Health	ND Quitline	121,850	121,850		121,850	

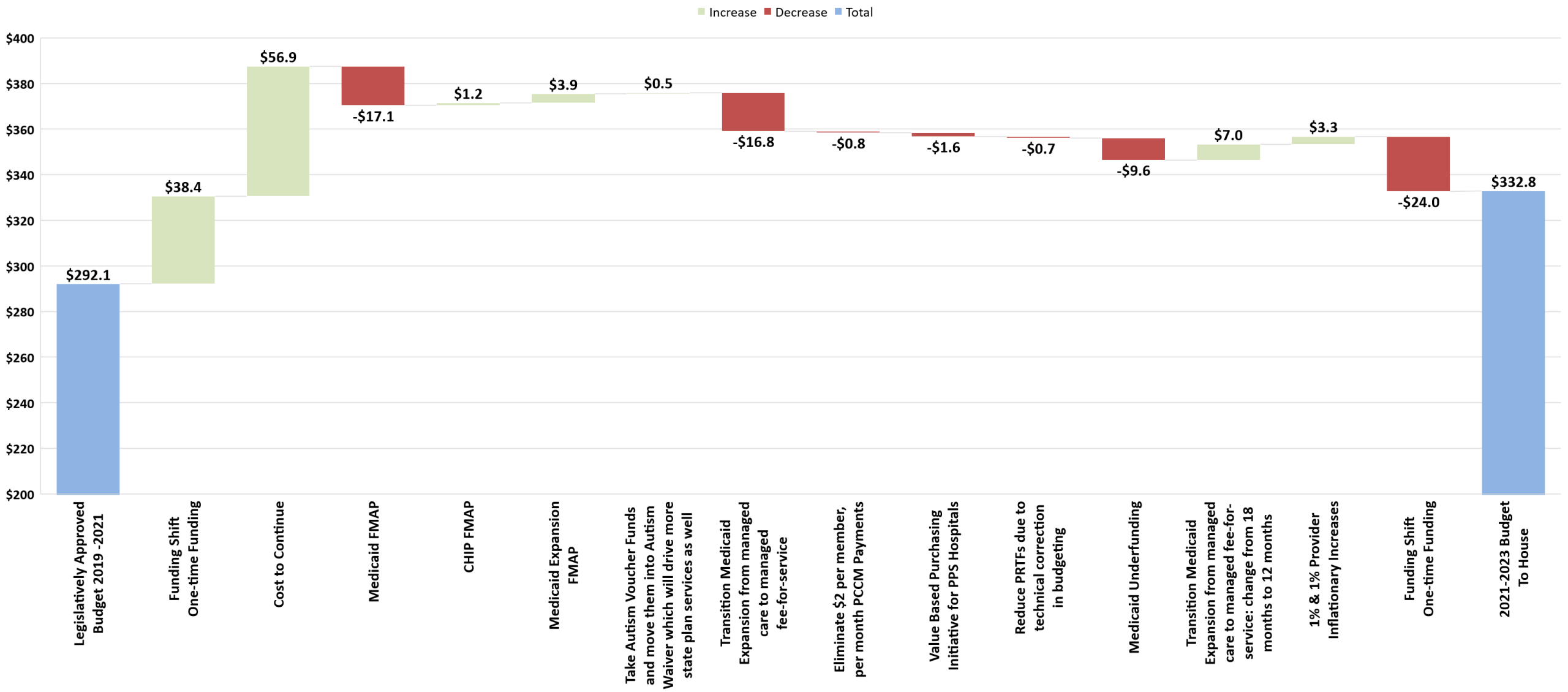
MEDICAL GRANTS TOTAL FUND CHANGE (IN MILLIONS)



OVERVIEW OF BUDGET CHANGES BY FUNDING SOURCE

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
General	287,764,723	342,465,788	172,337,929	42,758,836	385,224,624
Federal	849,792,766	977,292,683	417,969,286	30,619,128	1,007,911,811
Other	76,492,103	98,574,018	8,753,646	(14,266,550)	84,307,468
Total	1,214,049,592	1,418,332,489	599,060,861	59,111,414	1,477,443,903

MEDICAL GRANTS GENERAL FUND CHANGE (IN MILLIONS)





Funding Request

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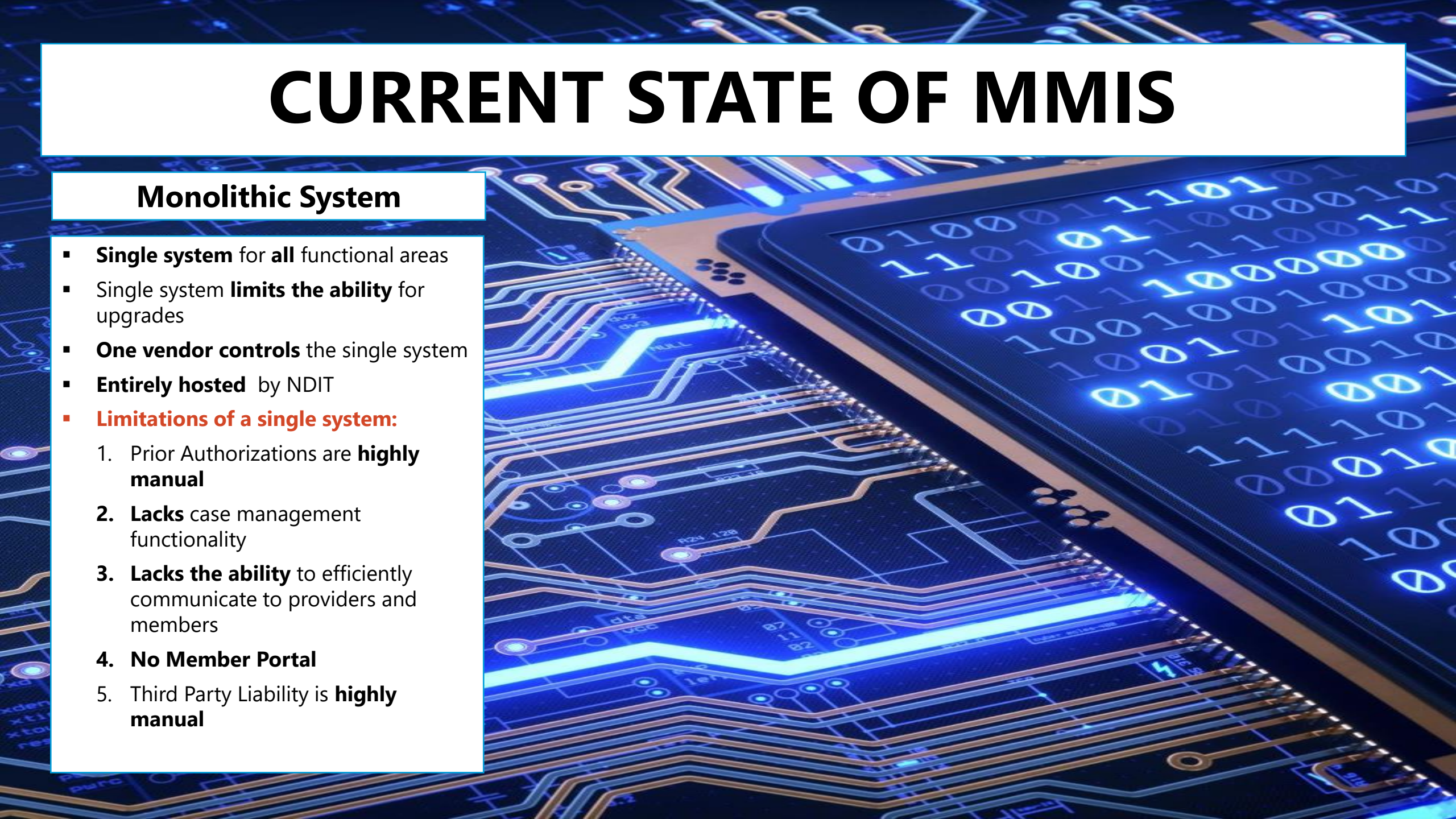
MMIS MODERNIZATION



CURRENT STATE OF MMIS

Monolithic System

- **Single system** for **all** functional areas
- Single system **limits the ability** for upgrades
- **One vendor controls** the single system
- **Entirely hosted** by NDIT
- **Limitations of a single system:**
  1. Prior Authorizations are **highly manual**
  2. **Lacks** case management functionality
  3. **Lacks the ability** to efficiently communicate to providers and members
  4. **No Member Portal**
  5. Third Party Liability is **highly manual**

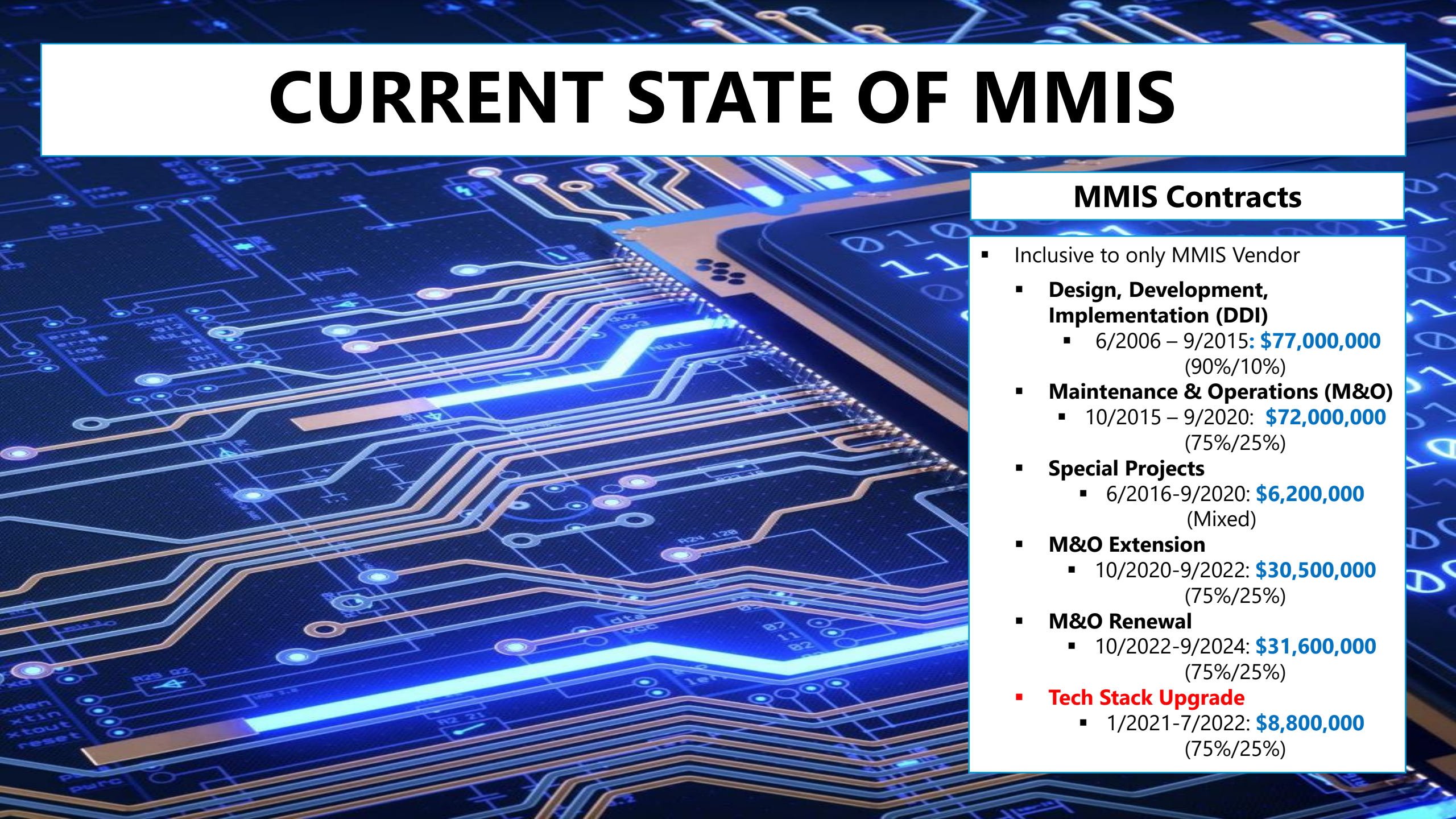


CURRENT STATE OF MMIS

Current Operations

- **Meets CMS regulations** of timely payment
  - **99.90%** of clean claims processed **within 30 days**
  - **100%** of clean claims processed **within 90 days**
- **In 2019:**
  - **2,952,206** Claims processed
  - **$1,308,172,318** paid to providers
- **Provider Portal:** Submit Claims, View Claims Status, Check Member Eligibility, View Remittance Advices, Submit Prior Authorization Requests, Provider Re-Validations

CURRENT STATE OF MMIS



MMIS Contracts

- Inclusive to only MMIS Vendor
  - **Design, Development, Implementation (DDI)**
    - 6/2006 – 9/2015: **$77,000,000** (90%/10%)
  - **Maintenance & Operations (M&O)**
    - 10/2015 – 9/2020: **$72,000,000** (75%/25%)
  - **Special Projects**
    - 6/2016-9/2020: **$6,200,000** (Mixed)
  - **M&O Extension**
    - 10/2020-9/2022: **$30,500,000** (75%/25%)
  - **M&O Renewal**
    - 10/2022-9/2024: **$31,600,000** (75%/25%)
  - **Tech Stack Upgrade**
    - 1/2021-7/2022: **$8,800,000** (75%/25%)



MMIS ASSESSMENT

Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A)

MMIS ASSESSMENTS MITA SS-A

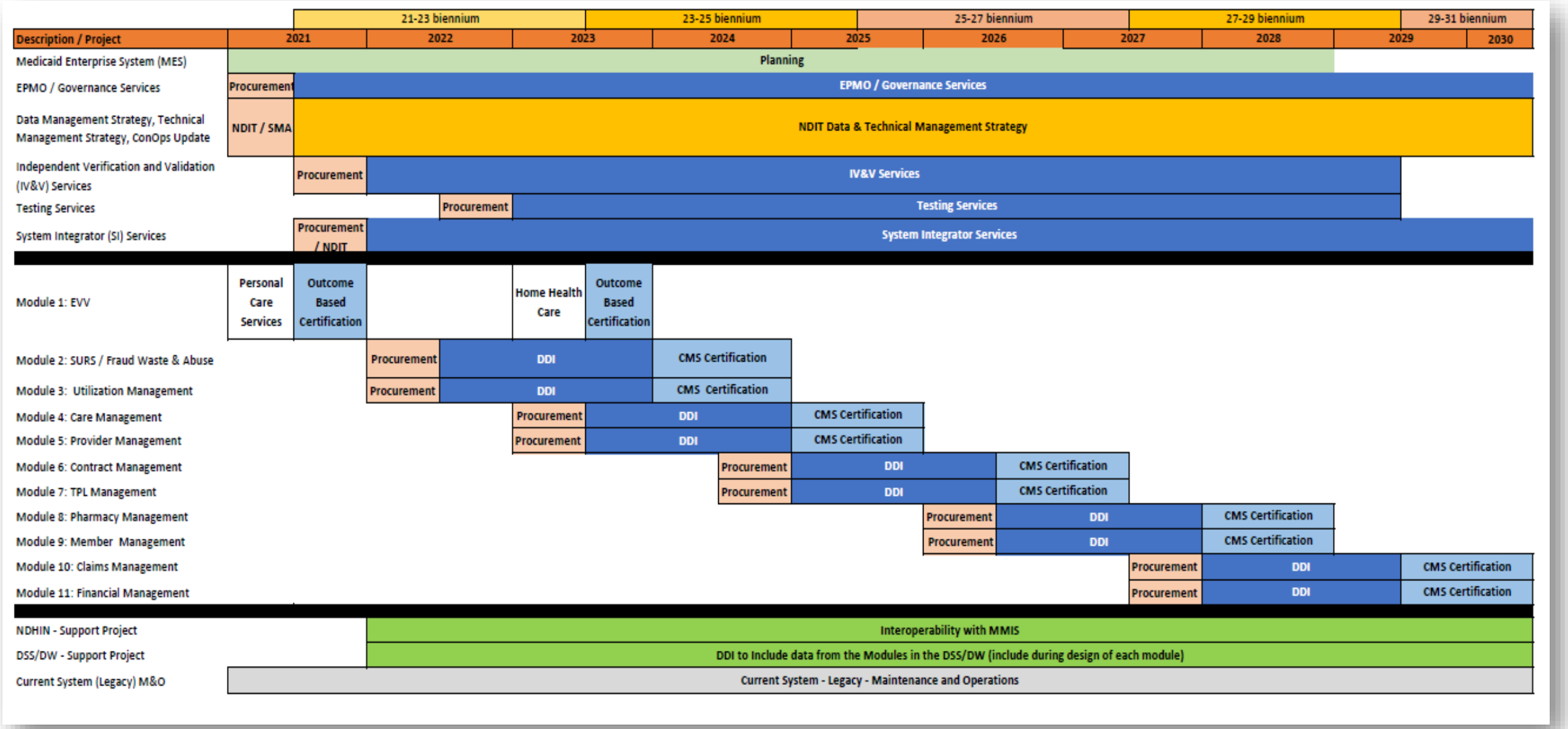
- Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A)
  - Required by CMS
  - Analysis of the current and proposed future state of MMIS
    - Business Architecture
    - Information Architecture
    - Technical Architecture
    - Standards and Conditions Architecture
  - Developed a Future MMIS Roadmap

KEY FINDINGS MITA SS-A

- Medicaid should develop and implement a MMIS modernization plan
- Medicaid should make progress toward an integrated Medicaid Enterprise System
- Modules should be based on the business needs
- Modules can adapt to rapidly changing technology needs
- Medicaid should adhere to CMS Modularity and Interoperability directives to receive enhanced FFP
- The State needs improved data governance & standards
- Medicaid should move towards process automation (Customer Satisfaction)
  - Increase Accuracy
  - Improves Timeliness
  - Reduce Costs


MODERNIZATION – THE ROAD AHEAD

MITA ROAD MAP-HIGH-LEVEL PROJECT SCHEDULE



PROGRESS IN OTHER STATES

Montana

Montana Program for Automating and Transforming HealthCare Project **(MPATH)** 6-year plan ($99 Million)

- Data Analytics (Multi-release March 2018-November 2019)
- Provider Services (Multi-release August 2019-April 2020)
- System Integration Services(Implemented July 1 ,2019)
- Care Management (Multi-release June 2020-February 2022)
- Claims Module-Planned Implementation (Late 2022/Early 2023)
- Additional RFP Releases (October 2019-December 2022)
  - Fraud, Waste & Abuse Analytics
  - TPL Recoveries
  - Customer Care
  - Pharmacy Benefit Management System
  - Drug Rebate Management
  - Electronic Visit Verification

Wyoming

The Wyoming Department of Health, Division of HealthCare Financing, MMIS Replacement Project Team for the Wyoming Integrated Next Generation System **(WINGS)**

- $75 million proposal
- Four Modules have been implemented and are live:
- Pharmacy Benefit Management System(PBMS)
- System Integrator
- Data Warehouse
- Fraud, Waste and Abuse Case Tracking
- Two Modules are in the implementation phase
- Benefit Management System-Claims Processing with Third Party Liability
- Electronic Visit Verification(EVV)
- Care/Case Management System Module RFP through procurement July 2020

2021-23 EXECUTIVE REQUEST

- $35,000,000 Budget **(90% Medicaid Match)**
  - Target 2 Modules
- Establish Large IT Oversite – May 2021
- Release RFP in 2021
  - Systems Integrator
  - Independent Verification and Validation (IV&V) Services
  - Module 1
- Release RFP in 2022 – Module 2

MMIS Modernization			
	Total	**Federal**	**State**
MMIS	$ 35,000,000	$ 30,673,314	$ 4,326,686



BUDGET SAVINGS ITEMS

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BUDGET SAVINGS

Equity
PCCM $2 PMPM Elimination, Dental Access Project



Equity
Remedial Eye Program, PRTF



Quality
Value-Based Purchasing



PCCM $2 PMPM ELIMINATION



Estimated Total Potential Savings **$1,652,240**

Elimination of PCCM PMPM Payments			
	Total	**Federal**	**State**
Primary Care Case Management	$ (1,652,240)	$ (882,371)	$ (769,869)

DENTAL ACCESS PROJECT



Estimated Total Potential Savings **$40,000**

Elimination of Dental Access Project (loan repayment for dentists who serve a high proportion of Medicaid members)			
	Total	**Federal**	**State**
Dental Access Project	$ (40,000)		$ (40,000)

REMEDIAL EYE PROGRAM, PRTF

Estimated Total Potential Savings **$1,401,399**

Elimination of Remedial Eye, PRTF Payments			
	Total	**Federal**	**State**
Remedial Eye Program	$ (5,000)	$ (0)	$ (5,000)
PRTF Utilization	$ (1,396,398)	$ (745,834)	$ (650,565)

VALUE BASED PURCHASING

North Dakota Hospital Quality: Compare Star Ratings

Star Rating	Hospital
★★★★	CHI St. Alexius Health Bismarck
★★★★	Essentia Health Fargo
★★	Altru Hospital Grand Forks
★★	Sanford Medical Center Bismarck
★★	Sanford Medical Center Fargo
★★	Trinity Hospital Minot

**Rating based on current data collection periods from Hospital Compare, last updated on July 22, 2020*



Hospital Value-Based Purchasing Program

Domains (weight 25%)	CHI St. Alexius Bismarck	Essentia	Altru	Sanford Bismarck	Sanford Fargo	Trinity
Clinical Outcomes (weighted score)	21.9	18.8	16.9	10.6	16.3	13.8
Person & Community Engagement (weighted score)	3.5	7.8	3.8	3.3	4.8	2.8
Safety (weighted score)	7.5	7.5	12.1	8.3	5.0	11.7
Efficiency & Cost Reduction (weighted score)	15.0	10.0	0.0	12.5	2.5	5.0
Total Performance Score Out of 100 points	**47.9**	**44.0**	**32.7**	**34.7**	**28.5**	**33.2**

**Total Performance Score is composed of the following Domains: Clinical Outcomes weight 25%, Person and Community Engagement weight 25%, Safety weight 25%, and Efficiency and Cost Reduction weight 25%.*
**Data from Hospital Compare Hospital Value-Based Purchasing Program data*

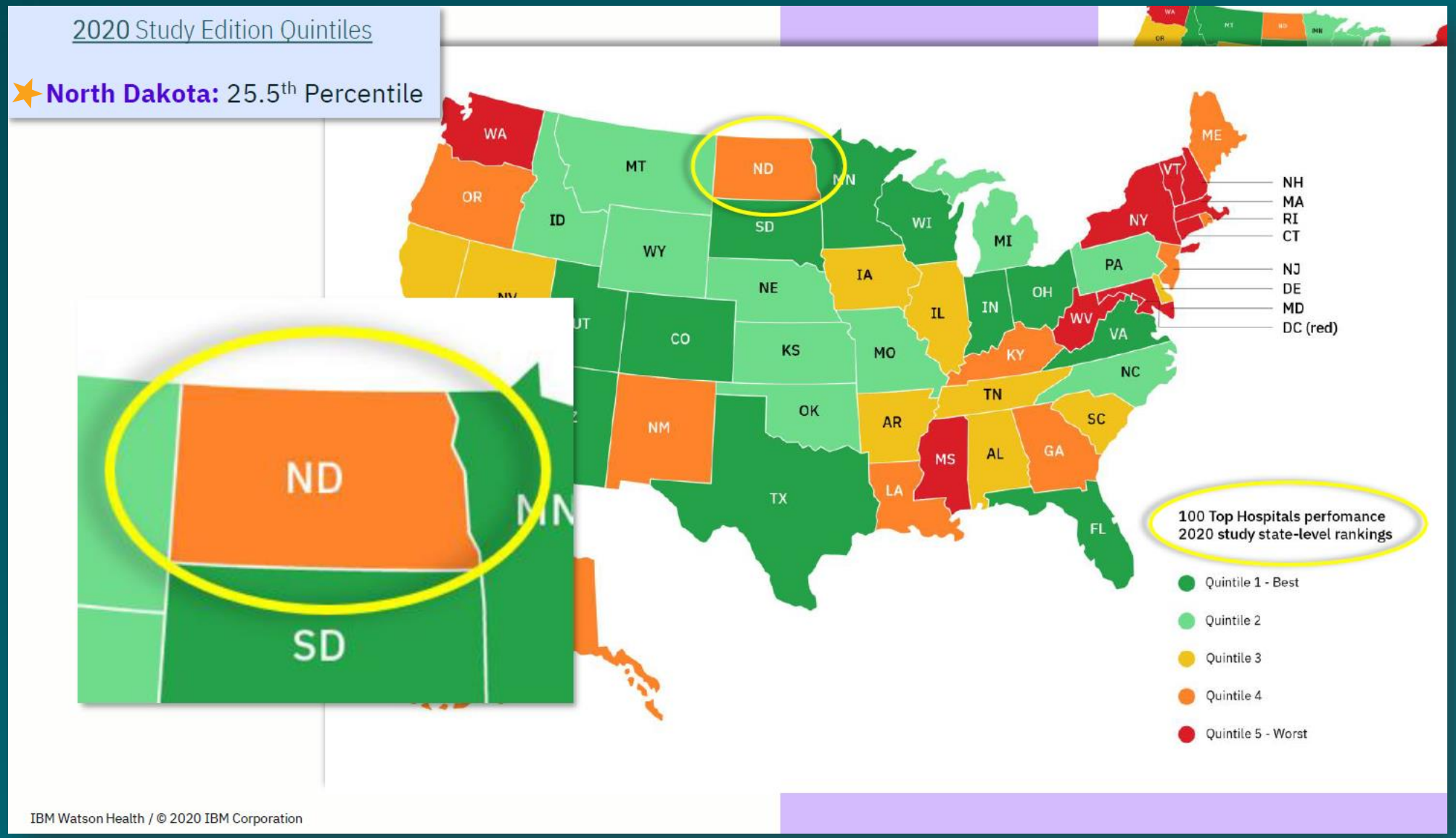
Hospital-Acquired Condition Reduction Program

	CHI St. Alexius Bismarck	Essentia	Altru	Sanford Bismarck	Sanford Fargo	Trinity
PSI-90 W Z Score	1.2	-1.2	2.4	1.3	1.8	-0.2
CLABSI W Z Score	0.8	0.3	-0.2	0.6	0.1	-1.0
CAUTI W Z Score	0.9	0.2	-0.4	0.4	0.2	-0.2
SSI W Z Score	-0.7	1.5	1.6	0.2	1.9	2.1
MRSA W Z Score	-0.6	0.0	-0.1	-0.5	-0.1	-0.3
CDI W Z Score	1.5	0.4	1.5	-0.1	1.3	0.1
Total HAC Score	0.5	0.2	0.8	0.3	0.9	0.1
Payment Reduction	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**

**Data used PSI-90 7/01/2016-6/30/2018 and HAI Measures 1/01/2017-12/31/2018, in 2014, CMS began reducing Medicare payments if HAC Score greater than 75th percentile of the Total HAC Score distribution will be subject to a payment reduction.*

**CMS Patient Safety Indicators (PSI) 90, CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, Clostridium difficile Infection (CDI) measures*

VALUE BASED PURCHASING



VALUE BASED PURCHASING

Becker Hospital **2020** Rankings For Patient Experience

Star Rating	Hospital
★★★★★	Essentia Health Fargo
★★★	CHI St. Alexius Health Bismarck
★★★	Altru Hospital Grand Forks
★★★	Sanford Medical Center Bismarck
★★★	Sanford Medical Center Fargo
★	Trinity Hospital Minot

VALUE BASED PURCHASING

DHS met with members of the North Dakota Hospital Association

- 6 Prospective Payment System (PPS) Hospitals
- 3 large Critical Access Hospitals

Meeting Dates

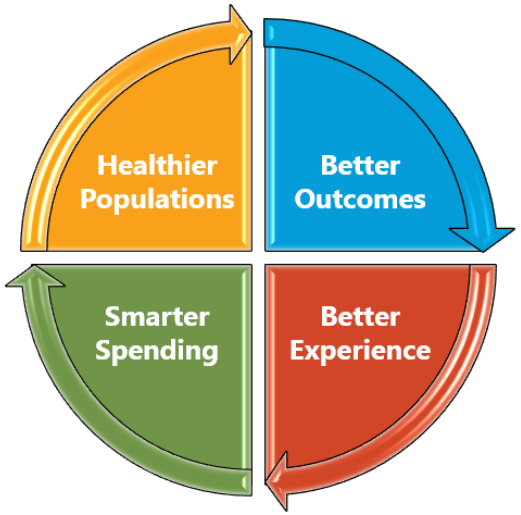
- **11/13/20** – Episodes of Care
- **12/3/20** – Pay-For-Performance
- **12/10/20** – Accountable Care Organizations

The 3 VBP Models presented by experts from other states

- Tennessee presented on Episodes of Care
- Wisconsin presented on Pay-For- Performance
- Caravan Health presented on Accountable Care Organization

VBP Models align with Quality

Quadruple Aim for ND Medicaid



VALUE BASED PURCHASING

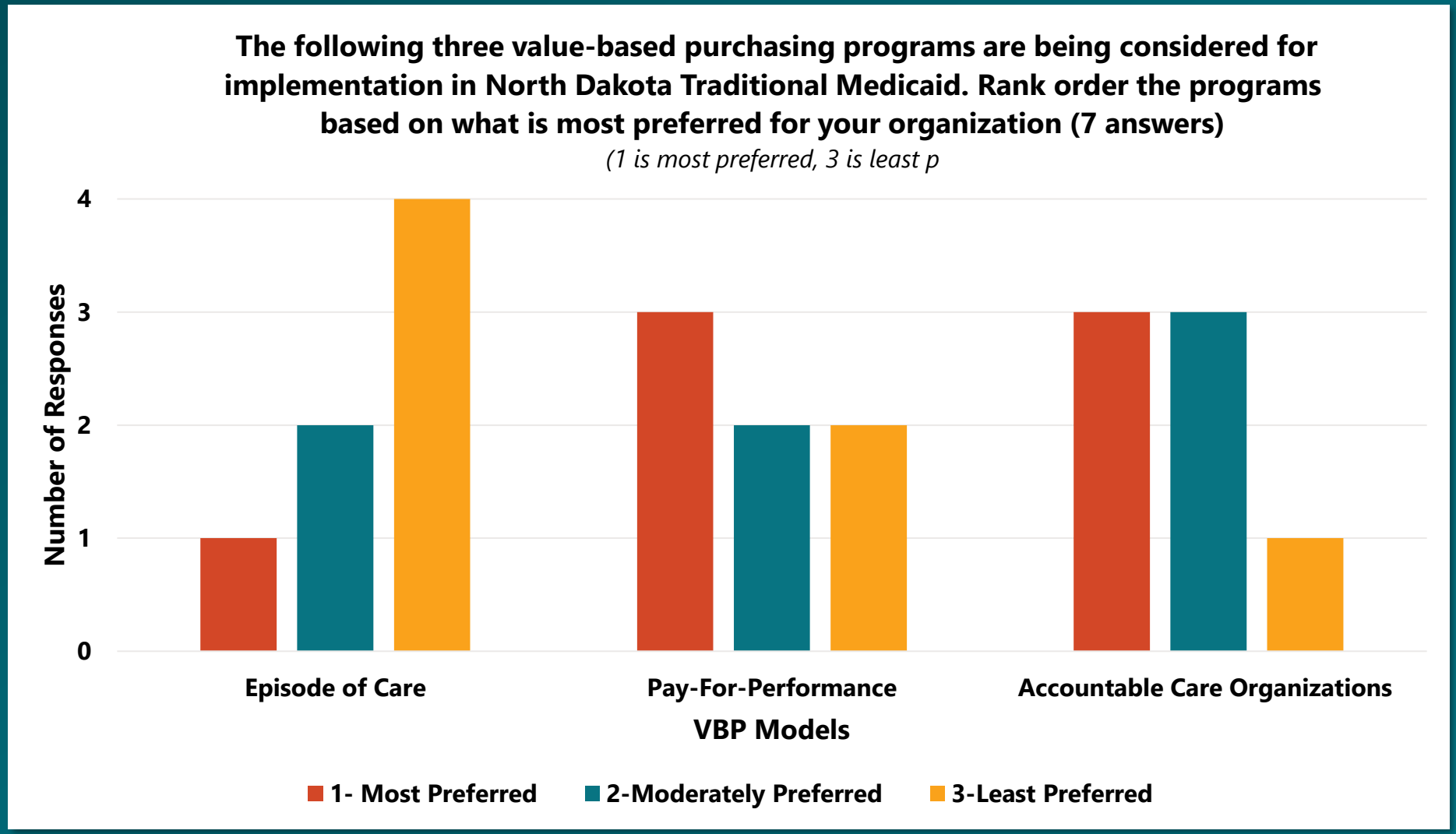
States that **incorporate VBP model** into their Medicaid program can **increase quality** and **bend the cost curve**

DHS administered a **survey** to North Dakota Hospital Association member to understand their preferred VBP model based on the presented models

All **PPS Hospitals**: Essentia, CHI St. Alexius, Altru, and Trinity responded to the survey, **except for Sanford**

All **3 CAHs** responded to the survey

VALUE BASED PURCHASING SURVEY RESULTS



VALUE BASED PURCHASING SURVEY RESULTS

VBP Models	Top Pro	Top Con
Episode of Care	No changes to current billing procedures	If cost is above an acceptable threshold, the provider owes a payment back to the state.
Pay-For-Performance	Simplicity from a billing perspective (one bill instead of many).	Any non-claims based measures will take additional funds to calculate.
Accountable Care Organization	Provides an opportunity to offer more comprehensive care.	Number of patients in the ACO - fewer Medicaid patients can mean more difficulty for providers to manage care and spread risk.

VALUE BASED PURCHASING SURVEY COMMENTS

What benefits do you foresee in transitioning to a value-based purchasing program in North Dakota Traditional Medicaid?

- If it frees up the state to really share data would be value add. Providers would like to get true gaps in care data.
- More focus on comprehensive care for patients to highlight better outcomes, payment model reflects trends in value-based care more so than traditional fee for service
- Successful value-based care programs improve the quality of care while reducing overall cost.
- Pay for performance
- If aligned with other value-based program, it facilitates the movement globally toward value-based payment mechanisms across the state of North Dakota.
- Closer alignment between payment and outcomes
- The trend the health care industry is headed

VALUE BASED PURCHASING SURVEY COMMENTS

What barriers do you foresee in transitioning to a value-based purchasing program in North Dakota Traditional Medicaid?

- Such a small population hard to get to real change.
- Lack of historical data for full evaluation of programs before shift, member attribution issues, patient compliance with care
- Data- timely, accurate data being shared with the providers at risk is critical to managing a population. This will require establishing the infrastructure and a willingness of both DHS and providers. 2. The small population of MCD in ND.
- One size does fit all, we have large and very small hospitals in ND
- Cost; time it takes to change the culture of an organization; the concern that money will initially be taken from all providers and then re-distributed to those that meet the thresholds.
- All programs eventually are takeaways financially. Organizations will have new infrastructure and administrative costs simply to assure they don't "lose" too much funding.
- If the program would be managed in house utilizing different metrics than those currently in existence in Commercial or Medicare Value Based programs.

VALUE BASED PURCHASING FOR HOSPITALS



Estimated Total Potential Savings **$6,250,000**

Value Based Purchasing for Hospitals			
	Total	**Federal**	**State**
Value-Based Purchasing	$ (6,250,000)	$ (4,687,500)	$ (1,562,500)

Thank you!

North Dakota Medicaid



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Division Director

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Medical Services Budget- House Bill 1012 Expansion

House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD Medical Services Director #4071

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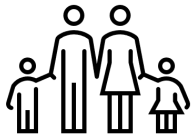
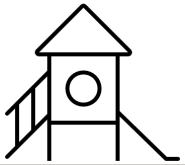
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



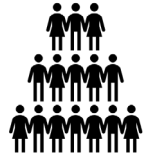
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Medicaid Expansion Eligibility for Adults

Family Size	Medicaid Expansion 138% of PL
	Monthly
1	$ 1,468
2	$ 1,983
3	$ 2,498
4	$ 3,013
5	$ 3,529
6	$ 4,044
7	$ 4,559
8	$ 5,074
9	$ 5,589
10	$ 6,105
+1	$ 516

$17,609 per year

$36,156 per year

$14,000 per capita in health care benefits

MEDICAL SERVICES DIVISION

How We Pay

Contracted Services 1915(b) Waiver

- States design an Alternative Benefit Plan that describes the services and must include Essential Health Benefits

- Medicaid Expansion **does not** cover:
  - Skilled Nursing Facility Services*
  - Dental Care Office Visits**
  - Routine Eye Care**
  - Any waivered services
  - Long Term Care services
  - Room and board for Residential Treatment services**

** Only covers up to 30 days and only covers a skilled level of care*
*** Only covered for 19- and 20-year-olds*

Medicaid Expansion

Managed Care Organization:

- Risk Based Capitation paid on a per member, per month basis
- Current Vendor: Sanford Health Plan (SHP)
- Contract is currently being re-bid
  - Notice of Intent to Award will be issued approximately 5/21/2021
  - Contract Start will be approximately 1/1/2022

Medicaid Expansion:

http://www.nd.gov/dhs/medicaidexpansion/

EXECUTIVE REQUEST 2021-2023



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NORTH DAKOTA LEGISLATION TO DATE

Since the initial implementation, each subsequent session of the ND Legislative Assembly has reauthorized ND Medicaid Expansion as administered and managed through a **Private Carrier**.

The 2019 ND Legislative Assembly (SB 2012) did make the following updates to the ND Medicaid Expansion Program:

- Directed the Department to continue the utilization of a private carrier for the administration and management **except for pharmacy services**, effective January 1, 2020.
- Directed the Managed Care Organization (MCO), while under contract with the Department, to
  - **Develop and implement a uniform provider reimbursement methodology**
  - **Added 1915(i) Behavioral Health Services through the MCO**

ND Medicaid Expansion Transition Principles

All North Dakota Medicaid **members** should be valued the same, **regardless of Category of Eligibility**, and should have **access to the same core services.**

All North Dakota Medicaid **providers** should be valued the same, **regardless of traditional or expansion**, and should have **equity in reimbursement.**

Taxpayers should be assured that their state and federal taxpayer dollars are not being used to disproportionately support **able bodied adults**, who can work and **transition off government assistance** unlike most traditional Medicaid clients.



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

Medicaid Expansion Comparison: under 100K People Delivery of Care Model

Medicaid Expansion Population

No MCOs

- Maine 19,812
- Alaska 51,144
- Vermont 55,431
- Montana 98,741

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

- New Hampshire 70,000 **3 MCOs serve ~213K*
- Delaware 62,534 **2 MCOs serve traditional and expansion ~199K*
- Rhode Island 66,641 **2 MCOs serve traditional and expansion ~250K*

Source: Medicaid Enrollment Report Updated 2/2020
https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html
https://www.kff.org/medicaid/stateindicator/totalmedicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

Month	Expansion SHP Members	Expansion SHP Members Non-Expansion Eligibility	Expansion SHP Members Any Medicaid Eligibility	Percent Remaining in Expansion SHP	Percent Remaining with Any Medicaid Eligibility
Jan 2019	20,719		20,719	100.0%	100.0%
Feb 2019	19,441	270	19,711	93.8%	95.1%
Mar 2019	18,399	436	18,835	88.8%	90.9%
Apr 2019	17,515	624	18,139	84.5%	87.5%
May 2019	16,594	812	17,406	80.1%	84.0%
Jun 2019	15,551	1,002	16,553	75.1%	79.9%
Jul 2019	14,672	1,155	15,827	70.8%	76.4%
Aug 2019	13,873	1,295	15,168	67.0%	73.2%
Sep 2019	13,117	1,372	14,489	63.3%	69.9%
Oct 2019	12,523	1,463	13,986	60.4%	67.5%
Nov 2019	11,937	1,532	13,469	57.6%	65.0%
Dec 2019	11,491	1,579	13,070	55.5%	63.1%



Medicaid Expansion Reimbursement Comparison Per Capita Costs Per State

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Medicaid Expansion Reimbursement Comparison MCO Capitation Rates

Monthly capitation (premium) amounts paid for each individual enrolled with the MCO for ND Medicaid Expansion

RURAL Cohort

ND Medicaid Expansion recipients residing within ND except for the counties of Burleigh, Cass, & Grand Forks

CATEGORY	AGE	GENDER	Capitation Rate 1/1/2015	Capitation Rate 1/1/2021
Childless Adults	19-44	M	$844.00	$945.26
Childless Adults	19-44	F	$1,078.69	$846.48
Childless Adults	45-64	M	$1,804.04	$1,829.36
Childless Adults	45-64	F	$1,598.75	$1,474.70
Adults with Children	19-44	M	$293.78	$945.26
Adults with Children	19-44	F	$559.06	$846.48
Adults with Children	45-64	M	$1,024.31	$1,829.36
Adults with Children	45-64	F	$1,385.59	$1,474.70
Retroactive Month(s) ONLY			$1,252.92	$1,581.90

The chart below shows only the yearly changes since the January 1, 2014 implementation of ND Medicaid Expansion (prior to 2019 MCO Rates were reviewed and adjusted every 6 months).

Medicaid Expansion Reimbursement Comparison

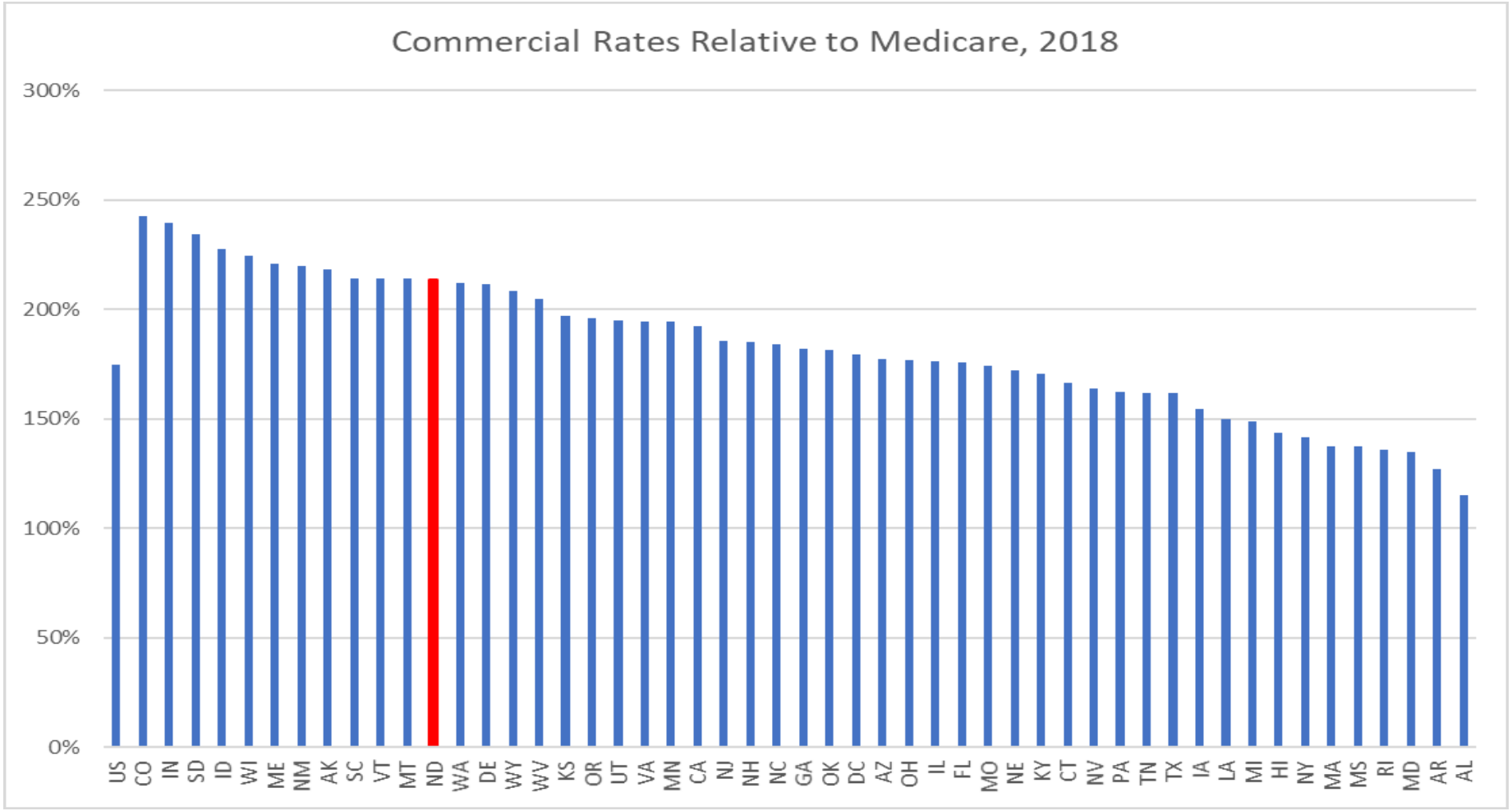
Provider Reimbursement % of Medicaid

Actual % of Medicaid*

Type of Service	CY17	CY18	CY19
Inpatient	158.7%	165.8%	151.7%
Outpatient	209.8%	208.0%	204.2%
Professional	168.2%	168.2%	165.4%
Total	**175.0%**	**177.8%**	**170.3%**

***Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures**

Medicaid Expansion Reimbursement Comparison Commercial Insurance Payment Rates



- **Commercial payments** for hospital services in ND are **214%** of the Medicare rate.
- **ND's commercial-to-Medicare** rate ratio for hospital payments is the **12th highest** in the U.S.

Source: North Dakota Insurance Department, "North Dakota 66th Legislative Assembly Interim Health Care Study," August 12, 2020

Medicaid Expansion Reimbursement Comparison

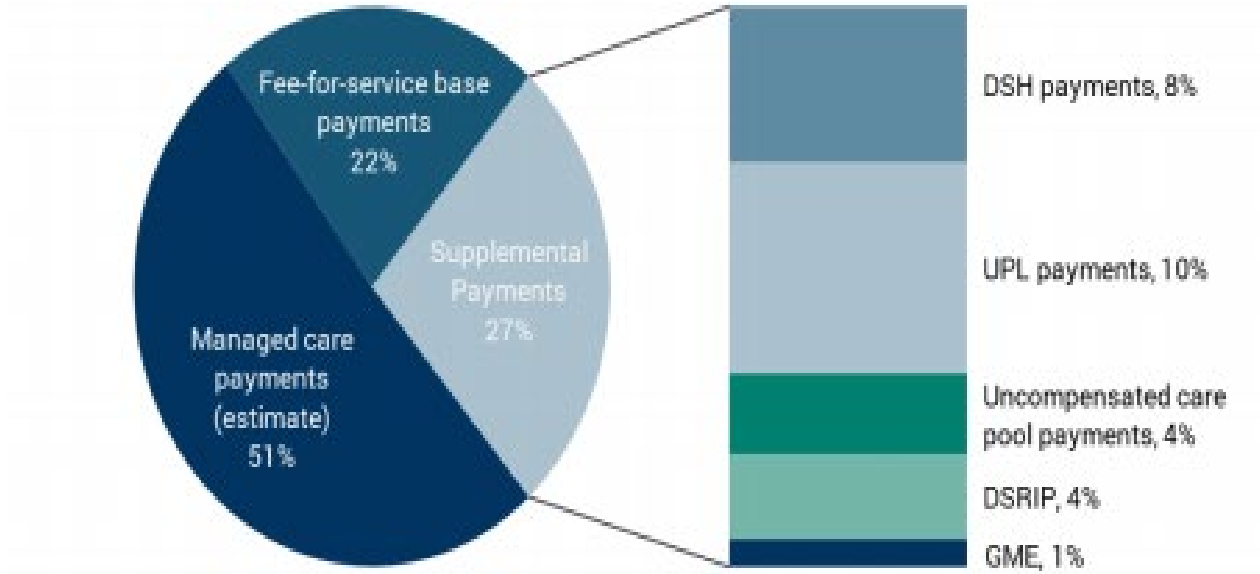
Medicaid FFS Physician Index

FFS MEDICAID PHYSICIAN INDEX		
ALL MD SERVICES	PRIMARY CARE	OTHER SERVICES
1. Alaska (2.28)	1. Alaska (2.55)	1. Alaska (1.94)
2. Montana (1.56)	2. Montana (1.65)	2. Nebraska (1.45)
3. Delaware (1.40)	3. Delaware (1.55)	3. Arkansas (1.44)
4. Wyoming (1.38)	***4. North Dakota (1.52)***	4. Montana (1.36)
5. Nevada (1.37)	5. Maryland (1.51)	5. South Dakota (1.34)
6. Maryland (1.35)	6. Nevada (1.50)	6. Delaware (1.28)
6. North Dakota (1.35)	7. Idaho (1.45)	7. Wyoming (1.27)
8. Washington, DC (1.27)	8. Wyoming (1.44)	8. New Mexico (1.25)
9. Idaho (1.25)	9. Washington, DC (1.39)	9. Iowa (1.22)
10. New Mexico (1.19)	10. Colorado (1.31)	10. Nevada (1.21)
10. Utah (1.19)	11. Utah (1.30)	11. Wisconsin (1.17)
12. Mississippi (1.17)	12. Mississippi (1.29)	***12. North Dakota (1.15)***

Source: Kaiser Family Foundation State Health Facts, based on Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees After the ACA Primary Care Fee Bump," Urban Institute, March 2017.
Note: Other services excludes ob/gyn.

Medicaid Expansion Reimbursement Comparison DHS Payments to Hospitals

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2018



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid Base and Supplemental Payments to Hospitals, March 2020 Issue Brief.



Medicaid Expansion Reimbursement Comparison DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- Medicaid disproportionate share hospital (DSH) payments offset hospitals' uncompensated care costs

- Federal rules provide Medicaid matching funds up to a maximum level of DSH payments. Federal limits apply at the individual hospital level and statewide. State DSH allotments are largely based on historical DSH payments.

- The DSH limit is the maximum amount of uncompensated care costs that a State can reimburse a hospital under Medicaid. It is based on **"cost"** of inpatient and outpatient services provided by each hospital and defined as sum of:
    1. **Medicaid shortfall:** the difference between a hospital's Medicaid payments and its cost to provide services to Medicaid-enrolled patients, and
    2. **Uninsured losses:** the cost of providing care to those without insurance for services received, less payments from uninsured.

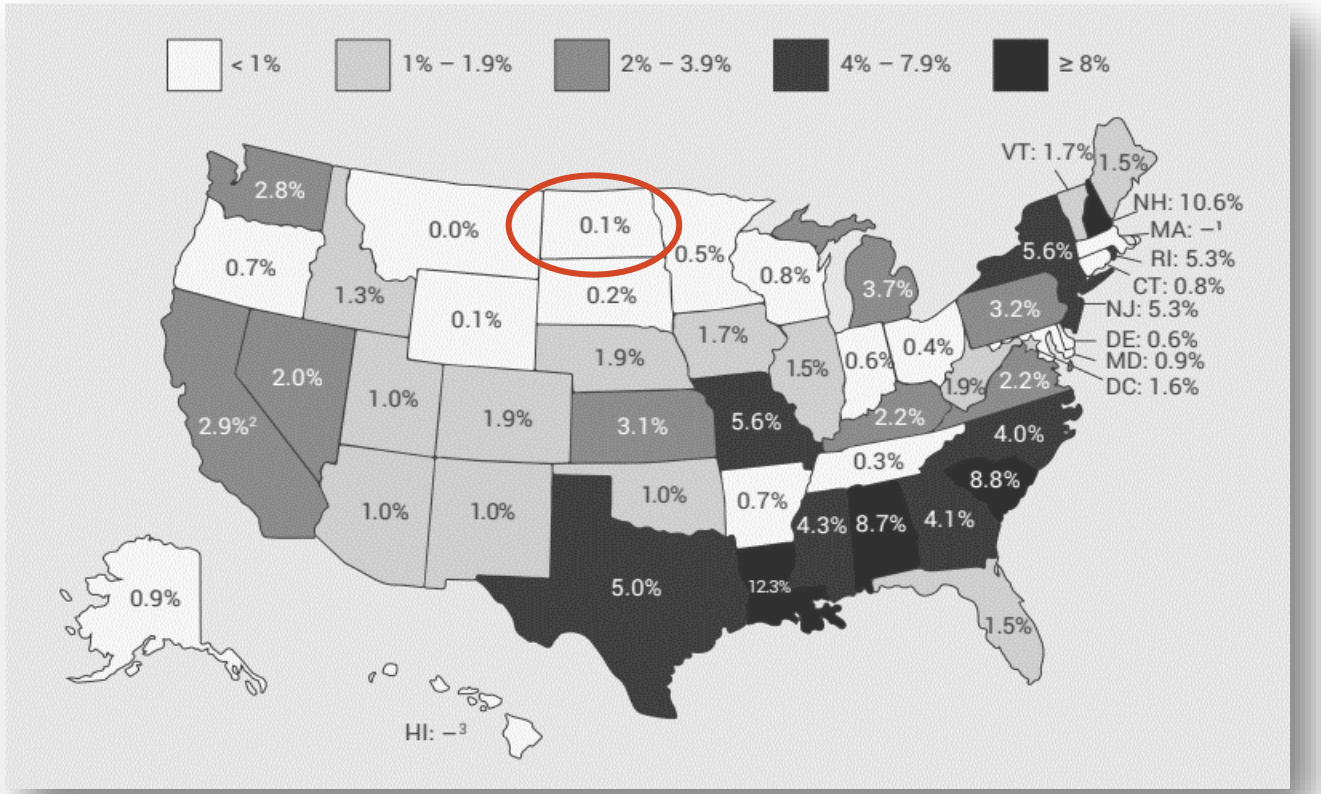
Medicaid Expansion Reimbursement Comparison

DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- **North Dakota Medicaid DSH spending is among the lowest in the nation** – both in terms of share of Medicaid spending (0.1%) and absolute dollars ($22.3 million federal and state)
- **North Dakota's Medicaid DSH allotment is about the same as South Dakota** ($22.4 million) and smaller than all other states except for Hawaii, Montana and Wyoming.

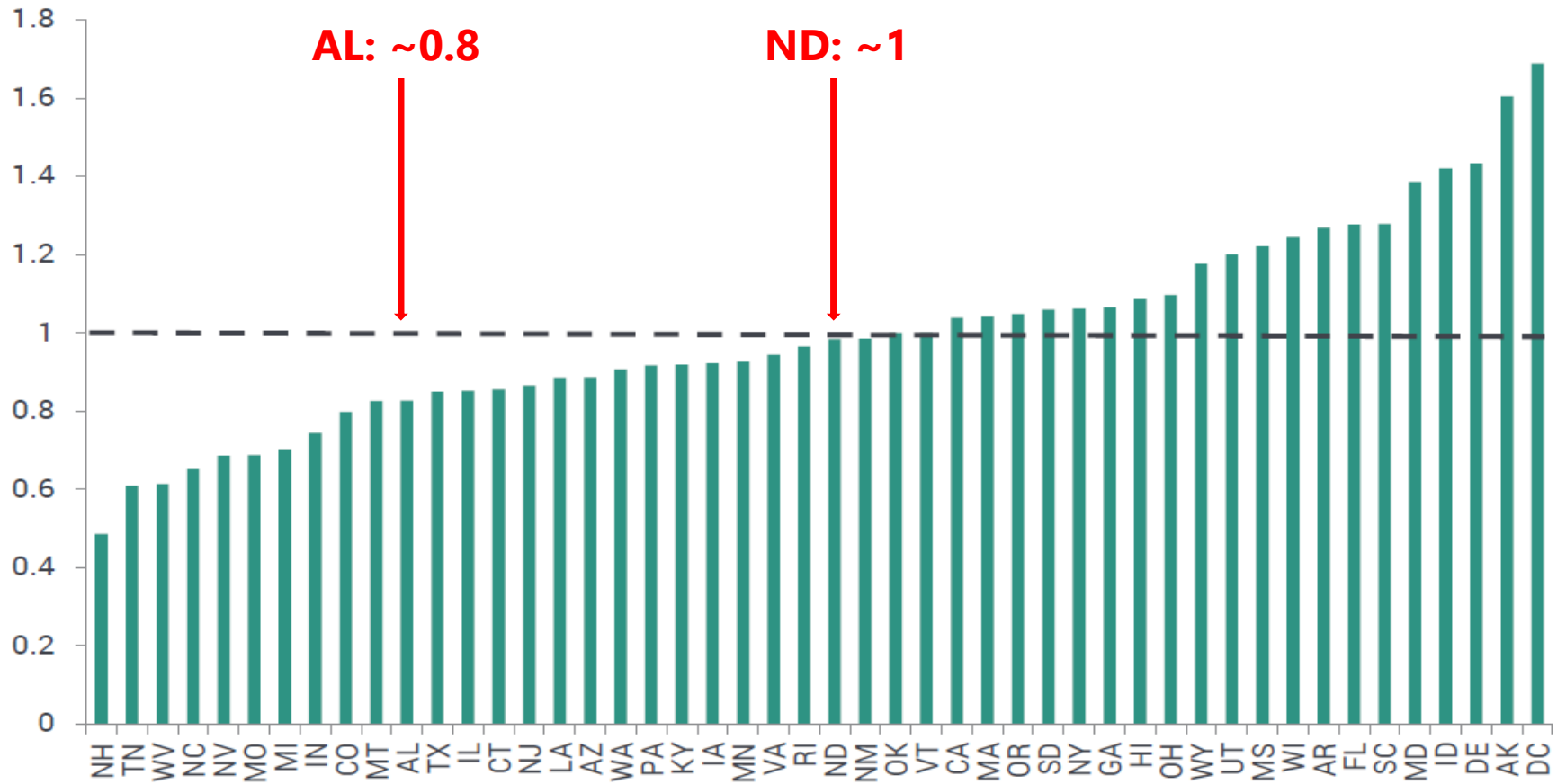
DSH Spending as % of Total Medicaid Benefit Spending by State, FY 2018



Source: Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," Washington, DC, March 2020.

Medicaid Expansion Reimbursement Comparisons Inpatient FFS Payment Index

EXAMPLE: MEDICAID-TO-MEDICARE INPATIENT FEE-FOR-SERVICE PAYMENT INDEX, CY 2010

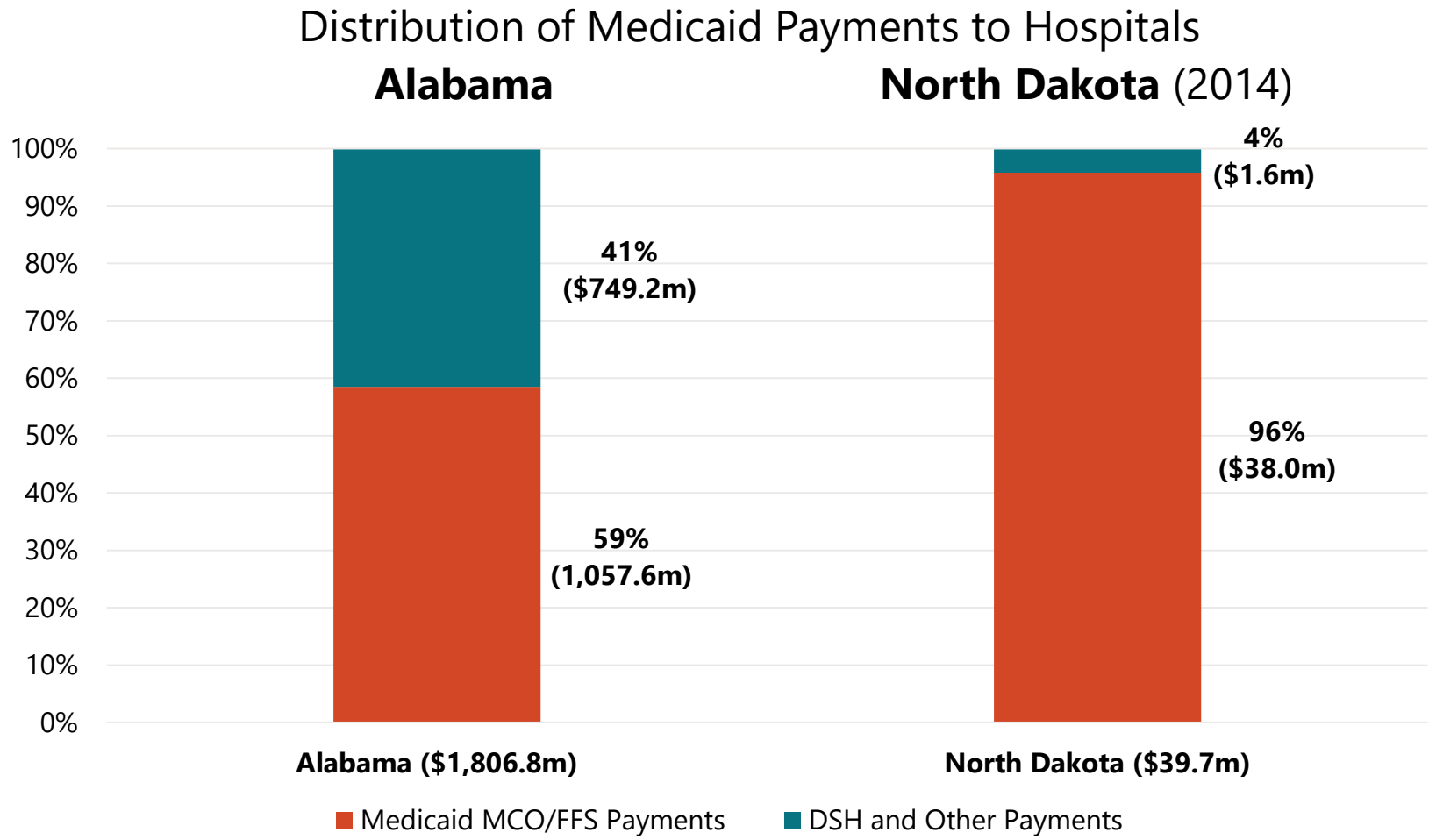


SOURCE: MACPAC. "Medicaid Hospital Payment: A Comparison Across States and to Medicare," Issue Brief, April 2017.
NOTE: The payment index values are normalized around the national average, which has a value of 1.0. For example, a state with an index value of 1.10 would have payments that were 10 percent higher than the national average. Kansas, Maine and Nebraska were excluded due to missing data.

Medicaid Expansion Reimbursement Comparisons

ND's Medicaid Payments

EXAMPLE: NORTH DAKOTA'S MEDICAID PAYMENTS ARE LARGELY IN BASE PAYMENTS



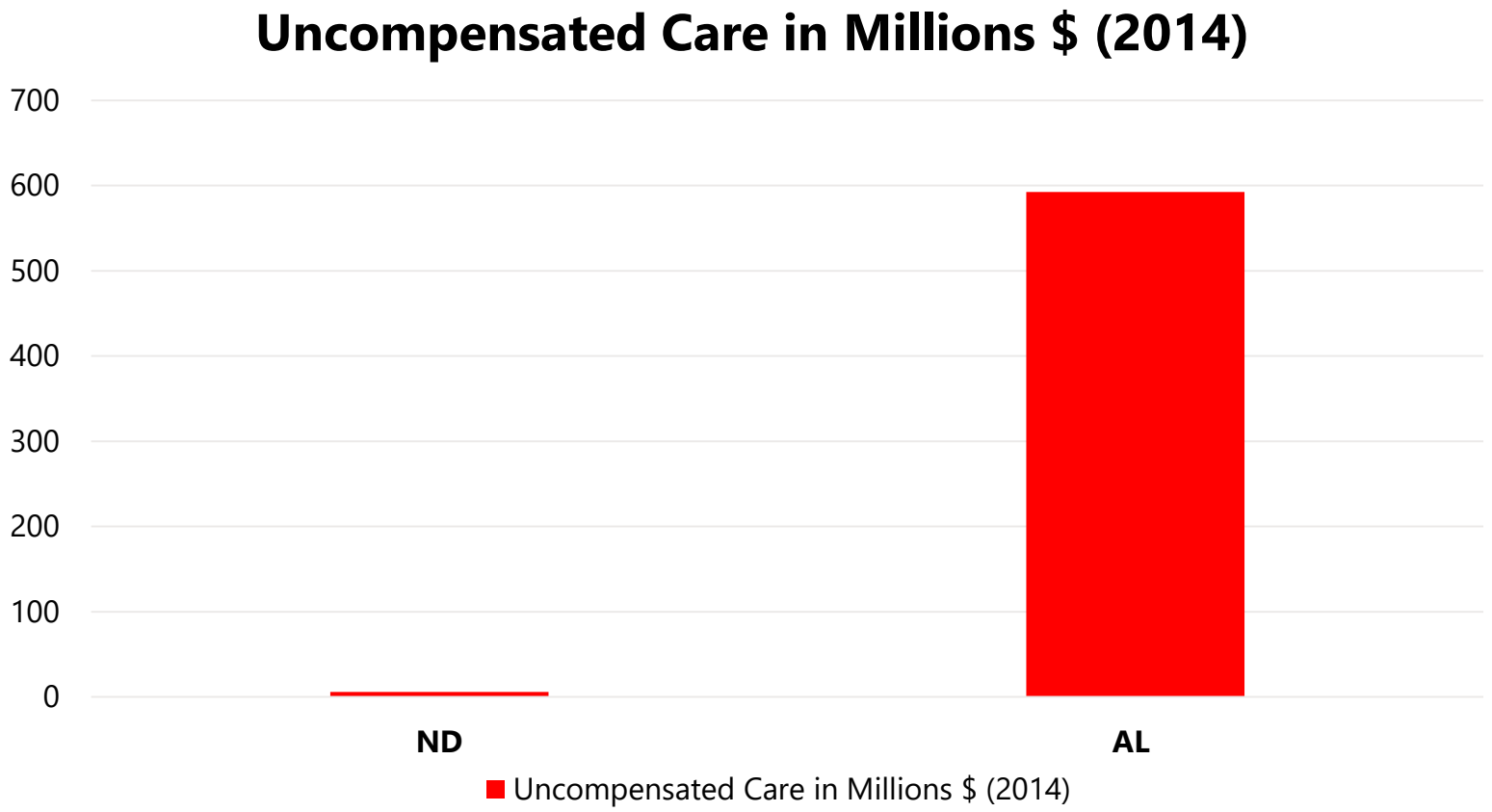
SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Medicaid Expansion Reimbursement Comparison

Hospital Uninsured & Uncompensated Care Comparison

ND hospitals uncompensated care is a fraction of AL uncompensated care

North Dakota	ALABAMA
7.9% uninsured	12.1% uninsured
$5.9 million total uncompensated care	$592.4 million total uncompensated care



SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid expansion costs per capita are the highest in the country. 54% higher than the second highest state of Alaska.

North Dakota Medicaid FFS rates for physicians are:

- higher than average and comparable to neighboring states

North Dakota hospital expenses are highest per capita and in growth in the U.S.

DSH payments in North Dakota are among the lowest in the United States

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid rates are not equitable

Payment to providers for the care of non-institutional, able-bodied adults, who can work and transition off Medicaid, are 75% to 100% higher than payments to providers for the care of other Medicaid populations like children, elderly, pregnant women, non-institutionalized adults.

Across all other state non-institutionalized programs, none incur per capita expenses as high as $14,107 for Medicaid expansion.

- Per pupil education $12,453
  - Per pupil Kindergartener $10,373
- Per pupil higher education $7,780
- Unemployment insurance $5,379 (average payment pf $448.26 times 12)

Summary of Medicaid Expansion Reimbursement Comparisons

- Transition from managed care to DHS administration will occur July 1, 2022 giving providers time to adjust, plan, and account for COVID impacts.
- As of 12/18/2020 North Dakota Medicaid providers received $326 million in provider relief funds from the federal government.
- HHS expected to **release $24.5 billion more** in provider relief funds so that providers can make up nearly 90% of lost revenues and net change in expenses. Payments will be made from 12/16/2020-1/31/2021.
  - **The department noted that more than 35,000 applicants won't receive an additional payment because the total relief they've received so far is 88% of their losses or they had no change in revenues or net expenses due to COVID-19.**



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration

Comparison Medicaid Expansion Financial Arrangement

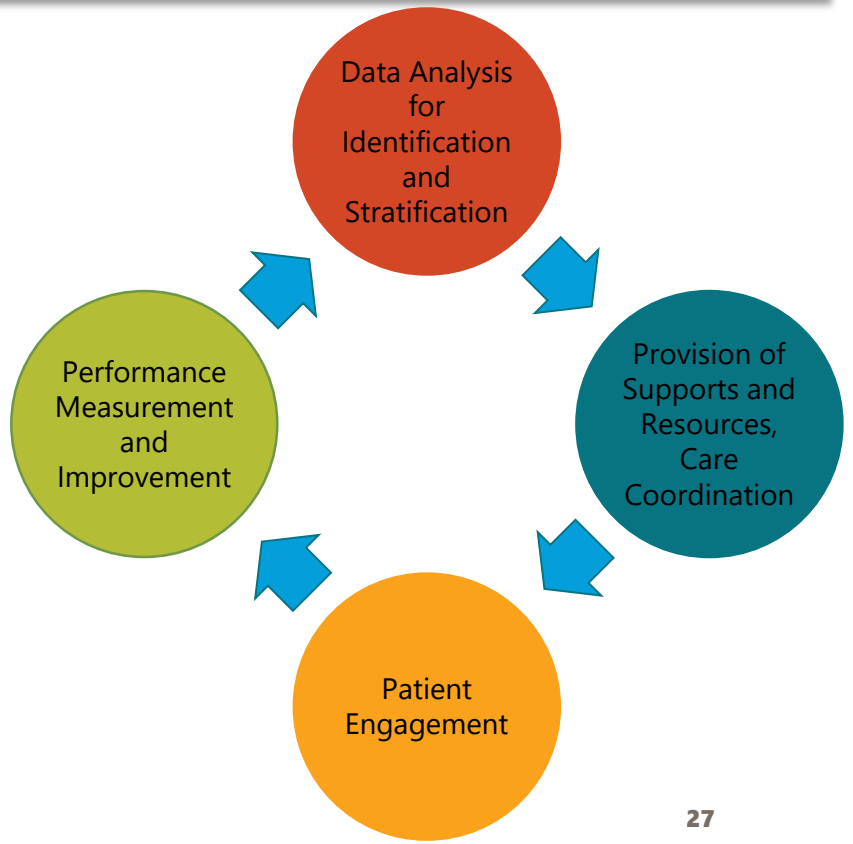
What is Managed Care?

Goal: to **control costs** while simultaneously **improving health care quality and outcomes**

Requires more than just care coordination, it involves a set of activities intended to **identify populations** to prioritize for extra support care planning and coordination, patient engagement, and analysis of data to evaluate outcomes and improve processes.

Activities to Improve Health Care Quality & Outcomes

- Intensive management of high-cost individuals.
- Selective contracting with providers willing to offer services at discounted rates.
- Initiatives to steer consumers away from high cost, low value services towards low cost, high value services.
- Requiring enrollees to obtain prior authorization from their primary care physician to gain access to specialty services.
- Focusing on preventive services.
- Monitoring the use of basic and ancillary services and using incentives to reward below-average use and disincentives to discourage excess use.
- Requiring providers to assume part of the financial risk or cost overruns for services they control, directly or indirectly.





Comparison Medicaid Expansion Financial Arrangement

Why do State Medicaid Programs use MCOs?

1. Managed Care Organization Takes on the Risk versus the State
2. Budget Predictability
3. Budget Savings
4. Improved Outcomes

Risk & Predictability

- As in any risk-based model the more people in the risk pool the more likely the managed care organization can spread the risk across health and less health individuals
- The larger the risk pool, the more predictable and stable premiums will be.
- Premiums also rely on the average health care costs of the enrollees
- Adverse selection occurs when the insurer attracts individuals when they have greater health care needs
- In **North Dakota**, the
  - **risk pool** is the **smallest** in the **entire country** using managed care
  - **premiums** have **not** been **predictable** or **stable**
  - **churn rate** indicates that **adverse selection** is probably occurring



Comparison Does Managed Care Save Money?

Inconclusive Evidence

Lewin Group Analysis

- AHIP funded
- Meta-analysis, a review of 24 studies
  - none were peer reviewed
  - proposes that cost savings range from 0.5% to 20%
  - Point to decreases in inpatient utilization but at that time inpatient was going down throughout the U.S. health system

Mathematica 5-State Analysis

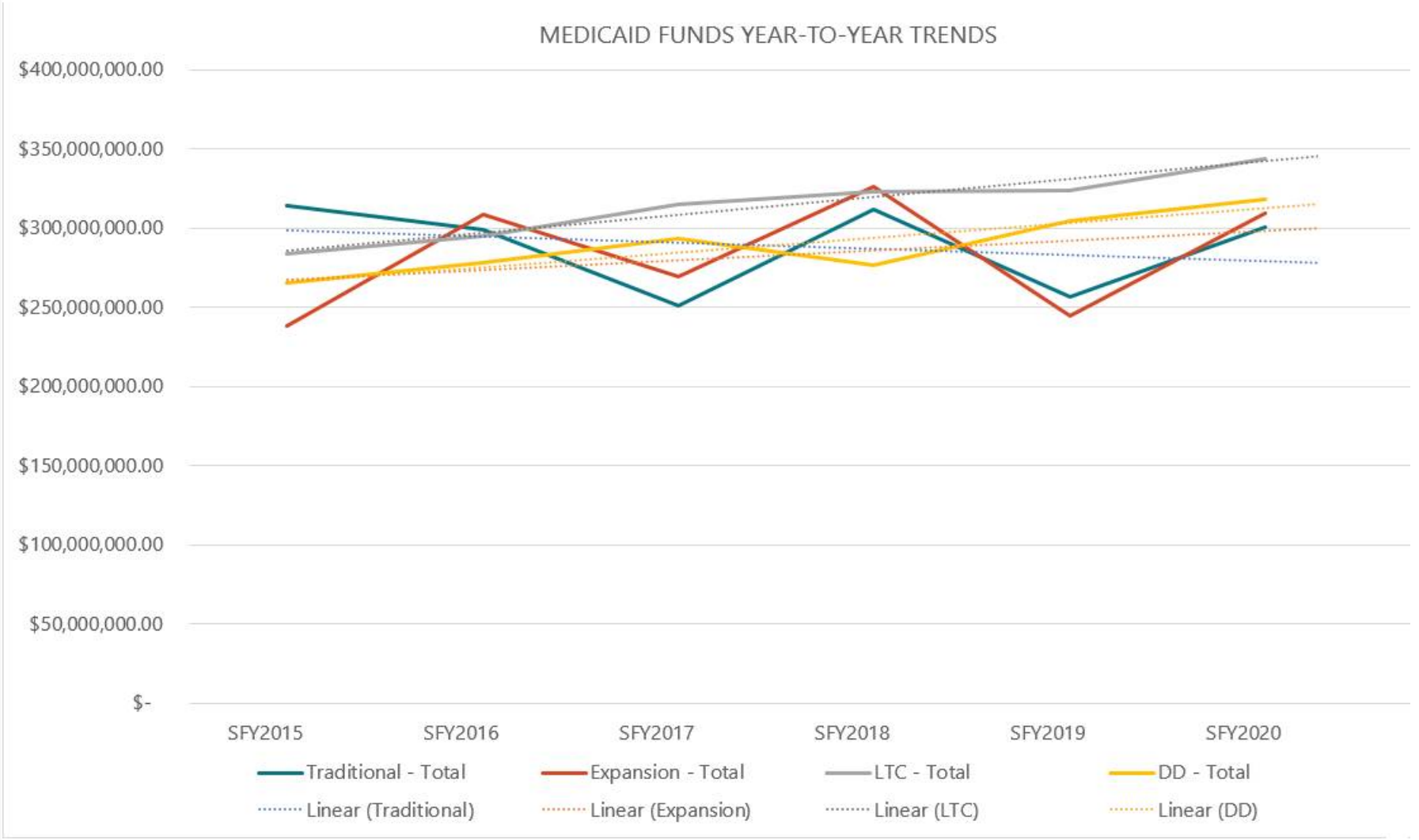
- Found no savings

Duggan Study from NBER Analysis

- Showed moving to managed care resulted in no improvement in health care and substantial increases in government spending.
- MCO did little to nothing to reduce spending.

Source:https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/

Comparing Has Medicaid Expansion Saved Money in North Dakota?





Comparing Has Medicaid Expansion Improved Health?

HEDIS and CAHPS measures are skewed toward members with **continuous enrollment**. In expansion we know the churn rate is high (~11,000 members) and we know that expenditures keep going up and not down.

The State's contracted actuary uses a different analytical tool to get a better idea of the **effectiveness of the managed care** organization called Prometheus.

- 43 episodes are built such as diabetes and knee surgery
- Compares the utilization and cost based on clinical standards
- Sorts potential waste and identifies care that should have been potentially avoided using the right interventions and clinical management

What is Care Coordination in an MCO?

Prior testimony in 2019 session on the number of care coordinators in managed care organization

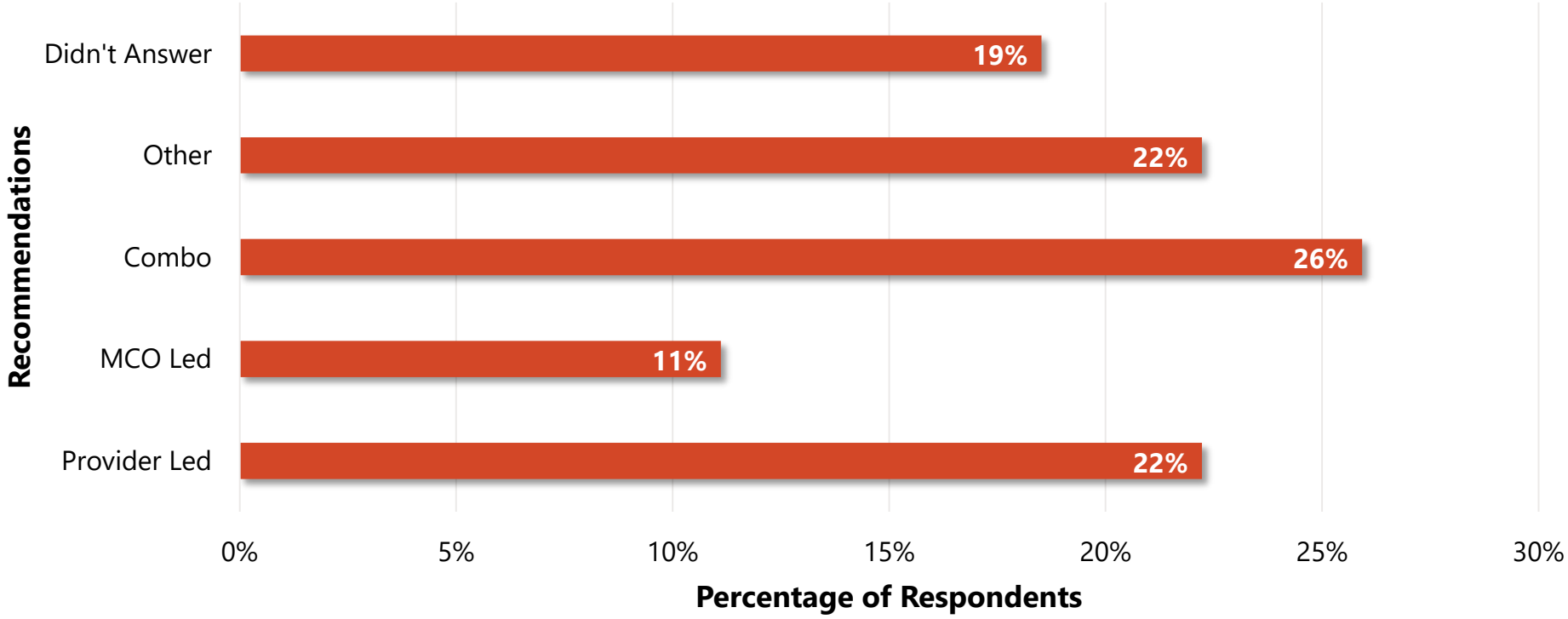
- Difference between care coordination, case management, and population health in managed care:
  - Care Coordination: contracted to primary care providers
  - Case Management: typically done by the MCO typically and targets high risk members, high touch and costly
  - Population Health: typically done by MCO and relies on data analytics to target sub-groups.

ND Medicaid Expansion MCO Survey

There are different approaches to care management by a MCO:

1. **Provider-led** (with an enhanced payment to providers for outcomes)
2. **MCO-led** (MCO has its own care managers)

What do you think is the ideal care management approach, why?



ND Medicaid Expansion MCO Survey

"Provider led care management because the care managers are direct member of the patients care team coordinating care and service for the patient. Hybrid models work will where MCO's support provider led programs with expertise in certain programs such as behavioral health."

"I believe the best method should be a combination of provider-led, when possible, and MCO-led, when necessary. Not all providers will be able to perform necessary care management, but that doesn't mean the MCO should simply take on all care management when there are providers who can and do perform important care management to the benefit of their patients. As such, those high performers should be eligible for enhanced reimbursement. Different strengths and areas of expertise to the table that complement each other.

"Ideally, we feel the care management should be owned by the primary care providers who work closest with the patient. With the enhanced primary care models, we are able to fill in the gaps more easily by being closely connected to the patients and providing ongoing care management to the patients through calls, virtual care, patient portals, goal setting and management, mental health counseling, and medication management."

"The ideal approach is a hybrid of the two. Both the MCO carrier and the provider."

"I feel that provider lead would be more beneficial as they understand the needs of their patients and understand barriers to service delivery unlike MCO. I have learned that direct contact with individuals allows for feedback and ability to understand how policies affect direct practice."



What did providers comment in the MCO Survey?

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

- Alabama (Medical Homes to ACO)
- South Dakota (Health Homes Model)
- Connecticut (ASO model) in early 2020

South Dakota avoided $7.3 million in costs using Health Homes in 5 years

Feedback from North Dakota Medicaid Stakeholders

- Noted that **Health Homes** was the preferred model
- Subsequent meeting with outpatient stakeholders

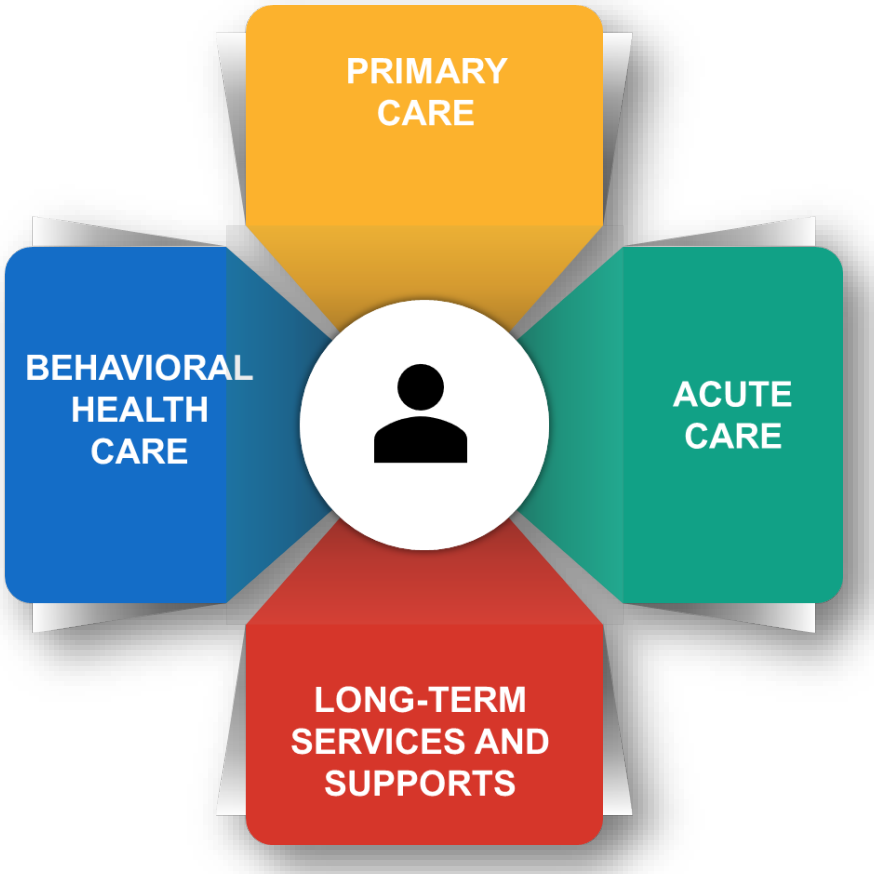
2021-2023 Executive Request

- Authorizes DHS to plan for **Health Homes** and seek CMS approval
- Enhanced payment will offset some of the reduction in rates.

Proposed Solution
Health Homes

Medicaid Health Homes

- Builds on the PCMH model
- Fosters a **"whole-person"** orientation to care for individuals with **chronic conditions** through the integration and coordination of:
  - Primary Care
  - Acute Care
  - Behavioral Health Care
  - Long-Term Services & Support



Proposed Solution
MCO → DHS Administration

Parity to Medicaid members

- Adults in **household** will have **same benefit package**
- Adult **dental** and **vision** will be **part of benefit package**

Significant administrative simplification

- Staff time available to develop an overall care coordination for Traditional and Expanded Medicaid, including review of Targeted Case Management, Primary Care Case Management, and Coordinated Services Program
- Client repayment for eligibility overpayments will be limited to actual claims paid vs. the cost of the monthly premium
- Administrative rules and procedures are the same for providers across the entire Medicaid program
- Only one program to manage, evaluate, and report on

Legislature has more control as compared to privately contracted services



Proposed Solution MCO → DHS Administration

Streamlined movement between traditional and expansion

- One ID card, one provider network, one set of letters and notifications, zones have one set of policies.
- Current situation:
  - Creates **confusion** as to which coverage option is applicable for date(s) of service
  - **Interrupts continuity** which can lead to fragmented care due to differences between the model processes such as the following:
    - Available Benefits
    - Utilization Management or Case Management
    - Service Authorization requirements and requests
    - Appeals for Adverse Benefit Determinations
    - Claims Submission
    - Provider Enrollment – Credentialing
    - Quality or Value Based Purchasing requirements
    - Oversight Requirements

MEDICAL SERVICES
Medicaid Expansion Transition

NORTH Dakota | Human Services
Be Legendary.™

From MCO Administration to DHS In-House Administration

SAVINGS



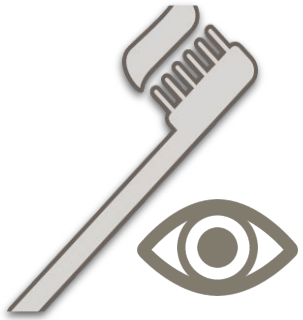
Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)



MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00



DHS Administrative Expenses

Staff Costs	$568,234.00
Contracts	$ 79,520.00
Other (Notices)	$ 23,332.00

$(10,749,572.00)



Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues from Public Testimony

Prior Testimony
Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals.
Handout shows the Medicaid percentage of payer mix for all hospitals. Average Medicaid is 8% of payer mix across all hospitals. According to enrollment data, about 20% of that is expansion enrollees.

Average estimated expansion payer mix for CAHs is 1.58% and 1.3% for PPS

HOSPITAL NAME	TOWN	HOSPITAL TYPE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ST ALEXIUS MEDICAL CENTER	BISMARCK	SHORT TERM		4%	4%	5%	4%	3%	1%	7%	7%	6%
TRINITY HOSPITALS/ST JOES	MINOT	SHORT TERM		0%	0%	0%	3%	4%	11%	11%	13%	13%
SANFORD MEDICAL CENTER - FARGO	FARGO	SHORT TERM		6%	4%	3%	4%	7%	9%	8%	8%	8%
SANFORD BISMARCK	BISMARCK	SHORT TERM		7%	7%	7%	5%	8%	7%	7%	8%	6%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	GRAND FORKS	SHORT TERM		10%	10%	10%	12%	8%	9%	9%	8%	
INNOVIS HEALTH	FARGO	SHORT TERM		5%	5%	5%	6%	7%	7%	8%	6%	6%
TIOGA MEDICAL CENTER	TIOGA	CRITICAL ACCESS HOSPITALS		0%	0%	0%	1%	1%	1%	1%	1%	1%
MOUNTRAIL COUNTY MEDICAL CENTER	STANLEY	CRITICAL ACCESS HOSPITALS		0%	0%	1%	2%	2%	2%	3%	3%	2%
MCKENZIE COUNTY HEALTHCARE SYSTEM	WATFORD CITY	CRITICAL ACCESS HOSPITALS		1%	1%	1%	3%	4%	6%	5%	4%	4%
GARRISON MEMORIAL HOSPITAL	GARRISON	CRITICAL ACCESS HOSPITALS		19%	20%	17%	26%	25%	25%	23%	22%	24%
TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	CRITICAL ACCESS HOSPITALS		9%	23%	25%	28%	30%	34%	30%	11%	26%
KENMARE COMMUNITY HOSPITAL	KENMARE	CRITICAL ACCESS HOSPITALS		0%	0%	0%	25%	33%	26%	25%	19%	17%
COOPERSTOWN MEDICAL CENTER	COOPERSTOWN	CRITICAL ACCESS HOSPITALS		1%	1%	3%	9%	0%	4%	3%	6%	6%
ST ANDREWS HEALTH CENTER	BOTTINEAU	CRITICAL ACCESS HOSPITALS		12%	13%	14%	18%	16%	14%	14%	17%	13%
NELSON COUNTY HEALTH SYSTEMS-HO	MCVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	1%	0%	1%	1%	3%
SANFORD MAYVILLE	MAYVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	3%	1%	2%	3%	3%	3%	3%
DAKAKAWEA MEDICAL CENTER	HAZEN	CRITICAL ACCESS HOSPITALS		5%	2%	2%	4%	3%	1%	5%	6%	5%
LISBON AREA HEALTH SERVICES	LISBON	CRITICAL ACCESS HOSPITALS		6%	8%	11%	9%	11%	10%	4%	7%	8%
NORTHWOOD DEACONESS HEALTH CENTER	NOTHWOOD	CRITICAL ACCESS HOSPITALS		1%	1%	1%	2%	4%	3%	4%	5%	5%
SOUTHWEST HEALTHCARE SERVICES	BOWMAN	CRITICAL ACCESS HOSPITALS		1%	1%	2%	2%	3%	2%	2%	1%	1%
JACOBSON MEMORIAL HOSPTAL	ELGIN	CRITICAL ACCESS HOSPITALS		1%	2%	23%	20%	19%	21%	20%	19%	19%
OAKES COMMUNITY HOSPITAL	OAKES	CRITICAL ACCESS HOSPITALS		4%	2%	2%	3%	7%	6%	2%	8%	9%
PRESENTATION MEDICAL CENTER	ROLLA	CRITICAL ACCESS HOSPITALS		0%	13%	12%	19%	24%	21%	28%	17%	20%
CARRINTON HEALTH CENTER	CARRINGTON	CRITICAL ACCESS HOSPITALS		1%	4%	4%	3%	5%	5%	2%	2%	6%
PEMBINA COUNTY MEMORIAL HOSPITAL	CAVALIER	CRITICAL ACCESS HOSPITALS		2%	1%	1%	4%	4%	2%	14%	2%	1%
UNITY MEDICAL CENTER	GRAFTON	CRITICAL ACCESS HOSPITALS		4%	4%	3%	3%	3%	6%	5%	4%	5%
WISHEK COMMUNITY HOSPITAL	WISHEK	CRITICAL ACCESS HOSPITALS		3%	3%	2%	1%	1%	2%	2%	2%	2%
ASHLEY MEDICAL CENTER	ASHLEY	CRITICAL ACCESS HOSPITALS		33%	11%	11%	1%	1%	1%	2%	2%	2%
CAVALIER COUNTY MEMORIAL HOSPITAL	LANGDON	CRITICAL ACCESS HOSPITALS		1%	8%	2%	3%	3%	1%	8%	1%	4%
MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	CRITICAL ACCESS HOSPITALS		2%	4%	3%	4%	6%	7%	4%	1%	9%
ST LUKES HOSPITAL	CROSBY	CRITICAL ACCESS HOSPITALS		5%	1%	1%	1%	0%	2%	1%	4%	3%
FIRST CARE HEALTH CENTER	PARK RIVER	CRITICAL ACCESS HOSPITALS		3%	3%	2%	2%	4%	3%	3%	3%	3%
ST ALOISIUS MEDICAL CENTER	PARVEY	CRITICAL ACCESS HOSPITALS		0%	0%	0%	4%	3%	5%	5%	4%	4%
LINTON HOSPITAL	LINTON	CRITICAL ACCESS HOSPITALS		0%	2%	1%	1%	3%	2%	3%	4%	2%
SANFORD HILLSBORO	HILLBORO	CRITICAL ACCESS HOSPITALS		28%	27%	31%	43%	3%	2%	2%	3%	4%
WEST RIVER REGIONAL MEDICAL CENTER	HETTINGER	CRITICAL ACCESS HOSPITALS		28%	1%	2%	1%	3%	1%	3%	3%	
TOWNER COUNTY MEDICAL CENTER	CANDO	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	2%	3%	3%	3%	2%
HEART OF AMERICA MEDICAL CENTER	RUGBY	CRITICAL ACCESS HOSPITALS		1%	21%	26%	21%	2%	25%	30%	3%	14%
MERCY HOSPITAL OF VALLEY CITY	DEVILS LAKE	CRITICAL ACCESS HOSPITALS		12%	16%	15%	20%	23%	26%	10%	14%	34%
MERCY MEDICAL CENTER	WILLISTON	CRITICAL ACCESS HOSPITALS		4%	3%	4%	5%	4%	6%	6%	41	6%
JAMESTOWN REGIONAL MEDICAL CENTER	JAMESTOWN	CRITICAL ACCESS HOSPITALS		9%	9%	8%	9%	10%	13%	13%	7%	10%
ST JOSEPHS HOSPITAL AND HEATLH CENTER	DICKINSON	CRITICAL ACCESS HOSPITALS		5%	6%	5%	5%	8%	8%	7%	2%	8%

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

- DHS collected and extracted information from PPS and CAH cost reports for 2019
  - Medicare is the **primary payer source** for the CAHs
  - Net operating margins were on average -**1.8%** *(Larger CAHs have better net operating margins)*
  - Historically, CAH **net operating margins are negative** and Medicare **sequestration** have **exacerbated** this issue.
- In 2019, estimated **total Medicaid revenues** were **9.9%** of total revenues
  - If 20% of the expenditures are for expansion, DHS estimates that CAHs will have reduced revenues of **approximately $4.7 million to $12.8 million** (75% of inpatient and 100% of outpatient)

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

Actuary studied CAH revenue structure for expansion at traditional and expansion rates. Would remove about **$7 to $7.5 million** from the CAH payment system.

	CY17 Number of CAHs	CY18 Number of CAHs	CY17 Percent of CAHs	CY18 Percent of CAHs
Repriced > Incurred Dollars	16	14	44.4%	38.9%
Incurred > Repriced Dollars	20	22	55.6%	61.1%



Prior Testimony Critical Access Hospital Impact

Another Source of Funding:

- CAHs can participate in Health Homes if they have a Rural Health Clinic or FQHC *(Large CAHs were included in value-based purchasing discussion as well)*

Possible solutions:

- Increase supplemental payment by **$7.5 million up to $12.8 million**, there is room in the Upper Payment Limit for Outpatient Hospital Expenditures of about $50 million of which about $15 million can be used for expansion. This would mean rebasing CAHs for inpatient and outpatient care.
- Could consider providing **$7.5 million** more in revenue to CAHs which is about **7% rate increase** on traditional spending for CAH acute and outpatient care.

Prior Testimony Critical Access Hospital Impact

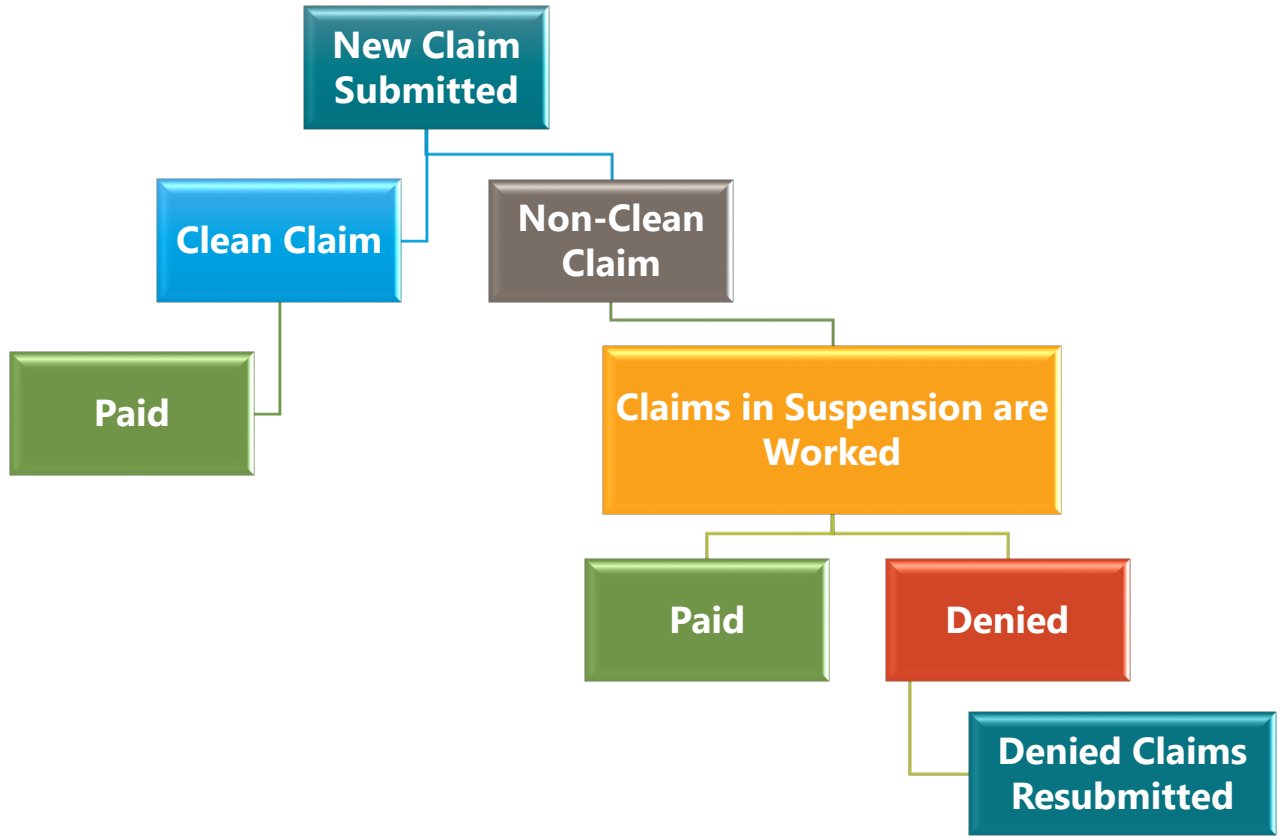
Prior testimony implied that critical access hospitals would close

- **DOH record on hospital closures-**
  - **Dakota Heartland Health System**, Fargo closed in 2002 (PPS)
  - **Richardton Memorial Hospital and Health Center**, Richardton closed in 2009 (CAH)
  - **Red River Behavior Health Systems**, Grand Forks closed in Sept 2020 (Psych)
  - **Altru Rehabilitation Center**, Grand Forks terminated their state hospital license in 2019 (Rehab) *(Altru still remains certified as a hospital and has 2 licensed locations)*

2 Hospital Closed Before Expansion &
2 Closed Since Expansion was Implemented

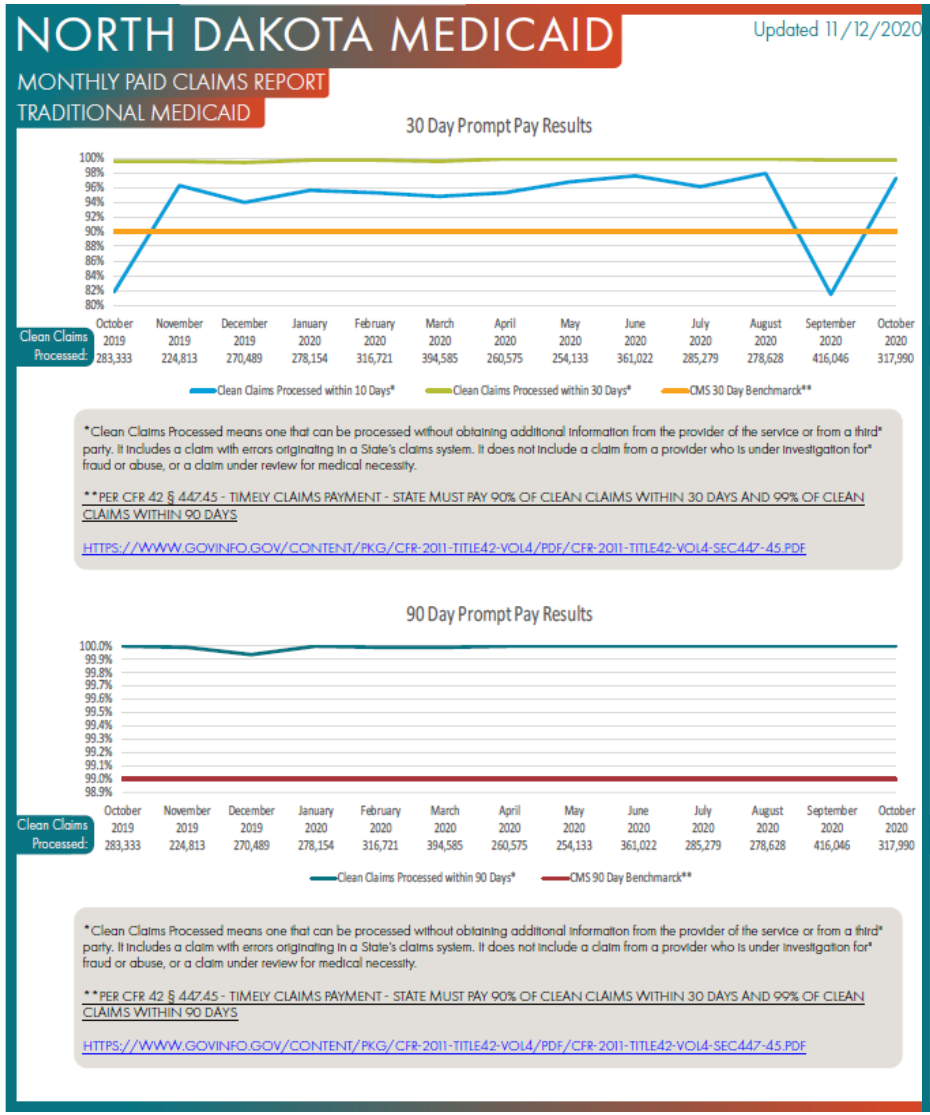
Prior Testimony Claims Payment Turn Around

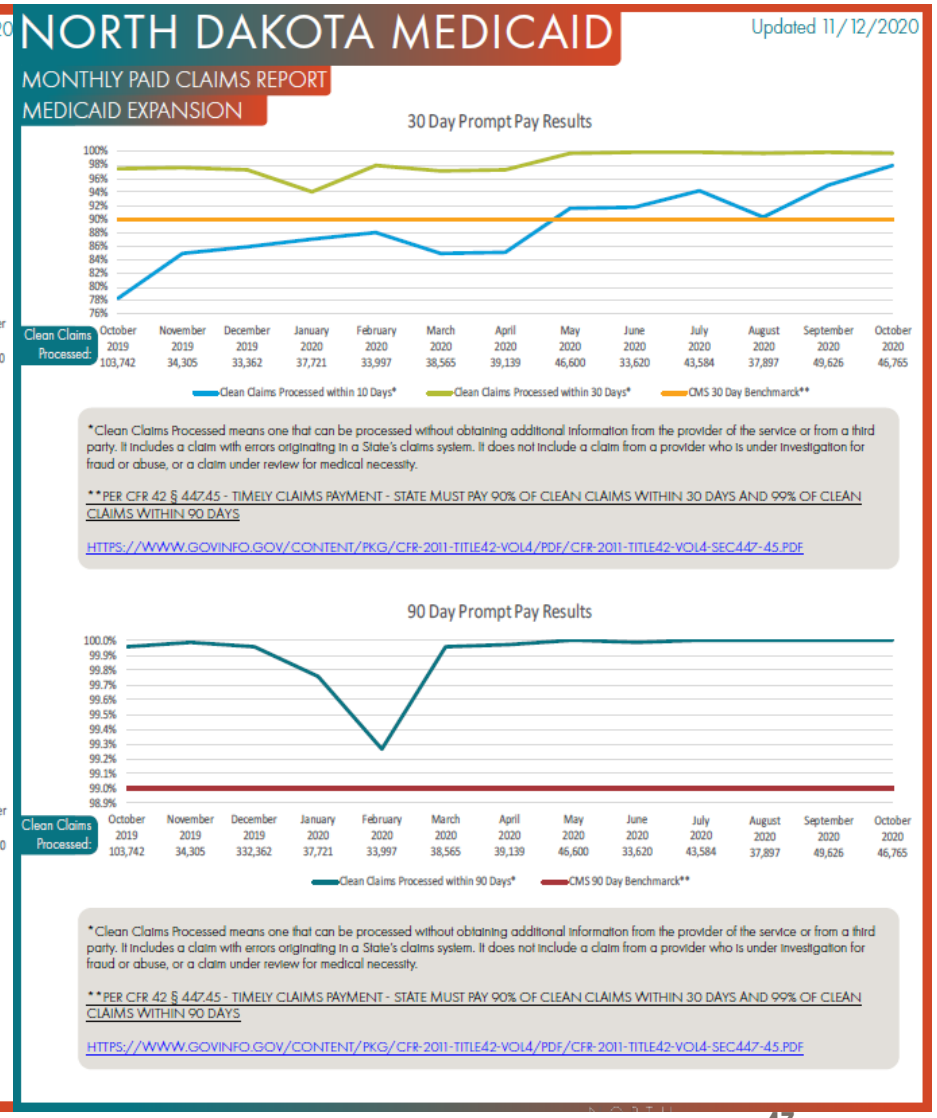
Lifecycle of a Claim



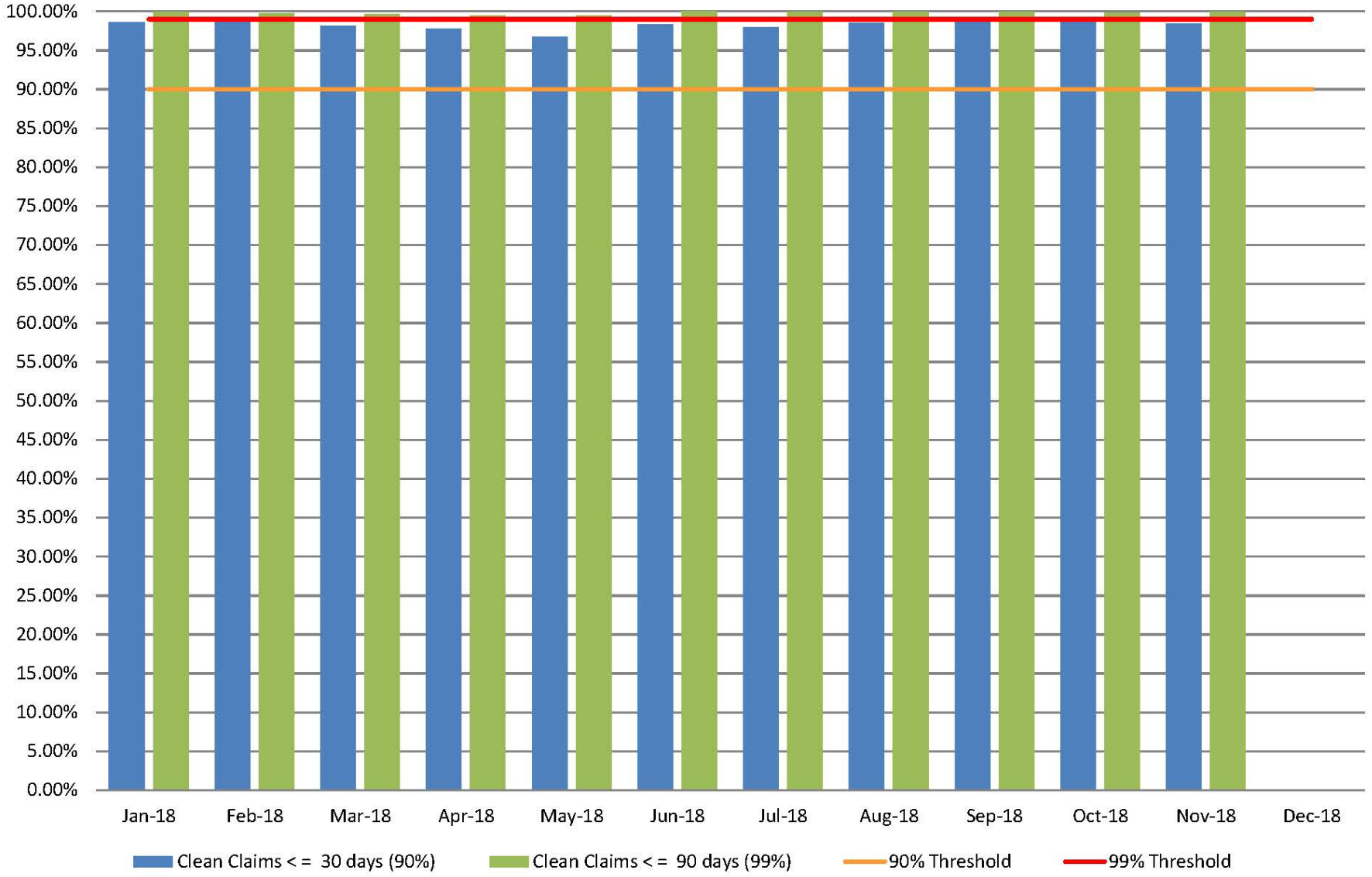
Prior Testimony
Claims Payment Turn Around

Clean Claim payment turnaround times between ND Traditional FFS Medicaid and MCO Medicaid Expansion



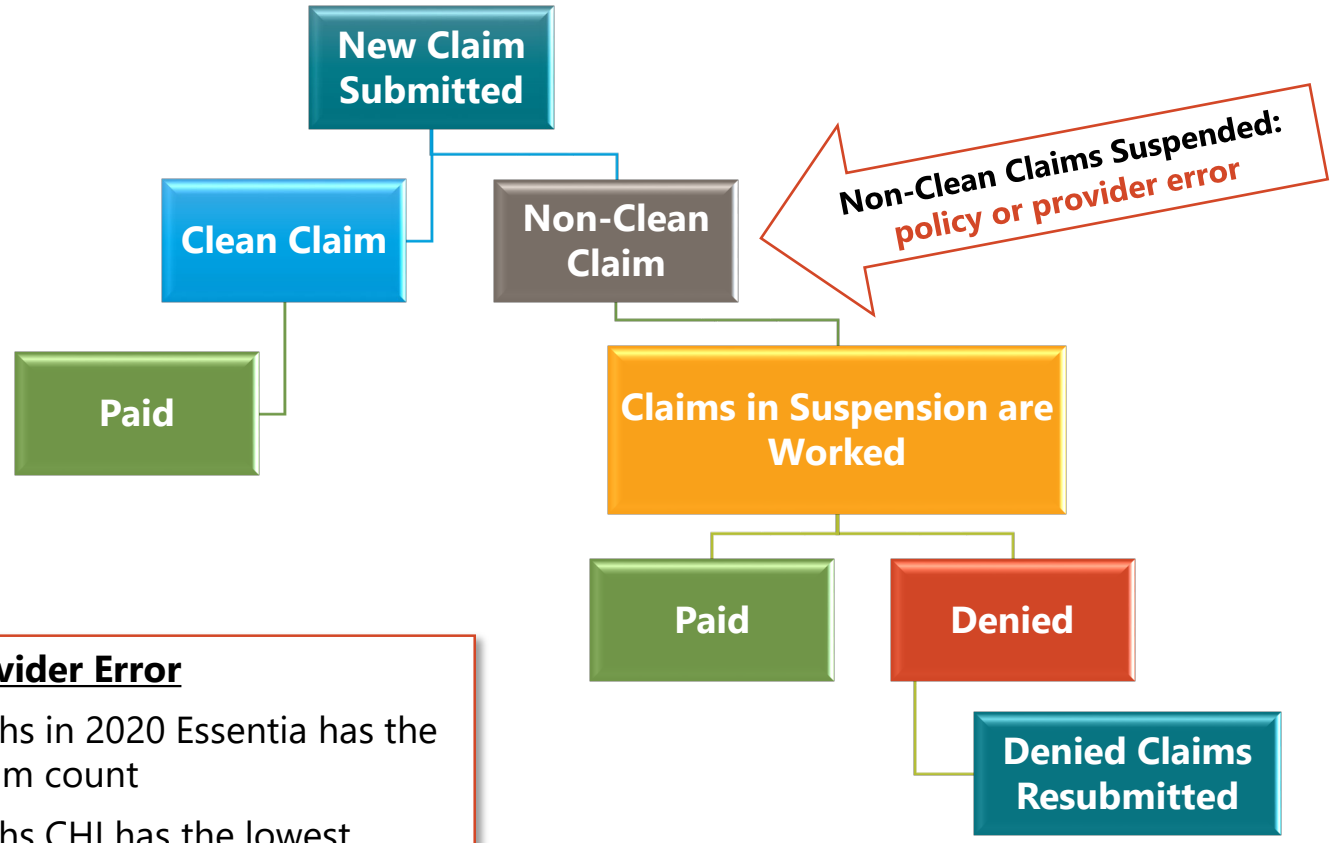


Prior Testimony
Claims Payment Turn Around



Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim

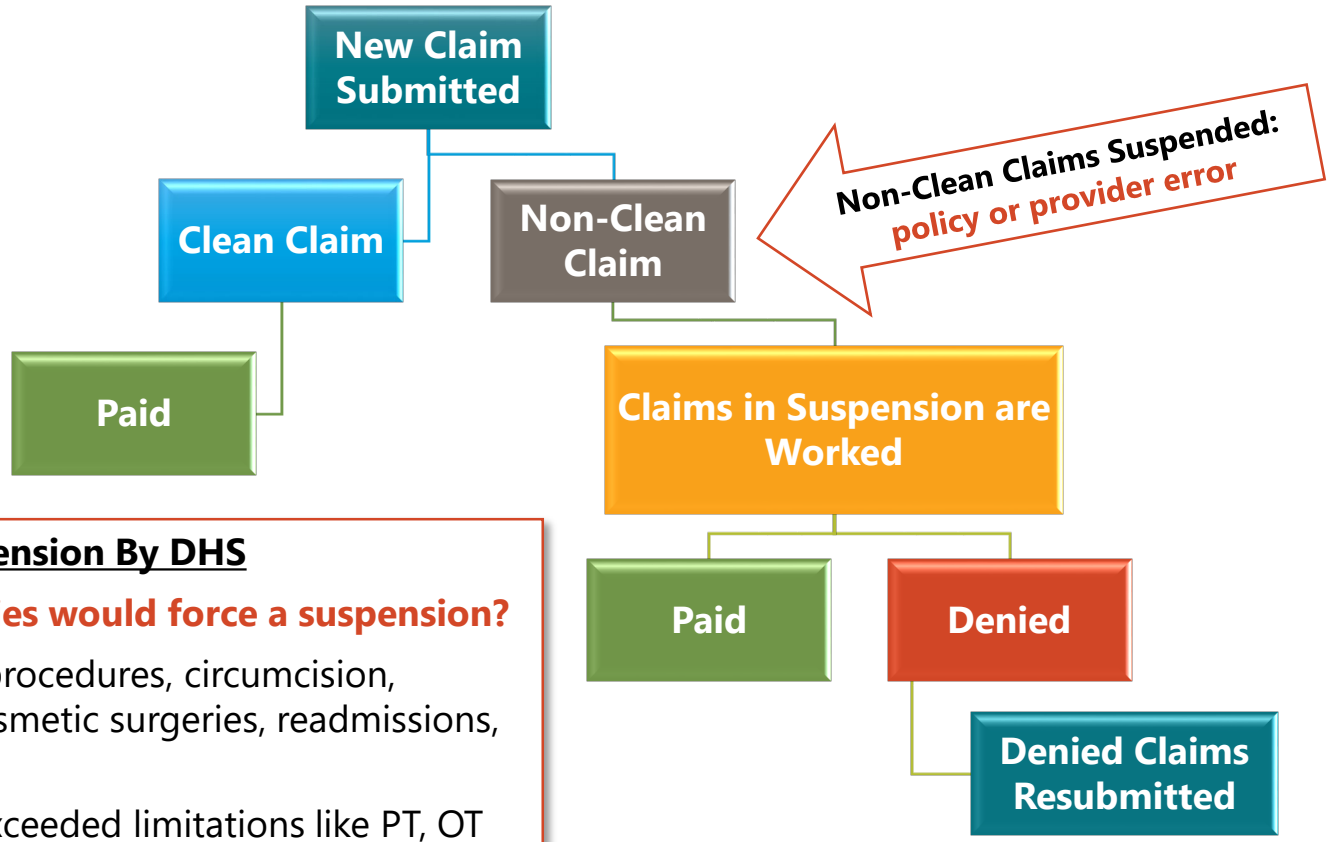


Provider Error

- 7 out of 12 months in 2020 Essentia has the highest clean claim count
- 6 out of 12 months CHI has the lowest
- 4 out of 12 months Altru has the lowest

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

What Medicaid policies would force a suspension?

- Review of certain procedures, circumcision, appendectomy, cosmetic surgeries, readmissions, etc.
- If a member has exceeded limitations like PT, OT
- Third party liability (TPL) as Medicaid is the payer of last resort
- DRGs not appropriate

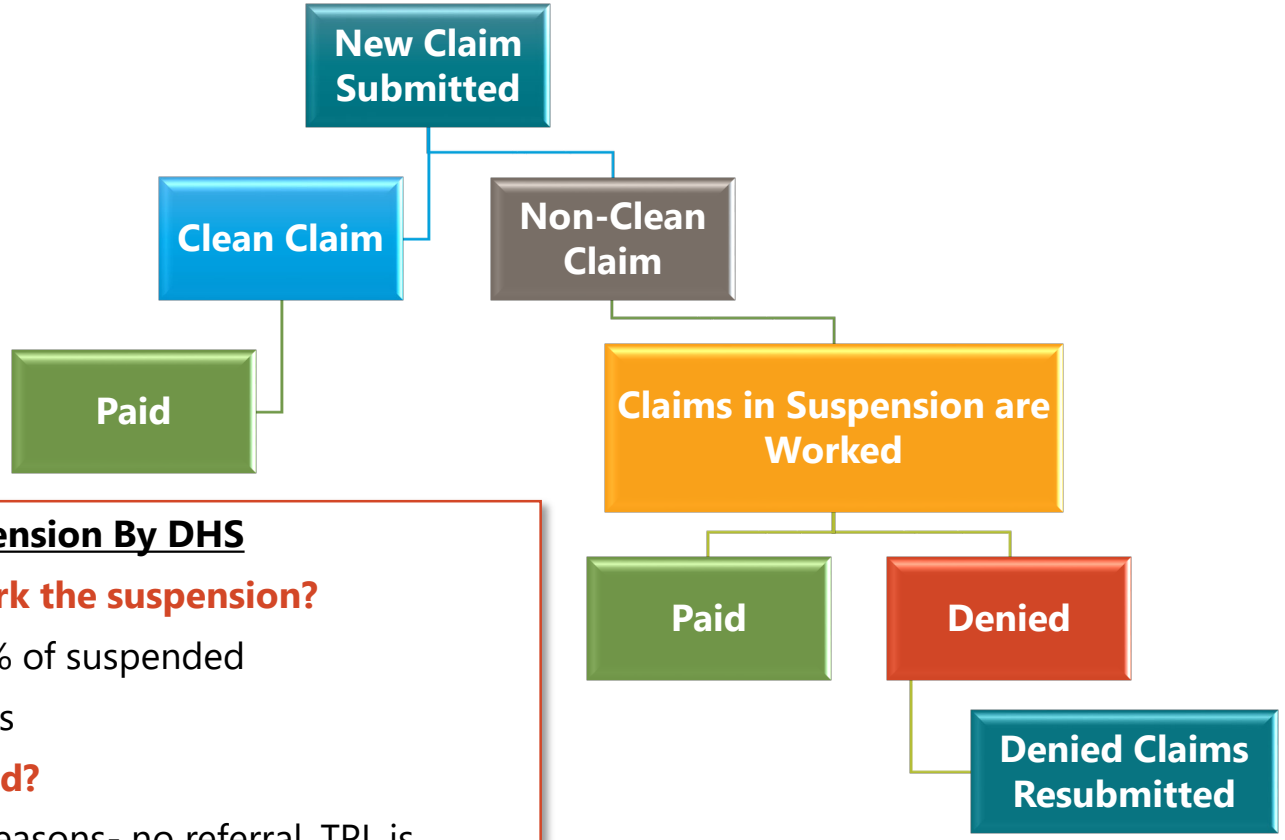
Prior Testimony Claims Payment Turn Around

MEDICAID ANNUAL PROFILE REPORT
Provider Review Results
Peer Group 1
Reviews: 7/1/2017 - 6/30/2018

Provider	# of Cases	# Cases Denied	Billing Denial	Technical Denial	Medical Necessity Denial	Denied %	Billing Denial %	Technical Denial %	Medical Necessity %	# DRGs Changed	% of Cases with DRG Changes
Sanford Medica Fargo	608	2	0	1	1	0.3%	0.0%	0.2%	0.2%	7	1.2%
Sanford Medica Bismarck	582	3	0	2	1	0.5%	0.0%	0.3%	0.2%	4	0.7%
Altru Hospital Grand Forks	437	10	0	0	10	2.3%	0.0%	0.0%	2.3%	21	4.8%
Trinity Hospital Minot	374	2	0	0	2	0.5%	0.0%	0.0%	0.5%	5	1.3%
St. Alexius Med Bismarck	275	9	1	0	8	3.3%	0.4%	0.0%	2.9%	9	3.3%
Essentia Health Fargo	187	4	0	2	2	2.1%	0.0%	1.1%	1.1%	6	3.2%
Peer 1	**2463**	**30**	**1**	**5**	**24**	**1.2%**	**0.0%**	**0.2%**	**1.0%**	**52**	**2.1%**

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

How long to take work the suspension?

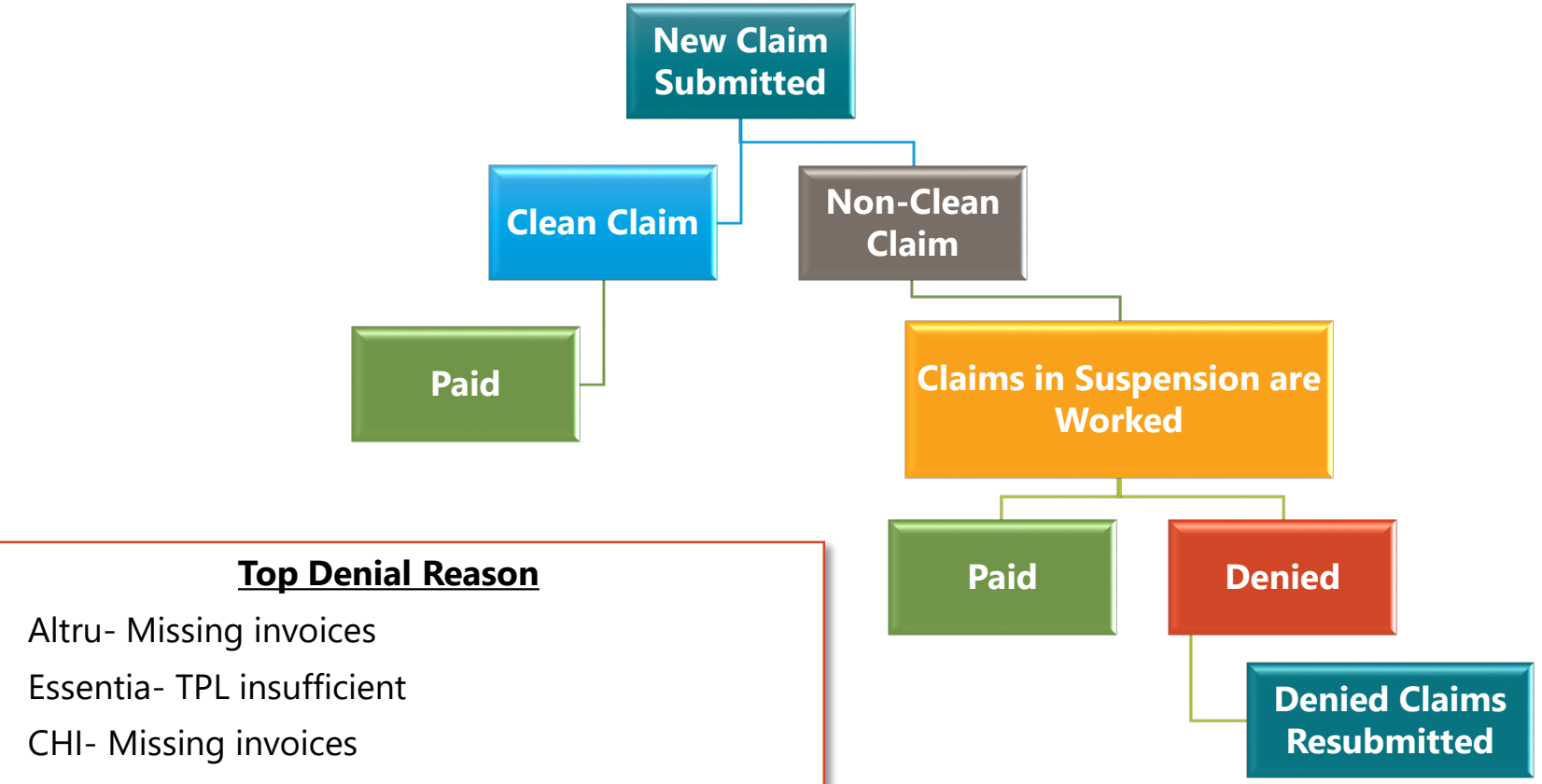
- Within 10 days 54% of suspended
- 84% within 30 days

Why are claims denied?

- These are provider reasons- no referral, TPL is insufficient, attending provider license expired, billing provider license expired, missing invoice
- These are state reasons to deny- diagnosis requires review, TPL issues, claim type on review, trauma/accident (looking for accident file like State Farm invoice)

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Top Denial Reason

- Altru- Missing invoices
- Essentia- TPL insufficient
- CHI- Missing invoices
- Trinity- Billing provider license expired
- Sanford Fargo- Billing provider license expired
- Sanford Bismarck- Billing provider license expired

Prior Testimony
ND Medicaid Savings

RX Claims- Net Costs By Quarter

Quarter	Spend	Per Member Per Month
3Q 2019	$3,030,829.88	$51.26
4Q 2019	$2,934,056.57	$49.27
1Q 2020	$2,419,967.44	$39.70
2Q 2020	$2,591,717.60	$40.15
3Q 2020	$2,794,276.77	$41.23

RX Claims Savings

- Rx Average PMPM 4Q17 – 4Q19
  - $48.16
- Rx average quarterly spend 4Q17 – 4Q19
  - $2.91 million
- Rx Average PMPM 1Q20 – 3Q20
  - $40.36
- Rx average quarterly spend 1Q20 – 3Q20
  - $2.6 million

Prior Testimony
ND Medicaid Savings

Savings From RX Carve Out- IHS

- **IHS claims are now 100% FMAP**
  - Prior to carve out, claims simply part of the rate
- **$3.6 million saved (1Q20 – 3Q20)**
  - Currently trending at $1.2 million per quarter
  - $3.6 million projected for next three quarters for total of $7.2 million in savings
- **Expansion contract included contractor being responsible for ensuring Medicaid Expansion was the payer of last resort**
- With DHS paying Rx claims, we have now included Expansion population in our processes for finding other coverage
- **A minimum of 190 recipients have been found to have Medicare coverage**
  - Premium ranges from roughly $900 to $1400 per month for different expansion recipients
  - 190 recipients X $1052 per month = $200,000 per month
- **$2.2 million in premium savings (Feb 2020 through Dec 2020)**
  - $1.2 million expected for next six months to total $3.4 million

Prior Testimony
ND Medicaid Savings

RX Carve Out Savings

	Realized Savings	Expected Total Savings
Claims	$ 1,509,000	$ 3,018,000
IHS	$ 3,600,000	$ 7,200,000
Premiums	$ 2,200,000	$ 3,400,000
Administration	$ 2, 641,000	$ 3,441,000
Total	**$ 9,950,000**	**$ 17,059,000**

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- IHS = $7.2 million **(*New savings)**
- Premiums = $3.4 million **(*New savings)**
- Admin = $3.441 million (< $3.991 million projected in 2019 session due to HIPF going away in 2021)

Total = $17.059 million (> $6.091 projected in 2019 session)



Prior Testimony ND Medicaid Savings

CHIP Savings (1Q20-3Q20)

Expected CHIP cost	**$6,706,332**
▪ *Average 2,378 kids per month x Average $313.38 premium per month*	
Actual CHIP cost	**$1,932,582**
Actual Provider Payments	**$2,872,734**
Drug rebates	**$940,152**
Savings	**$4,773,750**
% reduction	**71.18%**

Prior Testimony Commercial Premiums

Prior testimony implied that there would be an increase to commercial premiums if Medicaid expansion rates are set at traditional fee schedule.

Manatt Health Strategies consulted to see if there was any evidence of cost shifting due to decrease in government health payments for health care.

The answer was NO

Literature cited:

- Colorado Department of Health Care Policy and Financing, Colorado Hospital Cost Shift Analysis, January 2020
  - *"Despite significant reductions in uncompensated care and significant increases in Medicaid and Medicare rates, hospitals are persistently increasing the price of care."*
  - *"Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance. The increased funding generated by public, taxpayer funded programs— which are intended to reduce private insurance premiums and out-of-pocket costs — are not being passed along to health care consumers and employers."*
- Kaiser Health News, Medicaid Expansion Boosts Hospital Bottom Lines — And Prices, March 2019
- Colorado Health Institute: The Cost Shift Myth

Historical studies and articles:

- JAMA Forum, Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers, January 2017
- Journal of Health Economics, Shock, But No Shift: Hospitals' Responses to Changes in Patient Insurance Mix, September 2016 (full article)
- New York Times, Hospitals Are Wrong About Shifting Costs to Private Insurers, March 2016
- Milbank Quarterly, How Much Do Hospitals Cost Shift? A Review of the Evidence, March 2011 (Pre-ACA)

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

Medicaid expansion is still 90%/10% match regardless of if it is under a managed care company or DHS.

Even though the State match is only 10%, it is more difficult to find that State match each session. 10% of **a larger number** is harder to find than 10% of a smaller number. Suppose the Legislature does not support this policy proposal the total appropriation (at current rates**) $708 million of which $80 million is General Fund. This is an increase of $73 million from 19-21 ($14 million in General Fund)**

This point implies that taxpayers only are concerned with the 10% State match. American taxpayers are responsible for the **entire amount** as it comes from federal taxes and some from State taxes.

The federal government continues to investigate Medicaid expansion spending. GAO reports typically are the first steps before legislative action, and several have already been commissioned:

- from 2017 https://www.gao.gov/products/GAO-17-145 and
- from 2020 https://www.gao.gov/products/GAO-20-260
- from 2020 https://www.gao.gov/products/GAO-20-157
- from 2020 https://www.gao.gov/assets/720/710680.pdf.

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

During revenue downturns, 100% state-funded programs and **traditional Medicaid providers are disproportionately targeted for savings** versus expansion providers due to the funding split. Again, this creates a **non-equitable** Medicaid system.

100% General Fund or 50%/50%	**90%/10%**
Autism Voucher, Basic Care, AARP, Valley Senior Services, Alzheimer's Association, Independence Inc., Poppy's Promise, Red River Human Services Foundation, Enable Inc., Family Voices of ND, Mental Health America ND, Dacotah Foundation, Beyond Shelter, Cooper House, Edwin House, LaGrave on First, ShareHouse, Prairie St. John's, Northland PACE, ND Brain Injury Network, ND Brain Injury Advisory Council, ARC of ND, Nexus-PATH, Prairie Harvest Mental Health, Developmental Disabilities, HCBS, Nursing Homes, Dental, Vision, Pediatrics	**Expansion**

Developmental Disability providers and **Nursing Homes** have put in the hard work to have **more equitable reimbursement**, reducing the financial burden on the State



Other Solutions? 2019 NDHA Study

DHS is committed to considering all possible solutions brought forward by stakeholders.

In 2019 NDHA brought forth a study by Levitt that indicated Accountable Care Organizations (ACOs) would be a viable solution.

After careful review and study DHS has the following observations:

- ACOs, like managed care in general, requires a large enough risk pool to spread the risk. By continuing to separate traditional and expansion, there would not be a critical mass of members to make this a viable solution. NDHA members expressed this concern during recent value-based purchasing meetings.
- ACOs might be possible if hospitals would work together in a regional or statewide approach. NDHA members expressed concern about working in a regional approach at recent value-based purchasing meetings.
- ACOs do not bring down commercial rates.
- ACOs can only reduce costs if providers accept upside and downside risk. DHS could not identify any providers in the state that have accepted downside risk. Therefore, the state would only be sharing the savings when providers manage below the total cost of care. The State would realize no savings if providers were unable to manage under the total cost of care unless 2-sided risk was mandatory.

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **???**

Other Solutions? Use of Tribal Care Coordination Dollars

DHS is committed to considering all possible solutions brought forward by stakeholders

Tribal care coordination savings were mentioned as a way to save general fund dollars instead of transitioning Medicaid expansion

Below is an update on tribal care coordination savings:

- To date, IHS and 2 providers (Sanford and CHI) have entered into an agreement to coordinate care
- However, 100% FMAP cannot be claimed until tribes agree as well ***(Thus far, no tribe has agreed)***
- Legislation from 2109 set the savings split from the 100% FMAP at 60% State: 40% Tribes ***(No tribe has agreed to this split)***
- DHS did not include savings last biennium or this biennium on tribal care coordination as the decision to participate is solely left to the tribes
- DHS has been working with Sanford and CHI to ensure that when, and if, the agreements are signed the correct FMAP can be applied to the claims
- Note that this solution is independent of the managed care organization

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **Yes**,
for tribal members only

ND Medicaid
The Future

- Medical Services Division's aim is to restructure its Medicaid programs to promote better care and **quality** for members, **reduced burden** on providers, and be **trusted stewards** of taxpayer dollars.
- Medical Services aims to have **equity for all ND Medicaid members**, regardless of one's category of eligibility, allowing for continuity of care across the continuum to ensure high quality care and outcomes.
- Medical Services aims to **align benefits** across the entire Medicaid program. Legislators have inquired previously about providing dental benefits, vision benefits and long-term care and support services for expansion members.
- Medical Services strives for a comprehensive utilization management approach through **health homes** to ensure patient centered care across the continuum.
- Medical Services seeks to create a **realistic risk pool** that can ultimately be used to spread risk, lower cost, and drive value through the entire program.
- Medical Services aims to give providers **consistent processes** in relation to service authorization, appeals, claims submission, and provider enrollment.

Thank you!

North Dakota Medicaid



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Division Director

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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
1/28/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 2:22 p.m.

Discussion Topics:

- Department of Human Services
- Medical Services
- Medicaid Expansion
- MCO Capitation Rates
- Budget Savings

Caprice Knapp, Medicaid Dir (2:24 pm) testified about Medicaid expansion #4071

Eric Elkins, Medical Serv. (2:53 pm) testified about program savings #4071

Elrycc Berkman, Actuary(3:06 pm) testified about Critical Access Hospital Impact #4071

Brendan Joyce, Medicaid Pharmacist (3:16 pm) testified about medicaid #4071

Caprice Knapp, Medicaid Dir (3:46 pm) testified about Medicaid Expansion #4071

Chair Nelson closed the meeting at 4:16 p.m.

Cole Fleck, Committee Clerk



Medical Services Budget- House Bill 1012
Expansion #4071

House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD Medical Services Director

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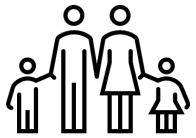
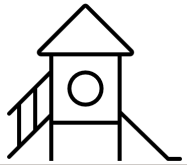
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



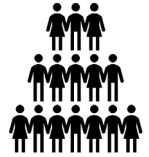
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Medicaid Expansion Eligibility for Adults

Family Size	Medicaid Expansion 138% of PL
	Monthly
1	$ 1,468
2	$ 1,983
3	$ 2,498
4	$ 3,013
5	$ 3,529
6	$ 4,044
7	$ 4,559
8	$ 5,074
9	$ 5,589
10	$ 6,105
+1	$ 516

$17,609 per year

$36,156 per year

$14,000 per capita in health care benefits

MEDICAL SERVICES DIVISION

How We Pay

Contracted Services 1915(b) Waiver

- States design an Alternative Benefit Plan that describes the services and must include Essential Health Benefits

- Medicaid Expansion **does not** cover:
  - Skilled Nursing Facility Services*
  - Dental Care Office Visits**
  - Routine Eye Care**
  - Any waivered services
  - Long Term Care services
  - Room and board for Residential Treatment services**

** Only covers up to 30 days and only covers a skilled level of care*
*** Only covered for 19- and 20-year-olds*

Medicaid Expansion

Managed Care Organization:

- Risk Based Capitation paid on a per member, per month basis
- Current Vendor: Sanford Health Plan (SHP)
- Contract is currently being re-bid
  - Notice of Intent to Award will be issued approximately 5/21/2021
  - Contract Start will be approximately 1/1/2022

Medicaid Expansion:

http://www.nd.gov/dhs/medicaidexpansion/

EXECUTIVE REQUEST 2021-2023



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NORTH DAKOTA LEGISLATION TO DATE

Since the initial implementation, each subsequent session of the ND Legislative Assembly has reauthorized ND Medicaid Expansion as administered and managed through a **Private Carrier**.

The 2019 ND Legislative Assembly (SB 2012) did make the following updates to the ND Medicaid Expansion Program:

- Directed the Department to continue the utilization of a private carrier for the administration and management **except for pharmacy services**, effective January 1, 2020.
- Directed the Managed Care Organization (MCO), while under contract with the Department, to
  - **Develop and implement a uniform provider reimbursement methodology**
  - **Added 1915(i) Behavioral Health Services through the MCO**

ND Medicaid Expansion Transition Principles

All North Dakota Medicaid **members** should be valued the same, **regardless of Category of Eligibility**, and should have **access to the same core services.**

All North Dakota Medicaid **providers** should be valued the same, **regardless of traditional or expansion**, and should have **equity in reimbursement.**

Taxpayers should be assured that their state and federal taxpayer dollars are not being used to disproportionately support **able bodied adults**, who can work and **transition off government assistance** unlike most traditional Medicaid clients.



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

Medicaid Expansion Comparison: under 100K People Delivery of Care Model

Medicaid Expansion Population

No MCOs

- Maine 19,812
- Alaska 51,144
- Vermont 55,431
- Montana 98,741

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

- New Hampshire 70,000 **3 MCOs serve ~213K*
- Delaware 62,534 **2 MCOs serve traditional and expansion ~199K*
- Rhode Island 66,641 **2 MCOs serve traditional and expansion ~250K*

Source: Medicaid Enrollment Report Updated 2/2020
https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html
https://www.kff.org/medicaid/stateindicator/totalmedicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

Month	Expansion SHP Members	Expansion SHP Members Non-Expansion Eligibility	Expansion SHP Members Any Medicaid Eligibility	Percent Remaining in Expansion SHP	Percent Remaining with Any Medicaid Eligibility
Jan 2019	20,719		20,719	100.0%	100.0%
Feb 2019	19,441	270	19,711	93.8%	95.1%
Mar 2019	18,399	436	18,835	88.8%	90.9%
Apr 2019	17,515	624	18,139	84.5%	87.5%
May 2019	16,594	812	17,406	80.1%	84.0%
Jun 2019	15,551	1,002	16,553	75.1%	79.9%
Jul 2019	14,672	1,155	15,827	70.8%	76.4%
Aug 2019	13,873	1,295	15,168	67.0%	73.2%
Sep 2019	13,117	1,372	14,489	63.3%	69.9%
Oct 2019	12,523	1,463	13,986	60.4%	67.5%
Nov 2019	11,937	1,532	13,469	57.6%	65.0%
Dec 2019	11,491	1,579	13,070	55.5%	63.1%



Medicaid Expansion Reimbursement Comparison Per Capita Costs Per State

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Medicaid Expansion Reimbursement Comparison MCO Capitation Rates

Monthly capitation (premium) amounts paid for each individual enrolled with the MCO for ND Medicaid Expansion

RURAL Cohort

ND Medicaid Expansion recipients residing within ND except for the counties of Burleigh, Cass, & Grand Forks

CATEGORY	AGE	GENDER	Capitation Rate 1/1/2015	Capitation Rate 1/1/2021
Childless Adults	19-44	M	$844.00	$945.26
Childless Adults	19-44	F	$1,078.69	$846.48
Childless Adults	45-64	M	$1,804.04	$1,829.36
Childless Adults	45-64	F	$1,598.75	$1,474.70
Adults with Children	19-44	M	$293.78	$945.26
Adults with Children	19-44	F	$559.06	$846.48
Adults with Children	45-64	M	$1,024.31	$1,829.36
Adults with Children	45-64	F	$1,385.59	$1,474.70
Retroactive Month(s) ONLY			$1,252.92	$1,581.90

The chart below shows only the yearly changes since the January 1, 2014 implementation of ND Medicaid Expansion (prior to 2019 MCO Rates were reviewed and adjusted every 6 months).

Medicaid Expansion Reimbursement Comparison

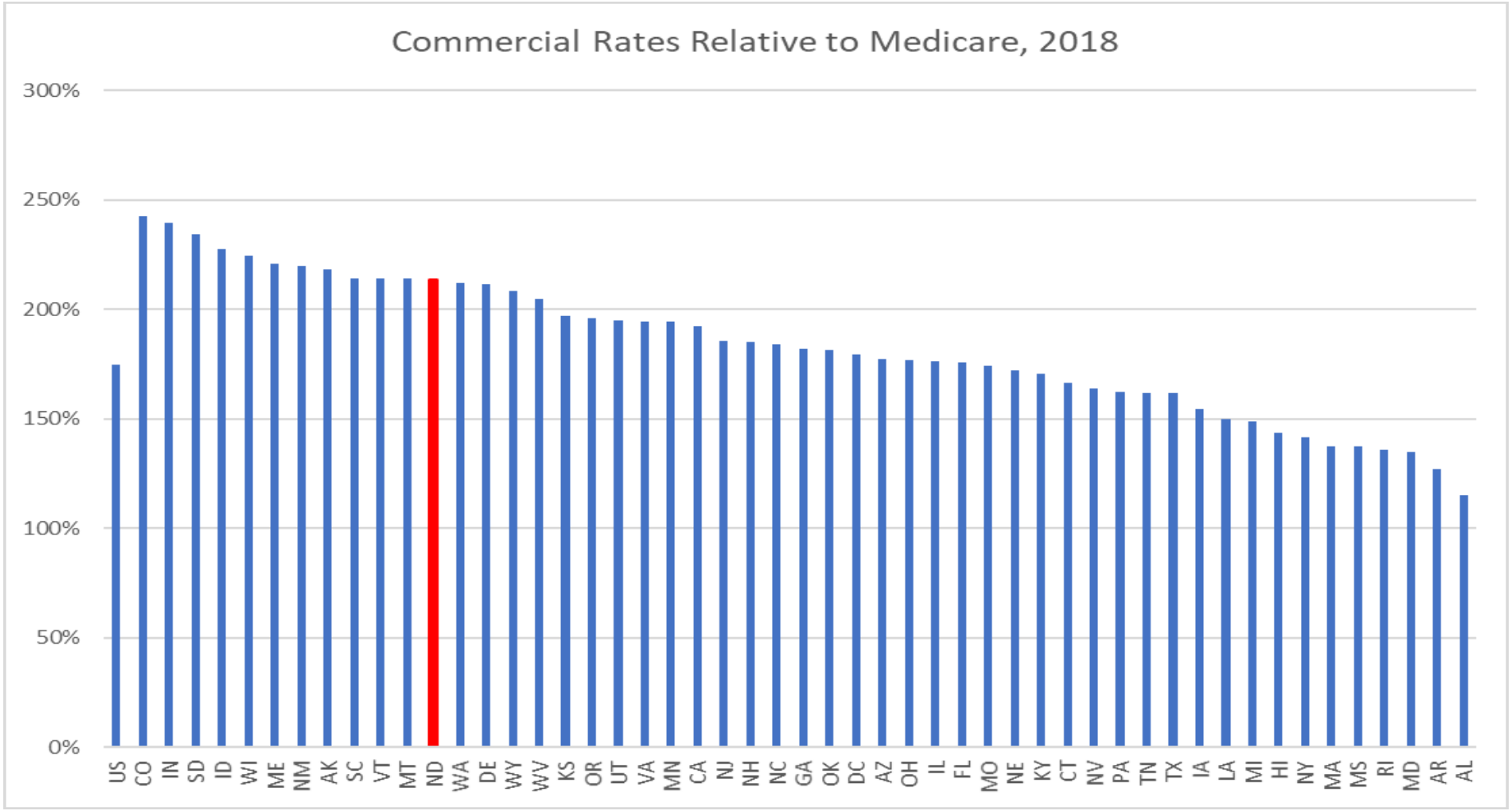
Provider Reimbursement % of Medicaid

Actual % of Medicaid*

Type of Service	CY17	CY18	CY19
Inpatient	158.7%	165.8%	151.7%
Outpatient	209.8%	208.0%	204.2%
Professional	168.2%	168.2%	165.4%
Total	**175.0%**	**177.8%**	**170.3%**

***Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures**

Medicaid Expansion Reimbursement Comparison Commercial Insurance Payment Rates



- **Commercial payments** for hospital services in ND are **214%** of the Medicare rate.
- **ND's commercial-to-Medicare** rate ratio for hospital payments is the **12th highest** in the U.S.

Source: North Dakota Insurance Department, "North Dakota 66th Legislative Assembly Interim Health Care Study," August 12, 2020

Medicaid Expansion Reimbursement Comparison

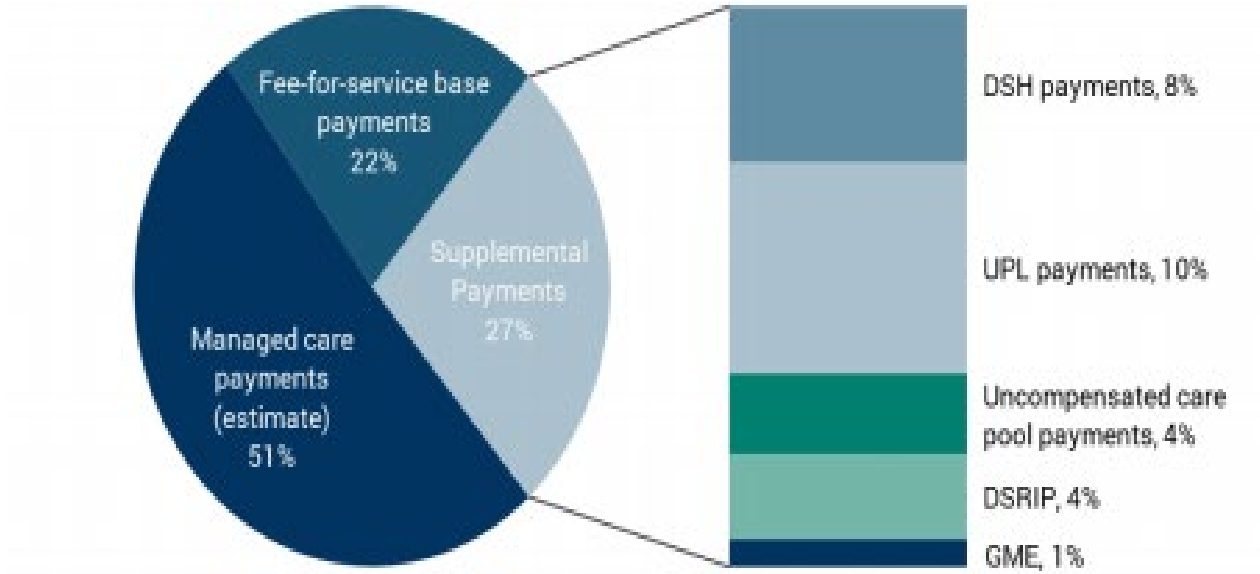
Medicaid FFS Physician Index

FFS MEDICAID PHYSICIAN INDEX		
ALL MD SERVICES	PRIMARY CARE	OTHER SERVICES
1. Alaska (2.28)	1. Alaska (2.55)	1. Alaska (1.94)
2. Montana (1.56)	2. Montana (1.65)	2. Nebraska (1.45)
3. Delaware (1.40)	3. Delaware (1.55)	3. Arkansas (1.44)
4. Wyoming (1.38)	***4. North Dakota (1.52)***	4. Montana (1.36)
5. Nevada (1.37)	5. Maryland (1.51)	5. South Dakota (1.34)
6. Maryland (1.35)	6. Nevada (1.50)	6. Delaware (1.28)
6. North Dakota (1.35)	7. Idaho (1.45)	7. Wyoming (1.27)
8. Washington, DC (1.27)	8. Wyoming (1.44)	8. New Mexico (1.25)
9. Idaho (1.25)	9. Washington, DC (1.39)	9. Iowa (1.22)
10. New Mexico (1.19)	10. Colorado (1.31)	10. Nevada (1.21)
10. Utah (1.19)	11. Utah (1.30)	11. Wisconsin (1.17)
12. Mississippi (1.17)	12. Mississippi (1.29)	***12. North Dakota (1.15)***

Source: Kaiser Family Foundation State Health Facts, based on Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees After the ACA Primary Care Fee Bump," Urban Institute, March 2017.
Note: Other services excludes ob/gyn.

Medicaid Expansion Reimbursement Comparison DHS Payments to Hospitals

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2018



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid Base and Supplemental Payments to Hospitals, March 2020 Issue Brief.



Medicaid Expansion Reimbursement Comparison DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- Medicaid disproportionate share hospital (DSH) payments offset hospitals' uncompensated care costs

- Federal rules provide Medicaid matching funds up to a maximum level of DSH payments. Federal limits apply at the individual hospital level and statewide. State DSH allotments are largely based on historical DSH payments.

- The DSH limit is the maximum amount of uncompensated care costs that a State can reimburse a hospital under Medicaid. It is based on **"cost"** of inpatient and outpatient services provided by each hospital and defined as sum of:
    1. **Medicaid shortfall:** the difference between a hospital's Medicaid payments and its cost to provide services to Medicaid-enrolled patients, and
    2. **Uninsured losses:** the cost of providing care to those without insurance for services received, less payments from uninsured.

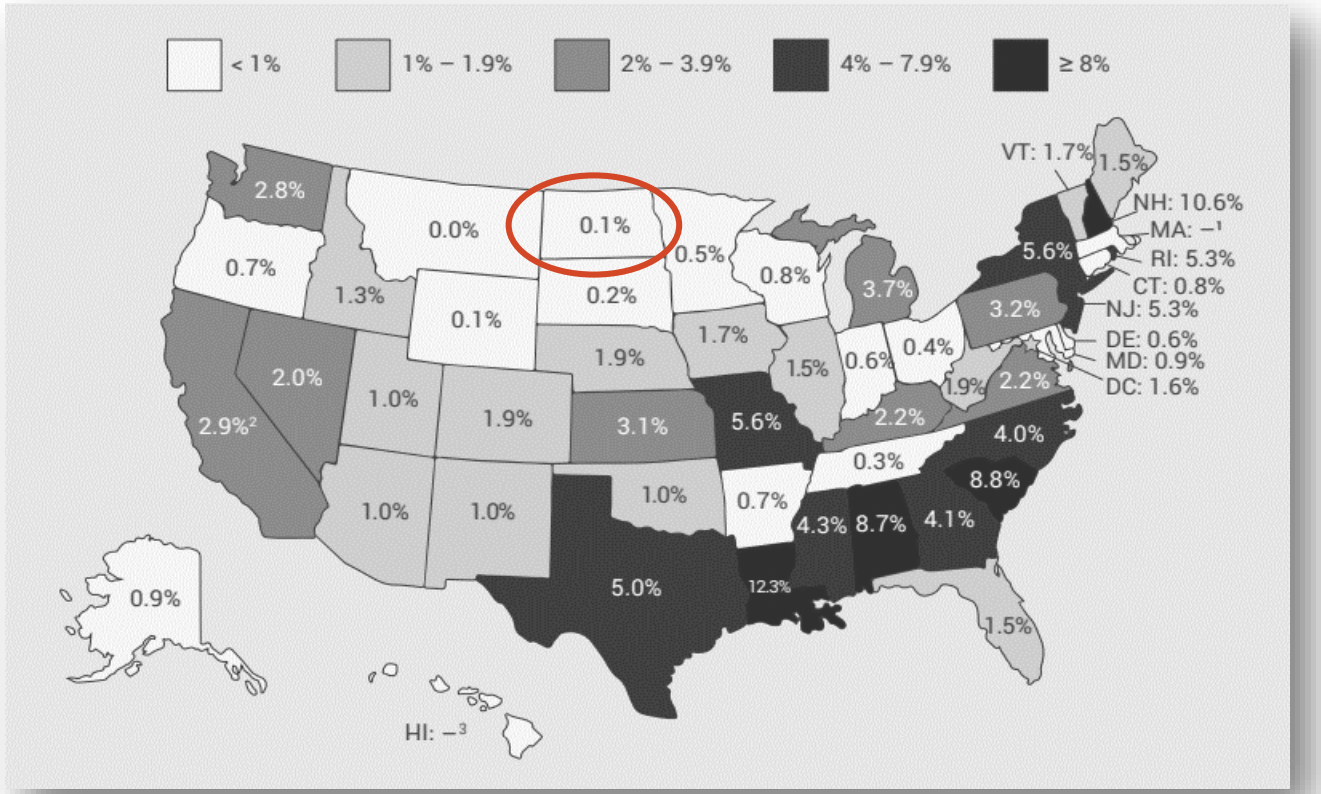
Medicaid Expansion Reimbursement Comparison

DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- **North Dakota Medicaid DSH spending is among the lowest in the nation** – both in terms of share of Medicaid spending (0.1%) and absolute dollars ($22.3 million federal and state)
- **North Dakota's Medicaid DSH allotment is about the same as South Dakota** ($22.4 million) and smaller than all other states except for Hawaii, Montana and Wyoming.

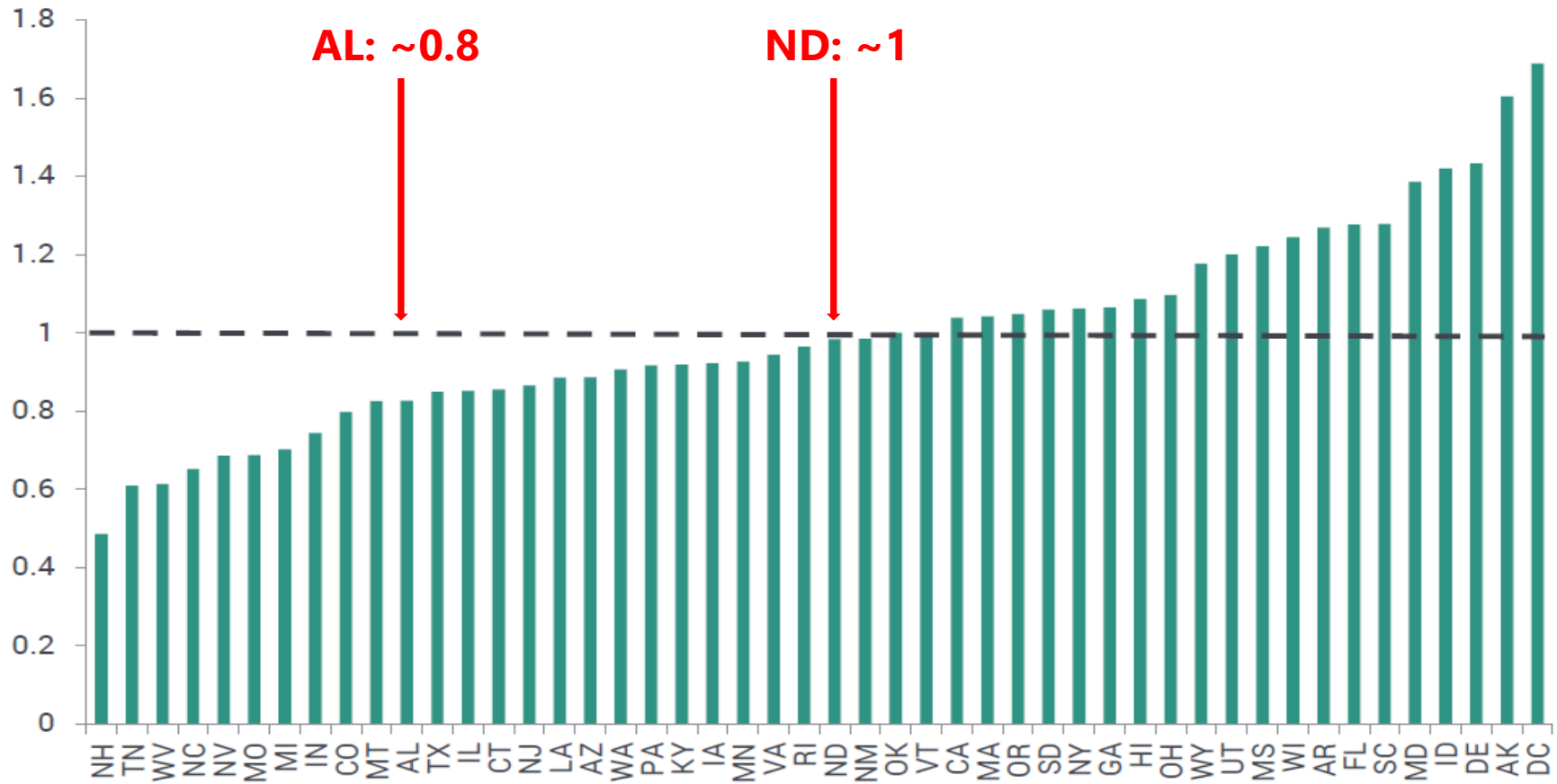
DSH Spending as % of Total Medicaid Benefit Spending by State, FY 2018



Source: Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," Washington, DC, March 2020.

Medicaid Expansion Reimbursement Comparisons Inpatient FFS Payment Index

EXAMPLE: MEDICAID-TO-MEDICARE INPATIENT FEE-FOR-SERVICE PAYMENT INDEX, CY 2010

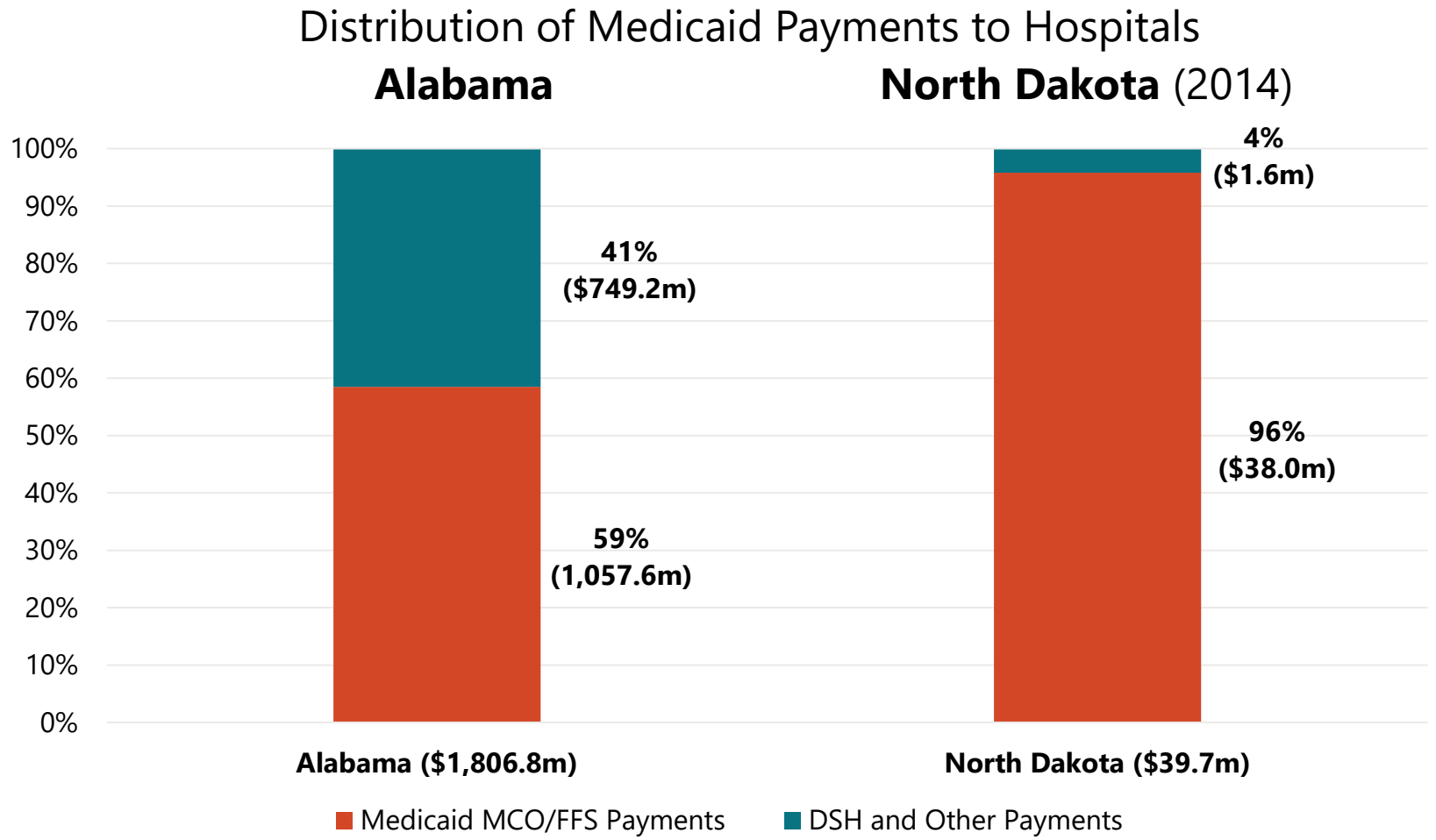


SOURCE: MACPAC. "Medicaid Hospital Payment: A Comparison Across States and to Medicare," Issue Brief, April 2017.
NOTE: The payment index values are normalized around the national average, which has a value of 1.0. For example, a state with an index value of 1.10 would have payments that were 10 percent higher than the national average. Kansas, Maine and Nebraska were excluded due to missing data.

Medicaid Expansion Reimbursement Comparisons

ND's Medicaid Payments

EXAMPLE: NORTH DAKOTA'S MEDICAID PAYMENTS ARE LARGELY IN BASE PAYMENTS



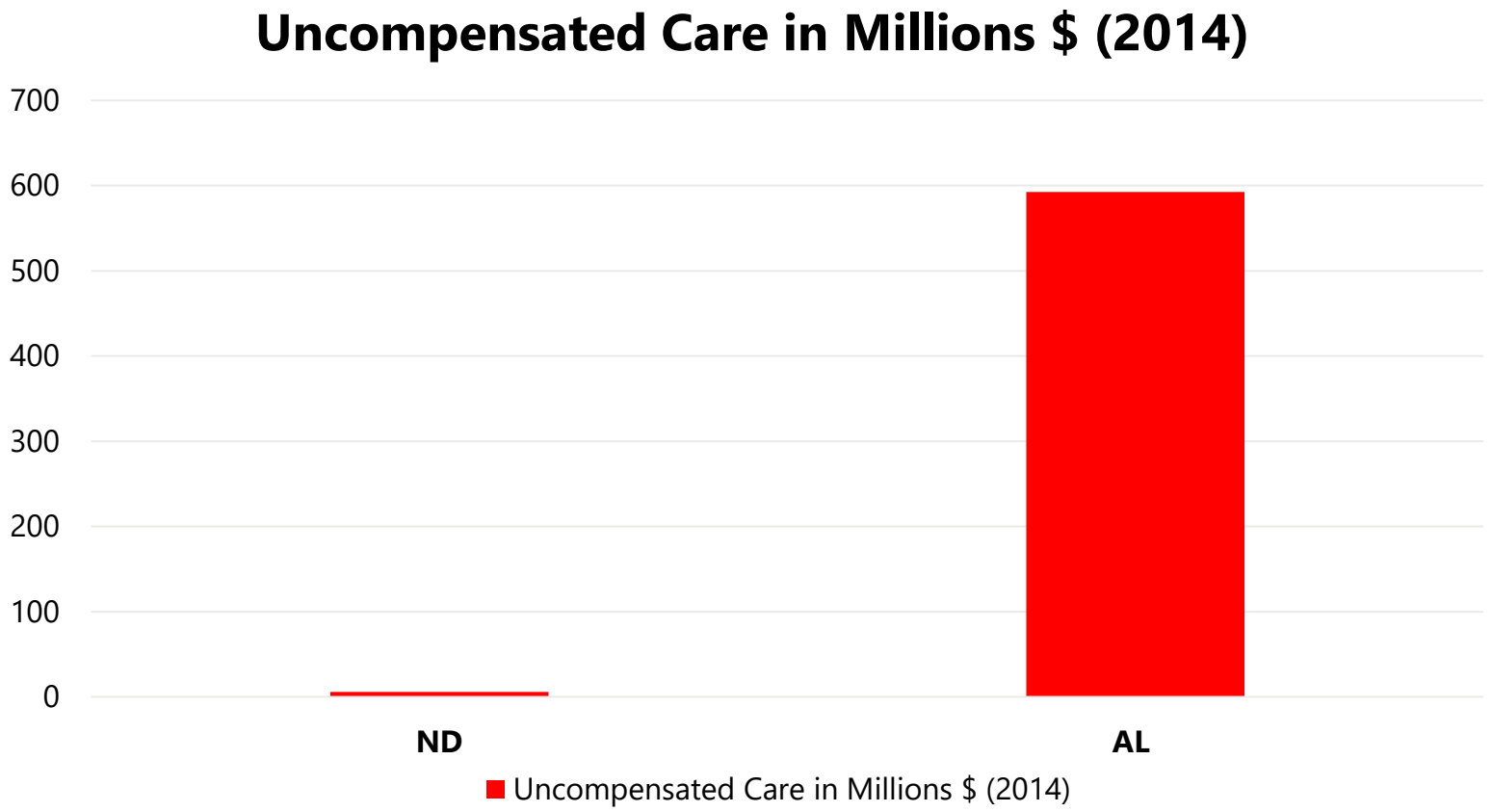
SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Medicaid Expansion Reimbursement Comparison

Hospital Uninsured & Uncompensated Care Comparison

ND hospitals uncompensated care is a fraction of AL uncompensated care

North Dakota	ALABAMA
7.9% uninsured	12.1% uninsured
$5.9 million total uncompensated care	$592.4 million total uncompensated care



SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid expansion costs per capita are the highest in the country. 54% higher than the second highest state of Alaska.

North Dakota Medicaid FFS rates for physicians are:

- higher than average and comparable to neighboring states

North Dakota hospital expenses are highest per capita and in growth in the U.S.

DSH payments in North Dakota are among the lowest in the United States

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid rates are not equitable

Payment to providers for the care of non-institutional, able-bodied adults, who can work and transition off Medicaid, are 75% to 100% higher than payments to providers for the care of other Medicaid populations like children, elderly, pregnant women, non-institutionalized adults.

Across all other state non-institutionalized programs, none incur per capita expenses as high as $14,107 for Medicaid expansion.

- Per pupil education $12,453
  - Per pupil Kindergartener $10,373
- Per pupil higher education $7,780
- Unemployment insurance $5,379 (average payment pf $448.26 times 12)

Summary of Medicaid Expansion Reimbursement Comparisons

- Transition from managed care to DHS administration will occur July 1, 2022 giving providers time to adjust, plan, and account for COVID impacts.
- As of 12/18/2020 North Dakota Medicaid providers received $326 million in provider relief funds from the federal government.
- HHS expected to **release $24.5 billion more** in provider relief funds so that providers can make up nearly 90% of lost revenues and net change in expenses. Payments will be made from 12/16/2020-1/31/2021.
  - **The department noted that more than 35,000 applicants won't receive an additional payment because the total relief they've received so far is 88% of their losses or they had no change in revenues or net expenses due to COVID-19.**



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration

Comparison Medicaid Expansion Financial Arrangement

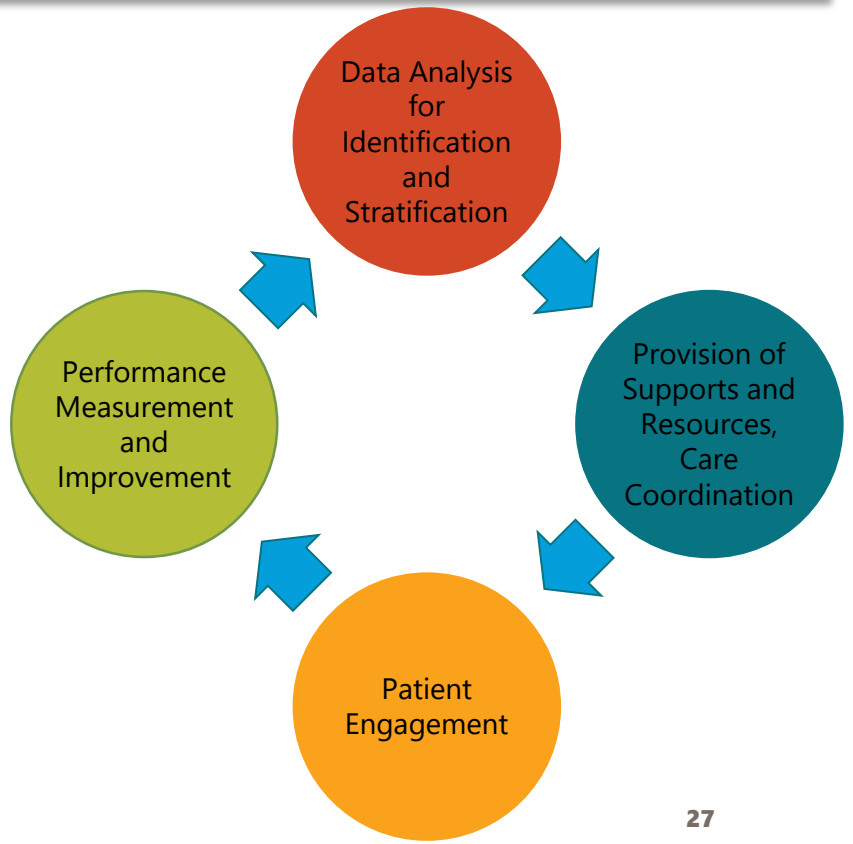
What is Managed Care?

Goal: to **control costs** while simultaneously **improving health care quality and outcomes**

Requires more than just care coordination, it involves a set of activities intended to **identify populations** to prioritize for extra support care planning and coordination, patient engagement, and analysis of data to evaluate outcomes and improve processes.

Activities to Improve Health Care Quality & Outcomes

- Intensive management of high-cost individuals.
- Selective contracting with providers willing to offer services at discounted rates.
- Initiatives to steer consumers away from high cost, low value services towards low cost, high value services.
- Requiring enrollees to obtain prior authorization from their primary care physician to gain access to specialty services.
- Focusing on preventive services.
- Monitoring the use of basic and ancillary services and using incentives to reward below-average use and disincentives to discourage excess use.
- Requiring providers to assume part of the financial risk or cost overruns for services they control, directly or indirectly.





Comparison Medicaid Expansion Financial Arrangement

Why do State Medicaid Programs use MCOs?

1. Managed Care Organization Takes on the Risk versus the State
2. Budget Predictability
3. Budget Savings
4. Improved Outcomes

Risk & Predictability

- As in any risk-based model the more people in the risk pool the more likely the managed care organization can spread the risk across health and less health individuals
- The larger the risk pool, the more predictable and stable premiums will be.
- Premiums also rely on the average health care costs of the enrollees
- Adverse selection occurs when the insurer attracts individuals when they have greater health care needs
- In **North Dakota**, the
  - **risk pool** is the **smallest** in the **entire country** using managed care
  - **premiums** have **not** been **predictable** or **stable**
  - **churn rate** indicates that **adverse selection** is probably occurring



Comparison Does Managed Care Save Money?

Inconclusive Evidence

Lewin Group Analysis

- AHIP funded
- Meta-analysis, a review of 24 studies
  - none were peer reviewed
  - proposes that cost savings range from 0.5% to 20%
  - Point to decreases in inpatient utilization but at that time inpatient was going down throughout the U.S. health system

Mathematica 5-State Analysis

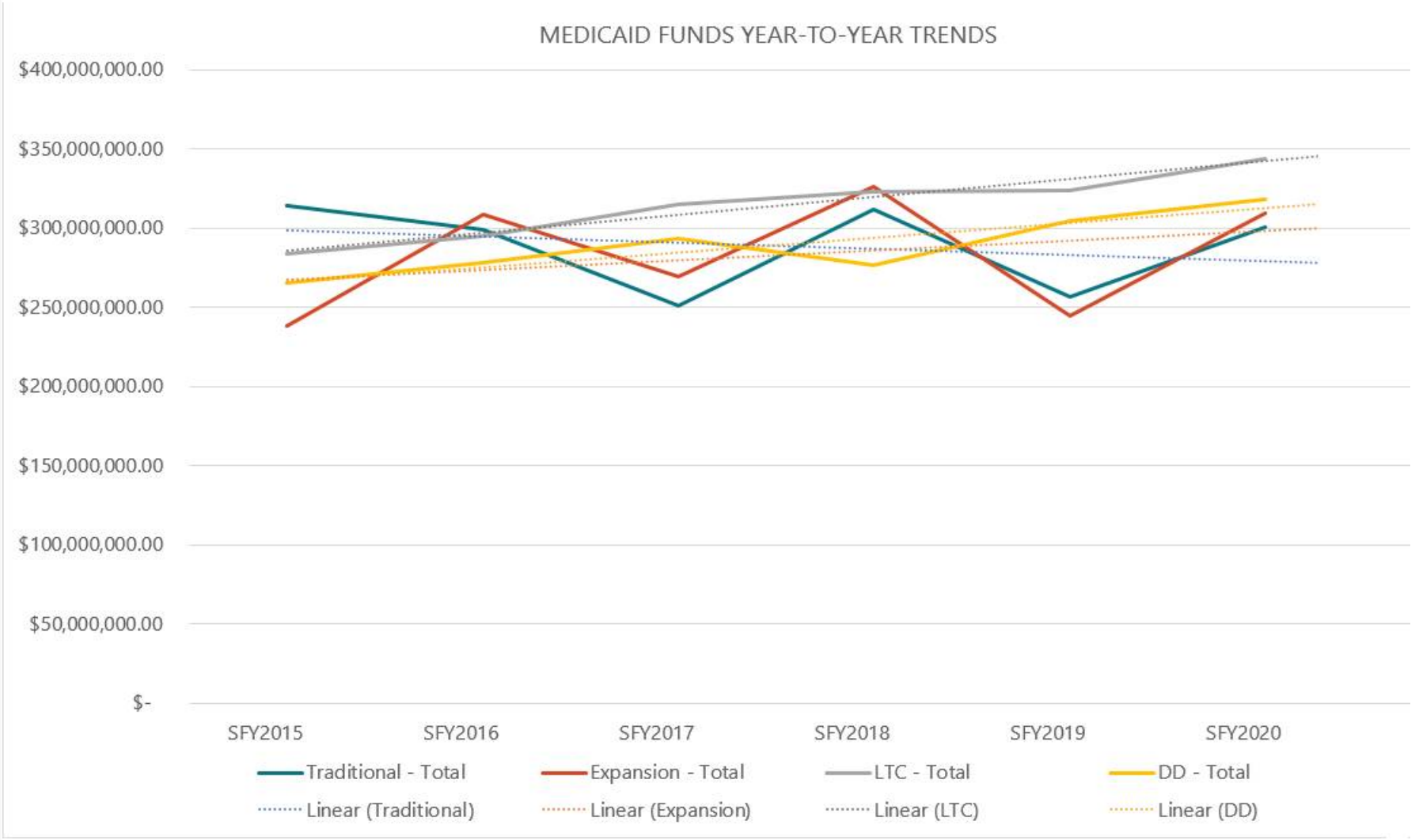
- Found no savings

Duggan Study from NBER Analysis

- Showed moving to managed care resulted in no improvement in health care and substantial increases in government spending.
- MCO did little to nothing to reduce spending.

Source:https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/

Comparing Has Medicaid Expansion Saved Money in North Dakota?





Comparing Has Medicaid Expansion Improved Health?

HEDIS and CAHPS measures are skewed toward members with **continuous enrollment**. In expansion we know the churn rate is high (~11,000 members) and we know that expenditures keep going up and not down.

The State's contracted actuary uses a different analytical tool to get a better idea of the **effectiveness of the managed care** organization called Prometheus.

- 43 episodes are built such as diabetes and knee surgery
- Compares the utilization and cost based on clinical standards
- Sorts potential waste and identifies care that should have been potentially avoided using the right interventions and clinical management

What is Care Coordination in an MCO?

Prior testimony in 2019 session on the number of care coordinators in managed care organization

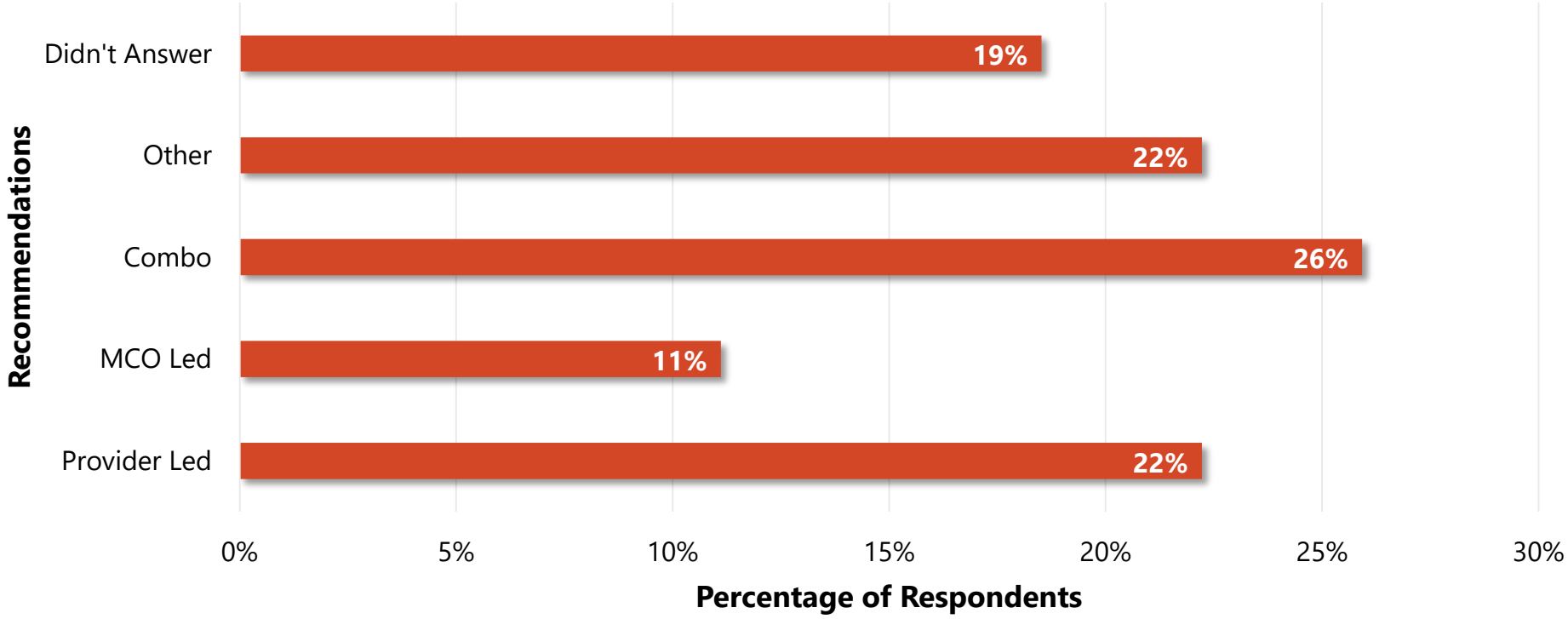
- Difference between care coordination, case management, and population health in managed care:
  - Care Coordination: contracted to primary care providers
  - Case Management: typically done by the MCO typically and targets high risk members, high touch and costly
  - Population Health: typically done by MCO and relies on data analytics to target sub-groups.

ND Medicaid Expansion MCO Survey

There are different approaches to care management by a MCO:

1. **Provider-led** (with an enhanced payment to providers for outcomes)
2. **MCO-led** (MCO has its own care managers)

What do you think is the ideal care management approach, why?



ND Medicaid Expansion MCO Survey

"Provider led care management because the care managers are direct member of the patients care team coordinating care and service for the patient. Hybrid models work will where MCO's support provider led programs with expertise in certain programs such as behavioral health."

"I believe the best method should be a combination of provider-led, when possible, and MCO-led, when necessary. Not all providers will be able to perform necessary care management, but that doesn't mean the MCO should simply take on all care management when there are providers who can and do perform important care management to the benefit of their patients. As such, those high performers should be eligible for enhanced reimbursement. Different strengths and areas of expertise to the table that complement each other.

"Ideally, we feel the care management should be owned by the primary care providers who work closest with the patient. With the enhanced primary care models, we are able to fill in the gaps more easily by being closely connected to the patients and providing ongoing care management to the patients through calls, virtual care, patient portals, goal setting and management, mental health counseling, and medication management."

"The ideal approach is a hybrid of the two. Both the MCO carrier and the provider."

"I feel that provider lead would be more beneficial as they understand the needs of their patients and understand barriers to service delivery unlike MCO. I have learned that direct contact with individuals allows for feedback and ability to understand how policies affect direct practice."



What did providers comment in the MCO Survey?

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

- Alabama (Medical Homes to ACO)
- South Dakota (Health Homes Model)
- Connecticut (ASO model) in early 2020

South Dakota avoided $7.3 million in costs using Health Homes in 5 years

Feedback from North Dakota Medicaid Stakeholders

- Noted that **Health Homes** was the preferred model
- Subsequent meeting with outpatient stakeholders

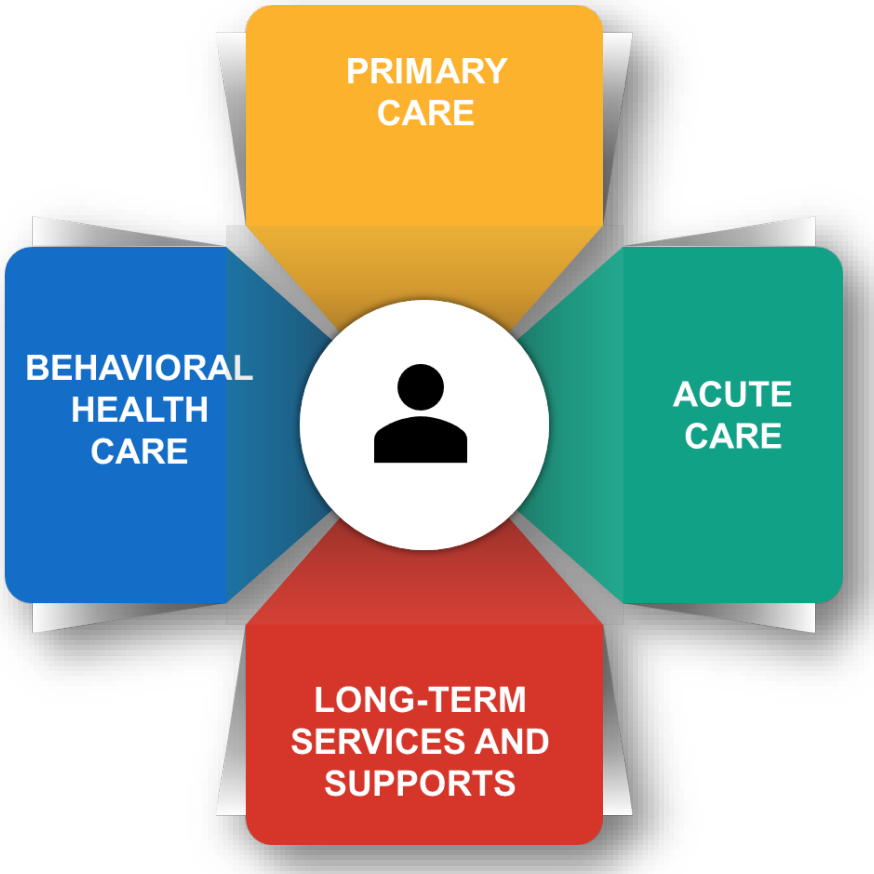
2021-2023 Executive Request

- Authorizes DHS to plan for **Health Homes** and seek CMS approval
- Enhanced payment will offset some of the reduction in rates.

Proposed Solution
Health Homes

Medicaid Health Homes

- Builds on the PCMH model
- Fosters a **"whole-person"** orientation to care for individuals with **chronic conditions** through the integration and coordination of:
  - Primary Care
  - Acute Care
  - Behavioral Health Care
  - Long-Term Services & Support



Proposed Solution
MCO → DHS Administration

Parity to Medicaid members

- Adults in **household** will have **same benefit package**
- Adult **dental** and **vision** will be **part of benefit package**

Significant administrative simplification

- Staff time available to develop an overall care coordination for Traditional and Expanded Medicaid, including review of Targeted Case Management, Primary Care Case Management, and Coordinated Services Program
- Client repayment for eligibility overpayments will be limited to actual claims paid vs. the cost of the monthly premium
- Administrative rules and procedures are the same for providers across the entire Medicaid program
- Only one program to manage, evaluate, and report on

Legislature has more control as compared to privately contracted services



Proposed Solution MCO → DHS Administration

Streamlined movement between traditional and expansion

- One ID card, one provider network, one set of letters and notifications, zones have one set of policies.
- Current situation:
  - Creates **confusion** as to which coverage option is applicable for date(s) of service
  - **Interrupts continuity** which can lead to fragmented care due to differences between the model processes such as the following:
    - Available Benefits
    - Utilization Management or Case Management
    - Service Authorization requirements and requests
    - Appeals for Adverse Benefit Determinations
    - Claims Submission
    - Provider Enrollment – Credentialing
    - Quality or Value Based Purchasing requirements
    - Oversight Requirements

MEDICAL SERVICES
Medicaid Expansion Transition

NORTH Dakota | Human Services
Be Legendary.™

From MCO Administration to DHS In-House Administration

SAVINGS



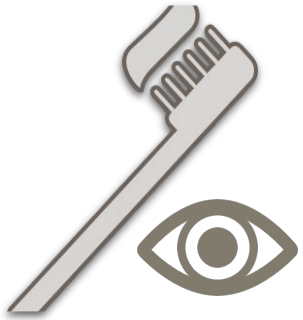
Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)



MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00



DHS Administrative Expenses

Staff Costs	$568,234.00
Contracts	$ 79,520.00
Other (Notices)	$ 23,332.00

$(10,749,572.00)



Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues from Public Testimony

Prior Testimony
Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals.
Handout shows the Medicaid percentage of payer mix for all hospitals. Average Medicaid is 8% of payer mix across all hospitals. According to enrollment data, about 20% of that is expansion enrollees.

Average estimated expansion payer mix for CAHs is 1.58% and 1.3% for PPS

HOSPITAL NAME	TOWN	HOSPITAL TYPE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ST ALEXIUS MEDICAL CENTER	BISMARCK	SHORT TERM		4%	4%	5%	4%	3%	1%	7%	7%	6%
TRINITY HOSPITALS/ST JOES	MINOT	SHORT TERM		0%	0%	0%	3%	4%	11%	11%	13%	13%
SANFORD MEDICAL CENTER - FARGO	FARGO	SHORT TERM		6%	4%	3%	4%	7%	9%	8%	8%	8%
SANFORD BISMARCK	BISMARCK	SHORT TERM		7%	7%	7%	5%	8%	7%	7%	8%	6%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	GRAND FORKS	SHORT TERM		10%	10%	10%	12%	8%	9%	9%	8%	
INNOVIS HEALTH	FARGO	SHORT TERM		5%	5%	5%	6%	7%	7%	8%	6%	6%
TIOGA MEDICAL CENTER	TIOGA	CRITICAL ACCESS HOSPITALS		0%	0%	0%	1%	1%	1%	1%	1%	1%
MOUNTRAIL COUNTY MEDICAL CENTER	STANLEY	CRITICAL ACCESS HOSPITALS		0%	0%	1%	2%	2%	2%	3%	3%	2%
MCKENZIE COUNTY HEALTHCARE SYSTEM	WATFORD CITY	CRITICAL ACCESS HOSPITALS		1%	1%	1%	3%	4%	6%	5%	4%	4%
GARRISON MEMORIAL HOSPITAL	GARRISON	CRITICAL ACCESS HOSPITALS		19%	20%	17%	26%	25%	25%	23%	22%	24%
TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	CRITICAL ACCESS HOSPITALS		9%	23%	25%	28%	30%	34%	30%	11%	26%
KENMARE COMMUNITY HOSPITAL	KENMARE	CRITICAL ACCESS HOSPITALS		0%	0%	0%	25%	33%	26%	25%	19%	17%
COOPERSTOWN MEDICAL CENTER	COOPERSTOWN	CRITICAL ACCESS HOSPITALS		1%	1%	3%	9%	0%	4%	3%	6%	6%
ST ANDREWS HEALTH CENTER	BOTTINEAU	CRITICAL ACCESS HOSPITALS		12%	13%	14%	18%	16%	14%	14%	17%	13%
NELSON COUNTY HEALTH SYSTEMS-HO	MCVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	1%	0%	1%	1%	3%
SANFORD MAYVILLE	MAYVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	3%	1%	2%	3%	3%	3%	3%
DAKAKAWEA MEDICAL CENTER	HAZEN	CRITICAL ACCESS HOSPITALS		5%	2%	2%	4%	3%	1%	5%	6%	5%
LISBON AREA HEALTH SERVICES	LISBON	CRITICAL ACCESS HOSPITALS		6%	8%	11%	9%	11%	10%	4%	7%	8%
NORTHWOOD DEACONESS HEALTH CENTER	NOTHWOOD	CRITICAL ACCESS HOSPITALS		1%	1%	1%	2%	4%	3%	4%	5%	5%
SOUTHWEST HEALTHCARE SERVICES	BOWMAN	CRITICAL ACCESS HOSPITALS		1%	1%	2%	2%	3%	2%	2%	1%	1%
JACOBSON MEMORIAL HOSPTAL	ELGIN	CRITICAL ACCESS HOSPITALS		1%	2%	23%	20%	19%	21%	20%	19%	19%
OAKES COMMUNITY HOSPITAL	OAKES	CRITICAL ACCESS HOSPITALS		4%	2%	2%	3%	7%	6%	2%	8%	9%
PRESENTATION MEDICAL CENTER	ROLLA	CRITICAL ACCESS HOSPITALS		0%	13%	12%	19%	24%	21%	28%	17%	20%
CARRINTON HEALTH CENTER	CARRINGTON	CRITICAL ACCESS HOSPITALS		1%	4%	4%	3%	5%	5%	2%	2%	6%
PEMBINA COUNTY MEMORIAL HOSPITAL	CAVALIER	CRITICAL ACCESS HOSPITALS		2%	1%	1%	4%	4%	2%	14%	2%	1%
UNITY MEDICAL CENTER	GRAFTON	CRITICAL ACCESS HOSPITALS		4%	4%	3%	3%	3%	6%	5%	4%	5%
WISHEK COMMUNITY HOSPITAL	WISHEK	CRITICAL ACCESS HOSPITALS		3%	3%	2%	1%	1%	2%	2%	2%	2%
ASHLEY MEDICAL CENTER	ASHLEY	CRITICAL ACCESS HOSPITALS		33%	11%	11%	1%	1%	1%	2%	2%	2%
CAVALIER COUNTY MEMORIAL HOSPITAL	LANGDON	CRITICAL ACCESS HOSPITALS		1%	8%	2%	3%	3%	1%	8%	1%	4%
MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	CRITICAL ACCESS HOSPITALS		2%	4%	3%	4%	6%	7%	4%	1%	9%
ST LUKES HOSPITAL	CROSBY	CRITICAL ACCESS HOSPITALS		5%	1%	1%	1%	0%	2%	1%	4%	3%
FIRST CARE HEALTH CENTER	PARK RIVER	CRITICAL ACCESS HOSPITALS		3%	3%	2%	2%	4%	3%	3%	3%	3%
ST ALOISIUS MEDICAL CENTER	PARVEY	CRITICAL ACCESS HOSPITALS		0%	0%	0%	4%	3%	5%	5%	4%	4%
LINTON HOSPITAL	LINTON	CRITICAL ACCESS HOSPITALS		0%	2%	1%	1%	3%	2%	3%	4%	2%
SANFORD HILLSBORO	HILLBORO	CRITICAL ACCESS HOSPITALS		28%	27%	31%	43%	3%	2%	2%	3%	4%
WEST RIVER REGIONAL MEDICAL CENTER	HETTINGER	CRITICAL ACCESS HOSPITALS		28%	1%	2%	1%	3%	1%	3%	3%	
TOWNER COUNTY MEDICAL CENTER	CANDO	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	2%	3%	3%	3%	2%
HEART OF AMERICA MEDICAL CENTER	RUGBY	CRITICAL ACCESS HOSPITALS		1%	21%	26%	21%	2%	25%	30%	3%	14%
MERCY HOSPITAL OF VALLEY CITY	DEVILS LAKE	CRITICAL ACCESS HOSPITALS		12%	16%	15%	20%	23%	26%	10%	14%	34%
MERCY MEDICAL CENTER	WILLISTON	CRITICAL ACCESS HOSPITALS		4%	3%	4%	5%	4%	6%	6%	41	6%
JAMESTOWN REGIONAL MEDICAL CENTER	JAMESTOWN	CRITICAL ACCESS HOSPITALS		9%	9%	8%	9%	10%	13%	13%	7%	10%
ST JOSEPHS HOSPITAL AND HEATLH CENTER	DICKINSON	CRITICAL ACCESS HOSPITALS		5%	6%	5%	5%	8%	8%	7%	2%	8%

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

- DHS collected and extracted information from PPS and CAH cost reports for 2019
  - Medicare is the **primary payer source** for the CAHs
  - Net operating margins were on average -**1.8%** *(Larger CAHs have better net operating margins)*
  - Historically, CAH **net operating margins are negative** and Medicare **sequestration** have **exacerbated** this issue.
- In 2019, estimated **total Medicaid revenues** were **9.9%** of total revenues
  - If 20% of the expenditures are for expansion, DHS estimates that CAHs will have reduced revenues of **approximately $4.7 million to $12.8 million** (75% of inpatient and 100% of outpatient)

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

Actuary studied CAH revenue structure for expansion at traditional and expansion rates. Would remove about **$7 to $7.5 million** from the CAH payment system.

	CY17 Number of CAHs	CY18 Number of CAHs	CY17 Percent of CAHs	CY18 Percent of CAHs
Repriced > Incurred Dollars	16	14	44.4%	38.9%
Incurred > Repriced Dollars	20	22	55.6%	61.1%



Prior Testimony Critical Access Hospital Impact

Another Source of Funding:

- CAHs can participate in Health Homes if they have a Rural Health Clinic or FQHC *(Large CAHs were included in value-based purchasing discussion as well)*

Possible solutions:

- Increase supplemental payment by **$7.5 million up to $12.8 million**, there is room in the Upper Payment Limit for Outpatient Hospital Expenditures of about $50 million of which about $15 million can be used for expansion. This would mean rebasing CAHs for inpatient and outpatient care.
- Could consider providing **$7.5 million** more in revenue to CAHs which is about **7% rate increase** on traditional spending for CAH acute and outpatient care.

Prior Testimony Critical Access Hospital Impact

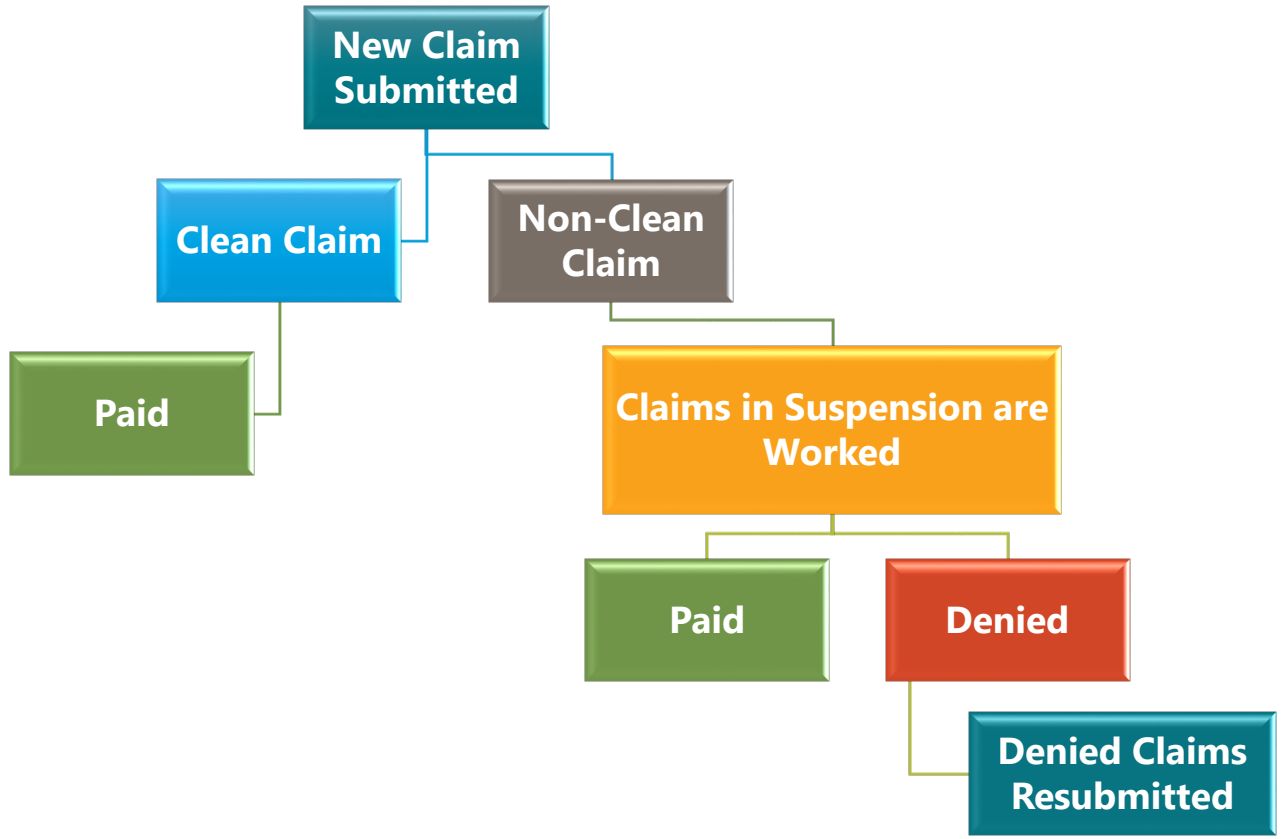
Prior testimony implied that critical access hospitals would close

- **DOH record on hospital closures-**
  - **Dakota Heartland Health System**, Fargo closed in 2002 (PPS)
  - **Richardton Memorial Hospital and Health Center**, Richardton closed in 2009 (CAH)
  - **Red River Behavior Health Systems**, Grand Forks closed in Sept 2020 (Psych)
  - **Altru Rehabilitation Center**, Grand Forks terminated their state hospital license in 2019 (Rehab) *(Altru still remains certified as a hospital and has 2 licensed locations)*

2 Hospital Closed Before Expansion &
2 Closed Since Expansion was Implemented

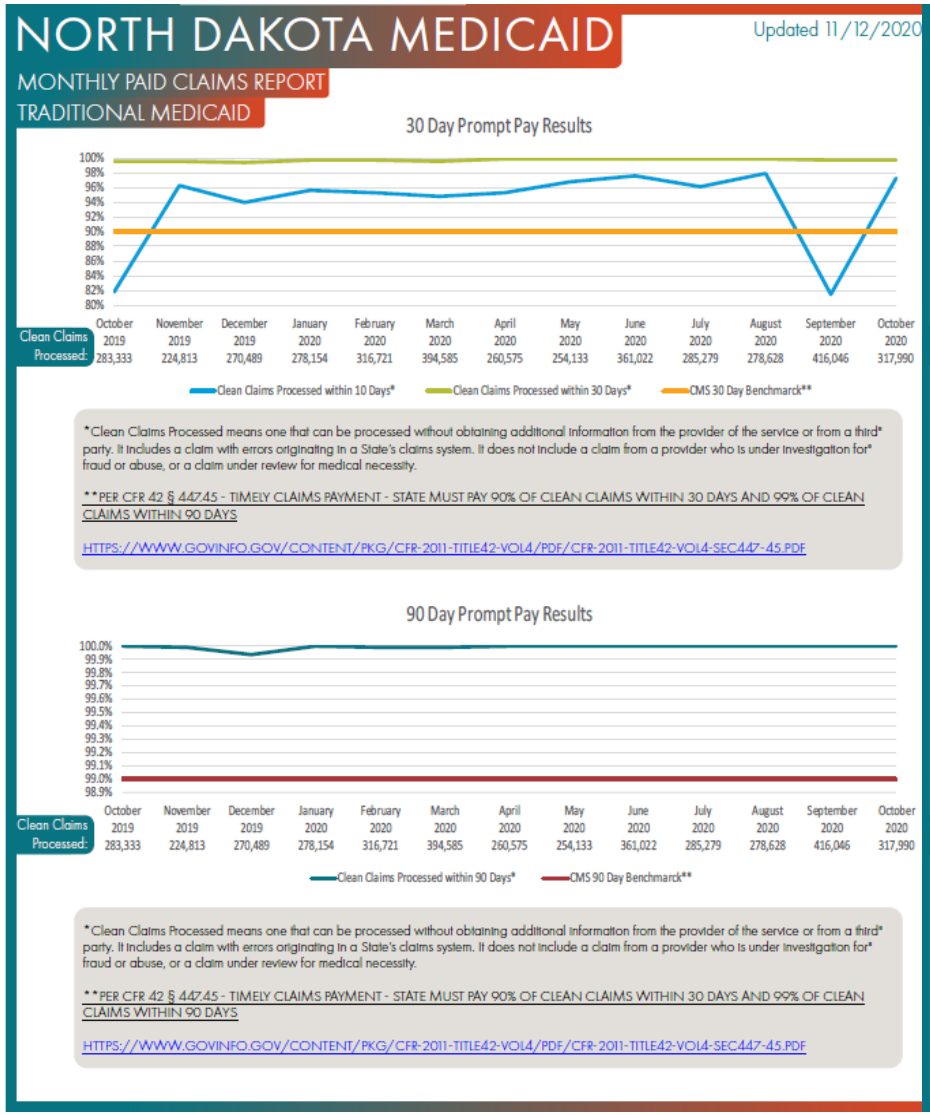
Prior Testimony Claims Payment Turn Around

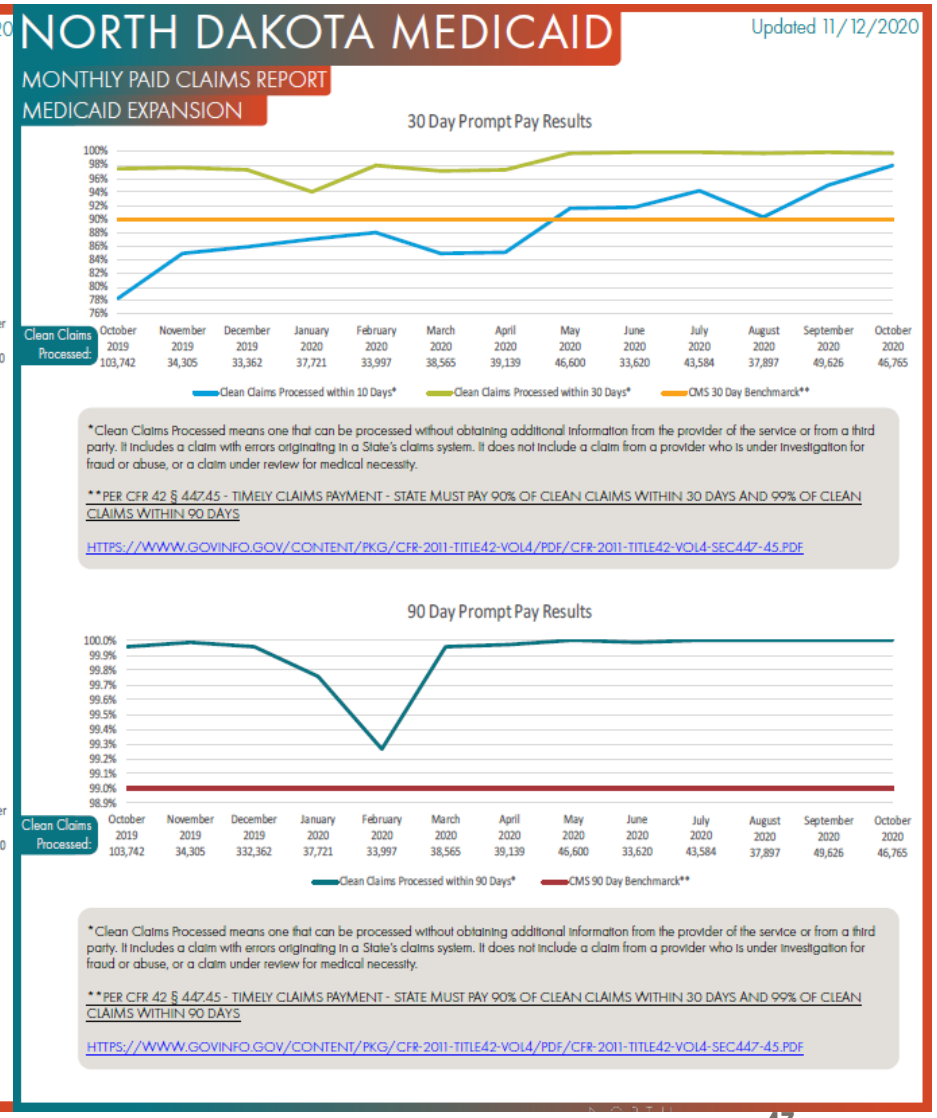
Lifecycle of a Claim



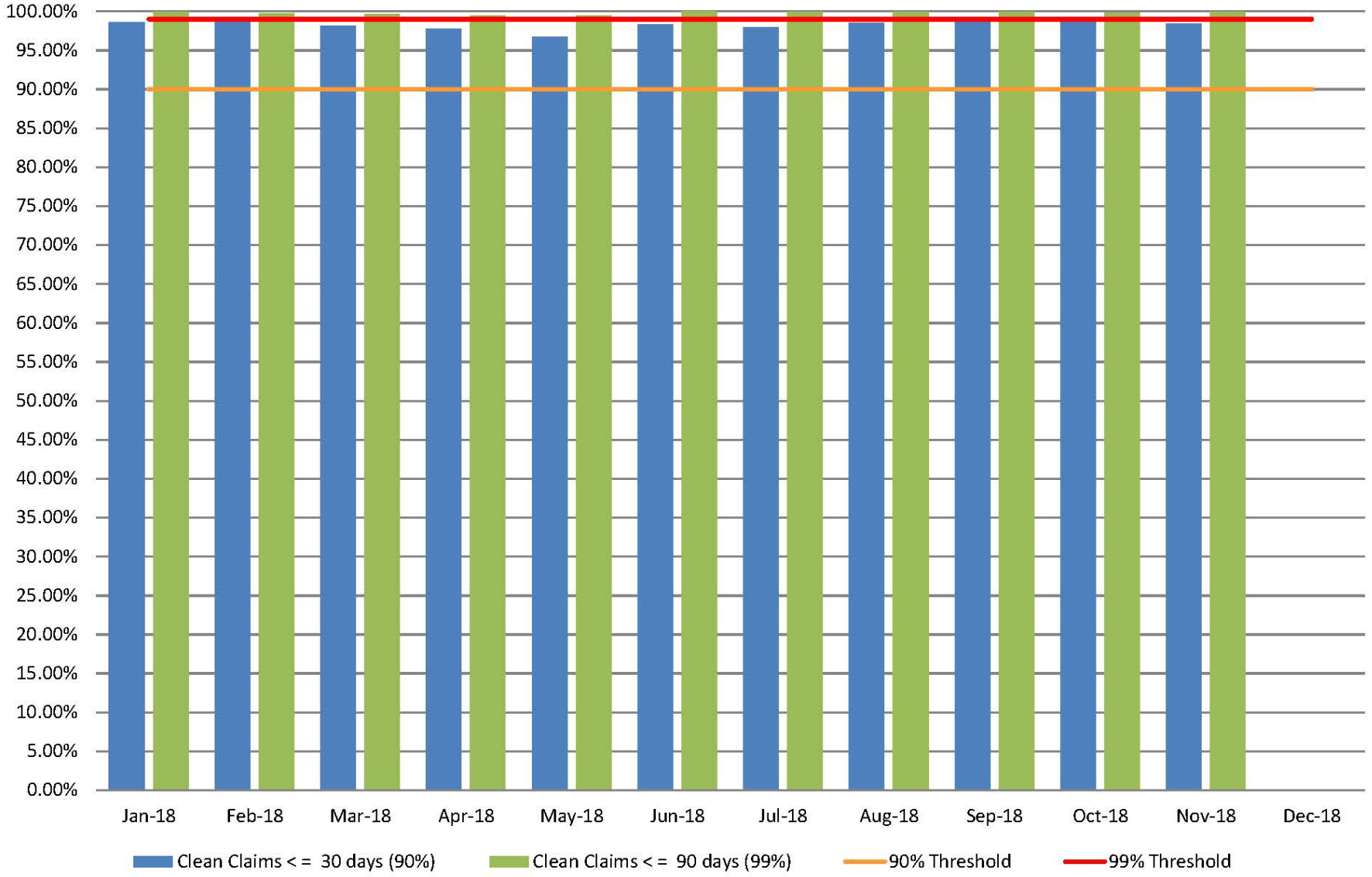
Prior Testimony
Claims Payment Turn Around

Clean Claim payment turnaround times between ND Traditional FFS Medicaid and MCO Medicaid Expansion



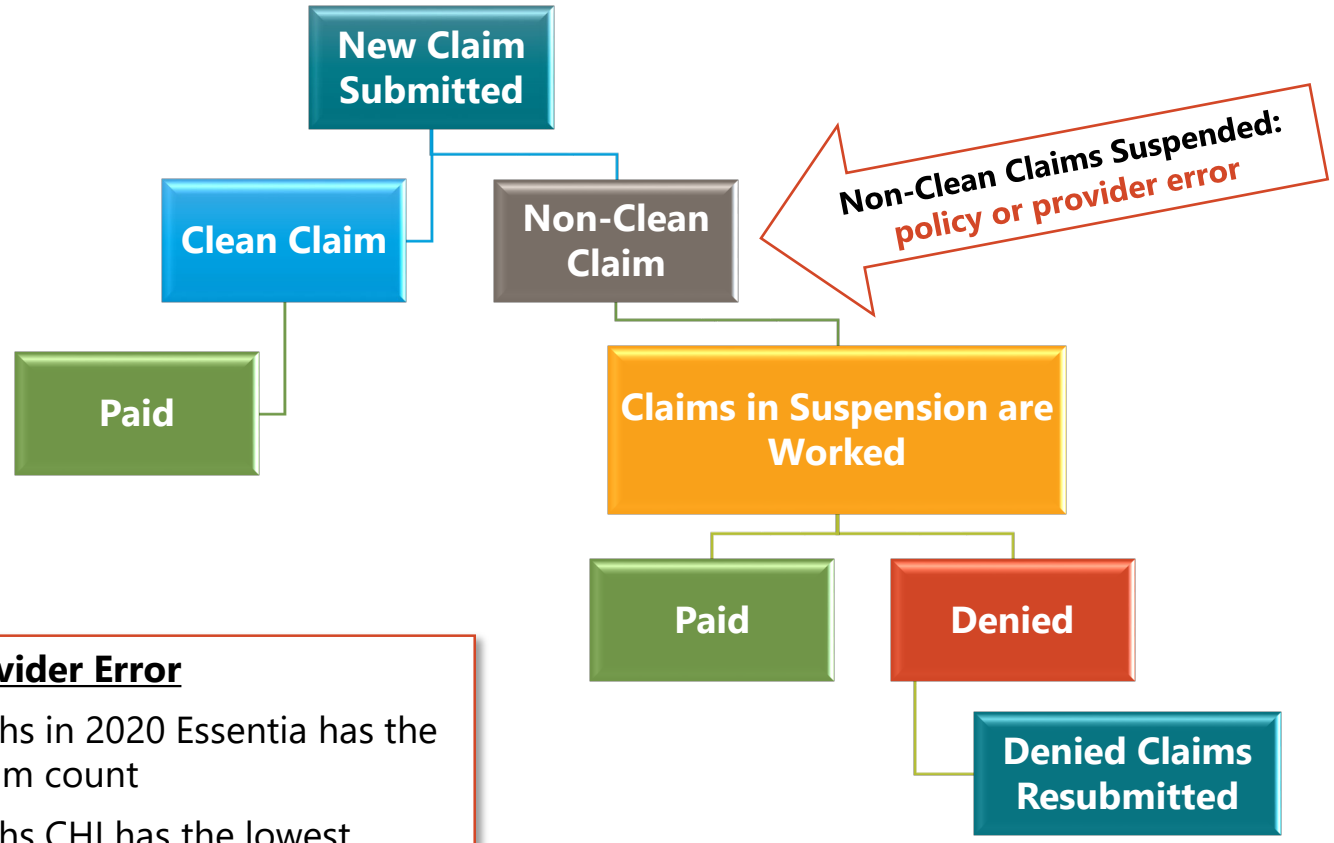


Prior Testimony
Claims Payment Turn Around



Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim

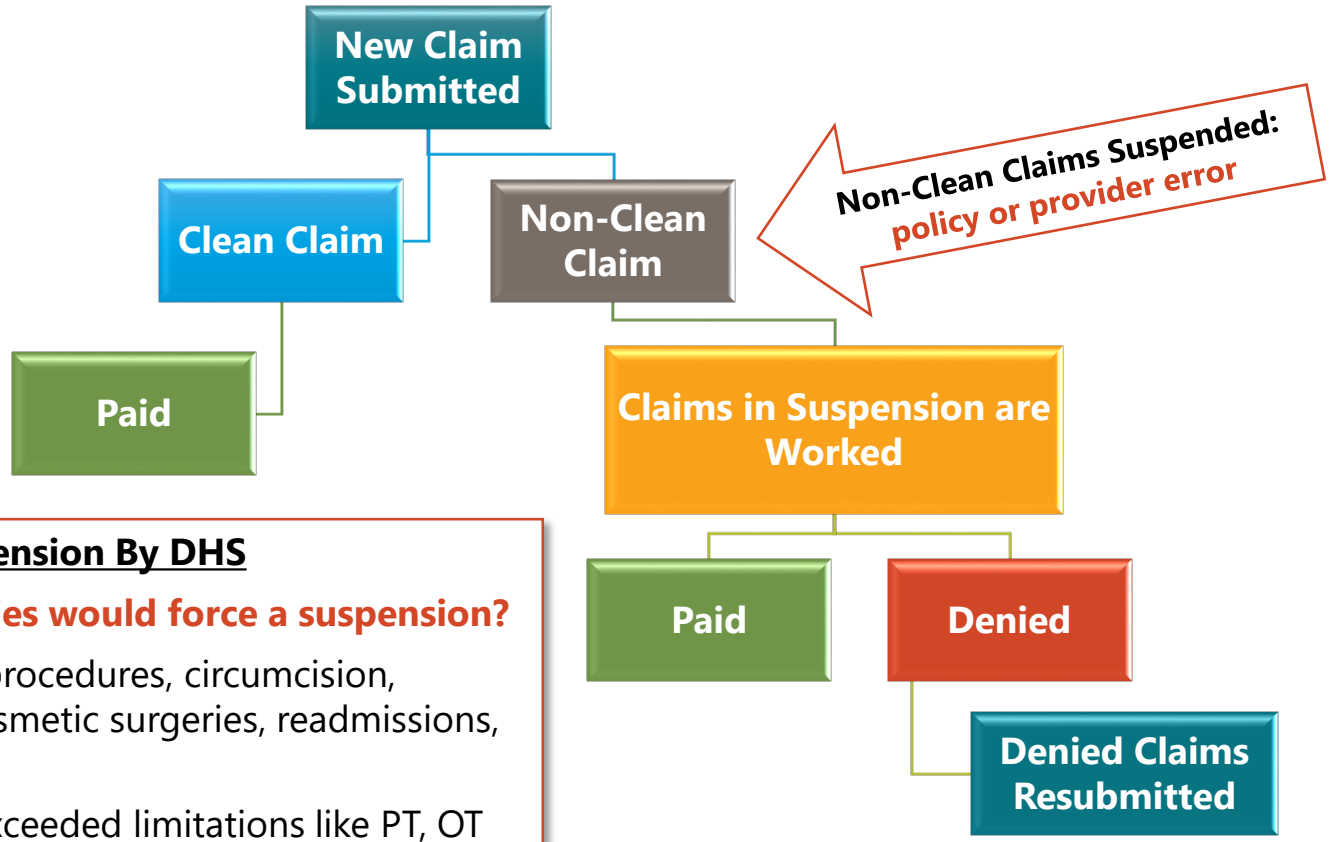


Provider Error

- 7 out of 12 months in 2020 Essentia has the highest clean claim count
- 6 out of 12 months CHI has the lowest
- 4 out of 12 months Altru has the lowest

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

What Medicaid policies would force a suspension?

- Review of certain procedures, circumcision, appendectomy, cosmetic surgeries, readmissions, etc.
- If a member has exceeded limitations like PT, OT
- Third party liability (TPL) as Medicaid is the payer of last resort
- DRGs not appropriate

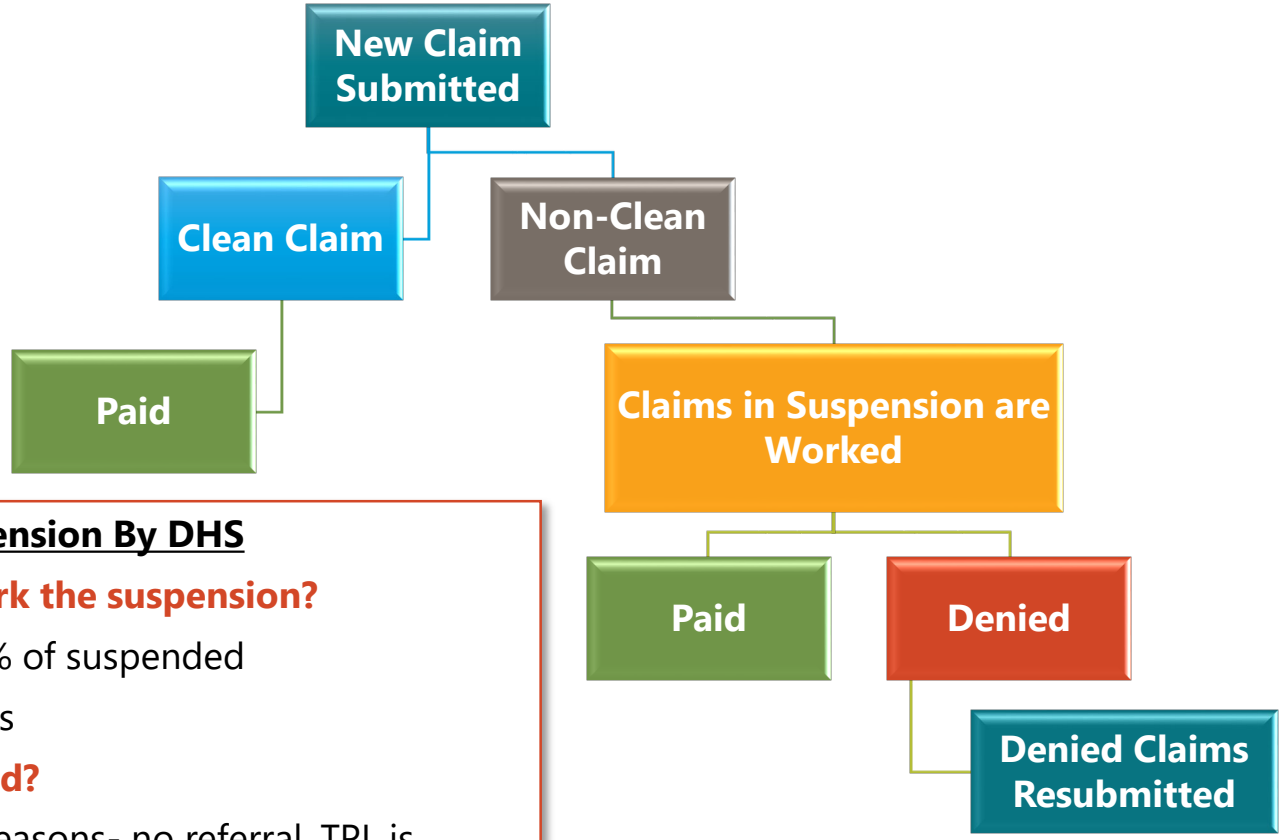
Prior Testimony Claims Payment Turn Around

MEDICAID ANNUAL PROFILE REPORT
Provider Review Results
Peer Group 1
Reviews: 7/1/2017 - 6/30/2018

Provider	# of Cases	# Cases Denied	Billing Denial	Technical Denial	Medical Necessity Denial	Denied %	Billing Denial %	Technical Denial %	Medical Necessity %	# DRGs Changed	% of Cases with DRG Changes
Sanford Medica Fargo	608	2	0	1	1	0.3%	0.0%	0.2%	0.2%	7	1.2%
Sanford Medica Bismarck	582	3	0	2	1	0.5%	0.0%	0.3%	0.2%	4	0.7%
Altru Hospital Grand Forks	437	10	0	0	10	2.3%	0.0%	0.0%	2.3%	21	4.8%
Trinity Hospital Minot	374	2	0	0	2	0.5%	0.0%	0.0%	0.5%	5	1.3%
St. Alexius Med Bismarck	275	9	1	0	8	3.3%	0.4%	0.0%	2.9%	9	3.3%
Essentia Health Fargo	187	4	0	2	2	2.1%	0.0%	1.1%	1.1%	6	3.2%
Peer 1	**2463**	**30**	**1**	**5**	**24**	**1.2%**	**0.0%**	**0.2%**	**1.0%**	**52**	**2.1%**

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

How long to take work the suspension?

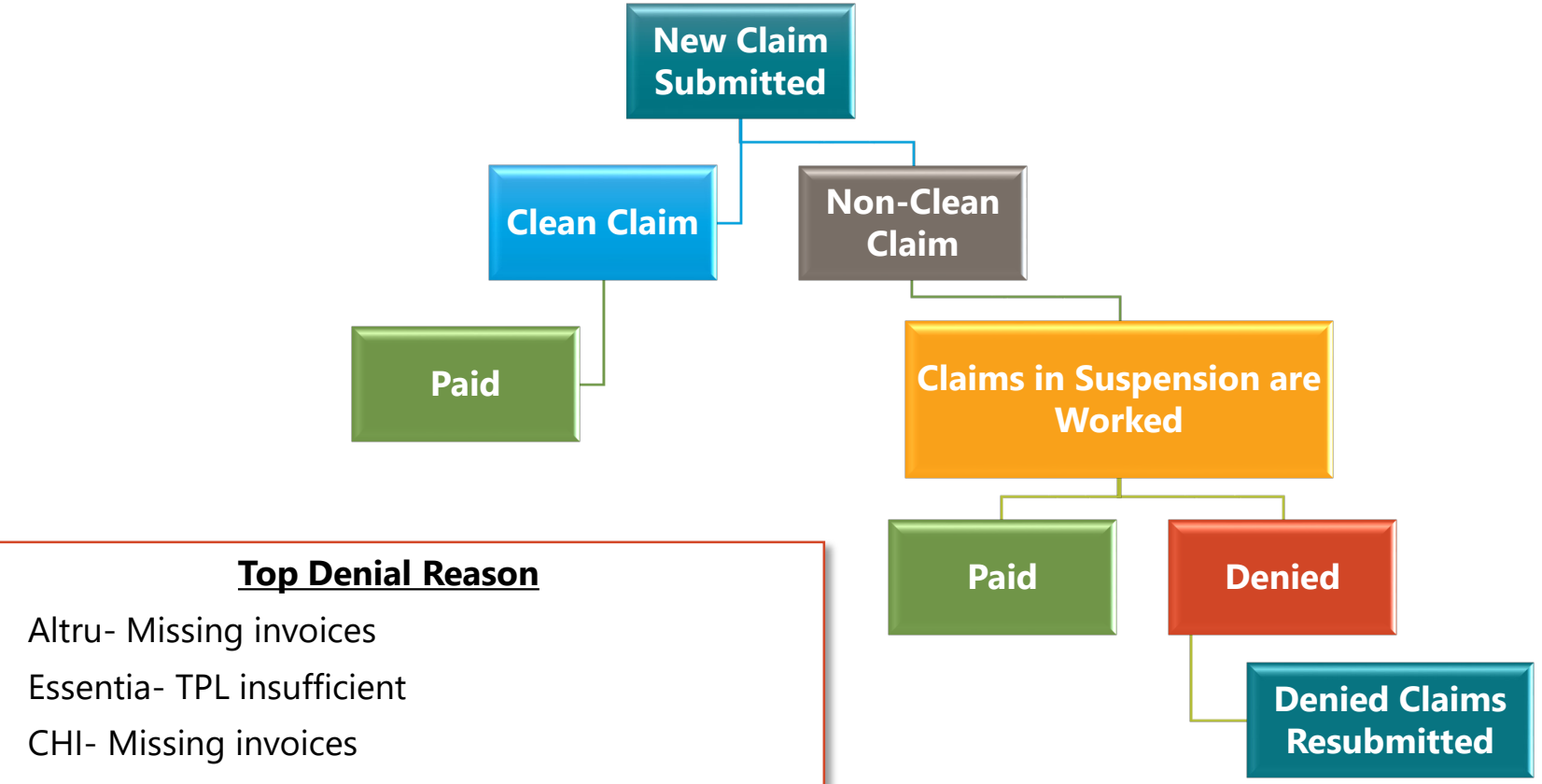
- Within 10 days 54% of suspended
- 84% within 30 days

Why are claims denied?

- These are provider reasons- no referral, TPL is insufficient, attending provider license expired, billing provider license expired, missing invoice
- These are state reasons to deny- diagnosis requires review, TPL issues, claim type on review, trauma/accident (looking for accident file like State Farm invoice)

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Top Denial Reason

- Altru- Missing invoices
- Essentia- TPL insufficient
- CHI- Missing invoices
- Trinity- Billing provider license expired
- Sanford Fargo- Billing provider license expired
- Sanford Bismarck- Billing provider license expired

Prior Testimony
ND Medicaid Savings

RX Claims- Net Costs By Quarter

Quarter	Spend	Per Member Per Month
3Q 2019	$3,030,829.88	$51.26
4Q 2019	$2,934,056.57	$49.27
1Q 2020	$2,419,967.44	$39.70
2Q 2020	$2,591,717.60	$40.15
3Q 2020	$2,794,276.77	$41.23

RX Claims Savings

- Rx Average PMPM 4Q17 – 4Q19
  - $48.16
- Rx average quarterly spend 4Q17 – 4Q19
  - $2.91 million
- Rx Average PMPM 1Q20 – 3Q20
  - $40.36
- Rx average quarterly spend 1Q20 – 3Q20
  - $2.6 million

Prior Testimony
ND Medicaid Savings

Savings From RX Carve Out- IHS

- **IHS claims are now 100% FMAP**
  - Prior to carve out, claims simply part of the rate
- **$3.6 million saved (1Q20 – 3Q20)**
  - Currently trending at $1.2 million per quarter
  - $3.6 million projected for next three quarters for total of $7.2 million in savings
- **Expansion contract included contractor being responsible for ensuring Medicaid Expansion was the payer of last resort**
- With DHS paying Rx claims, we have now included Expansion population in our processes for finding other coverage
- **A minimum of 190 recipients have been found to have Medicare coverage**
  - Premium ranges from roughly $900 to $1400 per month for different expansion recipients
  - 190 recipients X $1052 per month = $200,000 per month
- **$2.2 million in premium savings (Feb 2020 through Dec 2020)**
  - $1.2 million expected for next six months to total $3.4 million

Prior Testimony
ND Medicaid Savings

RX Carve Out Savings

	Realized Savings	Expected Total Savings
Claims	$ 1,509,000	$ 3,018,000
IHS	$ 3,600,000	$ 7,200,000
Premiums	$ 2,200,000	$ 3,400,000
Administration	$ 2, 641,000	$ 3,441,000
Total	**$ 9,950,000**	**$ 17,059,000**

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- IHS = $7.2 million **(*New savings)**
- Premiums = $3.4 million **(*New savings)**
- Admin = $3.441 million (< $3.991 million projected in 2019 session due to HIPF going away in 2021)

Total = $17.059 million (> $6.091 projected in 2019 session)



Prior Testimony ND Medicaid Savings

CHIP Savings (1Q20-3Q20)

Expected CHIP cost	**$6,706,332**
▪ *Average 2,378 kids per month x Average $313.38 premium per month*	
Actual CHIP cost	**$1,932,582**
Actual Provider Payments	**$2,872,734**
Drug rebates	**$940,152**
Savings	**$4,773,750**
% reduction	**71.18%**

Prior Testimony Commercial Premiums

Prior testimony implied that there would be an increase to commercial premiums if Medicaid expansion rates are set at traditional fee schedule.

Manatt Health Strategies consulted to see if there was any evidence of cost shifting due to decrease in government health payments for health care.

The answer was NO

Literature cited:

- Colorado Department of Health Care Policy and Financing, Colorado Hospital Cost Shift Analysis, January 2020
  - *"Despite significant reductions in uncompensated care and significant increases in Medicaid and Medicare rates, hospitals are persistently increasing the price of care."*
  - *"Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance. The increased funding generated by public, taxpayer funded programs— which are intended to reduce private insurance premiums and out-of-pocket costs — are not being passed along to health care consumers and employers."*
- Kaiser Health News, Medicaid Expansion Boosts Hospital Bottom Lines — And Prices, March 2019
- Colorado Health Institute: The Cost Shift Myth

Historical studies and articles:

- JAMA Forum, Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers, January 2017
- Journal of Health Economics, Shock, But No Shift: Hospitals' Responses to Changes in Patient Insurance Mix, September 2016 (full article)
- New York Times, Hospitals Are Wrong About Shifting Costs to Private Insurers, March 2016
- Milbank Quarterly, How Much Do Hospitals Cost Shift? A Review of the Evidence, March 2011 (Pre-ACA)

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

Medicaid expansion is still 90%/10% match regardless of if it is under a managed care company or DHS.

Even though the State match is only 10%, it is more difficult to find that State match each session. 10% of **a larger number** is harder to find than 10% of a smaller number. Suppose the Legislature does not support this policy proposal the total appropriation (at current rates**) $708 million of which $80 million is General Fund. This is an increase of $73 million from 19-21 ($14 million in General Fund)**

This point implies that taxpayers only are concerned with the 10% State match. American taxpayers are responsible for the **entire amount** as it comes from federal taxes and some from State taxes.

The federal government continues to investigate Medicaid expansion spending. GAO reports typically are the first steps before legislative action, and several have already been commissioned:

- from 2017 https://www.gao.gov/products/GAO-17-145 and
- from 2020 https://www.gao.gov/products/GAO-20-260
- from 2020 https://www.gao.gov/products/GAO-20-157
- from 2020 https://www.gao.gov/assets/720/710680.pdf.

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

During revenue downturns, 100% state-funded programs and **traditional Medicaid providers are disproportionately targeted for savings** versus expansion providers due to the funding split. Again, this creates a **non-equitable** Medicaid system.

100% General Fund or 50%/50%	**90%/10%**
Autism Voucher, Basic Care, AARP, Valley Senior Services, Alzheimer's Association, Independence Inc., Poppy's Promise, Red River Human Services Foundation, Enable Inc., Family Voices of ND, Mental Health America ND, Dacotah Foundation, Beyond Shelter, Cooper House, Edwin House, LaGrave on First, ShareHouse, Prairie St. John's, Northland PACE, ND Brain Injury Network, ND Brain Injury Advisory Council, ARC of ND, Nexus-PATH, Prairie Harvest Mental Health, Developmental Disabilities, HCBS, Nursing Homes, Dental, Vision, Pediatrics	**Expansion**

Developmental Disability providers and **Nursing Homes** have put in the hard work to have **more equitable reimbursement**, reducing the financial burden on the State



Other Solutions? 2019 NDHA Study

DHS is committed to considering all possible solutions brought forward by stakeholders.

In 2019 NDHA brought forth a study by Levitt that indicated Accountable Care Organizations (ACOs) would be a viable solution.

After careful review and study DHS has the following observations:

- ACOs, like managed care in general, requires a large enough risk pool to spread the risk. By continuing to separate traditional and expansion, there would not be a critical mass of members to make this a viable solution. NDHA members expressed this concern during recent value-based purchasing meetings.
- ACOs might be possible if hospitals would work together in a regional or statewide approach. NDHA members expressed concern about working in a regional approach at recent value-based purchasing meetings.
- ACOs do not bring down commercial rates.
- ACOs can only reduce costs if providers accept upside and downside risk. DHS could not identify any providers in the state that have accepted downside risk. Therefore, the state would only be sharing the savings when providers manage below the total cost of care. The State would realize no savings if providers were unable to manage under the total cost of care unless 2-sided risk was mandatory.

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **???**

Other Solutions? Use of Tribal Care Coordination Dollars

DHS is committed to considering all possible solutions brought forward by stakeholders

Tribal care coordination savings were mentioned as a way to save general fund dollars instead of transitioning Medicaid expansion

Below is an update on tribal care coordination savings:

- To date, IHS and 2 providers (Sanford and CHI) have entered into an agreement to coordinate care
- However, 100% FMAP cannot be claimed until tribes agree as well ***(Thus far, no tribe has agreed)***
- Legislation from 2109 set the savings split from the 100% FMAP at 60% State: 40% Tribes ***(No tribe has agreed to this split)***
- DHS did not include savings last biennium or this biennium on tribal care coordination as the decision to participate is solely left to the tribes
- DHS has been working with Sanford and CHI to ensure that when, and if, the agreements are signed the correct FMAP can be applied to the claims
- Note that this solution is independent of the managed care organization

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **Yes**,
for tribal members only

ND Medicaid
The Future

- Medical Services Division's aim is to restructure its Medicaid programs to promote better care and **quality** for members, **reduced burden** on providers, and be **trusted stewards** of taxpayer dollars.
- Medical Services aims to have **equity for all ND Medicaid members**, regardless of one's category of eligibility, allowing for continuity of care across the continuum to ensure high quality care and outcomes.
- Medical Services aims to **align benefits** across the entire Medicaid program. Legislators have inquired previously about providing dental benefits, vision benefits and long-term care and support services for expansion members.
- Medical Services strives for a comprehensive utilization management approach through **health homes** to ensure patient centered care across the continuum.
- Medical Services seeks to create a **realistic risk pool** that can ultimately be used to spread risk, lower cost, and drive value through the entire program.
- Medical Services aims to give providers **consistent processes** in relation to service authorization, appeals, claims submission, and provider enrollment.

Thank you!

North Dakota Medicaid



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NORTH Dakota | Human Services
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2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/1/2021am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Chair Nelson opened the meeting at 9:01 a.m.

Discussion Topics:

- Department of Human Services
- Department of transportation questions
- Statewide HSC budget
- Department of Human Services Questions and Answers

Mike Gerhart, DOT (9:02 am) testified about DOT questions #4527

Rosalie Etherington and Jeff Stenseth (9:20 am) testified about the Statewide HSC Budget Detail #4502

Arnie Strebe, CEO/ CFO (10:36 am) testified about questions the Representatives had, oral testimony

Krista Fremming, Medical Services (11:00 am) testified about Northland Pace enrollment questions #4558

Chair Nelson closed the meeting at 11:50 a.m.

Cole Fleck, Committee Clerk

STATE FLEET VEHICLE RENTAL RATES #4527

There are three components to the rental rates of state fleet vehicles. They are operating, depreciation, and replacement. The operating and depreciation can be charged to federal projects, however the replacement rate cannot.

Operating Rate

To determine the operating rental rate, the following components are included in the calculation:

1. Direct Labor and Payroll Additives.
2. Parts, Fuel, Commercial Repairs, Etc.
3. State Fleet Services Overhead.
4. Shop Overhead.
5. Insurance.
6. The rate computation will include the adjustment for over/under applied revenues.

These costs are rolled up over a 12-month period and then divided by the 12 month usage to arrive at an actual cost operating rate per mile/hour. We review these costs quarterly and make adjustments to the rate to avoid as much over/under applied revenue as possible.

Depreciation Rate

To determine the depreciation rental rate the following components are used in the calculation:

1. Miles or hours vehicle to be in service.
2. Years vehicle to be in service.
3. The rate computation will include the adjustment for gain/loss from sale.

Financial Management Division will use this information as well as the estimated salvage value to determine the current depreciation schedule to be assigned to each group of new units. Estimated salvage value is based on a percentage of new vehicle cost as dictated by recent auctions. All vehicle depreciation is straight line over the useful months' life of the vehicle minus the estimated salvage value. Depreciation is charged based on if vehicle is a pool or assigned vehicle.

- For pool vehicles, agencies are to budget depreciation based on miles/hours driven.
- For assigned vehicles, agencies are to budget based on number of vehicles in group times the group monthly assigned depreciation rate times 24 months. This rate will be charged each month regardless of usage.

Replacement Rate

The purpose of the replacement rate is to recover the cost associated with inflation of new vehicle prices from the time a new vehicle is purchased until the time it is to be replaced and/or the addition of new vehicles to a group to meet the state's needs.

If the new prices remain flat within a group or there are no new additions to the group, the replacement rate may not be needed for periods of time.

The process used to calculate the rates is in full compliance with 2 C.F.R. Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Compliance with this regulation allows agencies to apply State fleet usage costs to federal programs as applicable.

The rates are reviewed quarterly and, if necessary, adjusted to remain responsive to changing conditions. It should be noted the rates are not designed to result in a new profit or loss to state fleet; however, they are designed to cover the actual costs of operating and acquiring state fleet vehicles.

Replacement Guidelines

The following are examples of the guidelines used to replace some of the vehicle groups:

Group	Replacement age	Target miles
01 Mini Passenger Vans	7 Years	75,000 Miles
02 Sedans	5 Years	70,000 Miles
03 Light Duty Pickups and Cargo Vans	8 Years	85,000 Miles
04 Heavy Duty Pickups and Vans	7 Years	85,000 Miles
07 Highway Patrol Vehicles	5 Years	85-100,000 Miles
08 Game Enforcement	4 Years	80,000 Miles
09 Regulatory Vehicles	4 Years	85,000 Miles
12 Facility Vehicles	12 Years	N/A
13 Compact SUV	6 Years	80,000 Miles
18 Miscellaneous Trucks	12 Years	N/A
22 Tandem Axle Snow Plow Truck	15 Years	N/A

State Fleet consistently evaluates the depreciation (replacement years) to determine if changes should be made.

NORTH DAKOTA DEPARTMENT OF TRANSPORTATION
STATE FLEET SERVICE
2021 - 2023 BIENNIUM

ASSIGNED VEHICLE BUDGET GUIDELINES

DESCRIPTION	GROUP No.	OPER RATE	REPLCMNT RATE	MILE/HOUR RATE	DEPREC/ MONTH
Mini Pass. Van	**1**	**0.28**	**0.04**	**0.32**	**152.00**
Sedan/Wagon	2	0.22		0.22	161.00
Light Pickup/Cargo Van/Full-Size Utility	**3**	**0.34**	**0.12**	**0.46**	**192.00**
Heavy Pickup/Van/Full-Size Utility	4	0.21	0.06	0.27	216.00
Highway Patrol	**7**	**0.37**	**0.02**	**0.39**	**463.00**
Game & Fish Enforcement	8	0.28	0.04	0.32	400.00
Regulatory Vehicles	**9**	**0.21**	**0.02**	**0.23**	**304.00**
Facility Service Vehicle	12	0.77	0.20	0.97	140.00
Compact Utility/All	**13**	**0.38**	**0.20**	**0.58**	**243.00**
Miscellaneous Truck/Mid-Size Bus	18	32.00	3.00	35.00	210.00
Distributor Truck	**19**	**35.00**		**35.00**	**322.00**
Sign Truck/Garbage Truck	20	37.00		37.00	662.00
ndem Axle Truck/All	**22**	**63.00**	**15.00**	**78.00**	**682.00**
ruck Tractor	23	52.00		52.00	288.00
Water Commission Truck	**27**	**30.00**		**30.00**	**1,062.00**
Shuttle Bus	30	29.00		29.00	533.00
Drill Truck	**32**	**16.00**		**16.00**	**573.00**

FLEET *MOTOR POOL* VEHICLE BUDGET GUIDELINES

DESCRIPTION	GROUP No.	OPER & DEPR RATE	REPLCMNT RATE	MILE/HOUR RATE
Mini Pass. Van	**1**	**0.50**	**0.04**	**0.54**
Sedan/Wagon	2	0.42		0.42
Light Pickup/Cargo Van/Full-Size Utility	**3**	**0.60**	**0.12**	**0.72**
Heavy Pickup/Van/Full-Size Utility	4	0.68	0.06	0.74
Highway Patrol	**7**	**0.65**	**0.02**	**0.67**
Game & Fish Enforcement	8	0.42	0.04	0.46
Regulatory Vehicles	**9**	**0.35**	**0.02**	**0.37**
Facility Service Vehicle	12	1.56	0.20	1.76
Compact Utility/All	**13**	**0.62**	**0.20**	**0.82**
Miscellaneous Truck/Mid-Size Bus	18	48.00	3.00	51.00
Rotary Snowplow	**24**	**86.00**		**86.00**
Medical Simulator Trucks	25	43.00		43.00
Bridge Aerial Lift	**28**	**45.00**		**45.00**
eworker Truck	29	49.00		49.00
Fuel Truck	**31**	**14.00**		**14.00**

The replacement rate is a federally unallowable cost and therefore should not be charged to federal awards



HOUSE BILL 1012

House Appropriations | Human Resources Division #4502

Representative Jon Nelson, Chairman

STATEWIDE HSC DETAIL BUDGET

Rosalie Etherington, Chief Clinic Director/NDSH Superintendent

Jeff Stenseth, Field Services Operations Officer/SEHSC Regional Director

NORTH Dakota | Human Services

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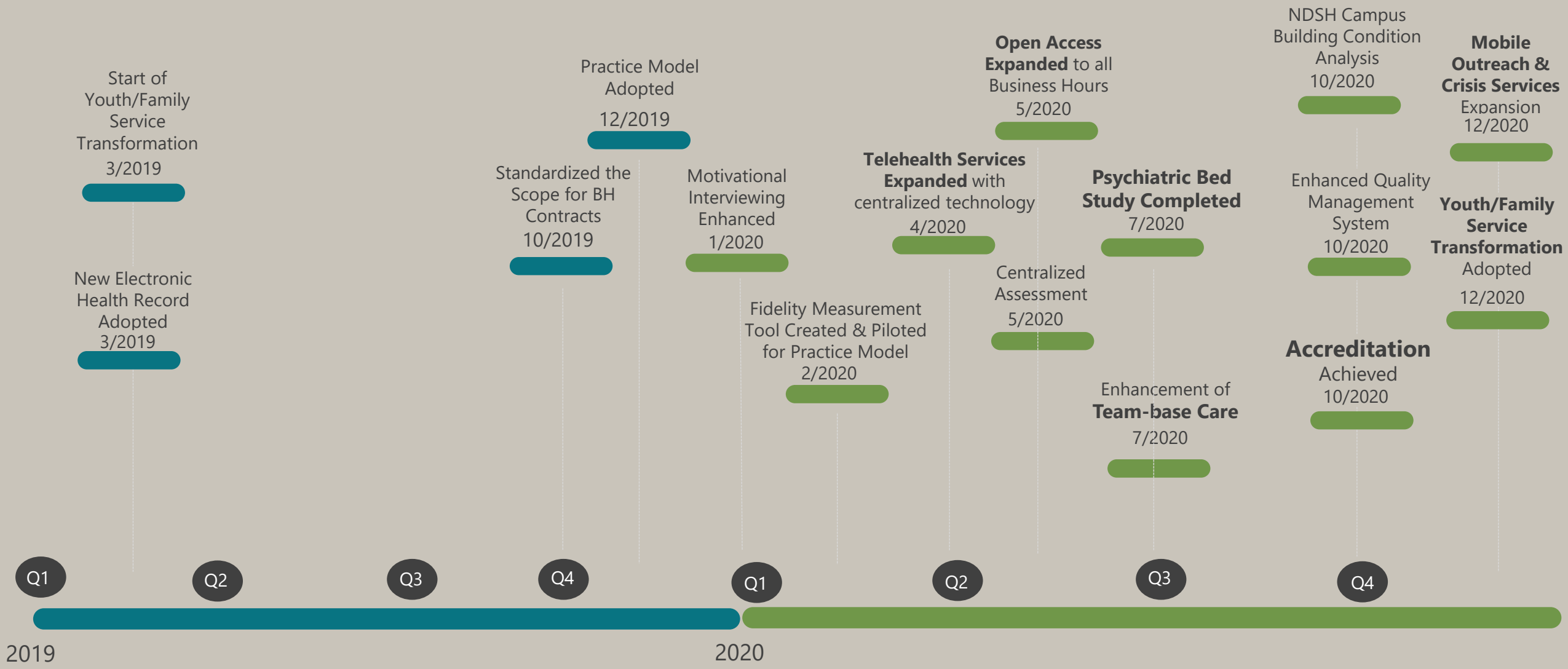
Field Service Initiatives, 2019 - 2020



Department of Human Services

Statewide Human Service Center Staff

19-21 Authorized FTE Base	19-21 Authorized FTE Realigned	21-23 Requested Base FTE	# vacancies 12-31-20 (from base)	Assignment of Requested FTE		
				% of FTE	Descriptor	# of FTE
7	10	10	0	60% 30% 10%	Administration Client Facing Administration Behavioral Health	6 3 1

COVID INFO

- Initial expansion of telehealth capacity and retained limited in-person care
- Maintained crisis response throughout
- Returned to primarily in-person care in November

Telework Headcount

Pre-COVID	Current
0	6

STATEWIDE POSITIONS

STATEWIDE ALIGNMENT

- Statewide Medical Director
- Statewide Nurse Practitioner
- Psychosocial Rehabilitation Director
- Quality Management and Accreditation Director
- Quality Improvement Manager
- Health Records and Coding Lead
- Medical Coder
- Statewide Telehealth Coordinator*
- Electronic Health Record Operations Specialist*
- Support Professional*

KEY STATEWIDE CONTRACTS

- Centralized Call Center/211
- Solutions Mobile Crisis
- Behavioral Health Inpatient Services
- Clay County Medical Detox
- Employment Extended Services Coordination

SEX OFFENDER TREATMENT CONTRACT

- Contract established March 2019
- Provides for Sex Offender Assessment and Treatment Services for low-risk adults and adolescents
- 60-79 persons served per month
- Service available to all 8 regions
- All participants offense and revocation free

EXTENDED SERVICES SUPPORTED EMPLOYMENT

Provides state general funds to community rehabilitation providers (CRP) to assist individuals with a qualifying disability (serious mental illness, brain injury, or other disability) to maintain the integrated, competitive, community-based employment or obtain employment if maintaining employment is no longer an option.

EXTENDED SERVICES SUPPORTED EMPLOYMENT FUNDING

- **Current Funding Structure**
  - **$398 per month per client if CRP provides at least 1 hour of service for the month**
    - July 1, 2019 to December 31, 2020
      - Average number of hours provided to clients in a month= **3.3 hours**
    - **Equals to approximately $120.50 per hour**
- **Proposed Funding Structure (Individuals served would not see a change in service)**
  - Change $398 month per individual served to match the 1915i Medicaid rate of $41.96 per hour for same service to be provided (if this was to occur with current numbers this would decrease the payout by 65%)
  - 3rd party payer source would not be Statewide HSC State General Funds
    - Medicaid and Medicaid Expansion would be the 3rd Party Payor source for the CRP to provide same exact service. About 57% of clients using State General Funds would be shifted to 1915i services qualifying for Medicaid and Medicaid Expansions funds.

OVERVIEW OF BUDGET CHANGES - SWHSC

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget
Salaries and Benefits	2,338,808	196,412	2,535,220
Operating	3,350,093	(1,059,492)	2,290,601
Capital	0	0	0
Grants	4,839,327	281,793	5,121,120
Total	10,528,228	(581,287)	9,946,941
General Fund	9,274,414	672,527	9,946,941
Federal Funds	1,253,814	(1,253,814)	0
Other Funds	0	0	0
Total	10,528,228	(581,287)	9,946,941
Full Time Equivalent (FTE)	10.00	0	10.00

DETAIL BUDGET CHANGES BY EXPENSE CATEGORY

Expense Category	2017 - 2019 Biennium Expenditures	2019 - 2021 Base Level Budget	2019 - 2021 Year 1 (SFY 20)	Increase/ (Decrease) to 2021 - 2023	2021 - 2023 Executive Budget Request
511x Salaries - Regular	1,601,125	1,350,716	816,870	505,869	1,856,585
513x Salaries - Temp	206,320	400,032	48,191	(400,032)	-
514x Salaries - Over Time	7,109	-	8,331	-	-
516x Salaries - Benefits	505,374	588,060	271,658	90,575	678,635
Total Salaries & Benefits	2,319,928	2,338,808	1,145,050	196,412	2,535,220
52x Travel	67,582	74,708	31,070	(5,205)	69,503
53x Supply	5,935	15,700	34,334	33,710	49,410
54x Postage & Printing	2,846	-	2,586	5,156	5,156
56x Utilities	538	454	438	(454)	-
58x Rent/Leases - Bldg./Equip	30,957	42,712	16,209	(42,712)	-
59x Repairs	1,716	934	925	(934)	-
61x Professional Development	9,175	5,370	2,932	6,630	12,000
62x Fees - Operating & Professional	126,016	3,377,177	1,074,546	(1,230,003)	2,147,174
60x IT Expenses	2,217	3,038	1,080	4,320	7,358
Total Operating	246,982	3,520,093	1,164,120	(1,229,492)	2,290,601
71x Grants, Benefits, & Claims	4,548,866	4,669,327	2,065,910	451,793	5,121,120
Total Grants	4,548,866	4,669,327	2,065,910	451,793	5,121,120
Total	7,115,776	10,528,228	4,375,080	(581,287)	9,946,941

FEES – OPERATING AND PROFESSIONAL

Statewide HSC - 2021-23 Biennium Budget

$ 3,377,177	**$ 2,147,174**	**$ 2,147,174**	**$ -**	**$ -**

Vendor (Please put "VC" in front of the vendor name if it is a contract and "OTH" in front of the vendor if it is not a contract)	Comments / Description	2019-21 Biennium Amount	2021-23 Biennium Amount	General Fund	Federal Funds	Other Funds
OTH - DSM 5 licensing	DSM Licenses	25,000	6,250	6,250		
VC – Case Western	DDCAT	45,000	66,000	66,000		
OTH - Licenses & Yrs of Service	Professional Licenses/Yrs of Service Awards	1,123	281	281		
VC - Rocky Mountain Rehabilitiation	Extended Services VR	571,618	285,809	285,809		
VC - Rocky Mountain Rehabilitiation	Extended Services BH	1,970,884	918,648	918,648		
VC - Rocky Mountain Rehabilitiation	Extended Services Autism	170,000	85,000	85,000		
VC - First Link	First Link	593,552	773,544	773,544		
	Provider Inflation 1%/1%		11,642	11,642		

GRANTS

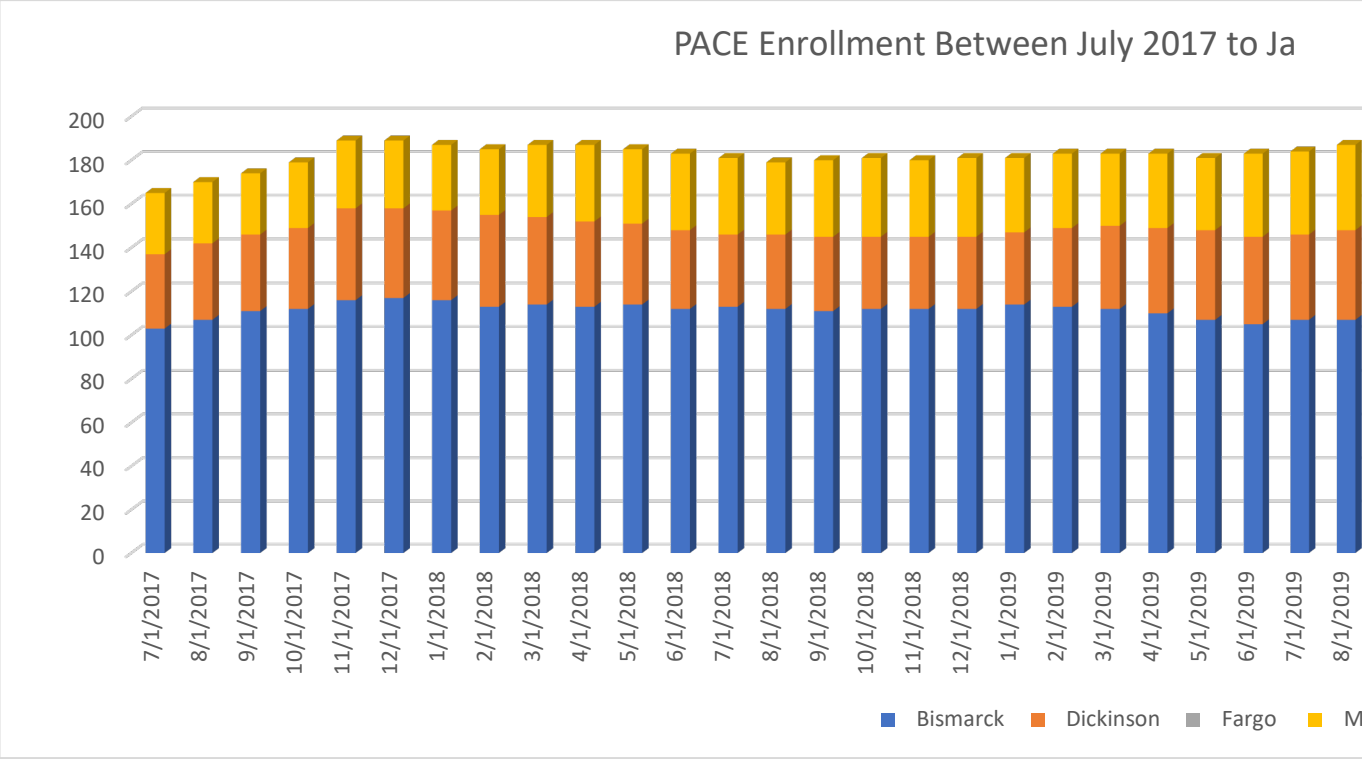
Vendor	2019-2021 Budget	2021-2023 Cost Changes	2021-2023 Caseload changes	2021-2023 15% Savings Plan	Provider Inflation	Sex Offender Treatment Contract	2021-2023 To House
Trinity Medical	447,640	1,753	15,690		7,000		472,083
Altru Health Systems	41,417	406	(26,150)		236		15,909
Richard P Stadter Psychiatric Center	20,166	(5,571)	(13,075)		23		1,543
Prairie St Johns	3,091,485	(273)	1,069,542	(1,204,008)	44,499		3,001,245
Sanford Medical Center Fargo	260,366	2,880	(75,312)		2,828		190,762
Sanford Medical Center Bismarck	133,806	1,274	(37,133)		1,474		99,421
St. Alexius - Bismarck	13,381		189		204		13,774
Subtotal Inpatient Hospitalization Contracts	4,008,261	469	933,751	(1,204,008)	56,264		3,794,737
Solutions Mobile On-Call Crisis	403,309				6,070		409,379
Mobile Crisis On-Call Expansion	257,757			(257,757)			-
Subtotal Other Crisis Care Services Contracts	661,066				6,070		409,379
Sex Offender Treatment Contract						917,004	917,004
Grand Total	**4,669,327**	**469**	**933,751**	**(1,461,765)**	**62,334**	**917,004**	**5,121,120**

Contact information

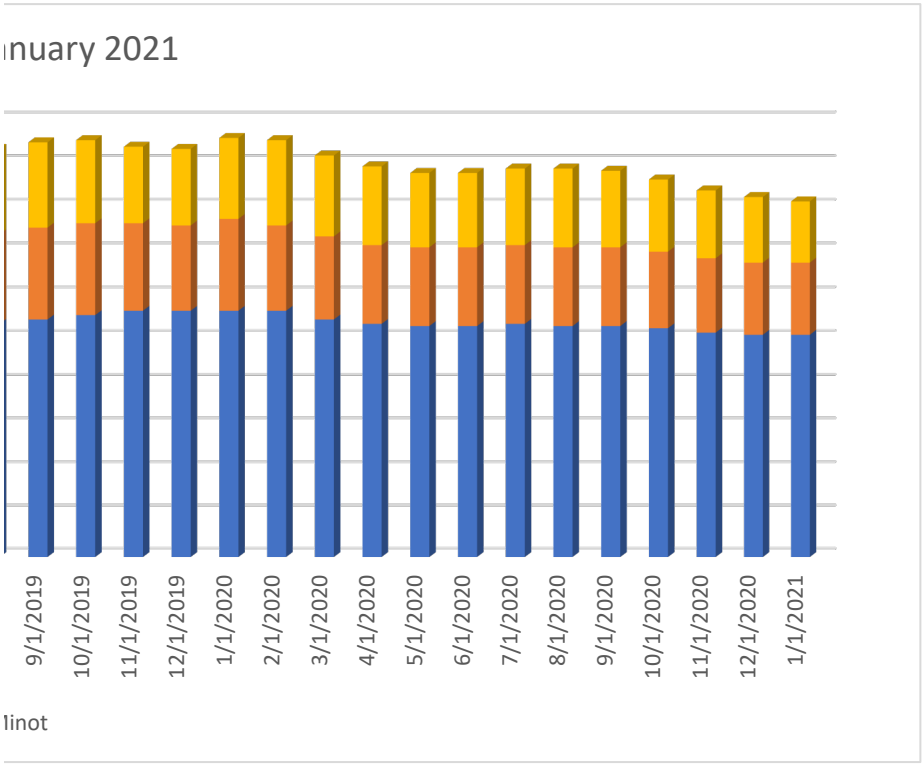
Rosalie Etherington
Chief Clinics Officer/NDSH Superintendent
E-mail: retherington@nd.gov

Jeff Stenseth
Chief Operating Officer/SEHSC Director
E-mail: jstenseth@nd.gov

	7/1/2017	8/1/2017	9/1/2017	10/1/2017	11/1/2017	12/1/2017	1/1/2018	2/1/2018
Bismarck	103	107	111	112	116	117	116	113
Dickinson	34	35	35	37	42	41	41	42
Fargo	0	0	0	0	0	0	0	0
Minot	28	28	28	30	31	31	30	30
Total Participants	**165**	**170**	**174**	**179**	**189**	**189**	**187**	**185**



3/1/2018	4/1/2018	5/1/2018	6/1/2018	7/1/2018	8/1/2018	9/1/2018	10/1/2018	11/1/2018
114	113	114	112	113	112	111	112	112
40	39	37	36	33	34	34	33	33
0	0	0	0	0	0	0	0	0
33	35	34	35	35	33	35	36	35
187	**187**	**185**	**183**	**181**	**179**	**180**	**181**	**180**



12/1/2018	1/1/2019	2/1/2019	3/1/2019	4/1/2019	5/1/2019	6/1/2019	7/1/2019	8/1/2019
112	114	113	112	110	107	105	107	107
33	33	36	38	39	41	40	39	41
0	0	0	0	0	0	0	0	0
36	34	34	33	34	33	38	38	39
181	**181**	**183**	**183**	**183**	**181**	**183**	**184**	**187**

9/1/2019	10/1/2019	11/1/2019	12/1/2019	1/1/2020	2/1/2020	3/1/2020	4/1/2020	5/1/2020
109	111	113	113	113	113	109	107	106
42	42	40	39	42	39	38	36	36
0	0	0	0	0	0	0	0	0
39	38	35	35	37	39	37	36	34
190	**191**	**188**	**187**	**192**	**191**	**184**	**179**	**176**

6/1/2020	7/1/2020	8/1/2020	9/1/2020	10/1/2020	11/1/2020	12/1/2020	1/1/2021
106	107	106	106	105	103	102	102
36	36	36	36	35	34	33	33
0	0	0	0	0	0	0	0
34	35	36	35	33	31	30	28
176	**178**	**178**	**177**	**173**	**168**	**165**	**163**

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/2/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson opened the meeting at 2:45 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- SUD Voucher
- Timeline changes
- Program Growth
- 1915i
- Benefits of 1915i
- Population Served
- Budget considerations
- WHODAS

Pamela Sagness, Director (2:48 pm) testified about the SUD voucher #5008

Pamela Sagness, Director (3:12 pm) testified about the 1915i #5010

Rosalie Etherington, Chief Clinic Dir (3:22 pm) testified about the WHODAS

#5037 #5038

Krista Fremming, Medical Services (3:39 pm) testified about the 1915i

#5041

Caprice Knapp, Medicaid Dir(3:50 pm) testified about the 1915i #5040

Chair Nelson closed the meeting at 4:00 p.m.

Cole Fleck, Committee Clerk

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House Bill 1012 #5008
House Appropriations
Representative Nelson, Chairman

Substance Use Disorder Voucher Overview

Pamela Sagness, Director

SUD Voucher

Goal: improve access to quality substance use disorder treatment services and allow for individual choice, by providing reimbursement where other third-party reimbursement is not available.

- Initiated during 2015 legislative session (NDCC 50-06-42)
- Began serving individuals in 2016

Since 2016, approximately 4,200 individuals have received services through the SUD Voucher.

Twenty-one providers are providing voucher services.

Timeline of Changes/Expansion

65th Legislative Session (2017)

Methadone maintenance was added as a covered service, effective July 1, 2017 **(HB 1012)**

66th Legislative Session (2019)

Providers who access the SUD Voucher were **expanded to public agencies** (i.e., public health and tribal agencies) who hold a substance abuse treatment program license - not including Human Service Centers. **(HB 1105)**

Eligibility age was changed from 18 to 14 years old, effective July 1, 2020. **(SB 2175)**

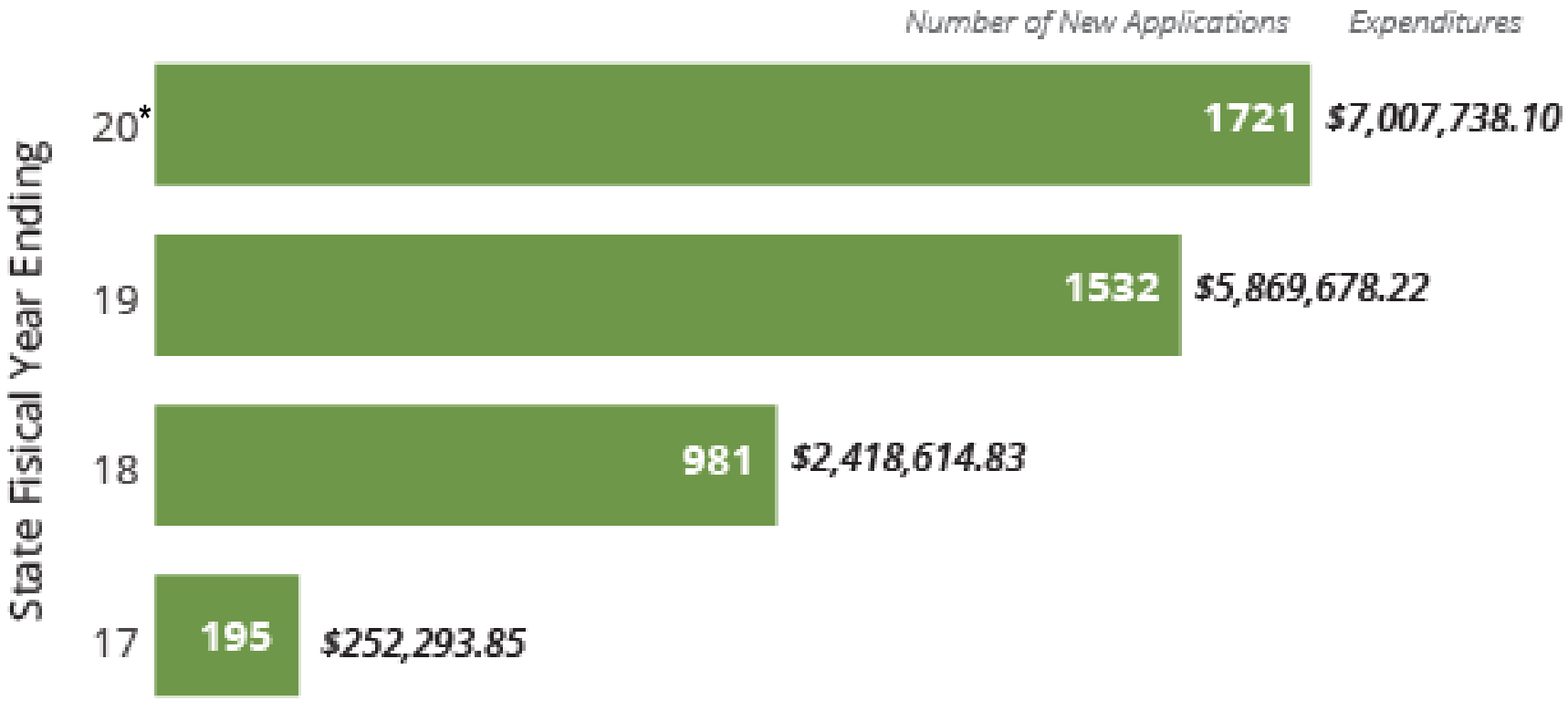
67th Legislative Session (2021)

House Bill 1402 is **proposed to include out of state providers within 5 miles of the North Dakota boarder** to access the SUD Voucher for North Dakota citizens

Appropriation and Expenditures

	2015-2017	2017-2019	2019-2021
Total Budget	$575,000	$4,917,087	$7,997,294
Amount Expended	$252,293.85	$8,288,293.05	$9,646,815.76 (as of Dec. 11, 2020)

Program Participant Growth and Expenditures



*New applications closed July 1, 2020.

2019-2021 Appropriation Update

	As of July 3, 2020	As of Dec. 11, 2020
Amount expended	$7,007,738.10	$9,646,815.76
Pending invoices	$1,125,508.45	$184,539.05
Remaining prior authorization	$10,558,630.11	$1,596,410.07*

**As of February 1, 2021*

Exhausted Appropriation

2019-2021 Appropriation: $7,997,294

CURRENT INDIVIDUALS

- Continue to be covered by their voucher and no interruption to their care and medically necessary services should occur.

NEW INDIVIDUALS

- Applications not considered for approval after 5pm on June 30, 2020.

NEW PROVIDERS

- Applications not considered for approval after 5pm on June 30, 2020.

Community-based Behavioral Health Program

Coronavirus Relief Funds (CRF)

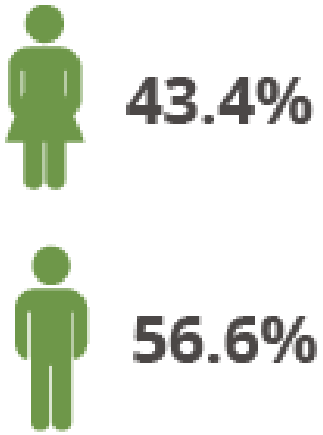
- On Friday, October 23, 2020 the North Dakota Emergency Commission approved an allocation of $1.7 million of the Coronavirus Relief Fund (CRF) for community-based behavioral health services.
- This request was reviewed and provided final approved by the Budget Section on October 28, 2020.
- Ends June 30, 2021.

By providing community-based behavioral health services to individuals in their homes and community the state can reduce the need for individuals to enter congregate settings such as residential treatment facilities, inpatient hospitalization, and avoiding the need for emergency department interventions.

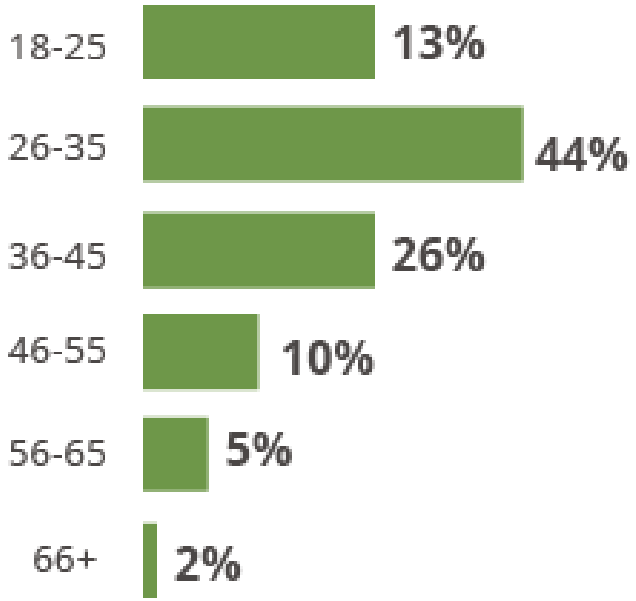
Participant Demographics

From July 1, 2019 through Sept. 30, 2020, approximately 2,296 individuals have received services.

Gender



Age



Race



- White - **73%**
- American Indian or Alaska Native - **19%**
- Black or African American - **5%**
- Hispanic or Latino - **3%**
- More than one race reported - **3%**

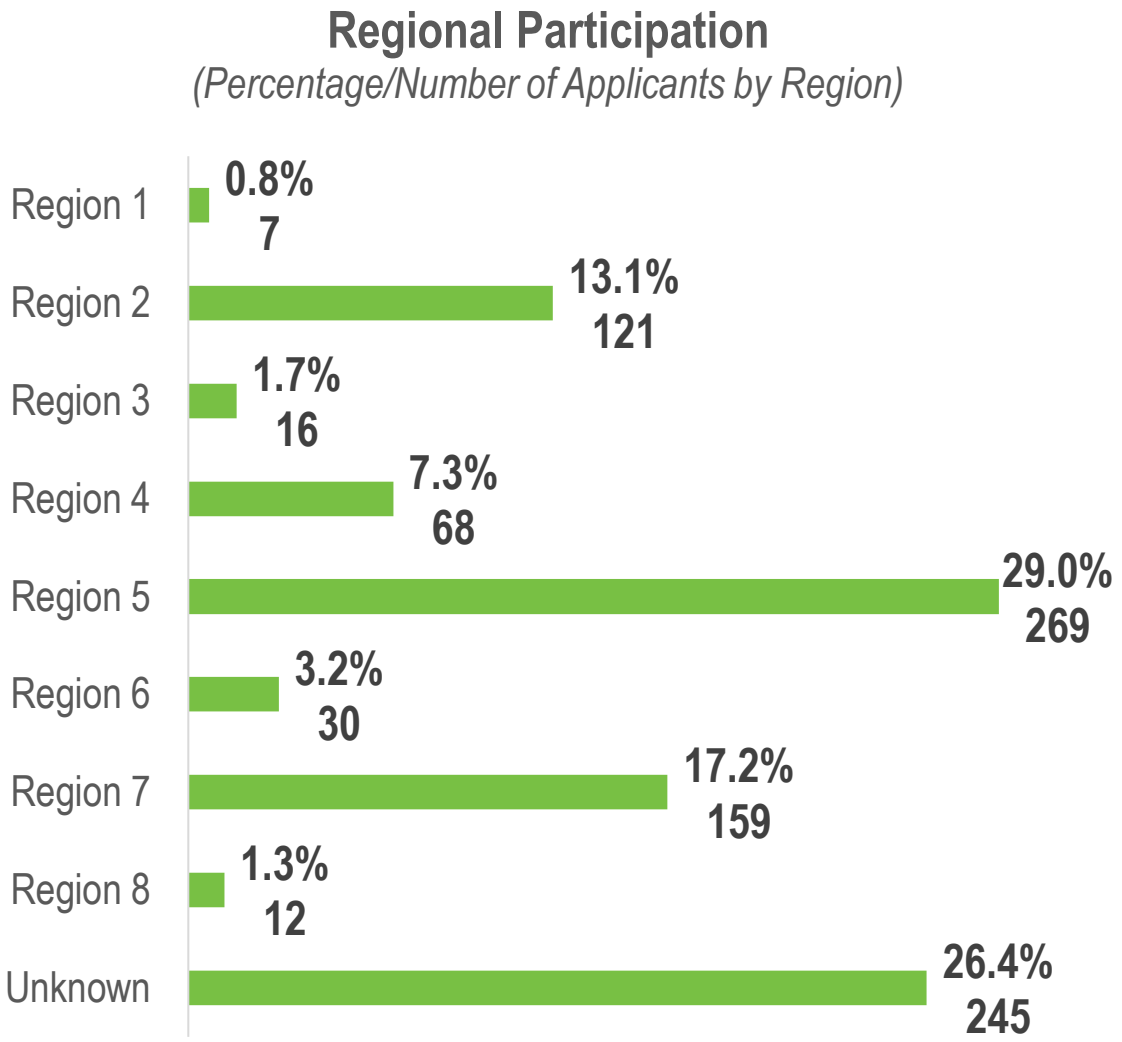
Native Hawaiian or Other Pacific Islander - **0%**

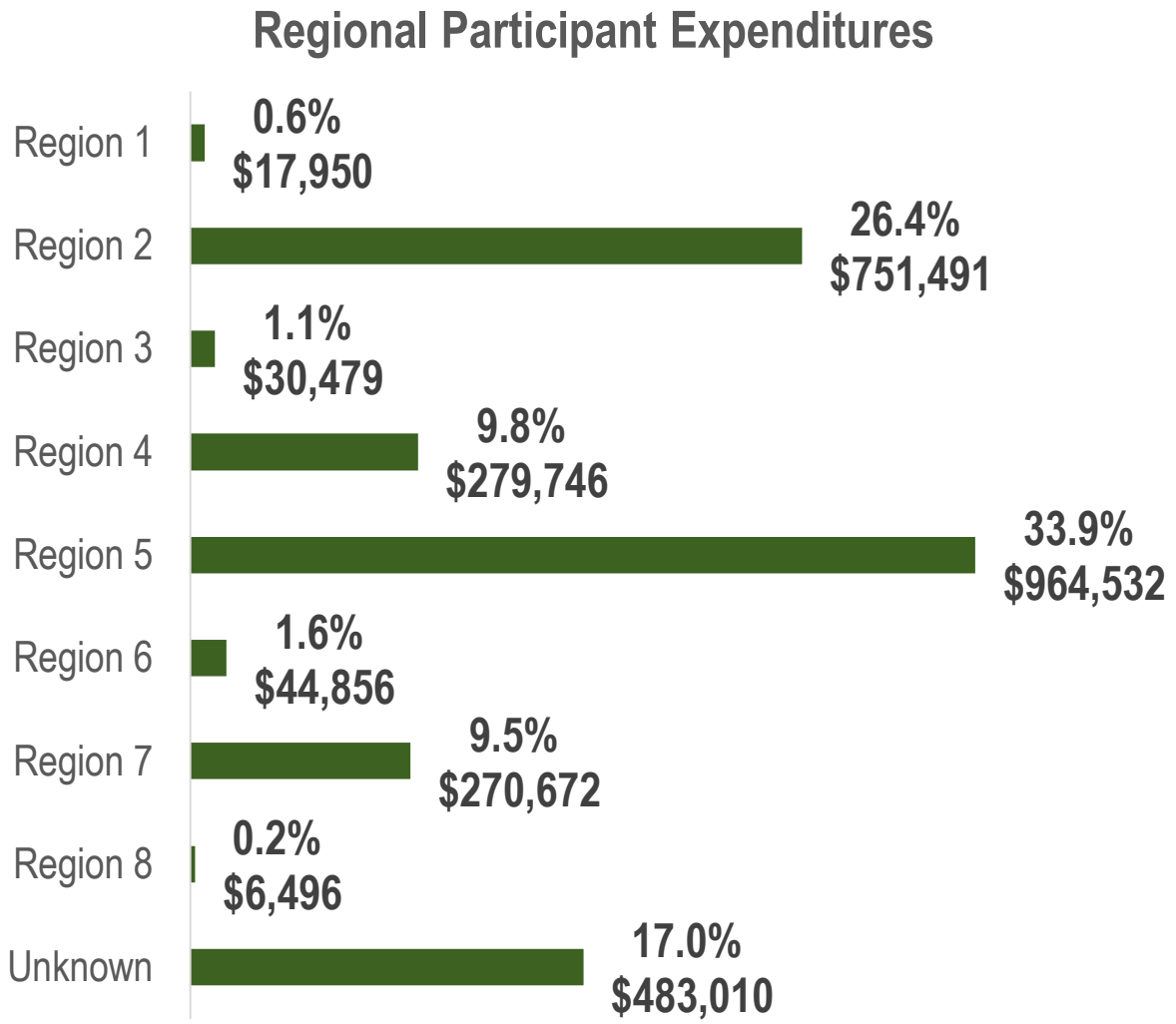
Asian - **0%**

Prefer not to answer - **0%**

6 Month Snapshot: Regional Participation and Expenditures

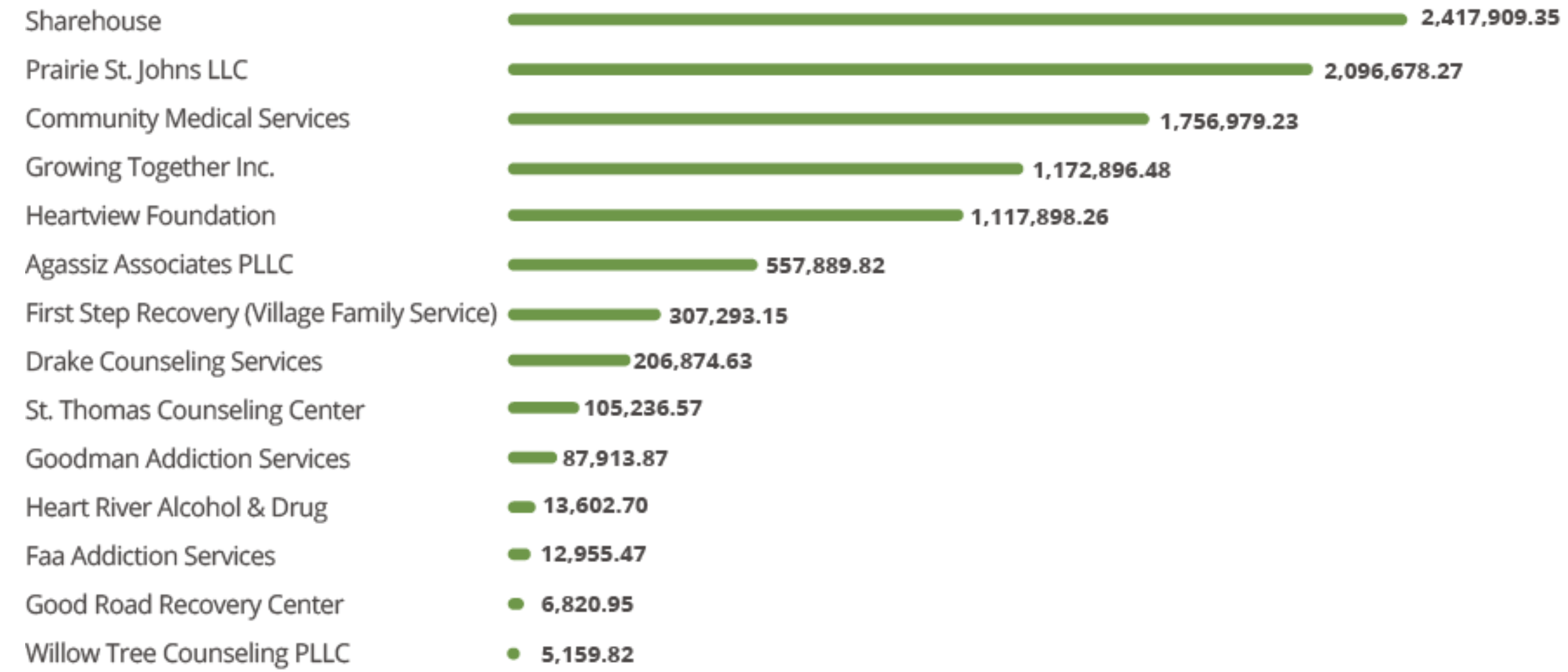
Applicants approved from February 2020 to August 2020





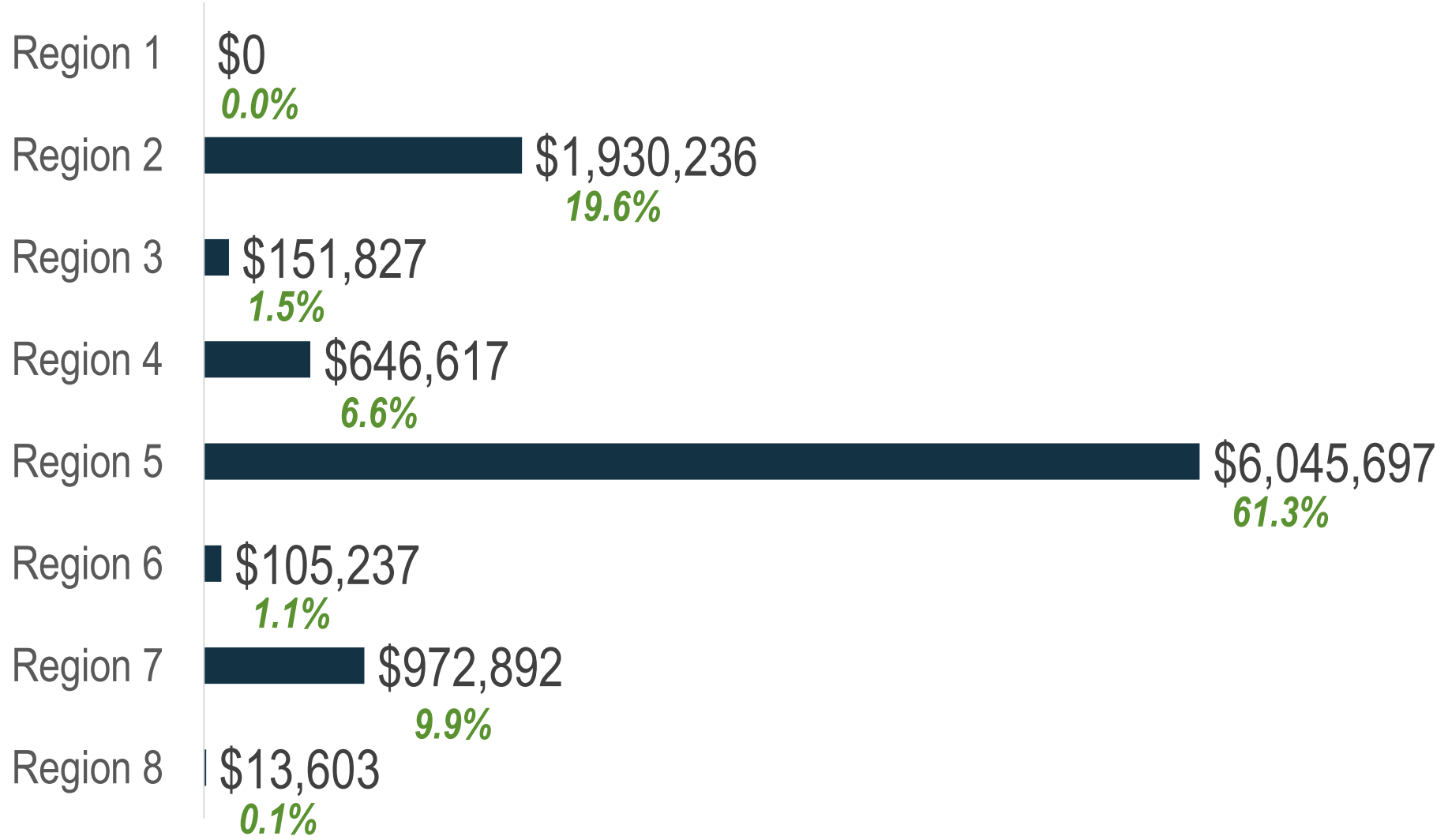
Total Voucher Reimbursements by Provider

The data below describes provider reimbursements from July 1, 2019 through December 11, 2020 ($9,866,108.57). Cumulative refunds received during this time totaled $219,292.81 for a net expenditure of $9,646,815.76.



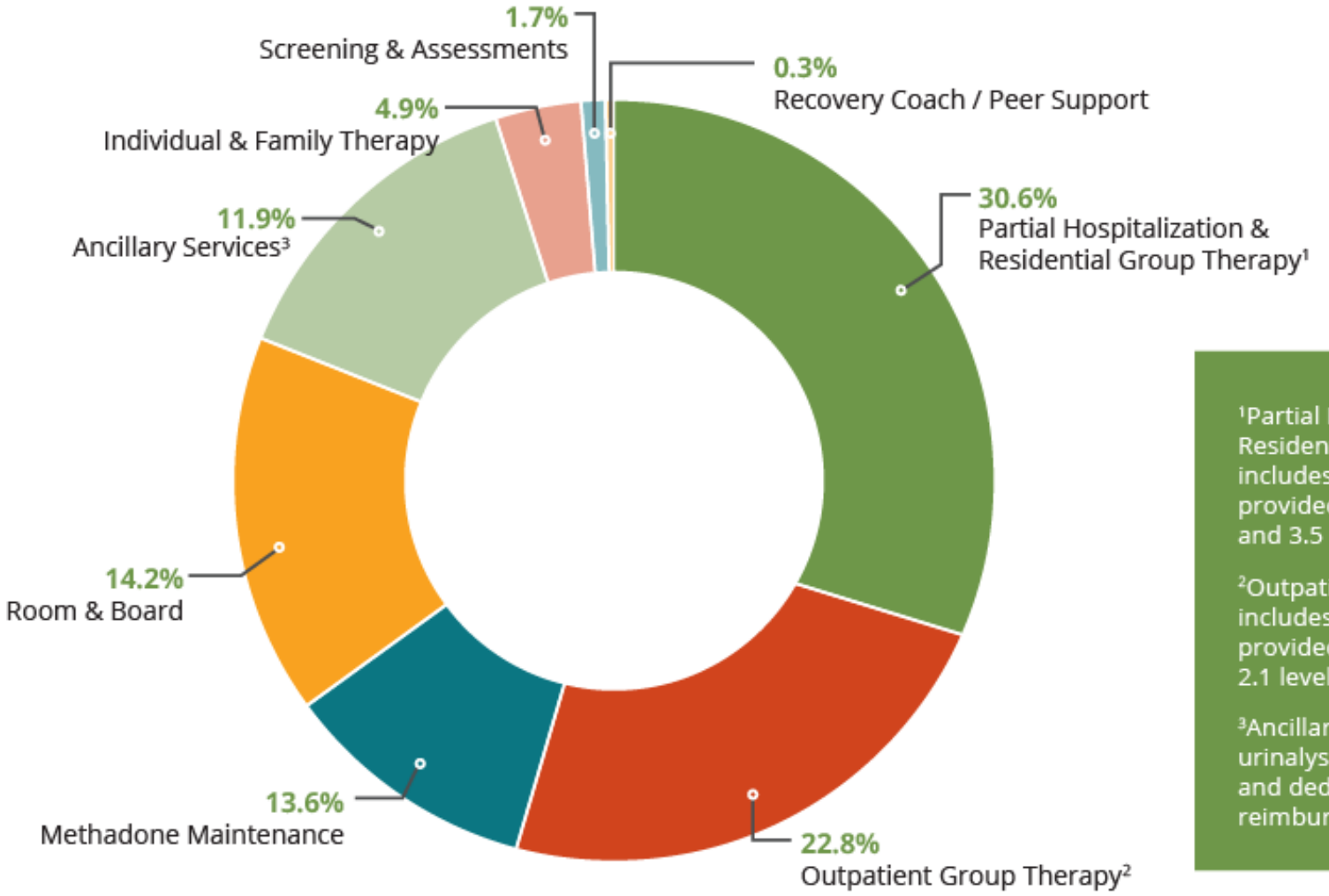
Regional Provider Reimbursements

July 1, 2019 – December 11, 2020



Expenditures by Service Type

Percentage of expenditures by service type from February 6, 2020 through December 11, 2020.



[1]Partial Hospitalization and Residential Group Therapy includes therapy services provided in the ASAM 2.5 and 3.5 levels of care

[2]Outpatient Group Therapy includes therapy services provided in the ASAM 1 and 2.1 levels of care

[3]Ancillary Services includes urinalysis, transportation, and deductible/copayment reimbursements

Since inception, all outcomes increased following services reimbursed through the SUD Voucher program.

PURPOSE

Identify the extent to which the individual participates in meaningful daily activities (employment, school, volunteering, family caretaking, other activities, etc.).

Average Outcome Scores Over Time



HEALTH

Identify how well the individual makes informed healthy choices supporting their physical health and emotional wellbeing (physical activity, attending medical appointments, taking medications as prescribed etc.)

Average Outcome Scores Over Time



COMMUNITY

Identify the extent to which the individual's relationships and social networks provide support, friendship, love, and hope for overall wellbeing.

Average Outcome Scores Over Time



HOME

Identify the stability and safety of the individual's living environment.

Average Outcome Scores Over Time



Pre Post

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House Bill 1012 #5010
House Appropriations
Representative Nelson, Chairman

1915i State Plan Amendment Overview

Pamela Sagness, Director

What is Behavioral Health?

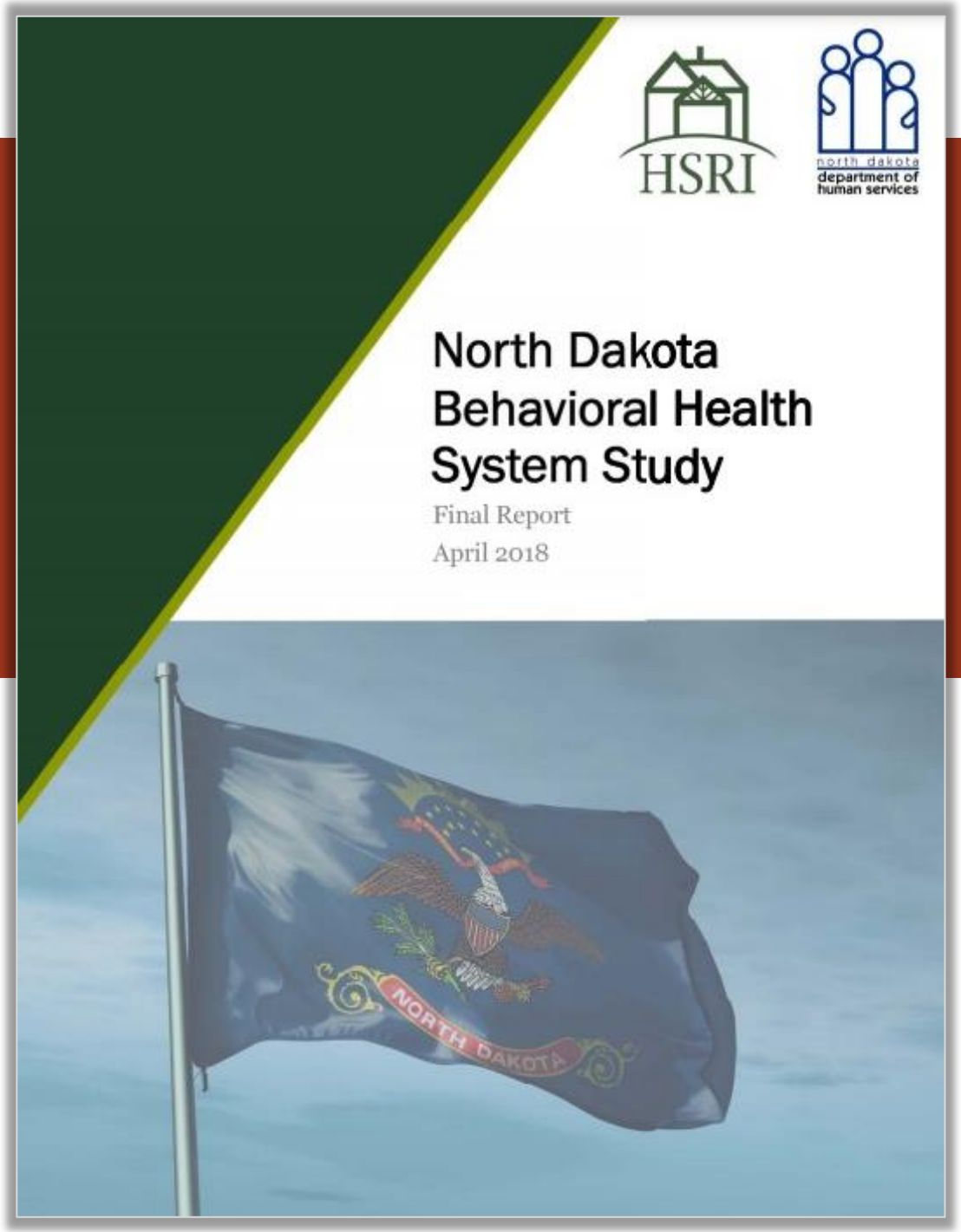
A state of mental/emotional being and/or choices and actions that affect **WELLNESS**.



ROADMAP

The Behavioral Health Systems Study, April 2018

The implementation of the Medicaid 1915(i) State Plan Amendment aligns with the 2018 North Dakota Behavioral Health System Study recommendation **12.2: Pursue 1915(i) Medicaid state plan amendments**.



Benefits of 1915(i)



Consumers

Services available closer to home and are specifically targeted to need



Behavioral Health Professionals

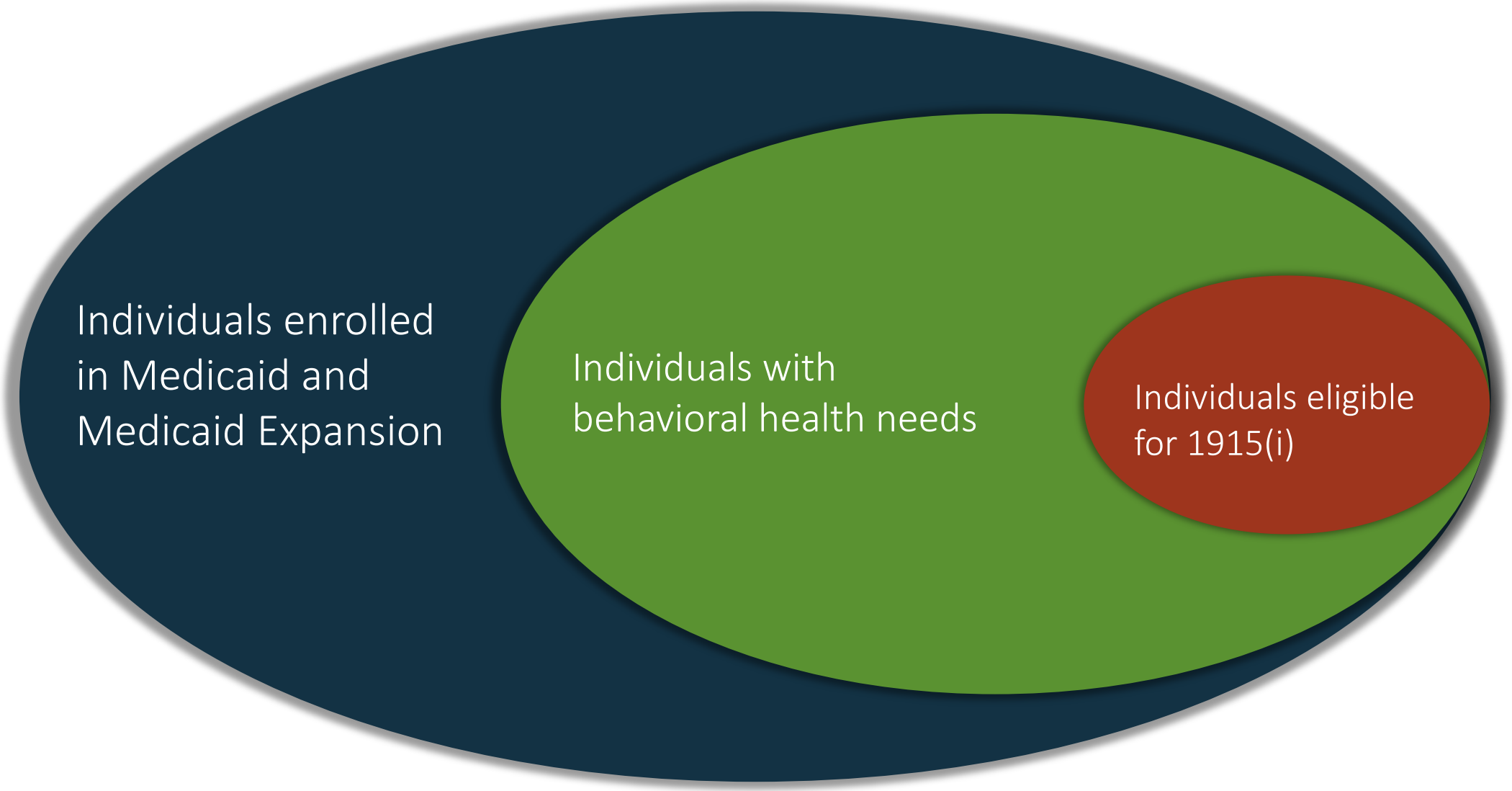
Opportunities to expand workforce through non-traditional behavioral health professionals and improve access in rural areas expands workforce



Private Providers

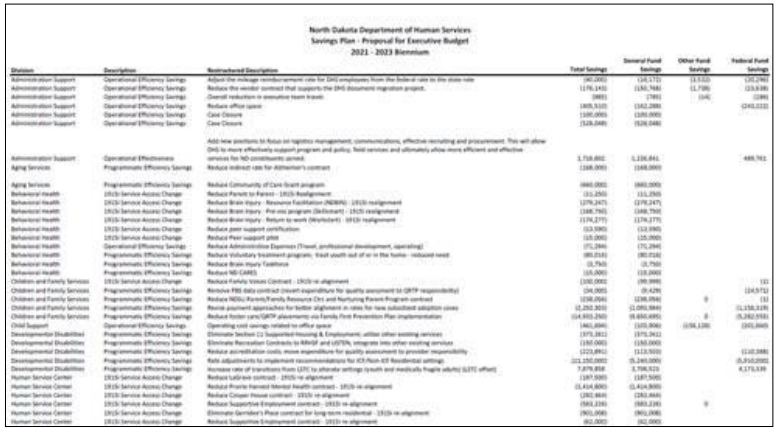
Opportunities to bill for new services, expanding services and increasing revenue

Population Served



Budget Considerations

- 1915(i) is in DHS Medical Services Budget
- See handout for DHS Savings Plan related to the 1915(i)



North Dakota Department of Human Services
Savings Plan - Proposal for Executive Budget
2021 - 2023 Biennium

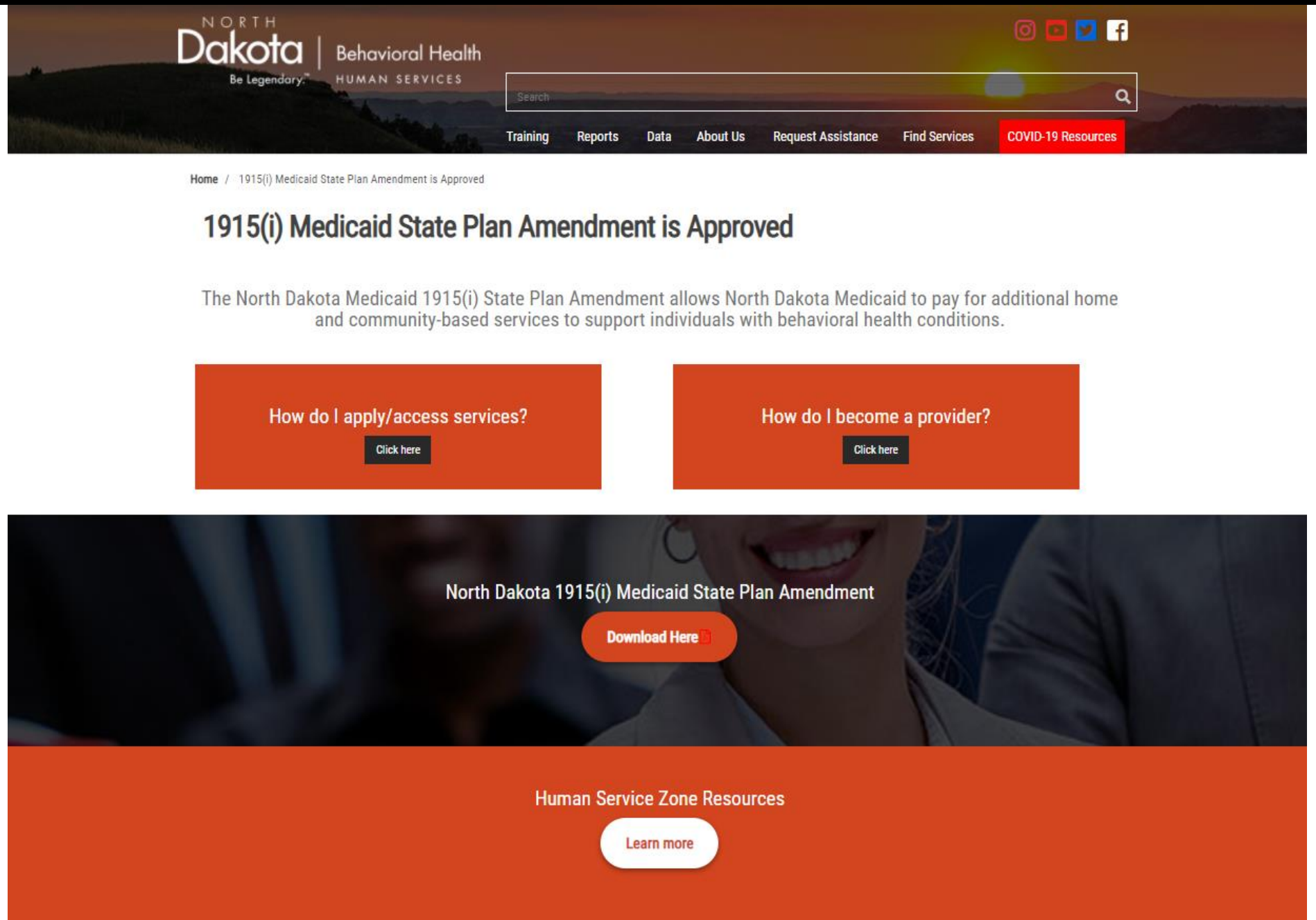
Division	Description	Restructured Description	Total Savings	General Fund Savings	Other Fund Savings	Federal Fund Savings
Administration Support	Operational Efficiency Savings	Adjust the mileage reimbursement rate for DHS employees from the federal rate to the state rate	(40,000)	(16,172)	(3,532)	(20,296)
Administration Support	Operational Efficiency Savings	Reduce the vendor contract that supports the DHS document migration project.	(179,141)	(150,768)	(1,739)	(23,634)
Administration Support	Operational Efficiency Savings	Overall reduction in executive team travel	(985)	(785)	(14)	(186)
Administration Support	Operational Efficiency Savings	Reduce office space	(305,510)	(162,288)		(143,222)
Administration Support	Operational Efficiency Savings	Case Closure	(100,000)	(100,000)		
Administration Support	Operational Efficiency Savings	Case Closure	(528,048)	(528,048)		
Administration Support	Operational Effectiveness	Add new positions to focus on logistics management, communications, effective recruiting and procurement. This will allow DHS to more effectively support program and policy, field services and ultimately allow more efficient and effective services for ND constituents served.	1,718,892	1,226,841		489,761
Aging Services	Programmatic Efficiency Savings	Reduce indirect rate for Alzheimer's contract	(168,000)	(168,000)		
Aging Services	Programmatic Efficiency Savings	Reduce Community of Care Grant program	(660,000)	(660,000)		
Behavioral Health	1915i Service Access Change	Reduce Parent to Parent - 1915i Realignment	(11,250)	(11,250)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Resource Facilitation (NDBIN) - 1915i realignment	(279,247)	(279,247)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Pre-voc program (Skillstart) - 1915i realignment	(168,750)	(168,750)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Return to work (Worksteb) - 1915i realignment	(174,277)	(174,277)		
Behavioral Health	1915i Service Access Change	Reduce peer support certification	(12,090)	(12,090)		
Behavioral Health	1915i Service Access Change	Reduce Peer support pilot	(15,000)	(15,000)		
Behavioral Health	Operational Efficiency Savings	Reduce Administrative Expenses (Travel, professional development, operating)	(71,294)	(71,294)		
Behavioral Health	Programmatic Efficiency Savings	Reduce Voluntary treatment program; treat youth out of or in the home - reduced need	(80,016)	(80,016)		
Behavioral Health	Programmatic Efficiency Savings	Reduce Brain Injury Taskforce	(2,750)	(2,750)		
Behavioral Health	Programmatic Efficiency Savings	Reduce ND CARES	(15,000)	(15,000)		
Children and Family Services	1915i Service Access Change	Reduce Family Voices Contract - 1915i re-alignment	(100,000)	(99,999)		(1)
Children and Family Services	Programmatic Efficiency Savings	Remove PBS data contract (novel expenditure for quality assurance) to QRTP responsibility	(14,000)	(8,429)		(14,571)
Children and Family Services	Programmatic Efficiency Savings	Reduce NDSU Parent/Family Resource Ctrs and Nurturing Parent Program contract	(238,056)	(238,056)	0	(1)
Children and Family Services	Programmatic Efficiency Savings	Revise payment approaches for better alignment in rates for new subsidized adoption cases	(2,292,303)	(1,091,984)		(1,158,319)
Children and Family Services	Programmatic Efficiency Savings	Reduce foster care/QRTP placements via Family First Prevention Plan implementation	(14,931,250)	(9,650,495)	0	(5,282,555)
Child Support	Operational Efficiency Savings	Operating cost savings related to office space	(461,694)	(370,906)	(158,128)	(101,660)
Developmental Disabilities	Programmatic Efficiency Savings	Eliminate Section 11 Supported Housing & Employment; utilize other existing services	(373,381)	(373,341)		
Developmental Disabilities	Programmatic Efficiency Savings	Eliminate Recreation Contracts to MHSF and USTN; integrate into other existing services	(150,000)	(150,000)		
Developmental Disabilities	Programmatic Efficiency Savings	Reduce accreditation costs; move expenditure for quality assessment to provider responsibility	(122,891)	(113,503)		(110,388)
Developmental Disabilities	Programmatic Efficiency Savings	Rate adjustments to implement recommendations for ICF/Non-ICF Residential settings	(11,150,000)	(5,240,000)		(5,910,000)
Developmental Disabilities	Programmatic Efficiency Savings	Increase rate of transitions from LTFC to alternate settings (youth and medically fragile adults) (LTFC offset)	7,879,858	3,708,321		4,171,539
Human Service Center	1915i Service Access Change	Reduce LaGrave contract - 1915i re-alignment	(187,500)	(187,500)		
Human Service Center	1915i Service Access Change	Reduce Prairie Harvest Mental Health contract - 1915i re-alignment	(1,414,800)	(1,414,800)		
Human Service Center	1915i Service Access Change	Reduce Cooper House contract - 1915i re-alignment	(261,864)	(261,864)		
Human Service Center	1915i Service Access Change	Reduce Supportive Employment contract - 1915i re-alignment	(563,235)	(385,236)	0	
Human Service Center	1915i Service Access Change	Eliminate Gerrider's Place contract for long-term residential - 1915i re-alignment	(901,008)	(901,008)		
Human Service Center	1915i Service Access Change	Reduce Supportive Employment contract - 1915i re-alignment	(62,000)	(62,000)		

- Opportunities for Private Providers to adopt a business model change

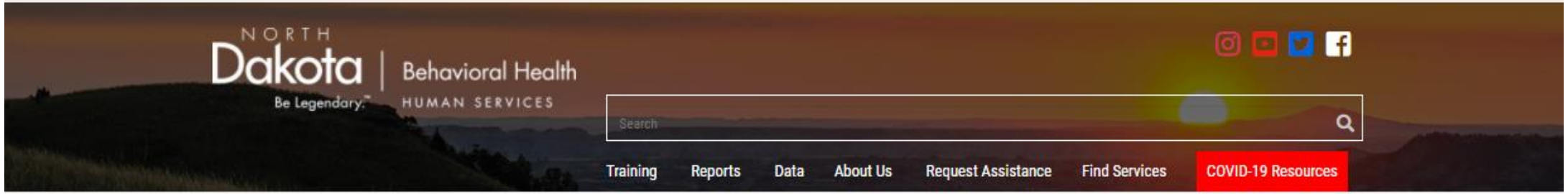
PROVIDER RESOURCES



www.behavioralhealth.nd.gov/1915(i)



www.behavioralhealth.nd.gov/1915(i)



Home / 1915(i) Medicaid State Plan Amendment is Approved / 1915(i) Providers

1915(i) Providers

How to become a 1915(i) Provider
Learn more

Provider Service Requirements
Learn more

Services & Fee Schedule
Learn More

Individual Eligibility
Learn more

Resources and Trainings
Learn more

How to Bill
Learn more

FAQs
Learn more

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By submitting this form, you are consenting to receive marketing emails from: Behavioral Health Division, 1237 W Divide Ave, Bismarck, ND, 58501, US, https://www.behavioralhealth.nd.gov/. You can revoke your consent to receive emails at any time by using the SafeUnsubscribe® link, found at the bottom of every email.
Emails are serviced by Constant Contact.

Sign Up!



Technical Assistance Calls for 1915(i) Providers

Medical Services and Behavioral Health Divisions are offering Technical Assistance for 1915(i) providers through a series of calls every Wednesday, beginning January 20, 2021, 1-2pm.
When

This training is offered online, every Wednesday from 1-2pm CT.

www.behavioralhealth.nd.gov/1915i/resources

www.behavioralhealth.nd.gov/1915i



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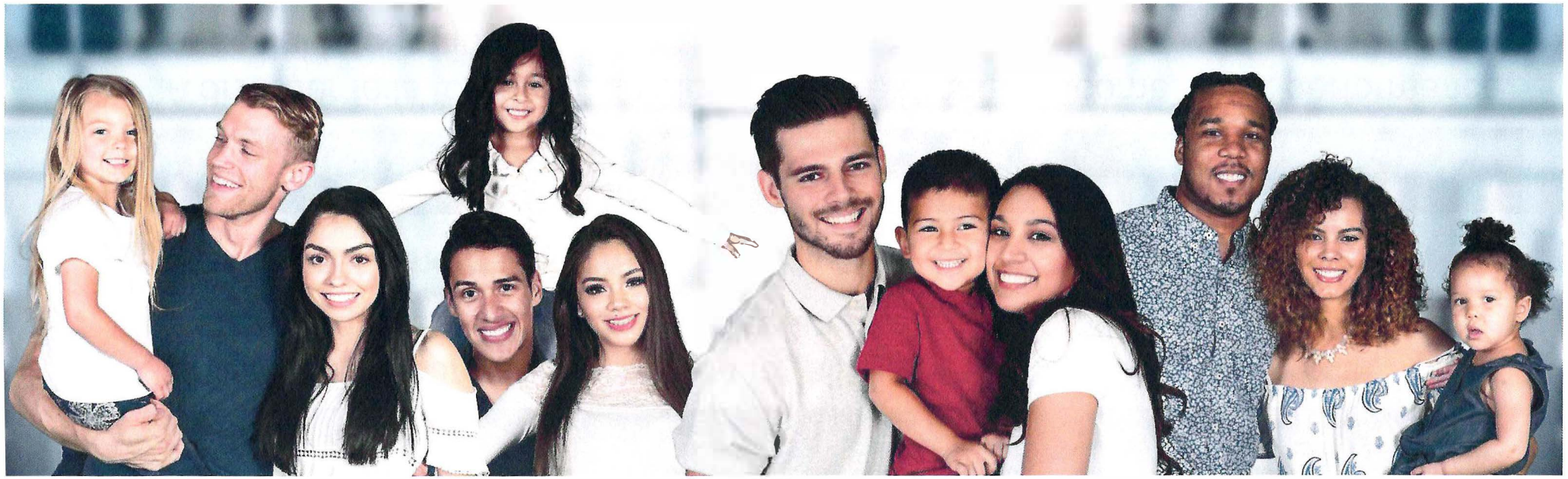
#5037



1915i Medicaid State Plan Discussion

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCALE (WHODAS)

Rosalie Etherington, Chief Clinics Director, State Hospital Superintendent

NORTH Dakota | Human Services

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WHODAS (WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCALE)

WHAT IT IS

Generic assessment for measuring health and disability across all of medicine and healthcare

WHY USE IT

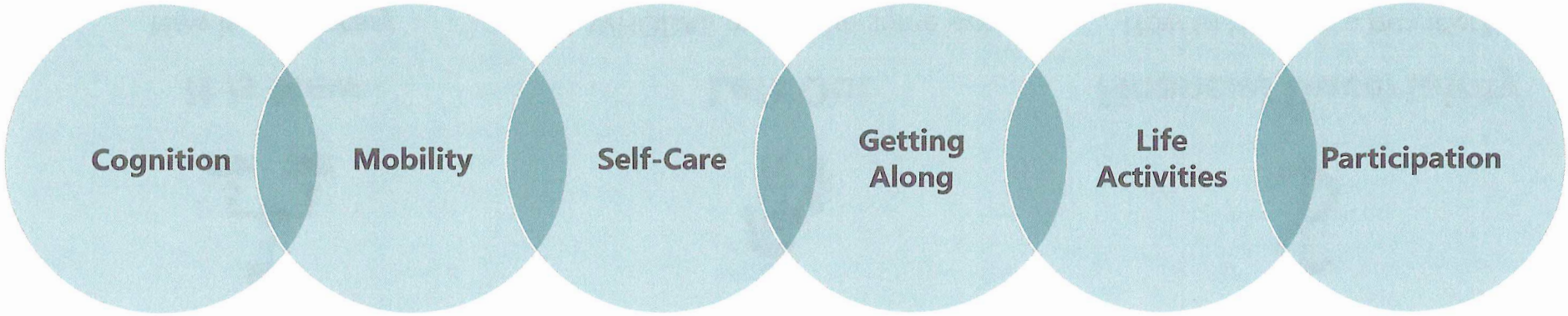
Excellent measurement precision for all medical and behavioral health disorders across age groups and cultures

Simple, fast, and freely available

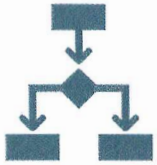
WHY DIAGNOSIS ISN'T ENOUGH

A disorder fails to predict service need, treatment outcome, work performance, or social integration

WHODAS – What it Measures?



Why Does it Seem So Hard?



It is New

New is often scary

New things takes practice

What if the WHODAS is wrong?



Left Out

WHODAS may leave some out

What if a person doesn't quality?



Financial Uncertainty

How to become a provider?

Will Medicaid pay?

Will it be enough?

STRATEGY

1

Train and Supervise

2

Measure and Monitor

3

Re-Train and Evaluate for Needed Change

#5038

North Dakota Department of Human Services
Savings Plan - Proposal for Executive Budget
2021 - 2023 Biennium

Division	Description	Restructured Description	Total Savings	General Fund Savings	Other Fund Savings	Federal Fund Savings
Administration Support	Operational Efficiency Savings	Adjust the mileage reimbursement rate for DHS employees from the federal rate to the state rate	(40,000)	(16,172)	(3,532)	(20,296)
Administration Support	Operational Efficiency Savings	Reduce the vendor contract that supports the DHS document migration project.	(176,143)	(150,768)	(1,738)	(23,638)
Administration Support	Operational Efficiency Savings	Overall reduction in executive team travel.	(985)	(785)	(14)	(186)
Administration Support	Operational Efficiency Savings	Reduce office space	(405,510)	(162,288)		(243,222)
Administration Support	Operational Efficiency Savings	Case Closure	(100,000)	(100,000)		
Administration Support	Operational Efficiency Savings	Case Closure	(528,048)	(528,048)		
Administration Support	Operational Effectiveness	Add new positions to focus on logistics management, communications, effective recruiting and procurement. This will allow DHS to more effectively support program and policy, field services and ultimately allow more efficient and effective services for ND constituents served.	1,716,602	1,226,841		489,761
Aging Services	Programmatic Efficiency Savings	Reduce indirect rate for Alzheimer's contract	(168,000)	(168,000)		
Aging Services	Programmatic Efficiency Savings	Reduce Community of Care Grant program	(660,000)	(660,000)		
Behavioral Health	1915i Service Access Change	Reduce Parent to Parent - 1915i Realignment	(11,250)	(11,250)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Resource Facilitation (NDBIN) - 1915i realignment	(279,247)	(279,247)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Pre-voc program (Skillsmart) - 1915i realignment	(168,750)	(168,750)		
Behavioral Health	1915i Service Access Change	Reduce Brain Injury - Return to work (Workstart) - 1915i realignment	(174,277)	(174,277)		
Behavioral Health	1915i Service Access Change	Reduce peer support certification	(13,590)	(13,590)		
Behavioral Health	1915i Service Access Change	Reduce Peer support pilot	(15,000)	(15,000)		
Behavioral Health	Operational Efficiency Savings	Reduce Administrstive Expenses (Travel, professional development, operating)	(71,294)	(71,294)		
Behavioral Health	Programmatic Efficiency Savings	Reduce Voluntary treatment program; treat youth out of or in the home - reduced need	(80,016)	(80,016)		
Behavioral Health	Programmatic Efficiency Savings	Reduce Brain Injury Taskforce	(3,750)	(3,750)		
Behavioral Health	Programmatic Efficiency Savings	Reduce ND CARES	(15,000)	(15,000)		
Children and Family Services	1915i Service Access Change	Reduce Family Voices Contract - 1915i re-alignment	(100,000)	(99,999)		(1)
Children and Family Services	Programmatic Efficiency Savings	Remove PBS data contract (revert expenditure for quality asessment to QRTP responsibility)	(34,000)	(9,429)		(24,571)
Children and Family Services	Programmatic Efficiency Savings	Reduce NDSU Parent/Family Resource Ctrs and Nurturing Parent Program contract	(238,056)	(238,056)	0	(1)
Children and Family Services	Programmatic Efficiency Savings	Revise payment approaches for better alighment in rates for new subsidized adoption cases	(2,250,303)	(1,093,984)		(1,156,319)
Children and Family Services	Programmatic Efficiency Savings	Reduce foster care/QRTP placements via Family First Prevention Plan implementation	(14,933,250)	(9,650,695)	0	(5,282,555)
Child Support	Operational Efficiency Savings	Operating cost savings related to office space	(461,694)	(103,906)	(156,128)	(201,660)
Developmental Disabilities	Programmatic Efficiency Savings	Eliminate Section 11 Supported Housing & Employment; utilize other existing services	(373,261)	(373,261)		
Developmental Disabilities	Programmatic Efficiency Savings	Eliminate Recreation Contracts to RRHSF and LiSTEN; integrate into other existing services	(150,000)	(150,000)		
Developmental Disabilities	Programmatic Efficiency Savings	Reduce accreditation costs; move expenditure for quality assessment to provider responsibility	(223,891)	(113,503)		(110,388)
Developmental Disabilities	Programmatic Efficiency Savings	Rate adjustments to implement recommendations for ICF/Non-ICF Residential settings	(11,150,000)	(5,240,000)		(5,910,000)
Developmental Disabilities	Programmatic Efficiency Savings	Increase rate of transitions from LSTC to alterate settings (youth and medically fragile adults) (LSTC offset)	7,879,858	3,706,523		4,173,335
Human Service Center	1915i Service Access Change	Reduce LaGrave contract - 1915i re-alignment	(187,500)	(187,500)		
Human Service Center	1915i Service Access Change	Reduce Prairie Harvest Mental Health contract - 1915i re-alignment	(1,414,800)	(1,414,800)		
Human Service Center	1915i Service Access Change	Reduce Cooper House contract - 1915i re-alignment	(283,464)	(283,464)		
Human Service Center	1915i Service Access Change	Reduce Supportive Employment contract - 1915i re-alignment	(583,226)	(583,226)	0	
Human Service Center	1915i Service Access Change	Eliminate Gerridee's Place contract for long-term residential - 1915i re-alignment	(901,008)	(901,008)		
Human Service Center	1915i Service Access Change	Reduce Supportive Employment contract - 1915i re-alignment	(62,000)	(62,000)		
Human Service Center	Operational Efficiency Savings	Reduce office space	(8,000)	(8,000)		(1)
Human Service Center	Operational Efficiency Savings	Reduce office space	(20,000)	(20,000)		

North Dakota Department of Human Services
Savings Plan - Proposal for Executive Budget
2021 - 2023 Biennium

Division	Description	Restructured Description	Total Savings	General Fund Savings	Other Fund Savings	Federal Fund Savings
Human Service Center	Operational Efficiency Savings	Operational Savings	(168,417)	(168,417)		
Human Service Center	Operational Efficiency Savings	Reduced office space	(280,000)	(280,000)		
Human Service Center	Program Ended	Reduce Dakota Pioneer contract - 1915i re-alignment	(170,000)	(170,000)		
Human Service Center	Programmatic Efficiency Savings	Alignment of rates paid to private hospitals	(1,293,348)	(1,293,348)		
Human Service Center	Programmatic Efficiency Savings	Replace Adult Case Aid contract with HSC staff and align with team-based care	(125,605)	(125,605)		
Human Service Center	Programmatic Efficiency Savings	Replace Adult Case Aid contract with HSC staff and align with team-based care	(150,000)	(150,000)	-	1
Human Service Center	Programmatic Efficiency Savings	Replace Adult Case Aid contract with HSC staff and align with team-based care	(367,625)	(367,625)		
Human Service Center	Programmatic Efficiency Savings	Reduce Adult Mental Health Tech contracts - 1915i re-alignment	(400,000)	(400,000)		
Information Technology	Operational Efficiency Savings	Reduce office space	(498,522)	(261,930)		(236,592)
Information Technology	Operational Efficiency Savings	Updated assumption about costs associated with mainframe processing through current biennium				
Information Technology	Operational Efficiency Savings	Updated assumption about costs associated with contracted support provided to DHS through NDIT	(7,017,198)	(4,161,227)	(1,349)	(2,854,623)
Information Technology	Operational Efficiency Savings	Updated assumption about costs associated with maintenance and operating costs of the SPACES platform				
Life Skills Transition Center	Programmatic Efficiency Savings	Youth - speed transitions and diversions for youth to alternate settings (DD offset)	(11,000,000)	(5,114,999)	(1)	(5,885,000)
Life Skills Transition Center	Programmatic Efficiency Savings	Adults - speed transitions for medically complex adults (DD offset)				
Life Skills Transition Center	Programmatic Efficiency Savings	Reduce expenditure for Assistive Device Customization Program	(306,701)	(142,615)		(164,086)
Life Skills Transition Center	Programmatic Efficiency Savings	Operational Savings	(178,788)	(178,788)		-
Life Skills Transition Center	Programmatic Efficiency Savings	FTE reduction due to census changes and operating efficiencies	(1,362,547)	(697,998)	-	(664,549)
Medical Services	Programmatic Efficiency Savings	Eliminate remedial eye program	(5,000)	(5,000)		
Medical Services	Programmatic Efficiency Savings	Technical adjustment; PRTF was over budgeted last biennium	(1,396,399)	(650,565)		(745,834)
Medical Services	Programmatic Efficiency Savings	Reduction in PACE rates and lower-than-expected enrollment	(1,914,733)	(891,831)		(1,022,902)
Medical Services	Programmatic Efficiency Savings	This is not a reduction- disregard	(992,368)			(992,368)
Medical Services	Programmatic Efficiency Savings	Assumes that hosptials will agree to some type of VBP arrangement. Reduces funds based on current state of hosptial rates	(6,250,000)	(1,562,500)		(4,687,500)
Medical Services	Programmatic Efficiency Savings	Transition Medicaid expansion from managed care to fee-for-service arrangement	(146,617,828)	(16,841,705)		(129,776,123)
Medical Services	Programmatic Efficiency Savings	Transition Medicaid expansion from managed care to fee-for-service arrangement	1,790,904	700,846		1,090,058
Medical Services	Programmatic Efficiency Savings	Reduction due to decreased occupancy, including shift of funds from Basic Care to HCBS base budget	(5,015,638)	(5,015,638)		
Medical Services	Programmatic Efficiency Savings	Waiver not utilized; able to address with existing waivers; eliminating duplicative admin burden	(596,112)	(277,552)		(318,560)
Medical Services	Programmatic Efficiency Savings	Eliminate and shift dollars into existing waiver and state plan services for ASD to draw down a match	425,617	(528,706)		954,323
Medical Services	Programmatic Efficiency Savings	Funds have not been utilized in some time	(92,883)	(62,134)		(30,749)
Medical Services	Programmatic Efficiency Savings	Alignment of all providers under the same rate for Targeted Case Management	(2,363,809)	(1,099,171)		(1,264,638)
Medical Services	Programmatic Efficiency Savings	Eliminate the $2 PMPM but maintain the requirement that clients have a PCP	(1,652,240)	(769,869)		(882,371)
North Dakota State Hospital	Programmatic Efficiency Savings	Eliminate one hospital unit after western hospital beds added/ Add one psychiatrist to maintain hospital caseloads.	(2,216,080)	(1,870,218)	(304,426)	(41,437)
North Dakota State Hospital	Programmatic Efficiency Savings	Eliminate DOCR TASC contract, close treatment unit and reduce FTE				
Vocational Rehabilitation	Programmatic Efficiency Savings	Remove grant to Bottineau Ski Park	(200,000)	(109,000)		(91,000)
Vocational Rehabilitation	Programmatic Efficiency Savings	Disregard; this is not savings as it is required state match for federal funds	(1,694,954)	(1,694,954)		
			(218,799,124)	(62,408,249)	(467,184)	(155,923,692)

**NOTE: Dollar amounts in column E reflect original proposal by DHS to OMB; some items may have been subsequently adjusted by OMB in final preparation of the Executive Budget.*

#5041

1915(i) Home and Community-Based Behavioral Health Services

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The 1915(i) Medicaid State Plan Amendment allows North Dakota Medicaid to pay for additional home and community-based services to support children and adults with behavioral health conditions which substantially interfere with their ability to function in the family, school, or community. This document provides responses to questions that have been raised about the program.

Medicaid-Related Questions and Responses

Question/Concern	Response
Why can't the same service provider deliver 1915(i) care coordination as well as other 1915(i) services?	Section 1915(i) of the Social Security Act requires the state to establish standards for conducting independent assessments to safeguard against conflicts of interest. The independent assessment is conducted as part of the care planning process. The assessment is intended to be separate from service provision to maintain the integrity of the process. In counties where the participant lives that are designated as mental health professional shortage areas, the same service provider may deliver multiple 1915(i) services. However, in counties without this designation (Burleigh, Cass, Grand Forks and Morton), the participant must choose a different provider for care coordination than for other 1915(i) services. The Department of Human Services requested that the same provider be able to deliver all 1915(i) services, regardless of the county, but the Centers for Medicare and Medicaid Services (CMS) did not approve the request.
Which Medicaid category of eligibility groups can qualify for 1915(i) services?	All category of eligibility groups may qualify to receive 1915(i) services, including those who qualify for Medicaid through a 1915(c) waiver.
What resources are available to assist new Medicaid providers with enrollment and billing processes?	North Dakota Medicaid has training and resources specific to 1915(i) providers on its website at http://behavioralhealth.nd.gov/1915i. Once providers are enrolled, claim submission templates can be set up in the Medicaid Management Information System (MMIS) web portal, which makes it easier for providers to submit claims for services they have delivered.
Why can't the 1915(i) program be geared towards preventing	The 1915(i) program is designed to serve individuals with intense behavioral health needs in their homes and communities to prevent them from needing institutional services including hospitals and psychiatric residential treatment facilities. Children who do not qualify for 1915(i) services can receive prevention, screening, diagnosis and treatment services through the Early

children from needing intensive services later?	Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is covered for all children through North Dakota Medicaid.
How can we track outcomes and value?	The 1915(i) program requires the State to perform quality assurance and quality control activities. It does not, however, require a formal evaluation of outcomes to determine if goals are reached to decrease inpatient or emergency department services and shift more toward home and community-based services. If the Legislature desires, funds of approximately $150,000 could be included in the program budget to request that our actuary review and analyze service utilization. Since the 1915(i) program will most likely take some time to be fully utilized by our members, a formal program evaluation could be delayed until the next biennium. Finally, North Dakota Medicaid plans to report on all the CMS adult core behavioral health measures in the upcoming biennium. These measures could be used as a proxy to track outcomes and value for the 1915i program.

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#5040

ND Medicaid 1915i Services Fee Schedule
as of 10/1/2020

Inclusion or exclusion of a procedure code, supply, product, or service does not imply Medicaid coverage, reimbursement, or lack thereof.

Code	Modifier	Description	Medicaid Fee	Rate Methodology
H2015		Care Coordination (per 15 minutes)	$20.40	Rate is equal to the SMI/SED Targeted Case Management rate
H0039	UK	Training and Supports for Unpaid Caregivers (per 15 minutes) [1]	$7.38	Rate is equal to the Skills Integration rate, a service provided under Rehabilitative Services
T2025		Training and Supports for Unpaid Caregivers (per service)	$500.00	
H0038		Peer Support (per 15 minutes)	$7.38	Rate is equal to the Skills Integration rate, a service provided under Rehabilitative Services
H0038	UK	Family Peer Support (per 15 minutes)	$7.38	Rate is equal to the Skills Integration rate, a service provided under Rehabilitative Services
T2027		Respite (per 15 minutes)	$7.31	Rate is equal to the Agency Respite Care rate in the HCBS waiver
T2003		Non-medical transportation; encounter/trip	$13.09	Rate is equal to the round trip rate in the HCBS waiver
T5999		Community Transition Services (per service)	$3,000.00	Rate is equal to the one-time transition amount per individual in the HCBS and DD waivers
H2021	U3	Benefits Planning (per 15 minutes)	$10.49	Rate is equal to the Supported Employment rate in the DD waiver
H2025	U3	Supported Education (per 15 minutes)	$10.49	Rate is equal to the Day Habilitation rate in the DD waiver
H2023		Prevocational Training (per 15 minutes) [1]	$10.49	Rate is equal to the Prevocational Services rate in the DD waiver
H2025	U4	Supported Employment (per 15 minutes)	$10.49	Rate is equal to the Day Habilitation rate in the DD waiver
H2021	U4	Housing Support Services (per 15 minutes)	$10.49	Rate is equal to the Benefits Planning rate

[1] This service can be billed for individual or group setting. If group setting is provided, modifier UA must be appended to the line and reimbursement will be 25% of the allowed amount.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/3/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 8:31 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Developmental Disabilities
- Reimbursement Project
- Timeline of the Project
- Medical Services
- ND Child Core Set
- Behavioral Health

Tina Bay, Dir. (8:32 am) testified about Disability Determination service

#5211

Caprice Knapp, Medicaid Dir (9:40 am) testified about Medical Services

#5218

Amber Hughes, Quality Manager (10:07 am) testified about Medical

Services #5220 #5221

Pam Segness, Dir(10:35 am) testified about Behavioral Health #5218

Chair Nelson closed the meeting at 11:11 a.m.



HOUSE APPROPRIATIONS, HUMAN RESOURCE DIVISION #5211

REPRESENTATIVE NELSON, CHAIRMAN

Tina Bay, Director Developmental Disabilities Division

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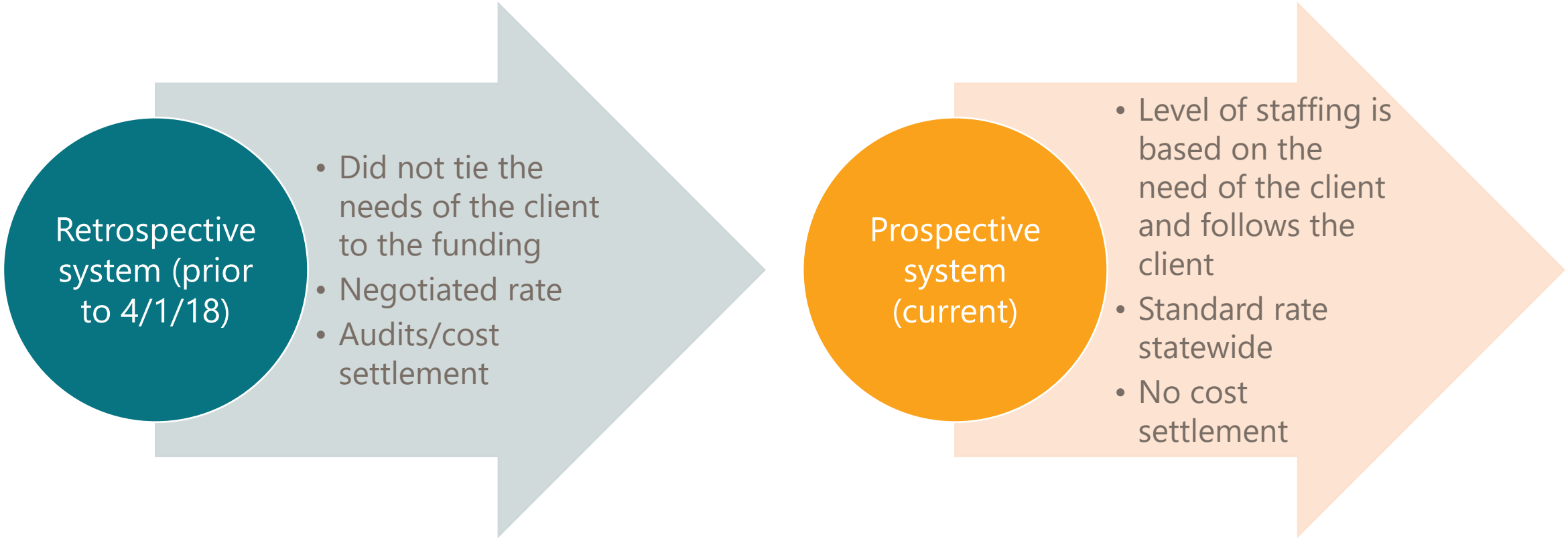
DEVELOPMENTAL DISABILITIES REIMBURSEMENT PROJECT – WHY CHANGE?



Timeline of Project

2009 - legislative session: HB 1517 directed the Department to contract to study the methodology and calculations for the rate setting structure.

- 2009/2010: Burns & Associates studied retrospective system and issued recommendations.

2011 - legislative session: SB 2043 directed the Department to work with DD providers to develop a prospective or related payment system with an independent rate model utilizing the Support Intensity Scale (SIS). Funding appropriated was enough to complete ½ of the work.

- 2011/2012: Steering committee created, consultants began development of component driven compensation structure and assessing clients.

2013 – legislative session: appropriations to complete the remaining work was provided.

- 2013/2014: Rates finalized, assessments continued, crosswalk developed, and universal budget impact completed.

2015/2017: NDACP requested delay of planned 7/1/15 implementation.

- Steering committee developed multiplier method to replace crosswalk, outliers process finalized, administrative rules, waiver and state plan amendments submitted.

2018: Implementation 4/1/18

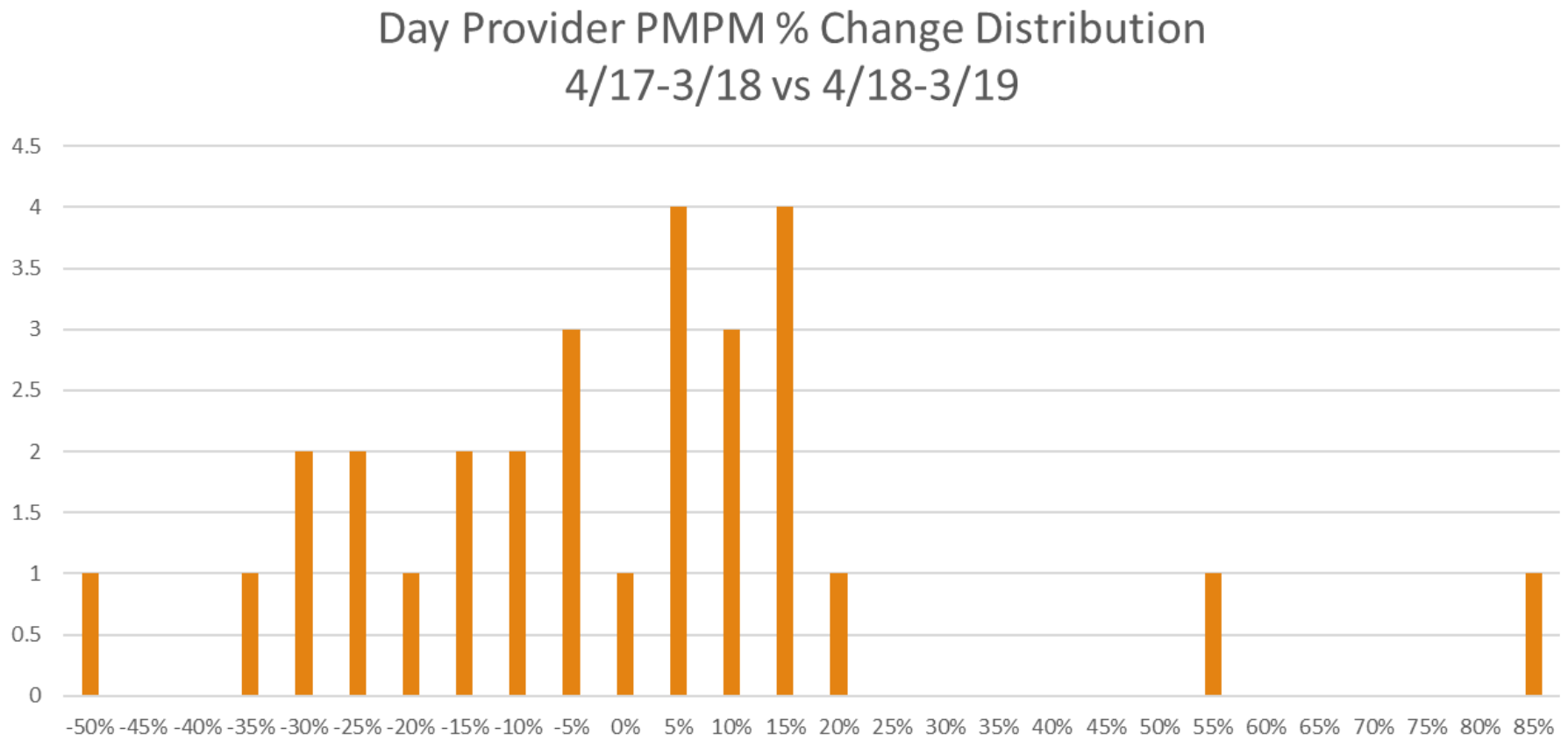
2019: DHS contracted with Optumas to conduct a year end review

DEVELOPMENTAL DISABILITIES REIMBURSEMENT PROJECT

Scope of year-end review

- Review of current rate structure and methodology
  - Review appropriateness of assumptions
  - Use real data experience
  - Identify possible opportunities for fine-tuning methodology
  - Solicit stakeholder feedback
  - Provide recommendations to the Department
- Address CMS feedback on vacancy and absence factors
- Develop Medically Fragile Residential Habilitation rates

Provider PMPM % Change Distribution - Day



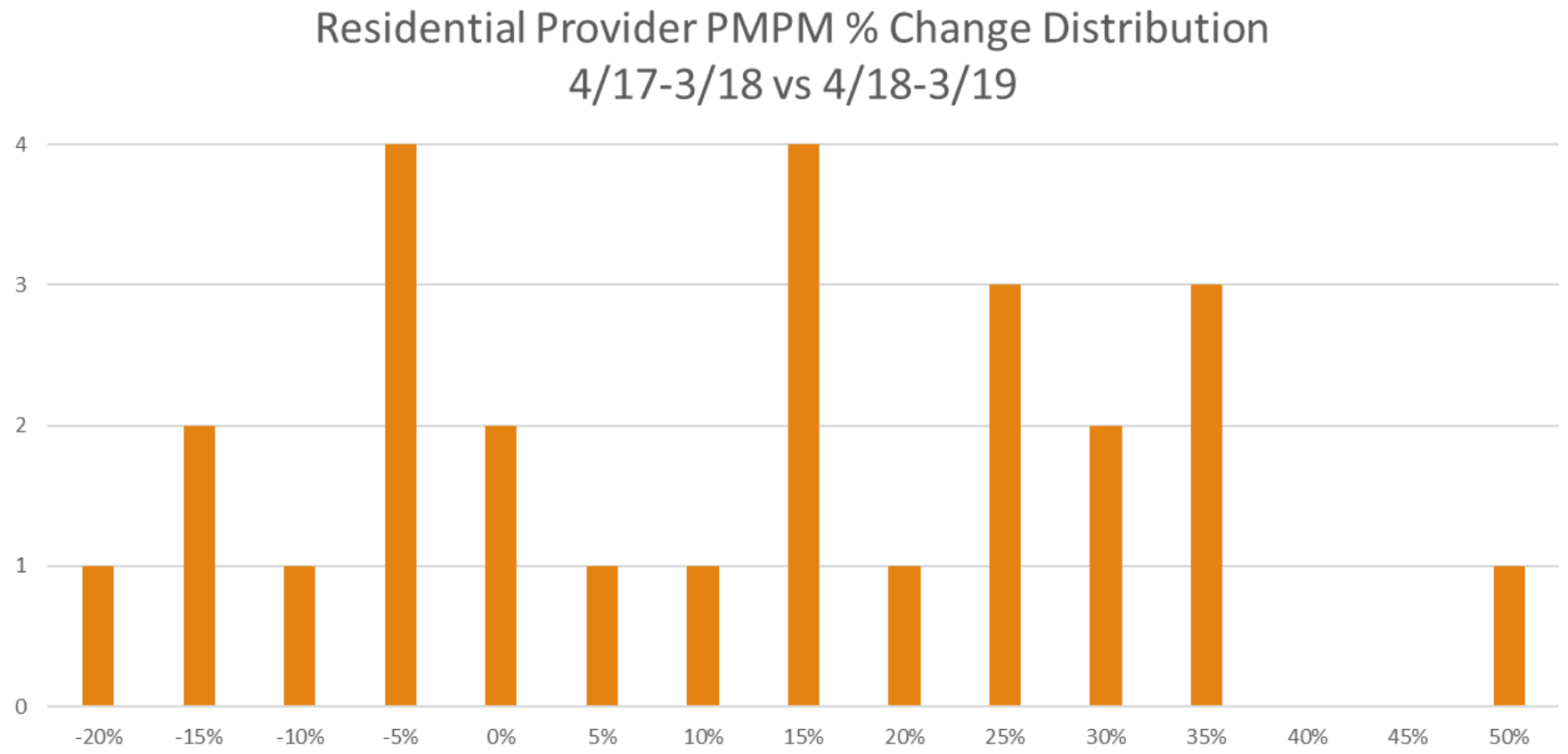
- Rounded to nearest 5%
- Includes only providers with 12 months prior *and* post rate change utilization
- All Providers Combined: -7.7%

Appendices – Day Services

- Includes only providers with utilizing members and costs under both systems
- Provider identification does not carry over by each service

	PMPM		
Provider	**Old**	**New**	**Impact**
Provider 1	$5,509	$2,696	-51.1%
Provider 2	$3,944	$2,542	-35.6%
Provider 3	$4,395	$3,060	-30.4%
Provider 4	$2,186	$1,572	-28.1%
Provider 5	$4,483	$3,346	-25.4%
Provider 6	$2,791	$2,093	-25.0%
Provider 7	$2,220	$1,794	-19.2%
Provider 8	$3,255	$2,758	-15.3%
Provider 9	$3,457	$2,959	-14.4%
Provider 10	$2,812	$2,537	-9.8%
Provider 11	$605	$548	-9.5%
Provider 12	$3,011	$2,791	-7.3%
Provider 13	$2,513	$2,425	-3.5%
Provider 14	$2,884	$2,792	-3.2%
Provider 15	$4,852	$4,808	-0.9%
Provider 16	$3,169	$3,262	2.9%
Provider 17	$2,094	$2,182	4.2%
Provider 18	$2,991	$3,119	4.3%
Provider 19	$1,472	$1,569	6.6%
Provider 20	$2,253	$2,442	8.4%
Provider 21	$2,869	$3,115	8.6%
Provider 22	$2,628	$2,931	11.5%
Provider 23	$1,727	$1,960	13.4%
Provider 24	$2,470	$2,838	14.9%
Provider 25	$2,677	$3,088	15.3%
Provider 26	$2,288	$2,652	15.9%
Provider 27	$2,613	$3,098	18.6%
Provider 28	$1,713	$2,619	52.9%
Provider 29	$2,391	$4,366	82.6%
All Providers Combined	**$2,861**	**$2,640**	**-7.7%**

Provider PMPM % Change Distribution - Res



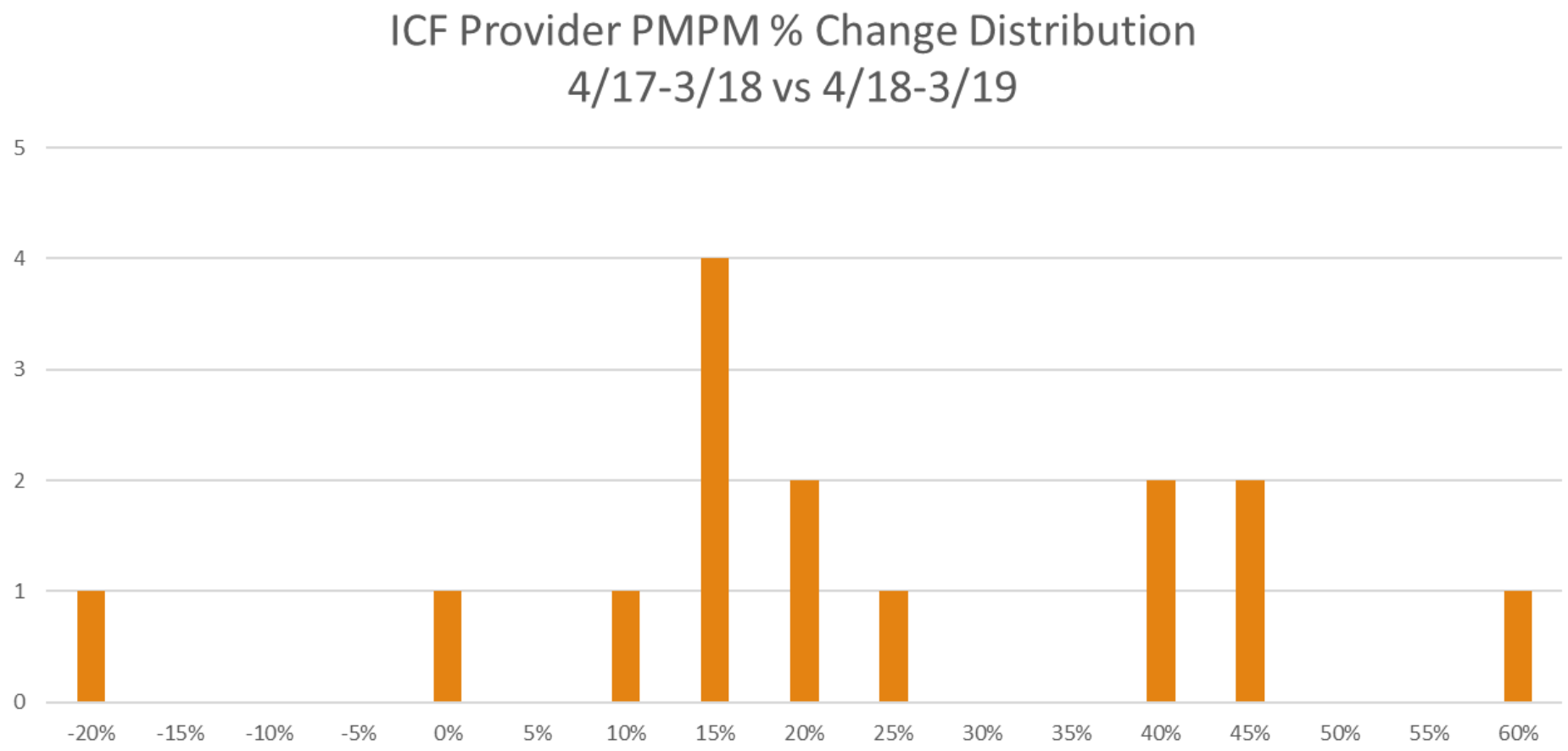
- Rounded to nearest 5%
- Includes only providers with 12 months prior *and* post rate change utilization
- All Providers Combined: +7.5%

Appendices – Residential Services

- Includes only providers with utilizing members and costs under both systems
- Provider identification does not carry over by each service

	PMPM		
Provider	**Old**	**New**	**Impact**
Provider 1	$8,909	$7,047	-20.9%
Provider 2	$7,587	$6,262	-17.5%
Provider 3	$5,483	$4,739	-13.6%
Provider 4	$9,359	$8,505	-9.1%
Provider 5	$4,877	$4,520	-7.3%
Provider 6	$9,301	$8,757	-5.8%
Provider 7	$7,050	$6,655	-5.6%
Provider 8	$7,914	$7,559	-4.5%
Provider 9	$7,772	$7,479	-3.8%
Provider 10	$12,861	$12,600	-2.0%
Provider 11	$7,610	$7,629	0.2%
Provider 12	$6,522	$6,841	4.9%
Provider 13	$7,163	$7,804	9.0%
Provider 14	$6,787	$7,669	13.0%
Provider 15	$6,035	$6,835	13.3%
Provider 16	$5,329	$6,084	14.2%
Provider 17	$5,049	$5,779	14.5%
Provider 18	$4,885	$5,941	21.6%
Provider 19	$7,984	$9,785	22.6%
Provider 20	$5,385	$6,610	22.8%
Provider 21	$4,707	$5,803	23.3%
Provider 22	$6,101	$7,883	29.2%
Provider 23	$1,304	$1,704	30.7%
Provider 24	$3,264	$4,354	33.4%
Provider 25	$3,962	$5,320	34.3%
Provider 26	$5,697	$7,792	36.8%
Provider 27	$5,016	$7,636	52.2%
All Providers Combined	**$6,169**	**$6,629**	**7.5%**

Provider PMPM % Change Distribution - ICF



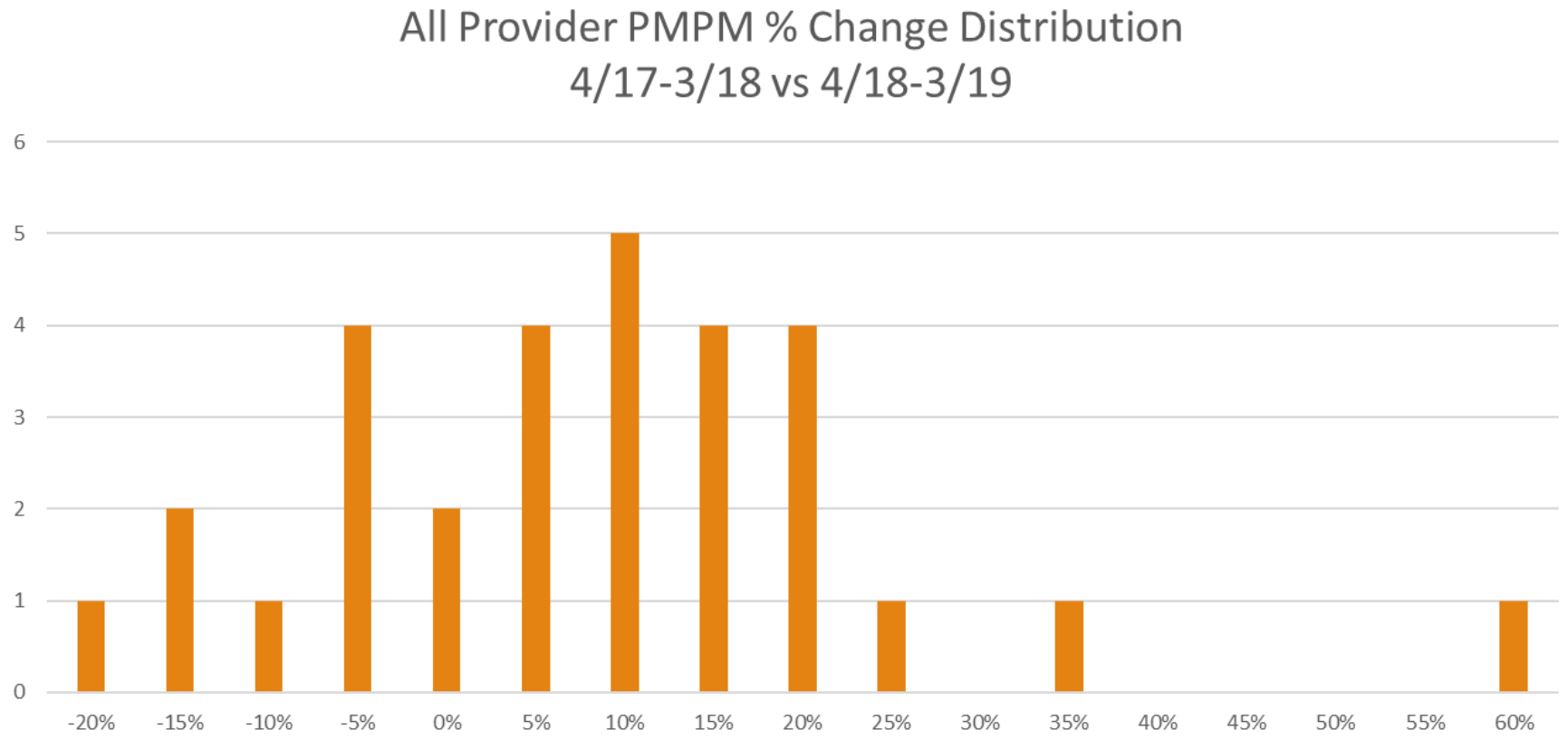
- Rounded to nearest 5%
- Includes only providers with 12 months prior *and* post rate change utilization
- All providers combined: +12.5%

Appendices – ICF

	PMPM		
Provider	**Old**	**New**	**Impact**
Provider 1	$27,157	$21,270	-21.7%
Provider 2	$17,091	$17,258	1.0%
Provider 3	$14,193	$15,363	8.2%
Provider 4	$12,561	$14,441	15.0%
Provider 5	$17,430	$20,078	15.2%
Provider 6	$16,781	$19,376	15.5%
Provider 7	$14,387	$16,867	17.2%
Provider 8	$11,149	$13,141	17.9%
Provider 9	$15,289	$18,370	20.2%
Provider 10	$14,815	$18,454	24.6%
Provider 11	$14,945	$21,151	41.5%
Provider 12	$12,092	$17,220	42.4%
Provider 13	$12,928	$18,513	43.2%
Provider 14	$10,373	$14,875	43.4%
Provider 15	$9,164	$14,473	57.9%
All Providers Combined	**$15,657**	**$17,608**	**12.5%**

- Includes only providers with utilizing members and costs under both systems
- Provider identification does not carry over by each service

Provider PMPM % Change Distribution - All



- Rounded to nearest 5%
- Includes only providers with 12 months prior *and* post rate change utilization
- All providers combined: +4.9%

Appendices – All Services Combined

- Includes only providers with utilizing members and costs under both systems
- Provider identification does not carry over by each service

	PMPM		
Provider	**Old**	**New**	**Impact**
Provider 1	$14,583	$11,428	-21.6%
Provider 2	$12,806	$10,679	-16.6%
Provider 3	$5,483	$4,739	-13.6%
Provider 4	$11,371	$10,511	-7.6%
Provider 5	$7,279	$6,937	-4.7%
Provider 6	$4,727	$4,541	-3.9%
Provider 7	$8,417	$8,138	-3.3%
Provider 8	$2,884	$2,792	-3.2%
Provider 9	$10,122	$10,038	-0.8%
Provider 10	$5,025	$4,990	-0.7%
Provider 11	$3,169	$3,262	2.9%
Provider 12	$5,817	$6,124	5.3%
Provider 13	$720	$763	6.1%
Provider 14	$13,018	$13,886	6.7%
Provider 15	$6,170	$6,751	9.4%
Provider 16	$5,201	$5,750	10.5%
Provider 17	$8,825	$9,832	11.4%
Provider 18	$2,628	$2,931	11.5%
Provider 19	$6,945	$7,799	12.3%
Provider 20	$7,868	$8,862	12.6%
Provider 21	$4,013	$4,524	12.7%
Provider 22	$10,844	$12,483	15.1%
Provider 23	$5,623	$6,584	17.1%
Provider 24	$7,257	$8,568	18.1%
Provider 25	$8,230	$9,968	21.1%
Provider 26	$8,431	$10,250	21.6%
Provider 27	$8,028	$9,821	22.3%
Provider 28	$7,213	$9,015	25.0%
Provider 29	$7,877	$10,683	35.6%
Provider 30	$7,158	$11,407	59.3%
All Providers Combined	**$8,613**	**$9,039**	**4.9%**

DEVELOPMENTAL DISABILITIES REIMBURSEMENT PROJECT

February 2020, Optumas finalized year end review

- Key findings :
  - Medically fragile residential habilitation rates: increase the program support component to represent the hours of nursing relative to the hours of direct support professionals for each acuity tier.
  - Absence factor: remove the 4% absence factor applied to every base residential rate and replace it with a 30-day personal assistance retainer policy.
  - Vacancy factor: add a 2% vacancy factor to the residential and ICF rate to account for vacancy costs.

DEVELOPMENTAL DISABILITIES REIMBURSEMENT PROJECT

- Key findings continued:
  - Day Services, Residential Habilitation, ICF services:
    - System-wide changes in SIS scores.
    - The decrease in the unit cost for day service is likely the result of the conversion from an hourly rate to 15-minute increments.
    - Overall rate change necessary to mitigate ongoing SIS score growth.

SUPPORTS INTENSITY SCALE (SIS) ADULT VERSION

The SIS is a standardized assessment tool that was

designed to measure the pattern and intensity of supports

that a person aged 16 years and older

with intellectual and developmental disabilities

requires to be successful in community settings.

Source: American Association on Intellectual and Developmental Disabilities (AAIDD) webpage: SIS Product Information https://www.aaidd.org/sis/product-information

The SIS has three sections

1. Exceptional Medical & Behavioral Needs*
2. Support Needs Index
   - Home living activities*
   - Community living activities*
   - Lifelong learning activities
   - Employment activities*
   - Health and safety*
   - Social activities
3. Supplemental Protection and Advocacy Scale

* These sections are **used in the rate determination** for ND. Both the medical and behavioral sections are weighted higher than the other sections. A change of 1pt in either the medical or behavioral sections results in a change in approximately 10 hours/month.

SUPPORTS INTENSITY SCALE (SIS) ADULT VERSION

Administration

- The assessment is done through an interview with the individual and qualified responders (known the individual for at least 3 months).

Utilization of the SIS

- 19 states and 2 Canadian provinces use the SIS-A.
- Of those, 9 use the assessment to inform decisions over the reimbursement rate or the allocation of the support budget for clients.

North Dakota Supports Intensity Scale

North Dakota Assessments:

- Contract with an independent vendor to conduct the interviews.
- Assessors must have experience in the human services field, hold a 4-year degree and complete ongoing training.

During the timeframe of July 1, 2020 – January 15, 2021:

- 481 assessments were completed. Of those assessments
- 381 were reoccurring assessments.

A preliminary review of these assessments reflected the following:

Exceptional Medical:

1) 118 or 30.97% had no change in score.
2) 110 or 28.87 % had an increase in score.
    a) 107 or 28.08% increased between 1 and 5 points;
    b) 3 or 0.79% increased between 6 and 9 points; and
    c) 0 increased by 10 or more points.
3) 153 or 40.16% had a decrease in score.
    a) 147 or 38.58% decreased between 1 and 5 points;
    b) 6 or 1.57% decreased between 6 and 9 points; and
    c) 0 decreased by 10 or more points

Exceptional Behavioral:

1) 101 or 26.51% had no change in score.
2) 102 or 26.77 % had an increase in score:
    a) 98 or 25.72% increased between 1 and 5 points;
    b) 4 or 1.05% increased between 6 and 9 points; and
    c) 0 increase by 10 or more points.
3) 178 or 46.72% had a decrease in score:
    a) 144 or 37.08% decreased between 1 and 5 points;
    b) 26 or 6.82% decreased between 6 and 9 points; and
    c) 8 or 2.10% decreased 10 or more points.

Developmental Disabilities Reimbursement Project: Rate Matrix

State of North Dakota
Rate Matrix
Fully Loaded Hour Value: "The Brick"

Effective July 1, 2020

2% Vacancy

Column Reference :		D	E	F	G	H	I	J	K	L	M	N			
Component Driven Service		Wage	ERE	D X E ERE $	D + F Sub	Relief Staff	G x H Relief $	G + I Sub	P S	D x K PS $	J + L Sub	Gross * 10%	With V Factor	F %	At Funded %
Residential Services															
ICF-ID	d	$17.85	35.1%	$6.27	$24.12	14.0%	$3.38	$27.50	87.2%	$15.57	$43.07	$47.85	$48.83	92.4%	$45.12
ICF-ID Medically Involved	d	$17.85	35.1%	$6.27	$24.12	14.0%	$3.37	$27.49	166.0%	$29.63	$57.12	$63.47	$64.77	92.4%	$59.84
ICF-ID Medically Intensive	d	$17.85	35.1%	$6.27	$24.12	14.0%	$3.37	$27.49	244.0%	$43.55	$71.04	$78.93	$80.54	92.4%	$74.42
Residential Habilitation	d	$17.93	35.1%	$6.29	$24.22	14.0%	$3.39	$27.61	39.6%	$7.10	$34.71	$38.57	$39.36	92.3%	$36.33
*Res Medical Acuity - Level 1	d	$17.93	35.1%	$6.29	$24.22	14.0%	$3.39	$27.61	42.7%	$7.66	$35.27	$39.19	$39.99	92.3%	$36.91
*Res Medical Acuity - Level 2	d	$17.93	35.1%	$6.29	$24.22	14.0%	$3.39	$27.61	64.7%	$11.60	$39.21	$43.57	$44.46	92.3%	$41.04
*Res Medical Acuity - Level 3	d	$17.93	35.1%	$6.29	$24.22	14.0%	$3.39	$27.61	92.1%	$16.51	$44.12	$49.03	$50.03	92.3%	$46.18
Independent Habilitation	h	$17.96	35.1%	$6.30	$24.26	14.0%	$3.40	$27.66	36.1%	$6.48	$34.14	$37.94	$37.94	100.0%	$37.94
Vocational/Day Services															
Day Habilitation	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	56.7%	$10.15	$37.74	$41.93	$41.93	100.0%	$41.93
Prevocational Services	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	56.7%	$10.15	$37.74	$41.93	$41.93	100.0%	$41.93
Small Group Employment Supports	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	56.7%	$10.15	$37.74	$41.93	$41.93	100.0%	$41.93
*Day/Voc Medical Acuity - Level 1	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	63.6%	$11.39	$38.98	$43.31	$43.31	100.0%	$43.31
*Day/Voc Medical Acuity - Level 2	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	69.4%	$12.43	$40.02	$44.46	$44.46	100.0%	$44.46
*Day/Voc Medical Acuity - Level 3	h	$17.91	35.1%	$6.29	$24.20	14.0%	$3.39	$27.59	77.8%	$13.93	$41.52	$46.13	$46.13	100.0%	$46.13
Individual Employment Supports	h	$23.82	35.1%	$8.36	$32.18	14.0%	$4.51	$36.69	23.1%	$5.50	$42.19	$46.88	$46.88	100.0%	$46.88

* Medical Acuity Tiers may be applied to individuals with a SIS Medical Score of 15 or higher and is available to a qualifying provider in Residential Habilitation, Day Habilitation, Prevocational Services, and Small Group Employment Supports only.

DEVELOPMENTAL DISABILITIES (DD) REIMBURSEMENT PROJECT

Next steps:

- The goal of the steering committee was to create a subcommittee to review the report and make recommendations to address the findings. This work was to be completed by mid April 2020 so changes would go into effect July 2020.
- Due to the COVID pandemic, initial subcommittee work was put on hold.
- Subcommittee reconvened and presented their findings to the steering committee in Oct 2020.
  - Rate adjustments - data confirms that assessment scores are higher than what we built our methodology on. Would like to see changes to the multiplier rather than across the board adjustments.
    - Consider having Optumas conduct another review to focus specifically on the SIS scores to see where adjustments could be made to the multiplier formula.
  - Day supports - adjust formula to account for the decrease in units.

#5218



Medical Services Budget- House Bill 1012
Quality

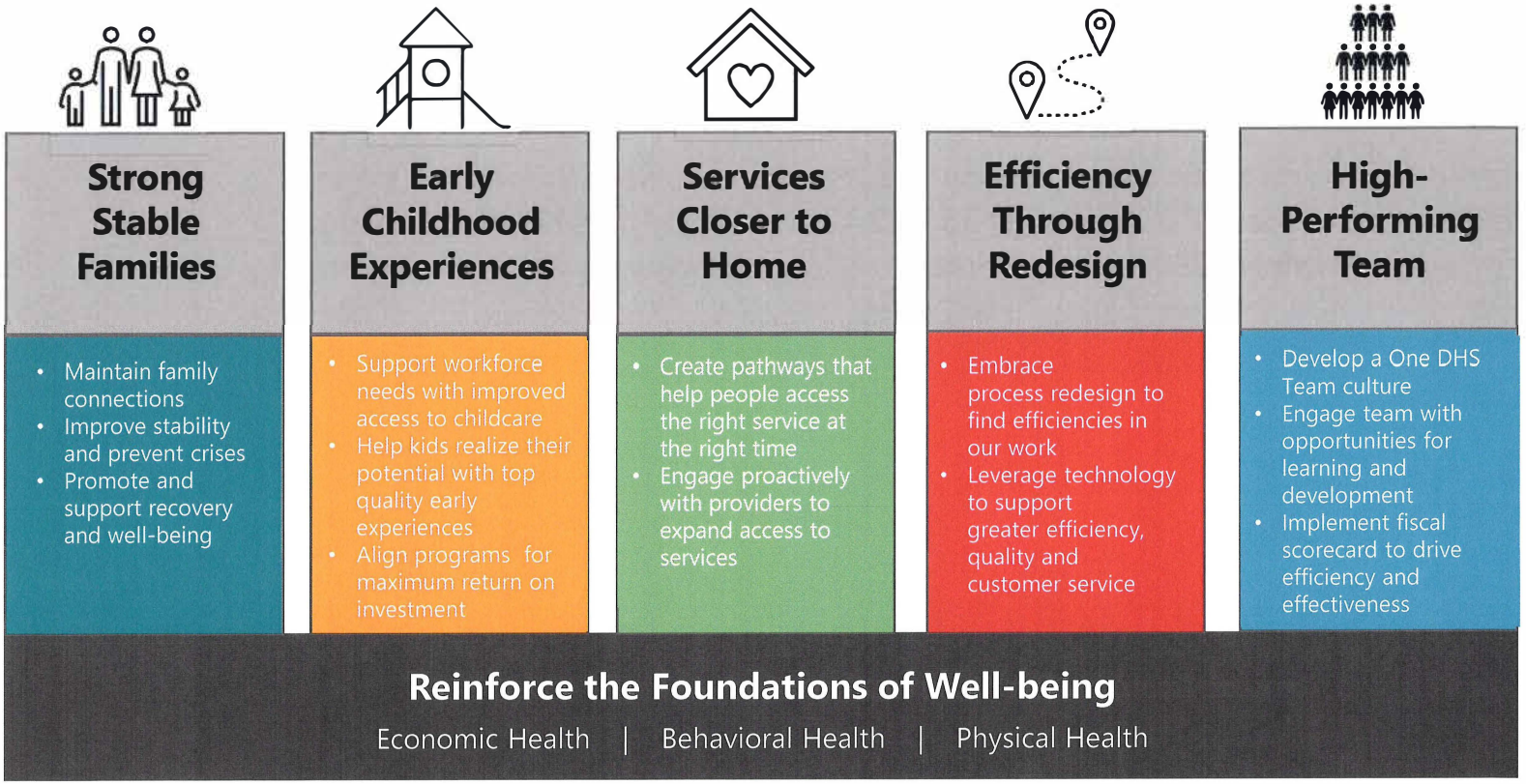
House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD Medical Services Director

NORTH Dakota Be Legendary.℠ | Human Services

DHS 2021 - 2025

KEY PRIORITIES:



North Dakota Medicaid

OUR VALUES:



We help...

our members receive safe, appropriate, quality care in a timely manner.



We communicate...

by listening, sharing information, and seeking feedback.



We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.



We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

In the United States...

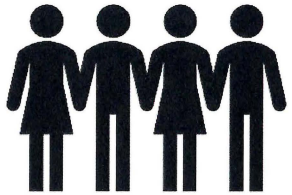


Medicaid covers **45%** of adults with disabilities



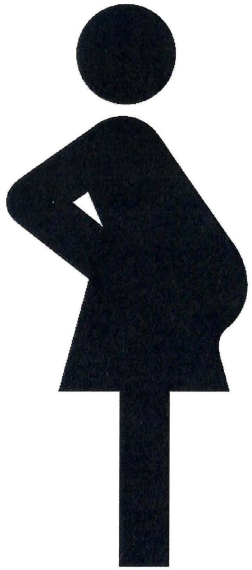
Medicaid covers **6** in **10** nursing home residents

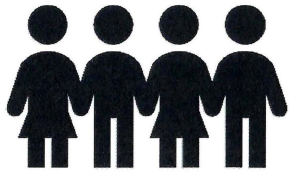




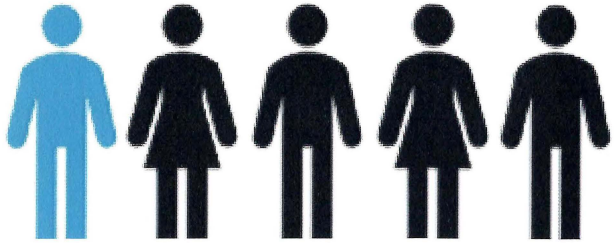
Medicaid and Medicaid Expansion covers low-income families and nonelderly adults with income up to **138% FPL**

Medicaid covers **43%** of all births





4 in **10** Medicaid enrollees are Children



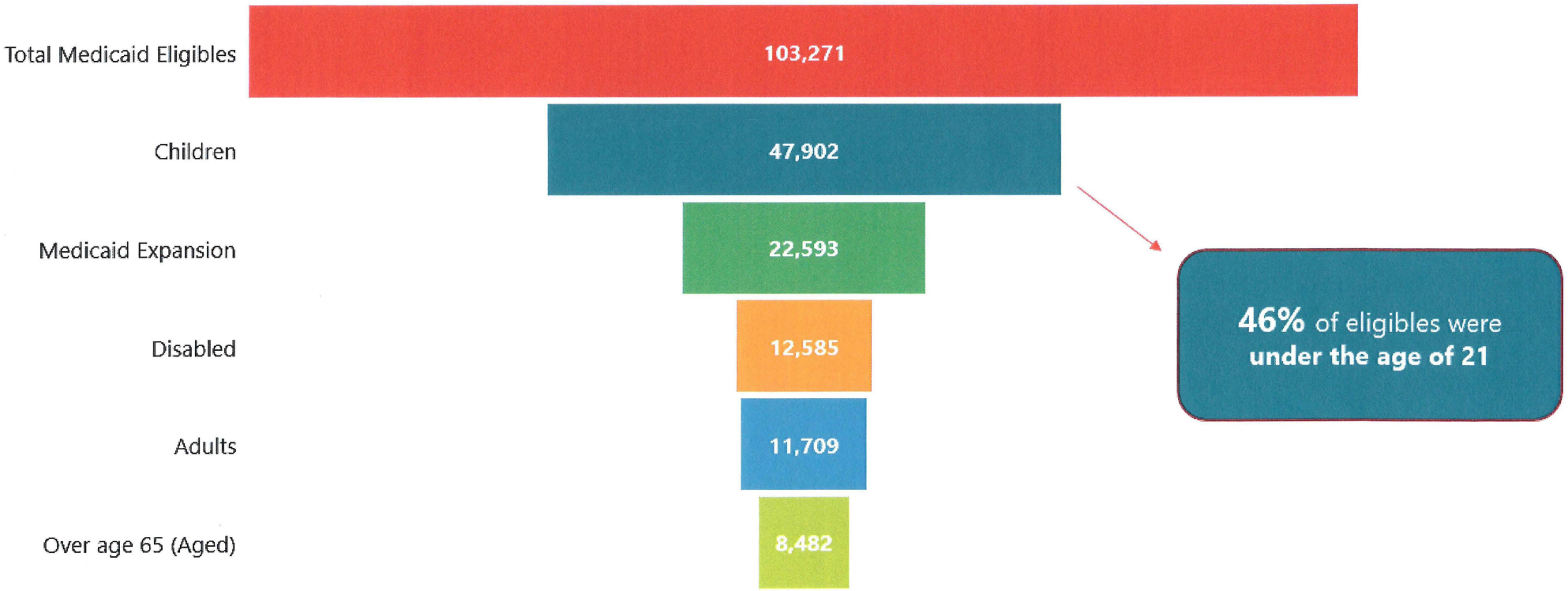
Medicaid covers **1** in **5** Americans

Who does Medicaid cover?

*Medicaid provides health and long-term care for **millions** of America's poorest and most vulnerable people.*

*Data retrieved from Kaiser Family Foundation (2019) 10 Things to Know about Medicaid: Setting the Facts Straight and MACPAC (2020) Factsheet Medicaid's Role in Financing Maternity Care

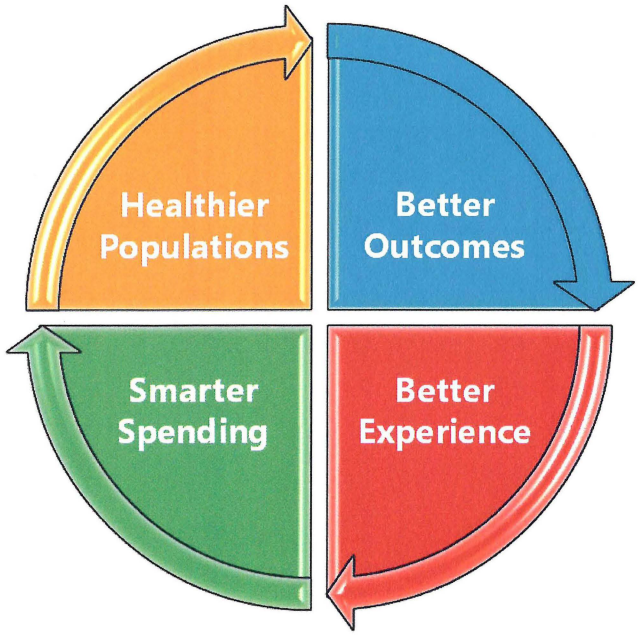
North Dakota Medicaid Eligibles



** Data from September 2020 Quarterly Budget Insight Report*

HOW TO DRIVE QUALITY

Quadruple Aim for ND Medicaid



*Institute for Healthcare Improvement Triple Aim

Value Equation

$$V_{\text{(VALUE)}} = \frac{Q_{\text{(QUALITY)}} + S_{\text{(SERVICE)}}}{\$_{\text{(COST)}}}$$

*University of Utah & Harvard Business School's Michael Perter value equation

HOW TO IMPROVE

Continuous Quality Improvement

Is a quality management process that encourages all health care team members to continuously as the questions:

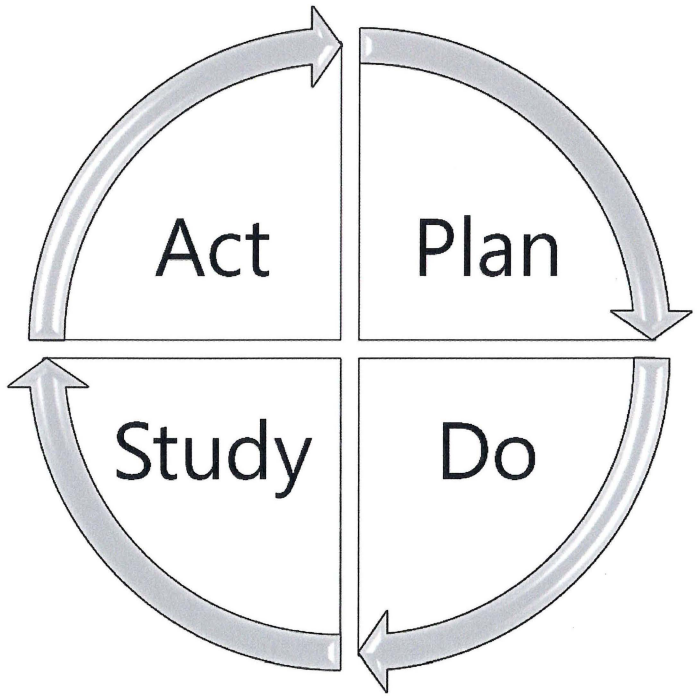
1. **How are we doing?**
2. **Can we do it better?**

The Institute for Healthcare Improvement Model for Improvement is a simple strategy that use **PDSA cycle** that accelerates improvement by seeking answers to three questions:

1. **What are we trying to accomplish?**
2. **How will we know that a change is an improvement?**
3. **What changes can we make that will result in improvement?**

**National Learning Consortium (2013) Continuous Quality Improvement Strategies to Optimize your Practice*

PDSA Cycle



**The W. Edwards Deming Institute PDSA Cycle*

HOW QUALITY IS MEASURED

Health Care Quality Measures for Medicaid:

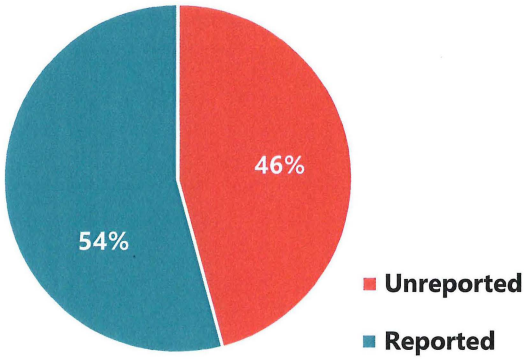
Child Core Set is a set of **24** measures encompassing: preventative health, maternal health, mental health, dental health, and experience of care.

https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-core-set.pdf

Adult Core Set is a set of **33** measures encompassing: preventative health, maternal health, mental health, dental health, and experience of care.

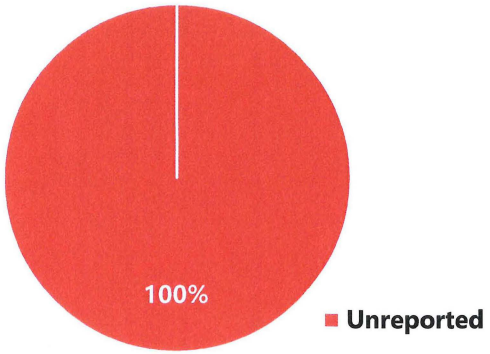
https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-core-set.pdf

ND Child Quality Measures



In 2019, ND reported on
13 Child Core Set Measures
Mandatory State Reporting for all Child Core Set Measures by 2024

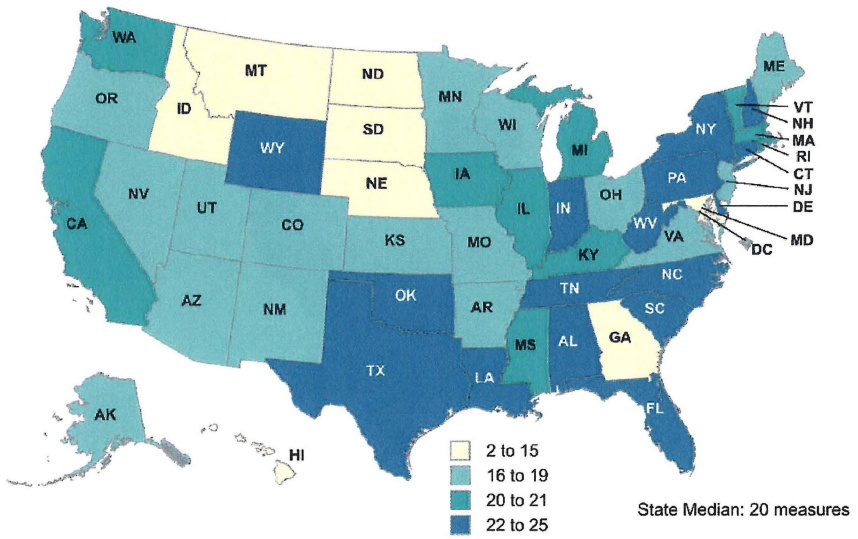
ND Adult Quality Measures



In 2019, ND reported on
0 Adult Core Set Measures
Mandatory State Reporting for all Adult Behavioral Health Measures by 2024

**Retrieved from Medicaid.gov Adult and Child Health Care Quality 2020 Measures*

Geographic Variation in the Number of Child Core Set Measures Reported by States, FFY 2019

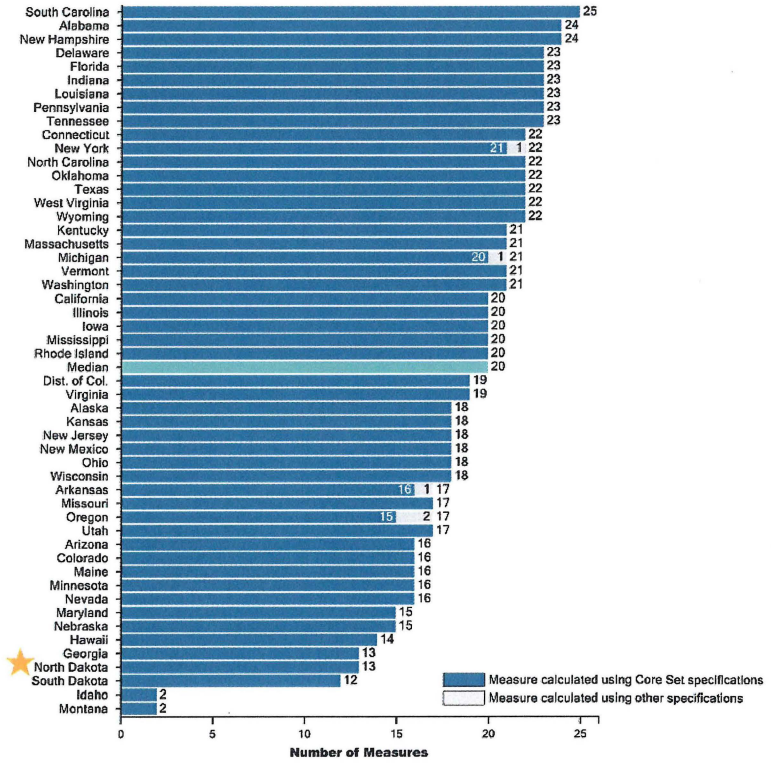


Sources: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020; Form CMS-416 reports for the FFY 2019 reporting cycle as of July 1, 2020; and Centers for Disease Control and Prevention Wide-ranging ONline Data for Epidemiologic Research (CDC WONDER) for calendar year 2018.

Notes: The term "states" includes the 50 states and the District of Columbia. The 2019 Child Core Set includes 26 measures. This chart excludes the CLABSI measure, which is obtained from CDC's National Healthcare Safety Network.

**Data retrieved from Medicaid.gov (2020) Child Chart Pack*

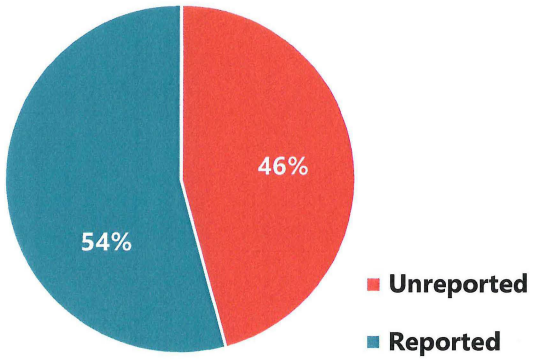
Number of Child Core Set Measures Reported by States, FFY 2019



Number of Child Core Set Measures Reported by North Dakota

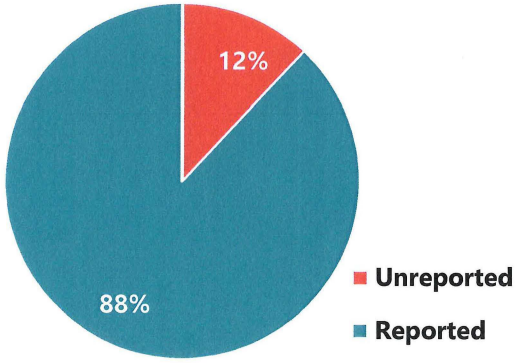
In **2019**, ND reported

13 Child Core Set Measures



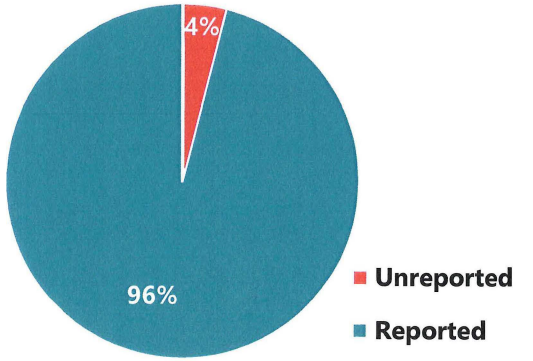
In **2020,** ND reported

21 Child Core Set Measures



For **2021**, projecting

23 Child Core Set Measures

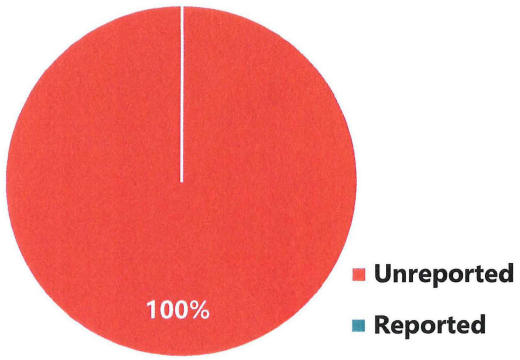


Mandatory State Reporting for all Child Core Set Measures by 2024

Number of Adult Core Set Measures Reported by North Dakota

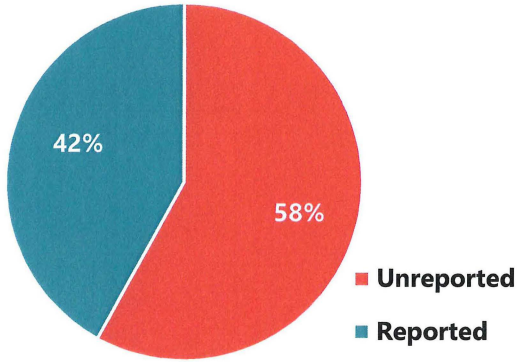
In **2019**, ND reported

0 Adult Core Set Measures



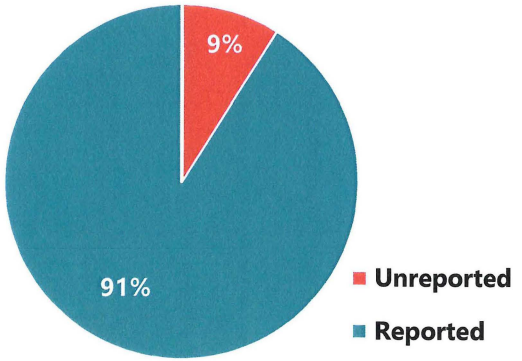
In **2020,** ND reported

21 Adult Core Set Measures



For **2021**, projecting

23 Adult Core Set Measures



Mandatory State Reporting for all Behavioral Health Measures in Adult Core Set by 2024

Medicaid & CHIP Scorecard FFY 2019

Primary Care Access and Preventive Care

Immunizations for Adolescents: Age 13

Visit this measure on: Medicaid & CHIP SCORECARD

Learn more about this measure +

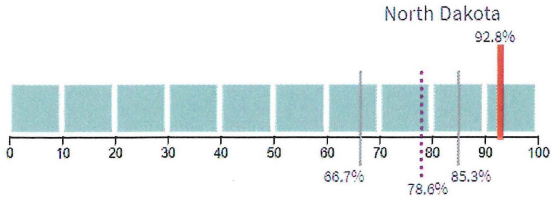
Rate: Select One

- Combination 1 Rate: Percentage Receiving Meningococcal Conj…

Population

Medicaid only

44 States Reporting **92.8%** State Rate



Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Higher rates are better for this measure

This state uses the following methodology to calculate this measure: **Administrative**

Learn more about this methodology +

Rates include FFS and PCCM populations. State attributes higher HPV vaccination rate to immunization program focused on increasing HPV vaccination rates, including media campaigns and targeted beneficiary and provider outreach. Administrative data source is state immunization registry.

Well-Child Visits in the First 15 Months of Life

Visit this measure on: Medicaid & CHIP SCORECARD

Learn more about this measure +

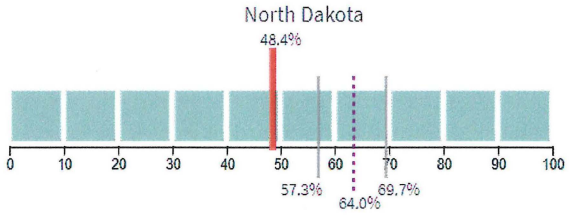
Rate

- Percentage who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life

Population

Medicaid only

48 States Reporting **48.4%** State Rate



Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Higher rates are better for this measure

This state uses the following methodology to calculate this measure: **Administrative**

Learn more about this methodology +

Rate includes FFS and PCCM populations.

Adolescent Well-Care Visits: Ages 12 to 21

Visit this measure on: Medicaid & CHIP SCORECARD

Learn more about this measure +

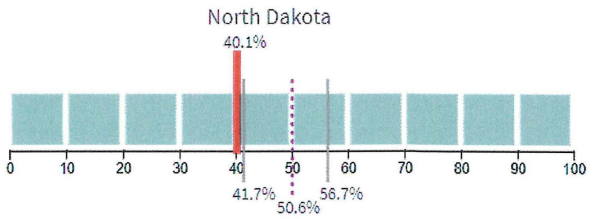
Rate

- Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 12 to 21

Population

Medicaid only

49 States Reporting **40.1%** State Rate



Drag left or right to move the scale. Zoom in or out by placing your cursor over the graph and scrolling or double clicking.

Higher rates are better for this measure

This state uses the following methodology to calculate this measure: **Administrative**

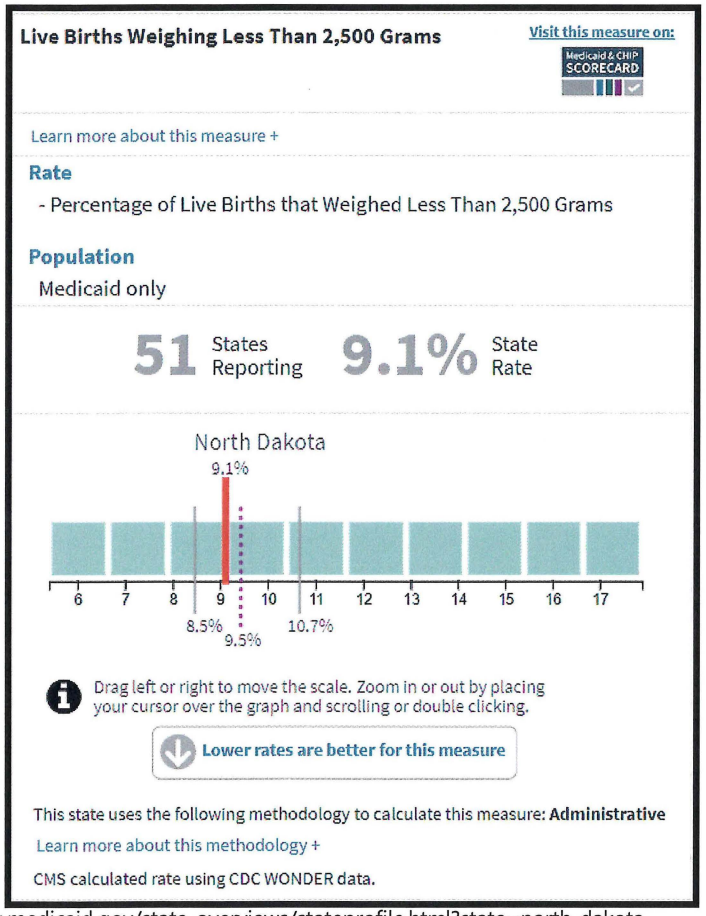
Learn more about this methodology +

Rate includes FFS and PCCM populations.

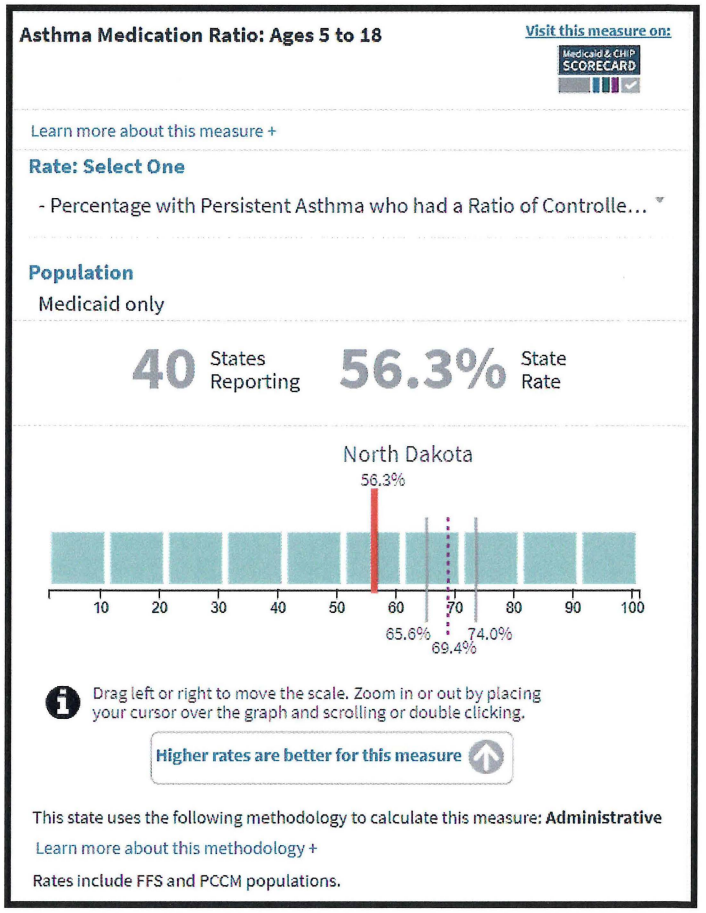
Source: https://www.medicaid.gov/state-overviews/stateprofile.html?state=north-dakota

Medicaid & CHIP Scorecard FFY 2019

Maternal and Perinatal Health



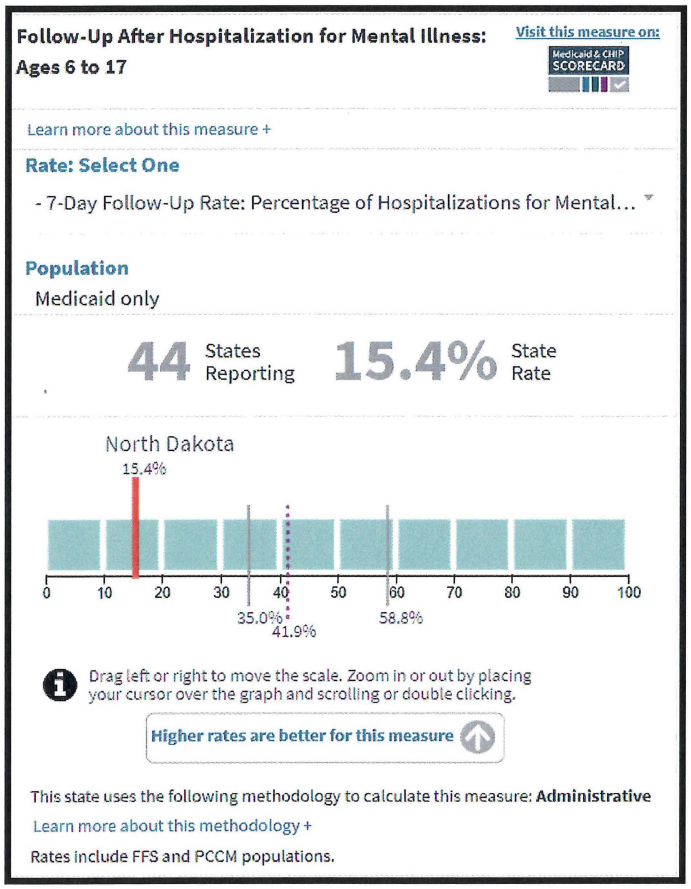
Care of Acute and Chronic Conditions



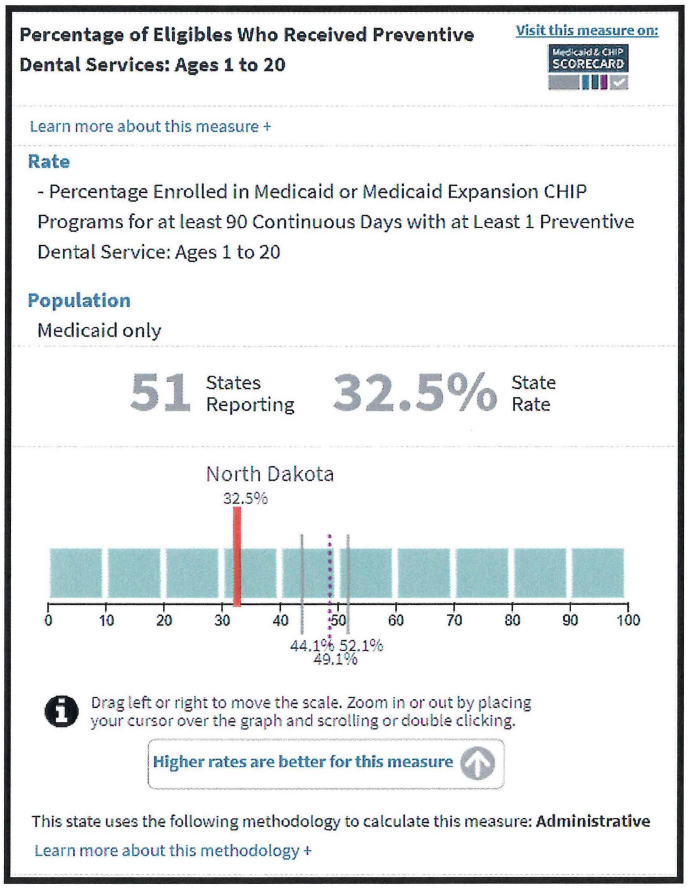
Source: https://www.medicaid.gov/state-overviews/stateprofile.html?state=north-dakota

Medicaid & CHIP Scorecard FFY 2019

Behavioral Health Care



Dental and Oral Health Services



Source: https://www.medicaid.gov/state-overviews/stateprofile.html?state=north-dakota

Quality Performance for Medicaid Expansion

North Dakota Medicaid Expansion Performance Measurement Scorecard Data Measurement Year (MY) 2017 - 2019				
Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to
Adult Body Mass Index Assessment	93.40	93.33	94.17	♦♦♦
Flu Vaccinations for Adults, Ages 18-64	41.75	38.93	38.60	♦
Breast Cancer Screening	50.35	54.97	54.69	♦
Cervical Cancer Screening	42.61	43.60	44.79	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	37.50	40.52	46.03	♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	77.86	76.86	73.97	♦♦♦
Comprehensive Diabetes Care: Eye Exam	50.09	51.12	49.64	♦
Comprehensive Diabetes Care: HbA1c Control (<8%)	55.01	55.96	60.83	♦♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is better*	30.58	32.12	28.71	♦♦♦
Comprehensive Diabetes Care: HbA1c Testing	92.62	92.57	90.27	♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy	91.21	93.61	89.05	♦
Controlling High Blood Pressure	73.43	68.37	70.00	♦♦♦
Annual Monitoring for Patients on Persistent Medications: Total Rate	86.11	88.29	NR	NC
Asthma Medication Ratio: Ages 19-50	NR	NR	55.00	♦♦
Asthma Medication Ratio: Ages 51-64	NR	NR	51.72	♦
Asthma Medication Ratio: Ages 19-64 (Total)	NR	NR	53.93	♦
PQI 01: Diabetes Short-Term Complications Admission Rate (denominator is total member months x100,00 for ages 18-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.07	40.85	46.53	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (denominator is total member months x100,00 for ages 40-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.26	28.97	48.58	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total member months x100,00 for ages 18-64 and 65+, Rate is numerator events/100,000 member months)* *Lower is better*	23.91	29.07	27.11	♦♦
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 18-39, Rate is numerator events/100,000 member months)* *Lower is better*	8.29	3.47	2.90	♦♦♦
Plan All-Cause Readmissions Rate: Ages 18-44* *Lower is better* ^^	NR	NR	1.5441	NC
Plan All-Cause Readmissions Rate: Ages 45-54* *Lower is better* ^^	NR	NR	1.5655	NC
Plan All-Cause Readmissions Rate: Ages 55-64* *Lower is better* ^^	NR	NR	1.1399	NC
Plan All-Cause Readmissions Rate: Total* *Lower is better* ^^	NR	NR	1.4182	♦

Scorecard LTSS System Performance

Dimension	Rank	Number of indicators with trend*	Number of indicators showing:		
			Substantial improvement	Little or no change	Substantial decline
OVERALL	**28**	**21**	**7**	**13**	**1**
Affordability & Access	**30**	6	1	4	1
Choice of Setting & Provider	**25**	6	2	4	0
Quality of Life & Quality of Care	**20**	2	1	1	0
Support for Family Caregivers**	**34**	4	2	2	0
Effective Transitions	**22**	3	1	2	0

The **Scorecard** aims to empower state and federal policy makers and consumers with information they need to effectively assess their state's performance across multiple dimensions and indicators, learn from other states, and improve the lives of older adults, people with physical disabilities, and their families.

*Data used for this Scorecard was analyzed in 2019, **prior to the COVID-19 outbreak**. Therefore, performance on this Scorecard does not include the impact of the pandemic on the LTSS system, which is considerable.

Source: http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/North%20Dakota%20Fact%20Sheet.pdf



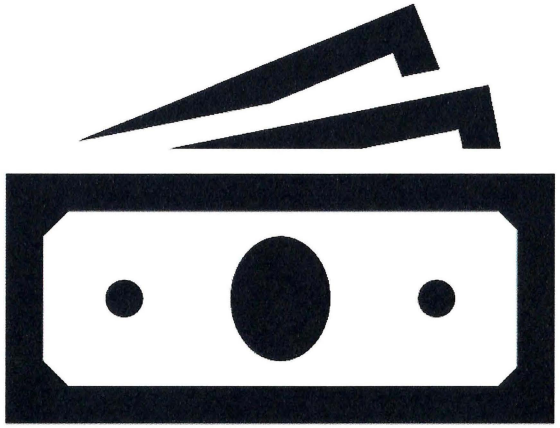
ABOUT FREE THROUGH RECOVERY

Free Through Recovery is a community based behavioral health program designed to increase recovery support services for individuals involved with the criminal justice system who have behavioral health concerns.

THE MISSION OF FREE THROUGH RECOVERY IS TO IMPROVE HEALTHCARE OUTCOMES AND REDUCE RECIDIVISM BY DELIVERING HIGH-QUALITY COMMUNITY BEHAVIORAL HEALTH SERVICES LINKED WITH COMMUNITY SUPERVISION.

Pay for Performance Model

- Providers are paid a monthly base rate for each participant with the opportunity to receive performance pay if the participant meets at least 3 out of 4 monthly outcomes.



Outcome Monitoring



Stable Housing

Is the person living in a residence that is supportive of their recovery?



Stable Employment

Is the person actively seeking or participating in employment?



Recovery

Is the participant demonstrating effort to reduce their substance use or the harm associated with their use and/or improve their mental health functioning.



Criminal Justice

Did the participant avoid law enforcement involvement resulting in arrest, criminal charge, or probation violation resulting in initiation of revocation?

FREE THROUGH Recovery

FTR Data Dashboard

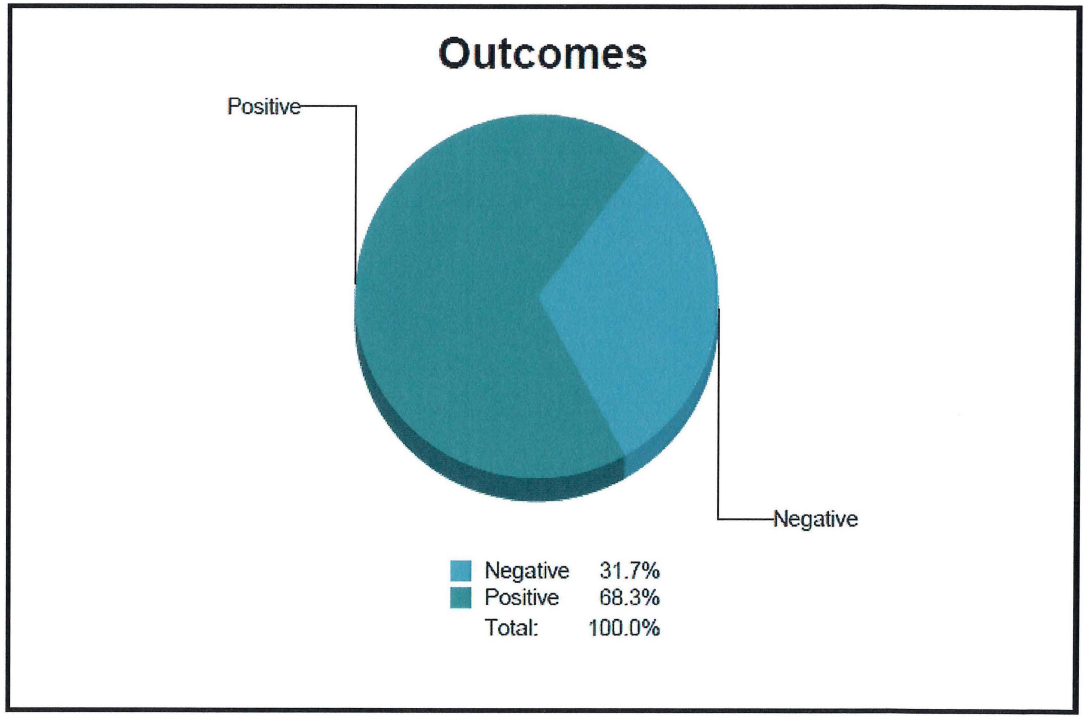
Report Dates: 02/01/2018 thru 12/31/2020

Housing	Total
Negative	24%
Positive	76%

Employment	Total
Negative	34%
Positive	66%

Recovery	Total
Negative	30%
Positive	70%

Law Enforcement	Total
Negative	29%
Positive	71%



Thank You!

NORTH Dakota | Human Services

Be Legendary.™



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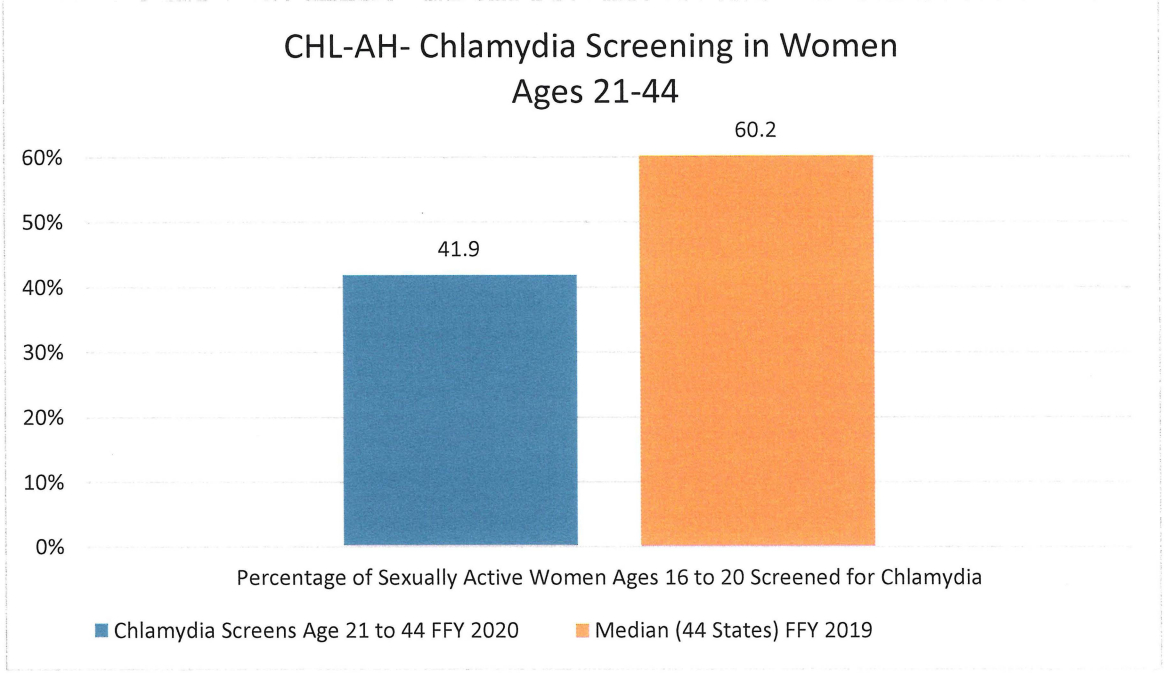
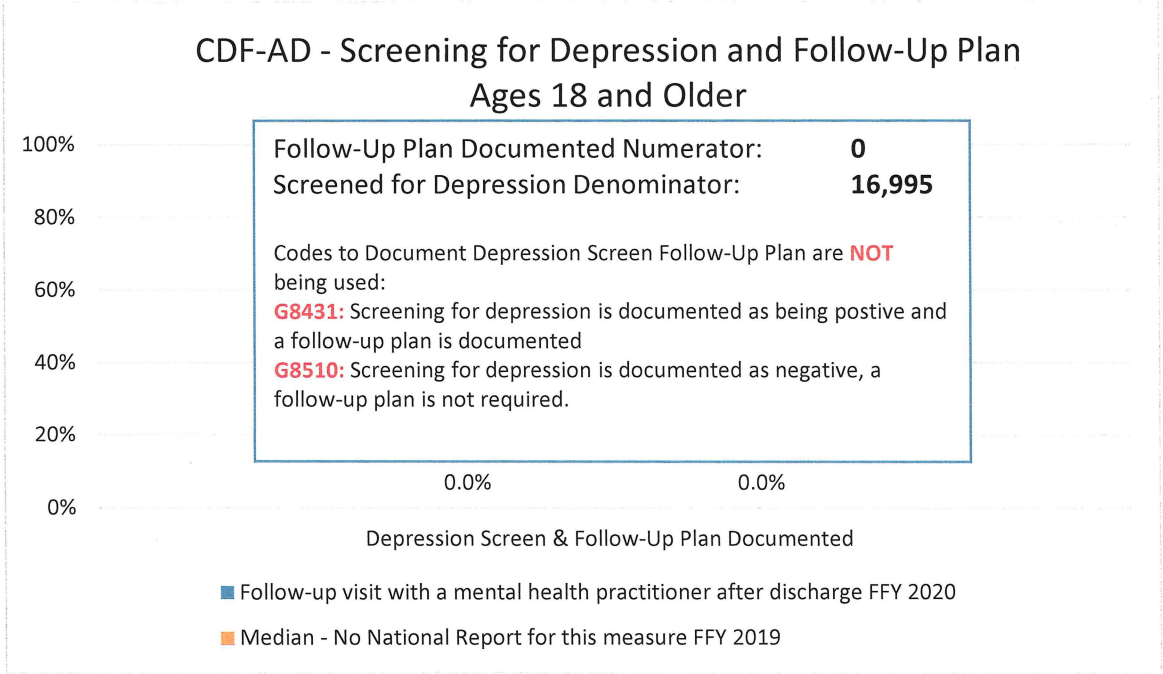
North Dakota's Adult Core Set:
Adult's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

Primary Care Access and Preventive Care





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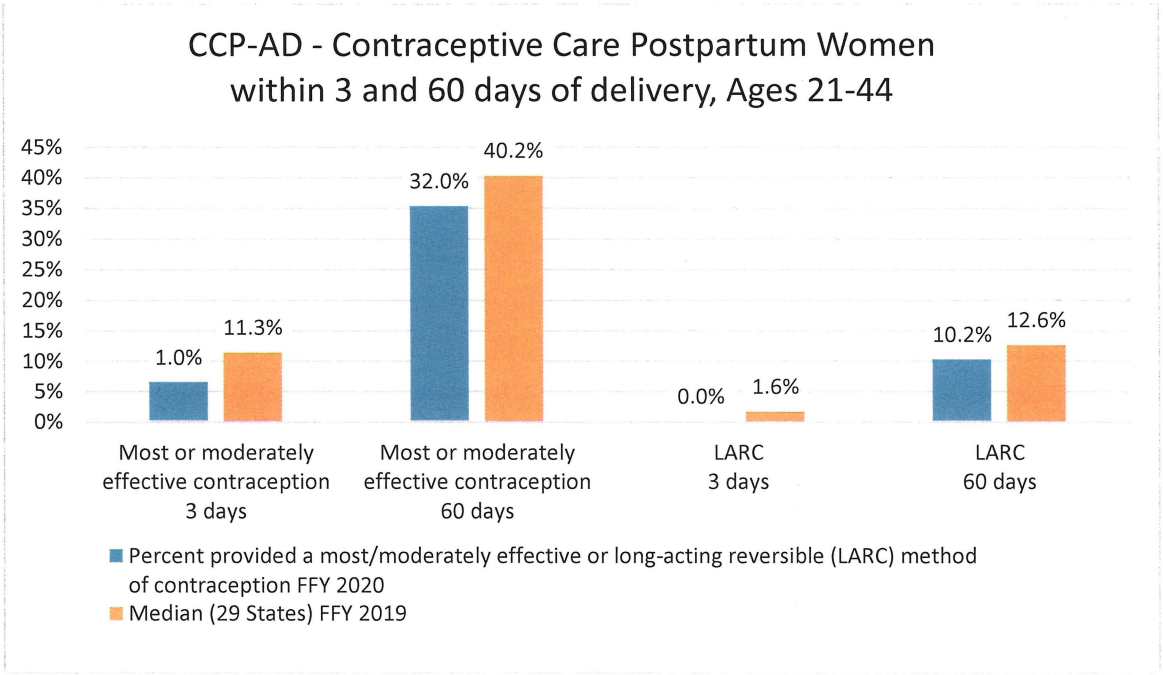
Maternal and Perinatal Health



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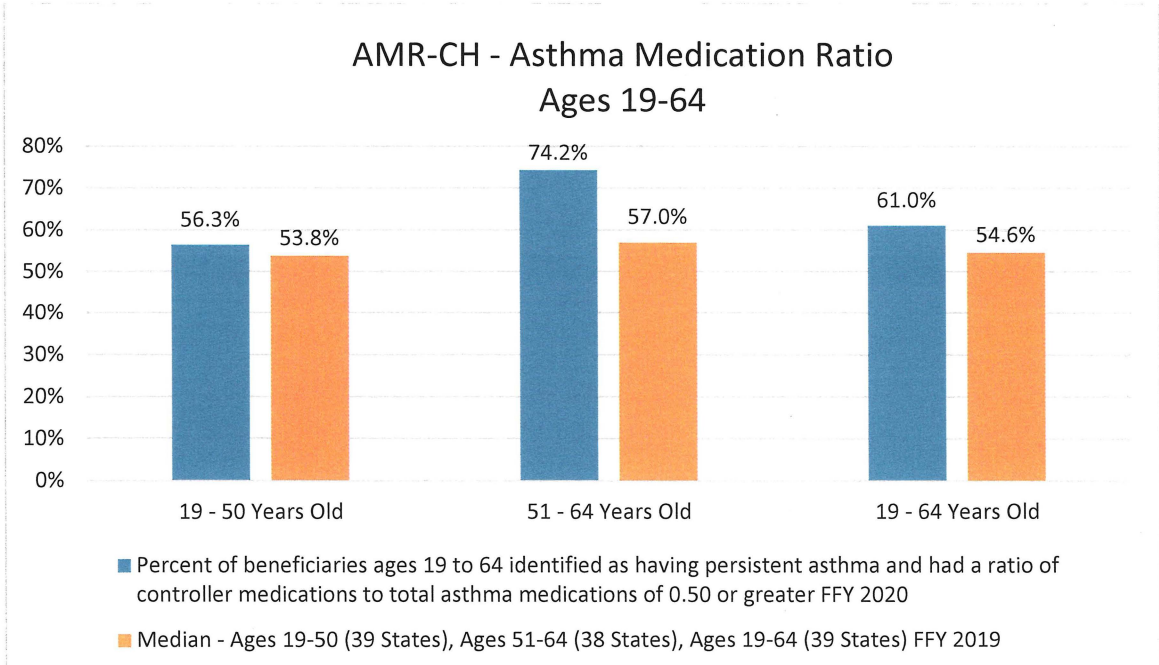

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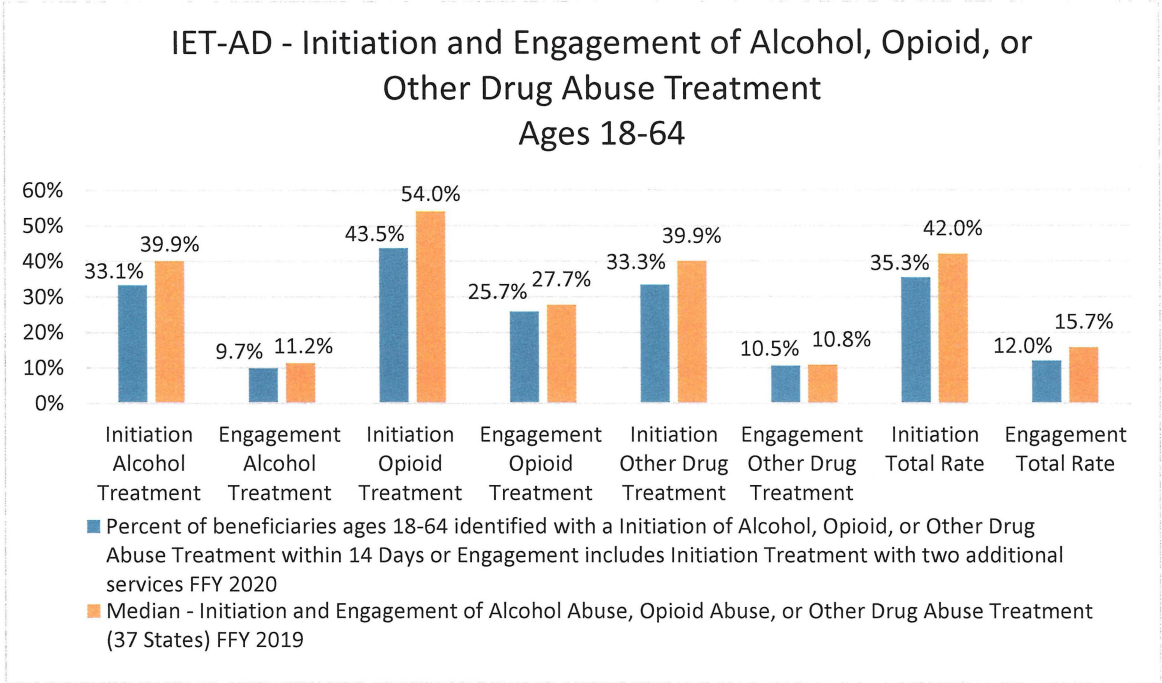
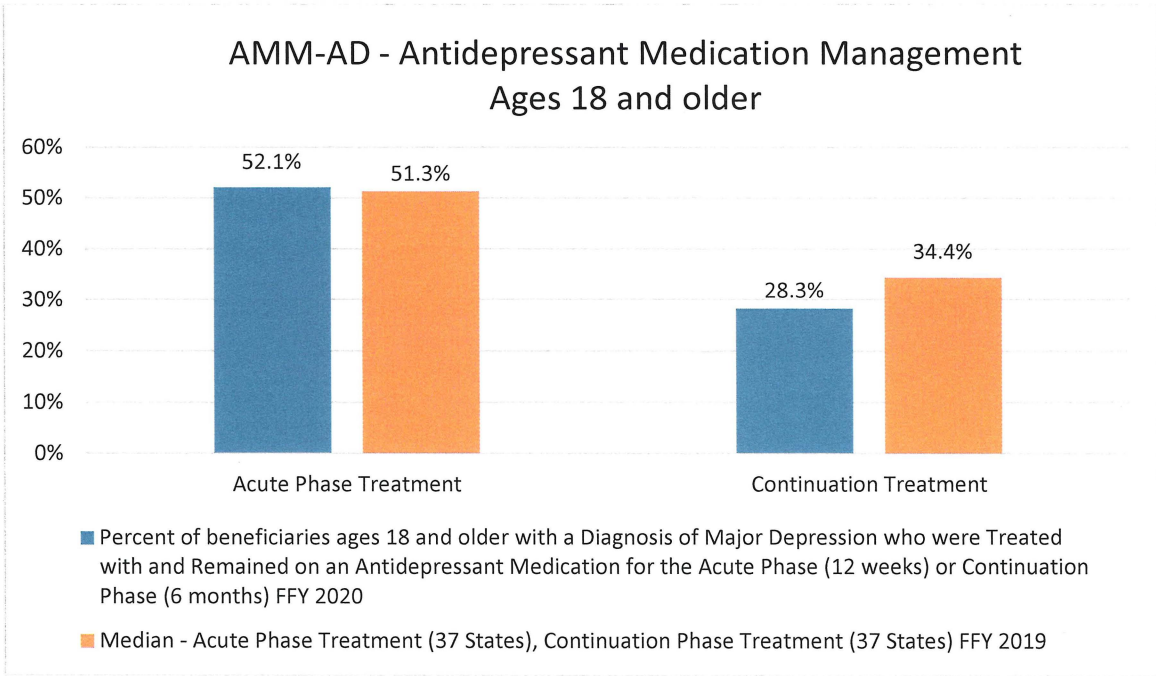
Behavioral Health Care





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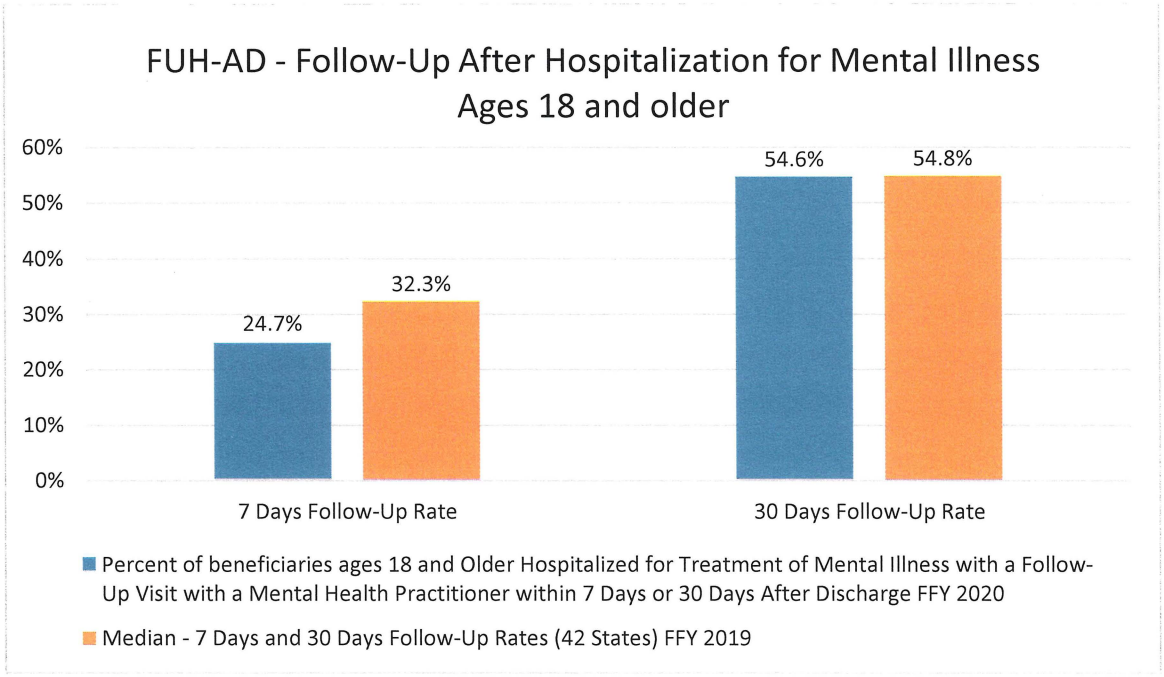

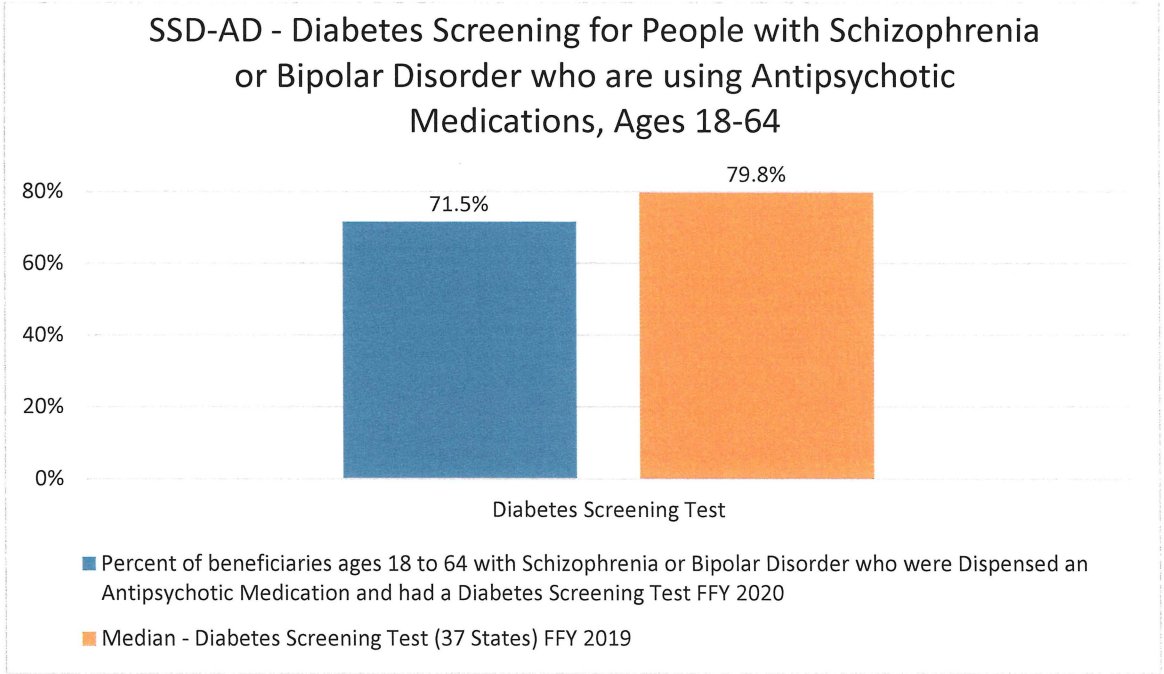

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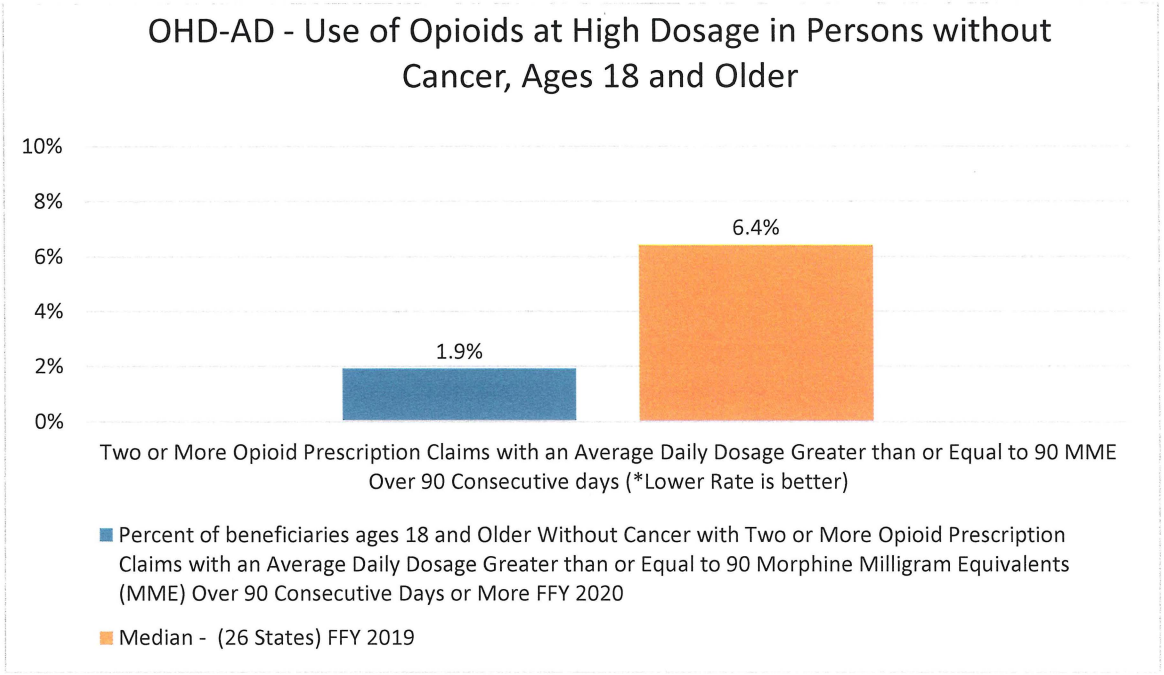

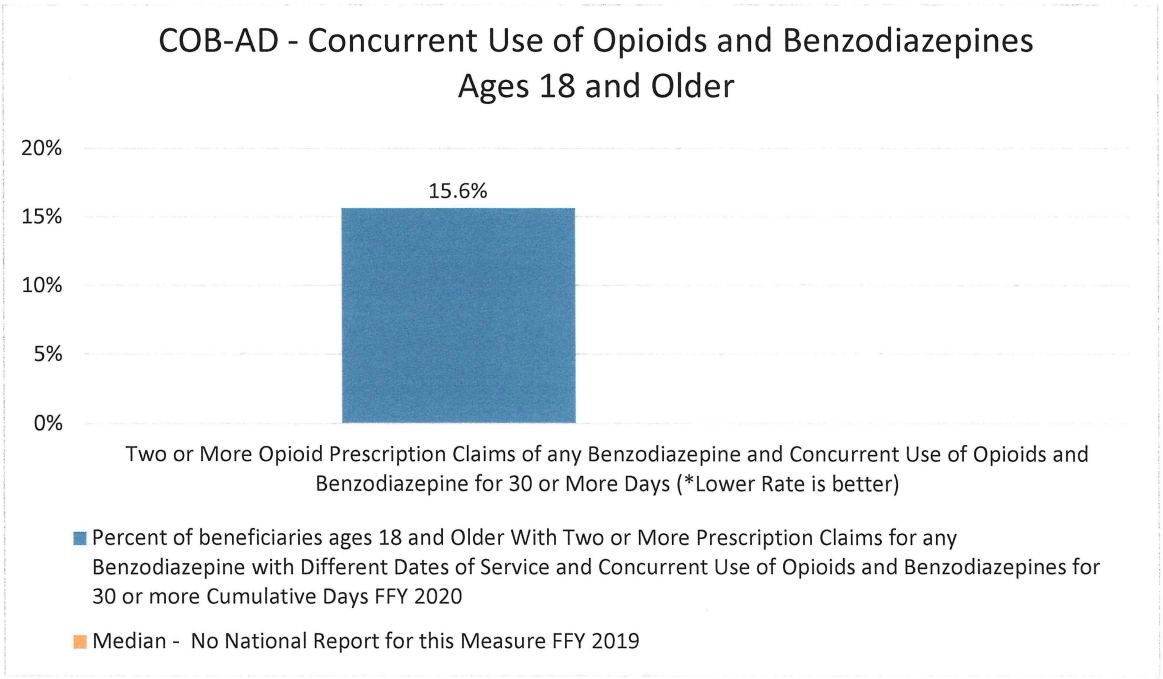

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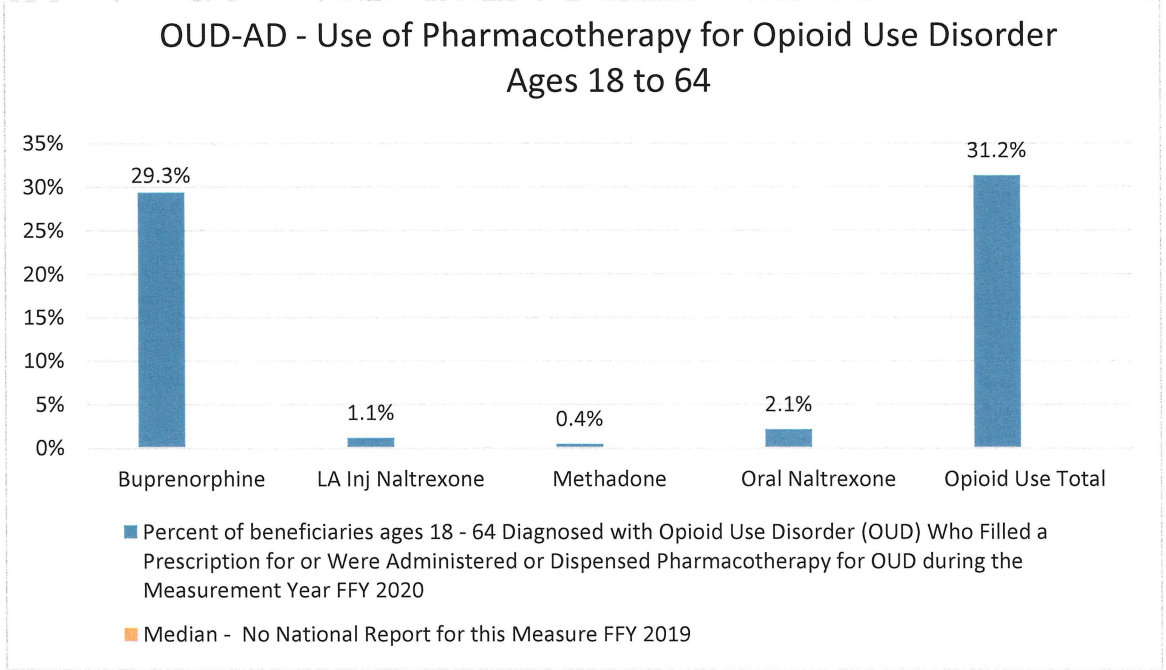
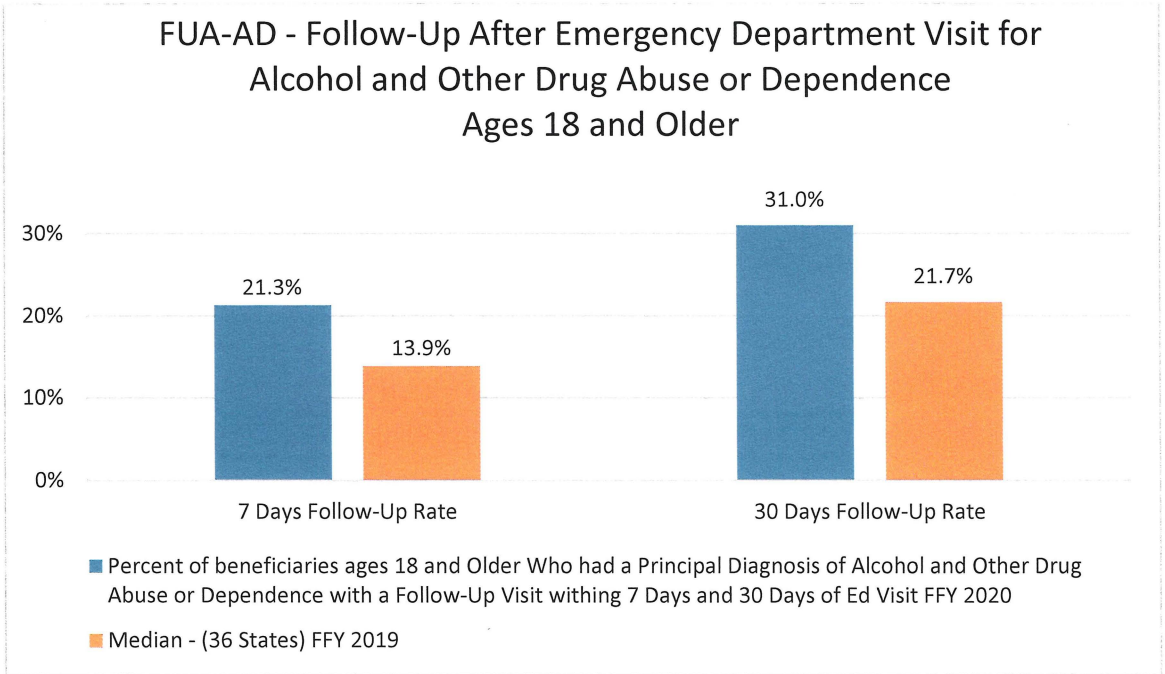
Federal Fiscal Year 2020





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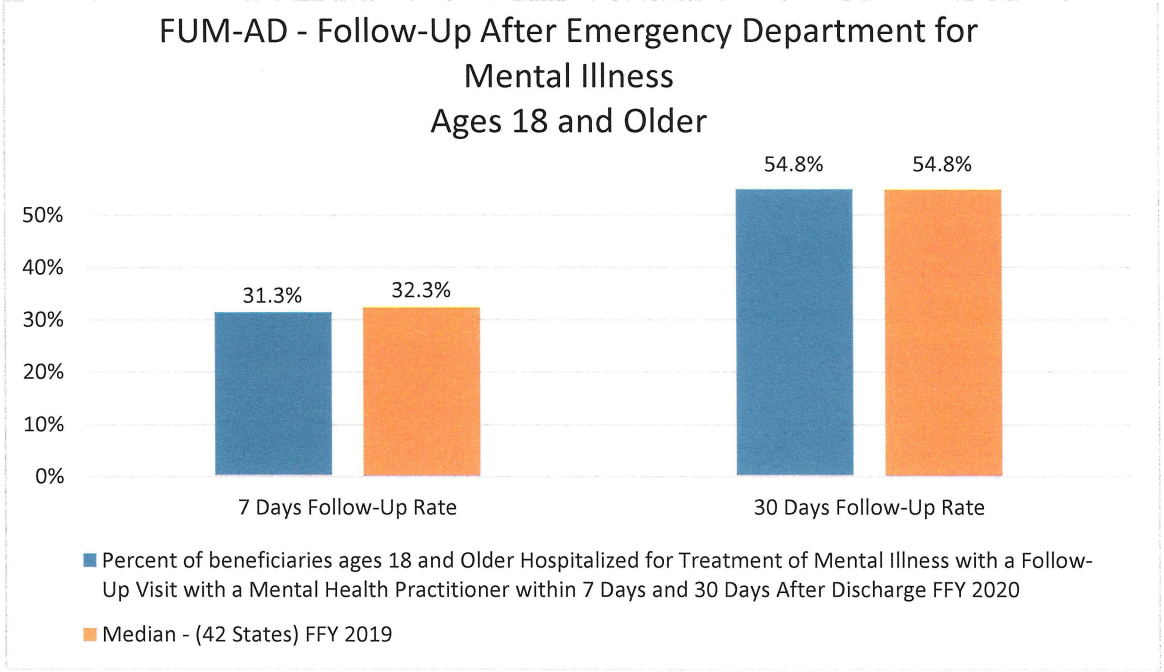
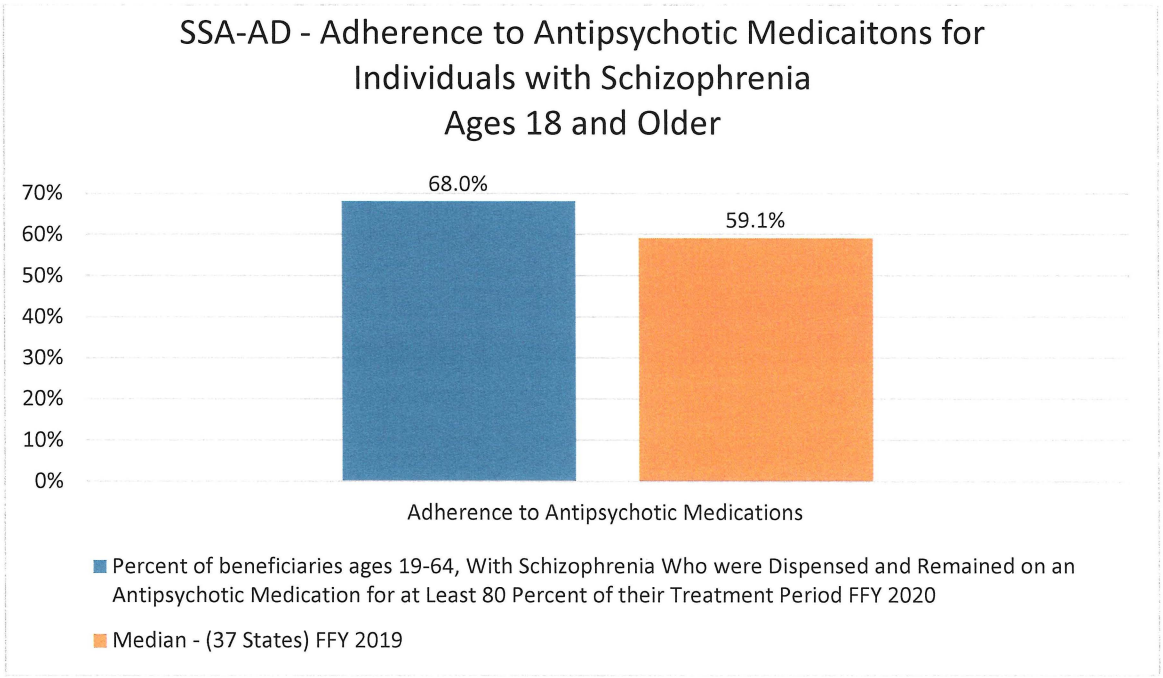
Federal Fiscal Year 2020





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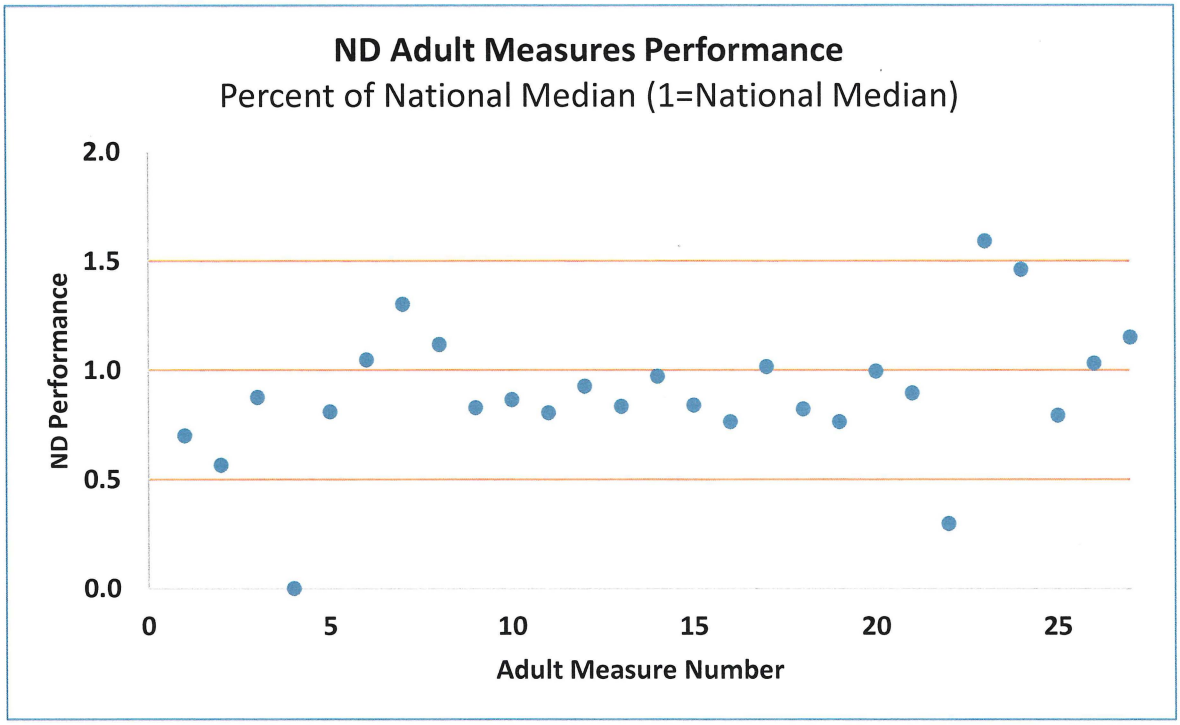
Adult's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020



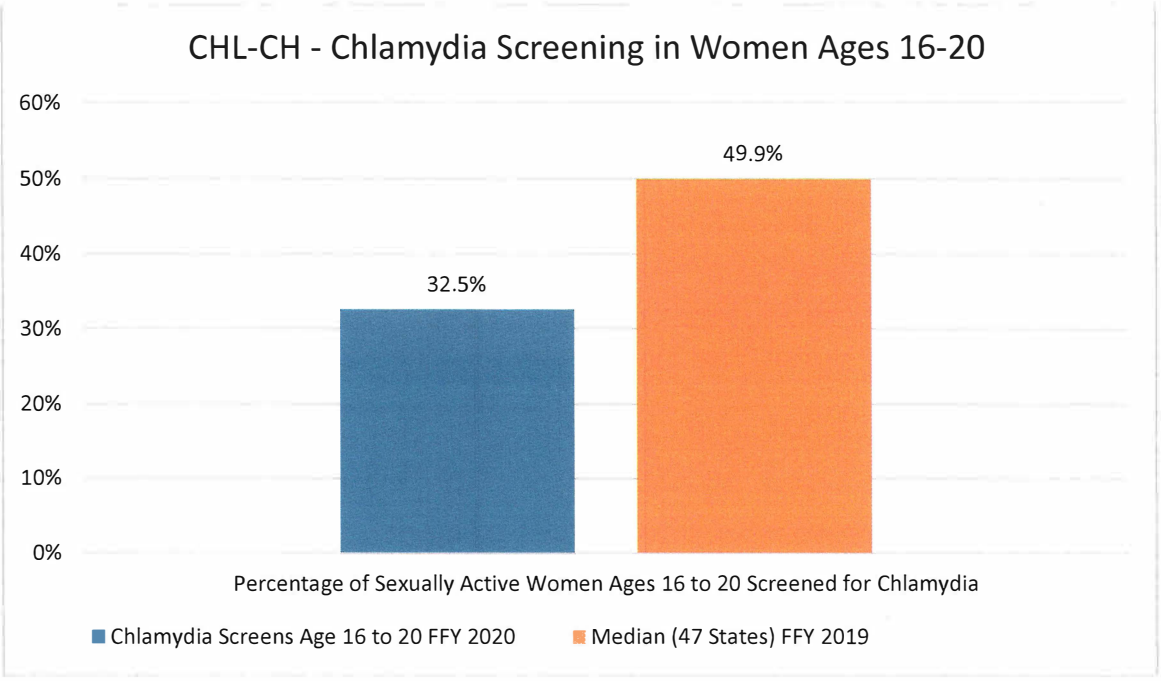
North Dakota's Adult Core Set:
Adult's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

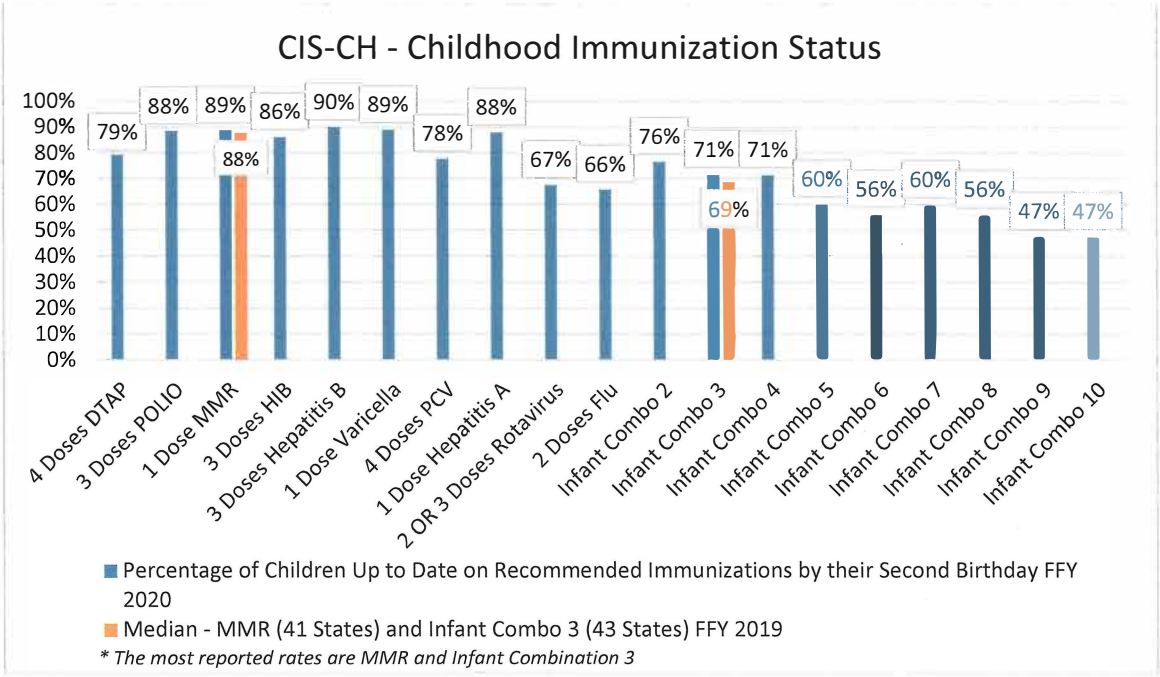
Adult Core Set							
Measure		2019	2020	2021	2022	2023	2024
Primary Care Access and Preventive Care							
CCS	Cervical Cancer Screening						
CHL	Chlamydia Screening in Women Ages 21 to 24						
FVA	Flu Vaccinations for Adults Ages 18 to 64						
CDF	Screening for Depression and Follow-Up Plan: Ages 18 and up						
BCS	Breast Cancer Screening						
ABA	Adult Body Mass Index Assessment						
Maternal and Perinatal Health							
PC01	PC-01: Elective Delivery						
PPC	Prenatal and Postpartum Care: Postpartum Care						
CCP	Contraceptive Care – Postpartum Women Ages 21 to 44						
CCW	Contraceptive Care – All Women Ages 15 to 20						
Care of Acute and Chronic Conditions							
CBP	Controlling High Blood Pressure						
HPC	Comprehensive Diabetes Care: HbA1C Poor Control (>9.0%)						
PQI01	PQI 01: Diabetes Short-Term Complications Admission Rate						
PQI05	PAI 05: COPD or Asthma in Older Adults Admission Rate						
PQI08	PQI 08: Heart Failure Admission Rate						
PQI15	PQI 15: Asthma in Younger Adults Admission Rate						
PCR	Plan All-Cause Readmission						
AMR	Asthma Medication Ration: Ages 19 to 64						
HVL	HIV Viral Load Suppression						
Behavioral Health Care							
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment						
MSC	Medical Assistance with Smoking and Tobacco Use Cessation						
AMM	Antidepressant Medication Management						
FUH	Follow-Up After Hospitalization for Mental Illness: Age 18 and older						
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications						
HPCMI	Diabetes Care for People with Serious Mental Illness: HBA1c Poor Control (>9.0%)						
OHD	Use of Opioids at High Dosage in Persons without Cancer						
COB	Concurrent Use of Opioids and Benzodiazepines						
OUD	Use of Pharmacotherapy for Opioid Use Disorder						
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence						
FUM	Follow-Up After Emergency Department Visit for Mental Illness						
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia						
Experience of Care							
CPA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)						
Long-Term Services & Supports							
NCIDDS	National Core Indicators Survey						



North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020 #5221

Primary Care Access and Preventive Care





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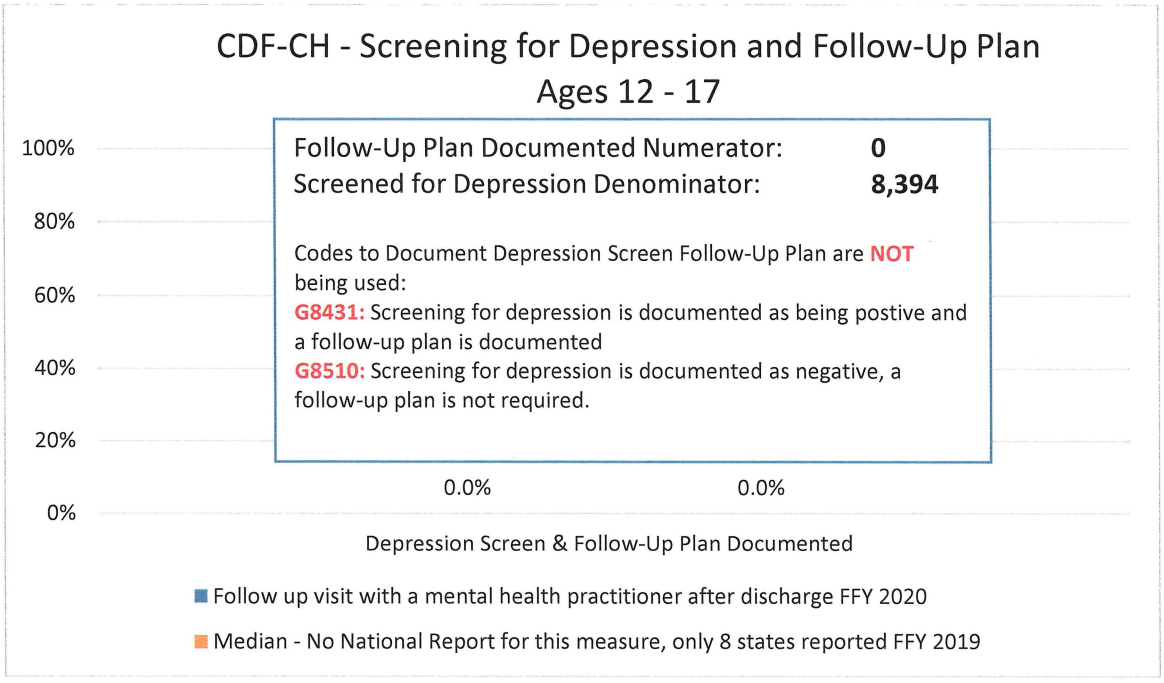
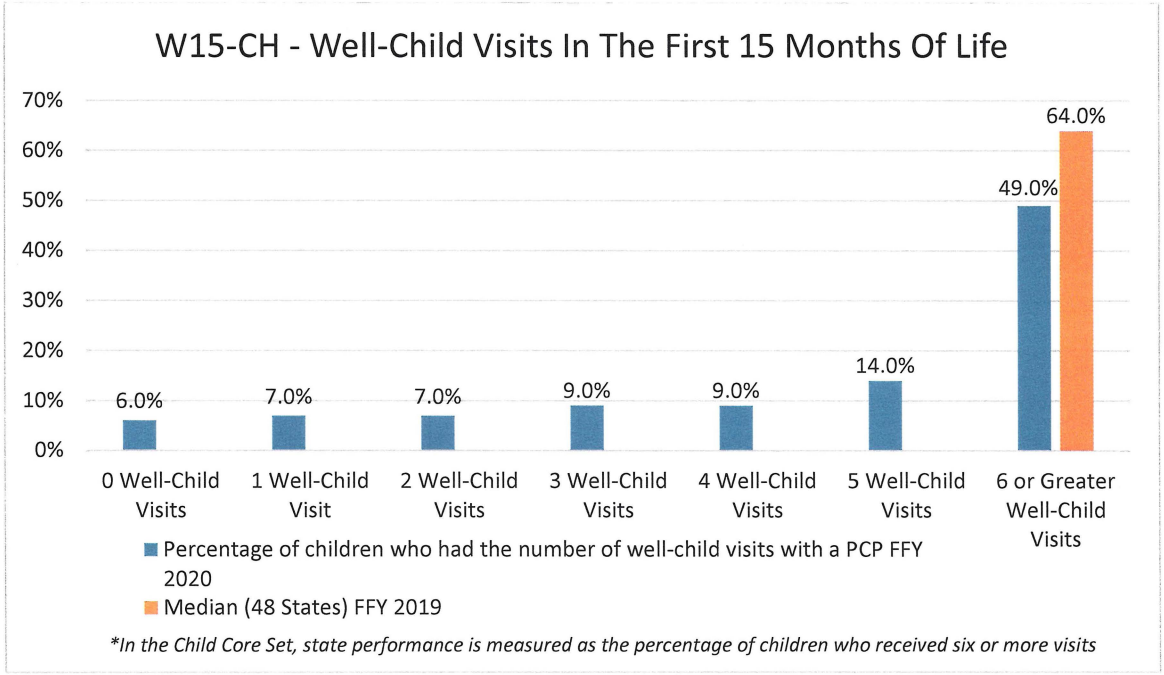
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020





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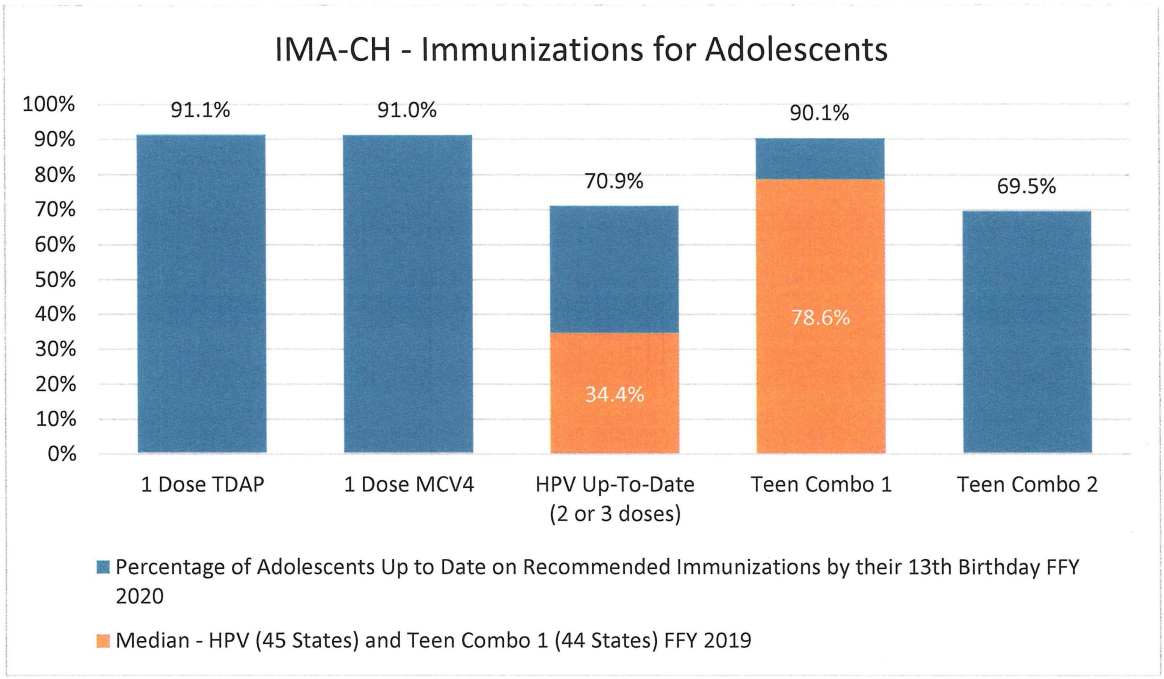
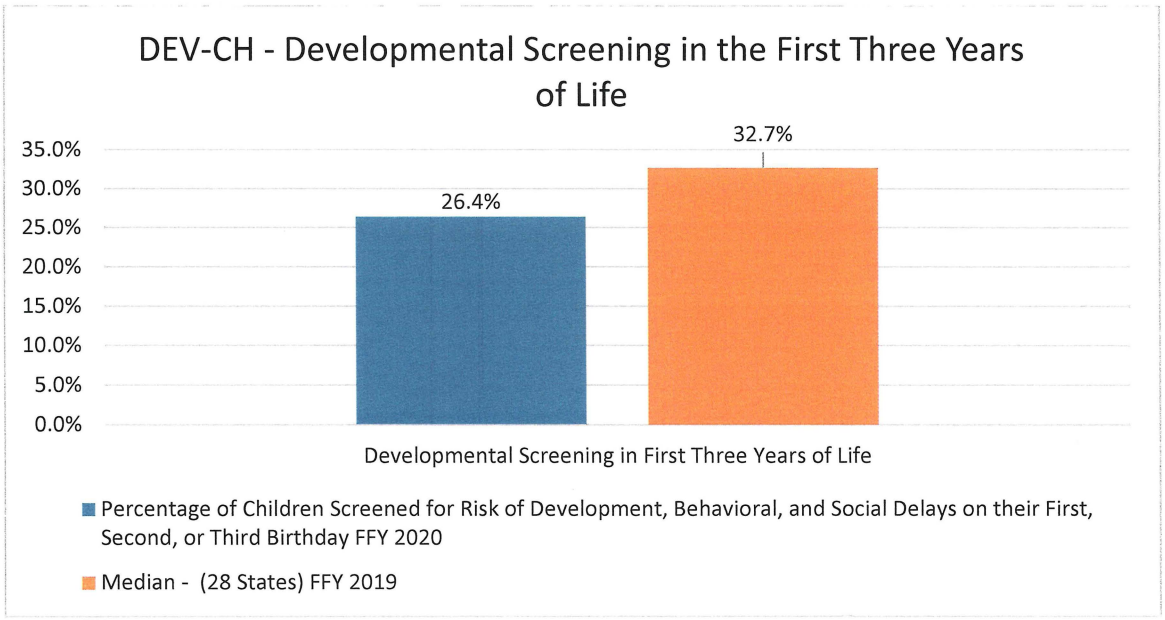
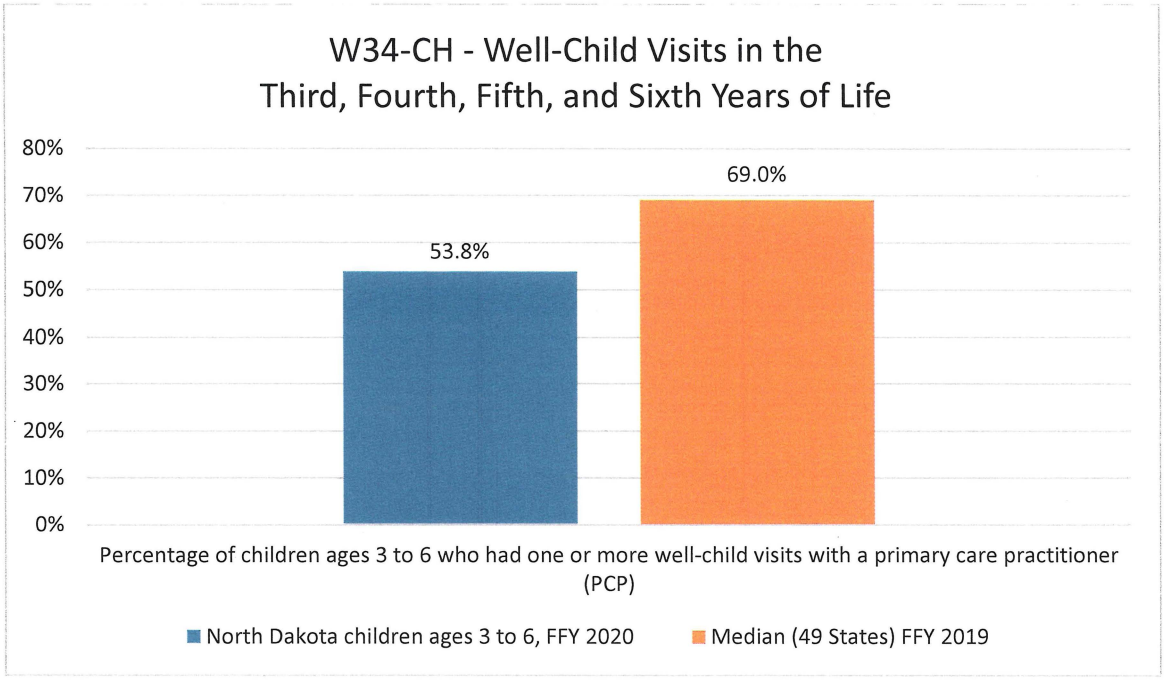
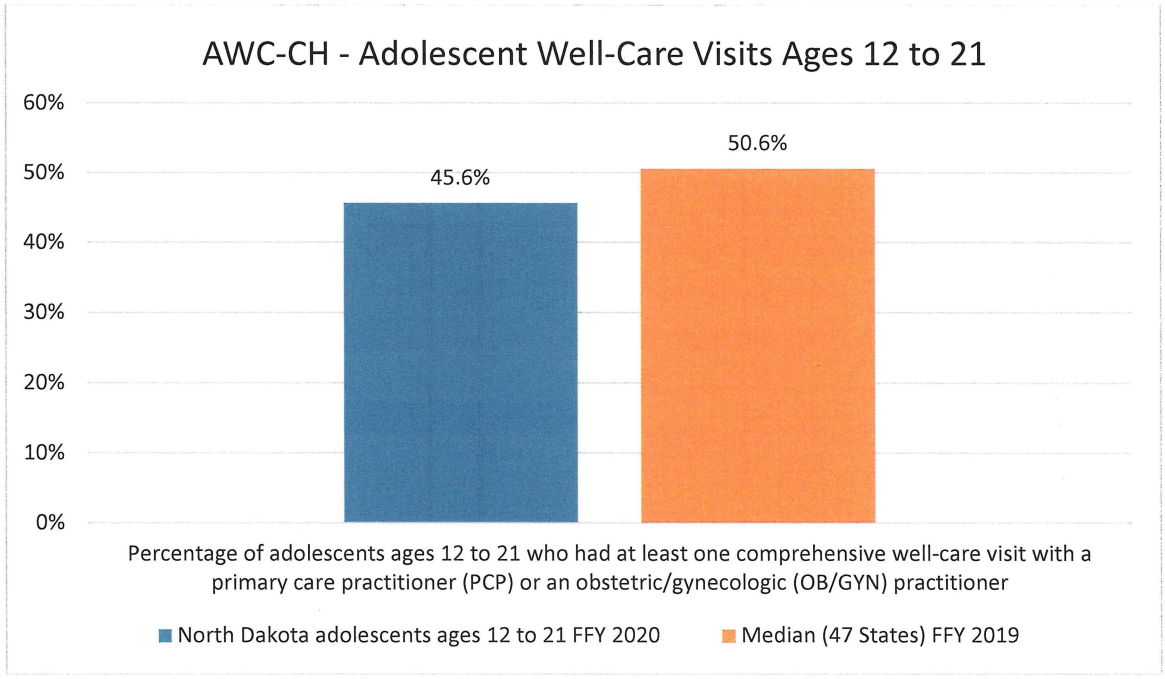
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020





North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

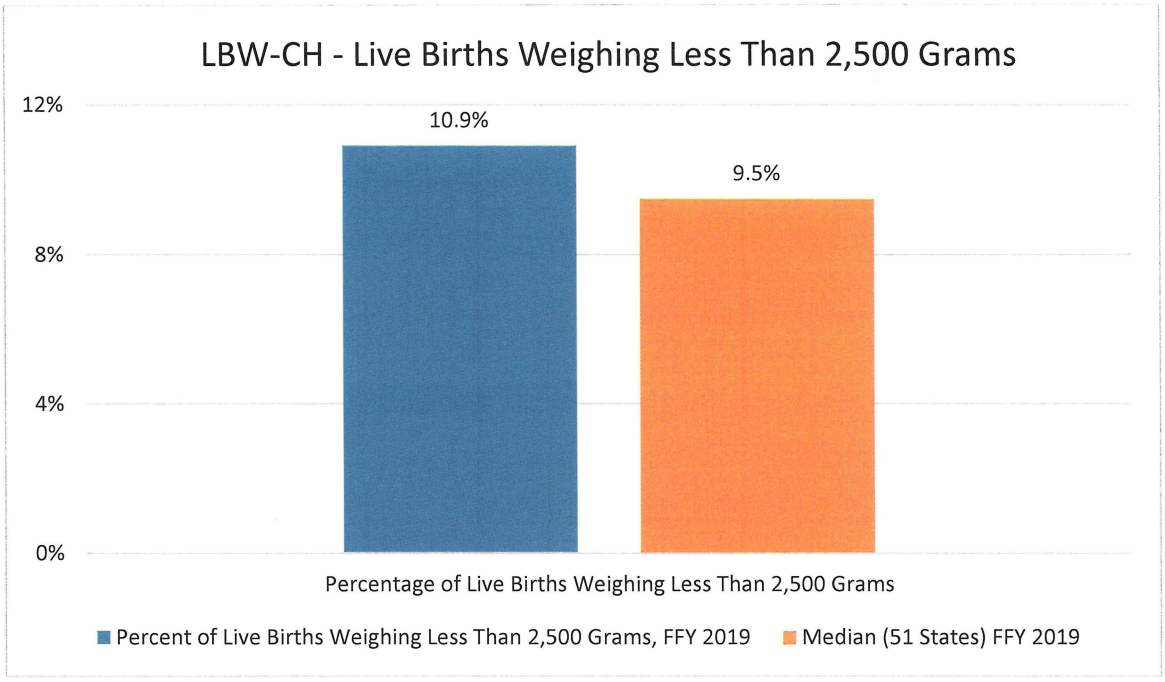


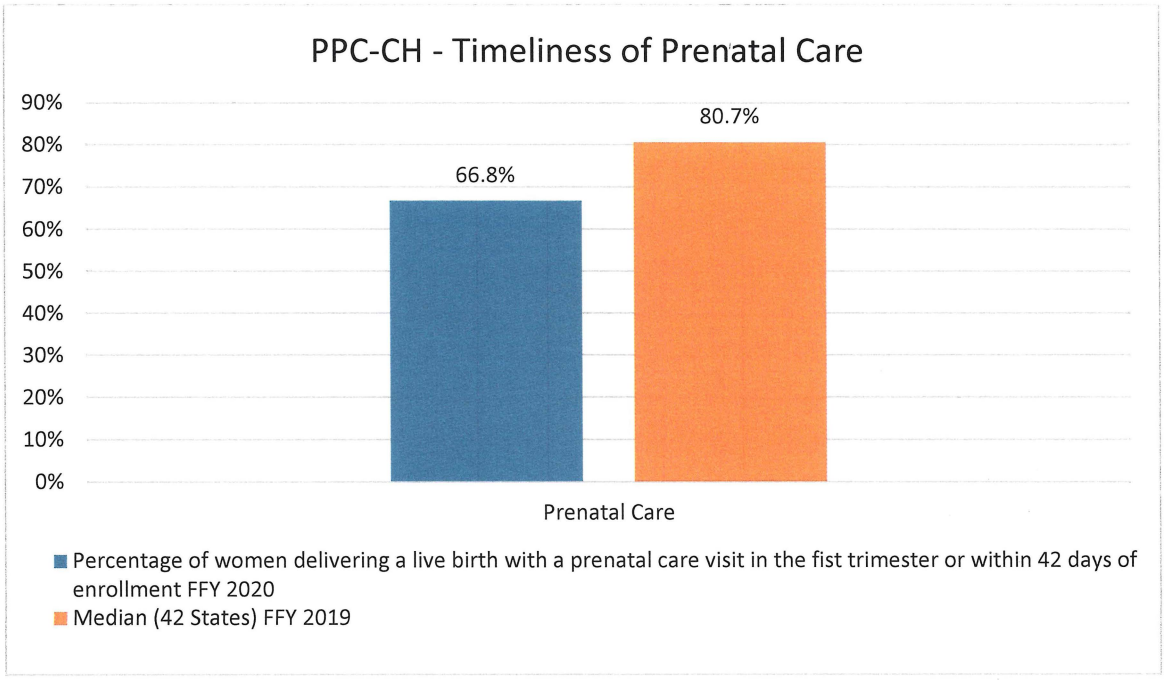


North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

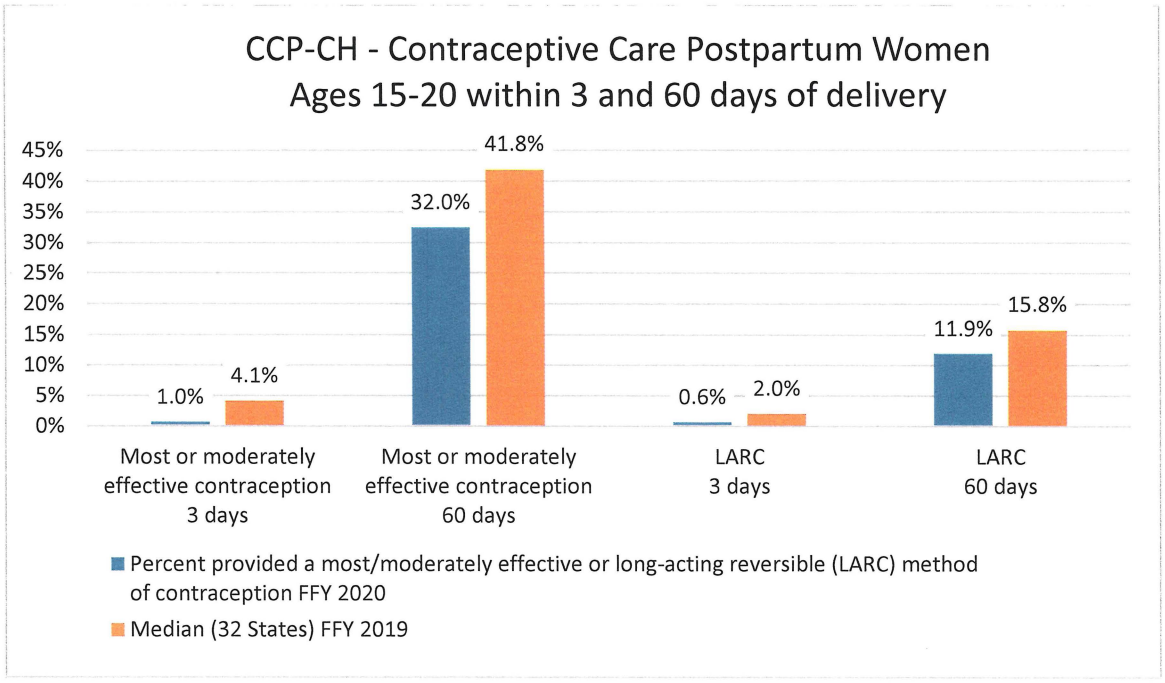
Maternal and Perinatal Health

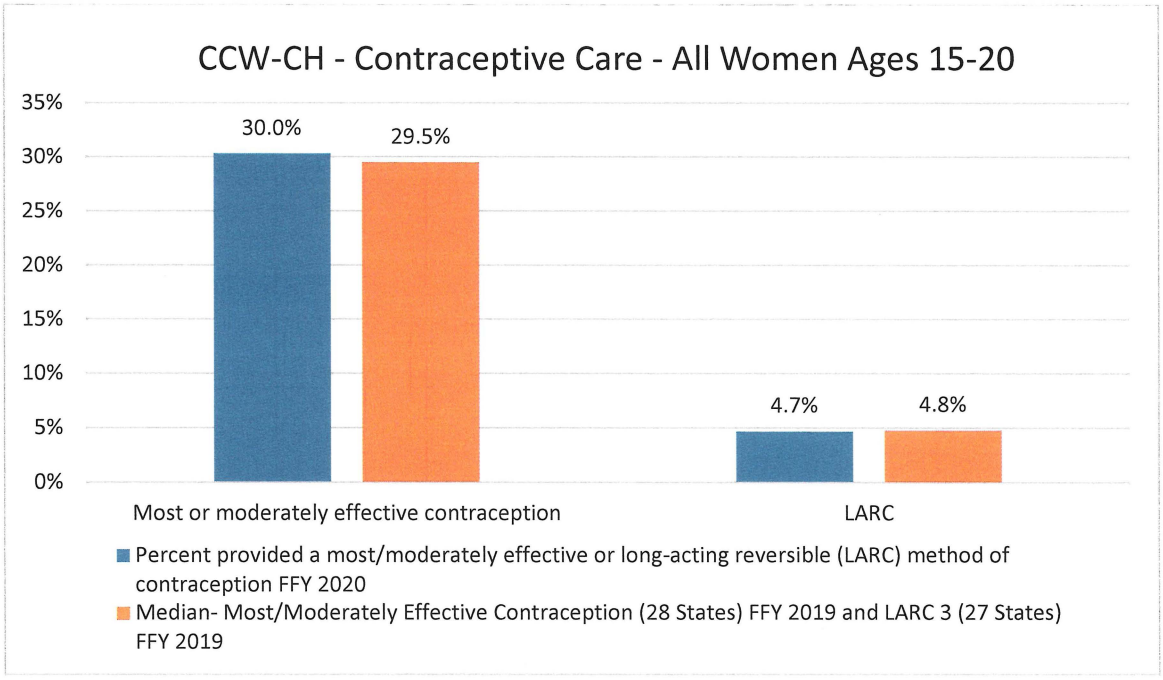
LBW-CH Chart is for FFY 2019, data for FFY 2020 will be sent out in Spring 2021





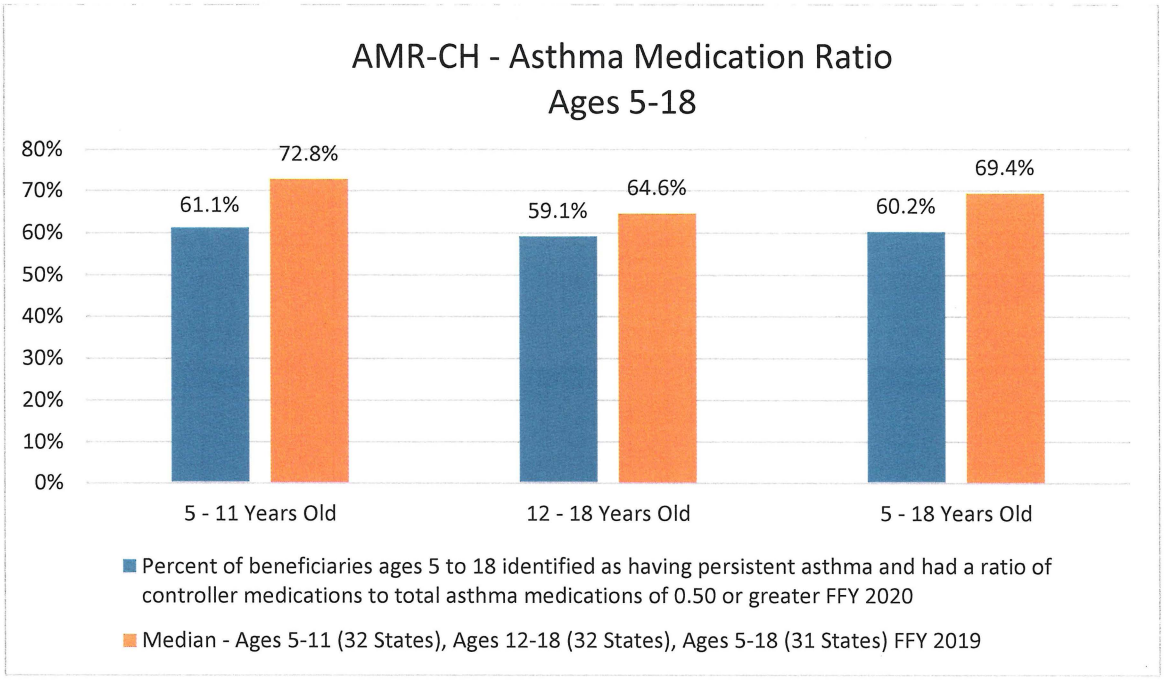
North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

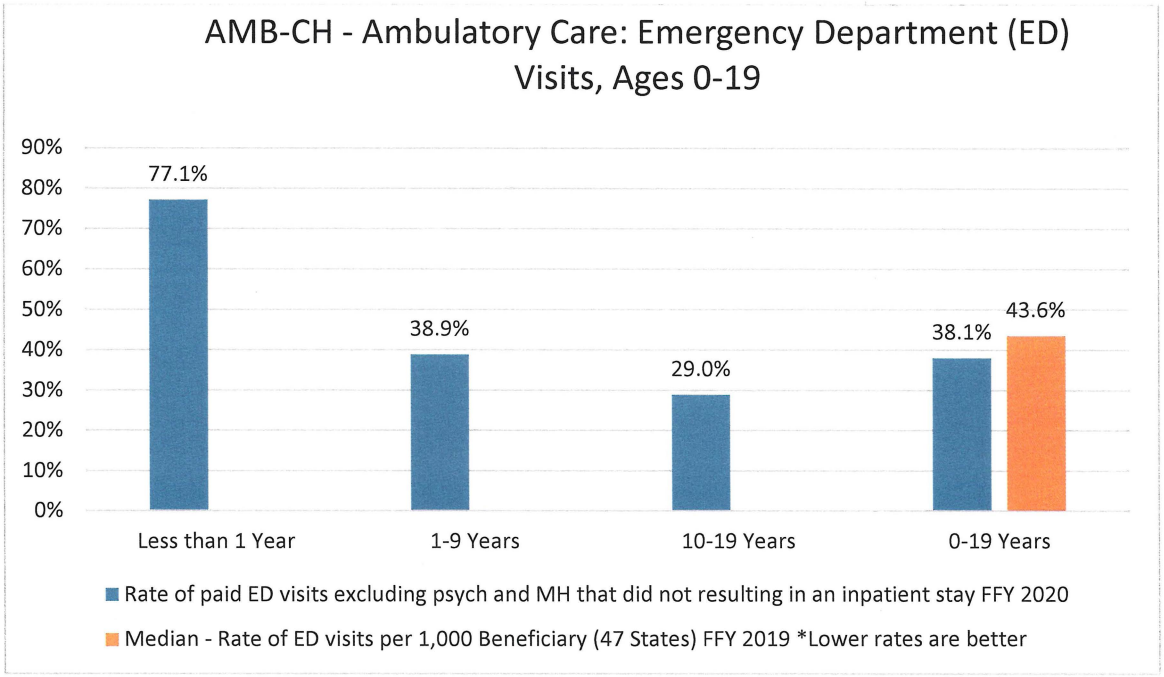




North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

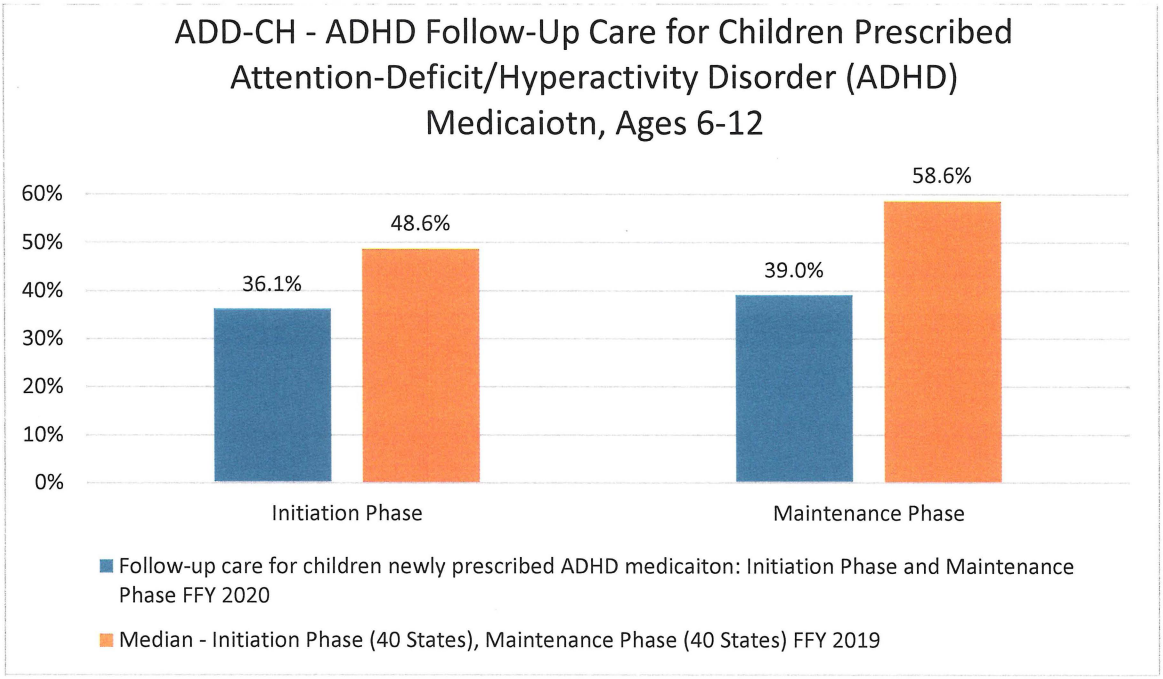
Care of Acute and Chronic Conditions

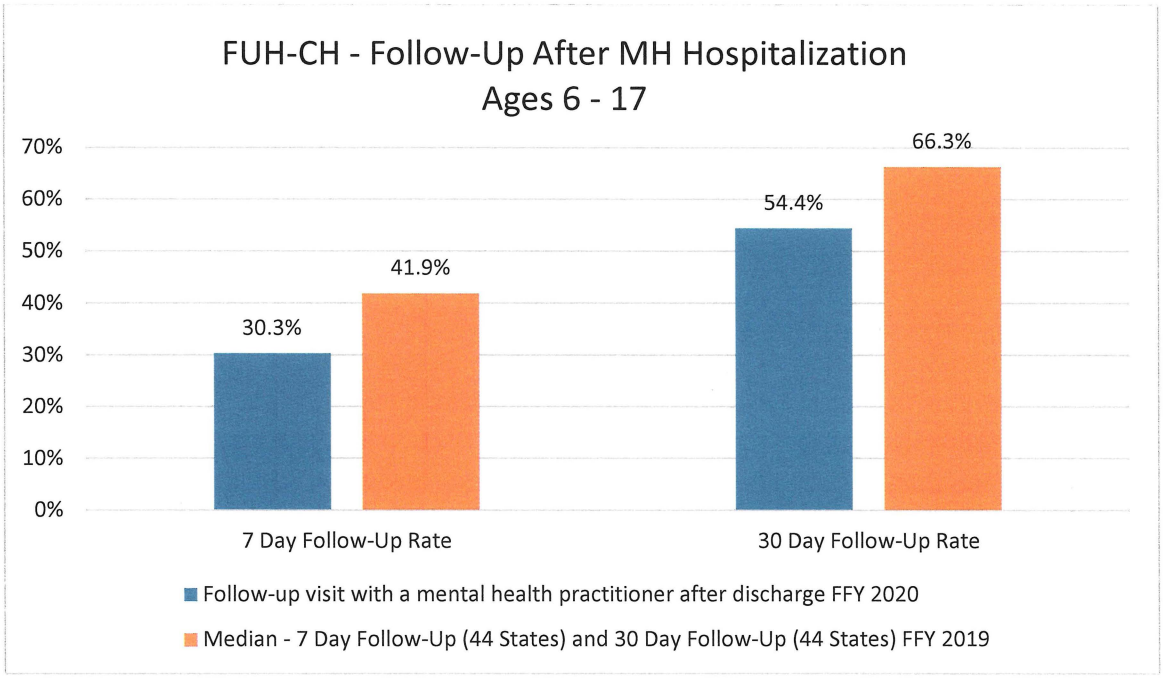




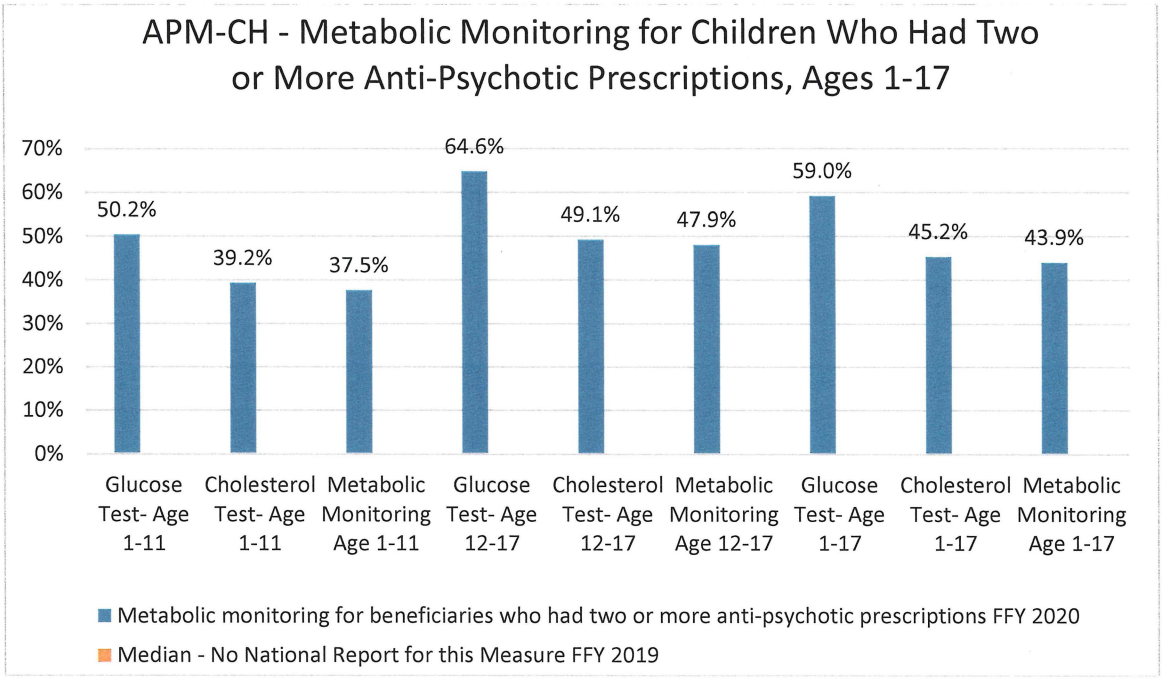
North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

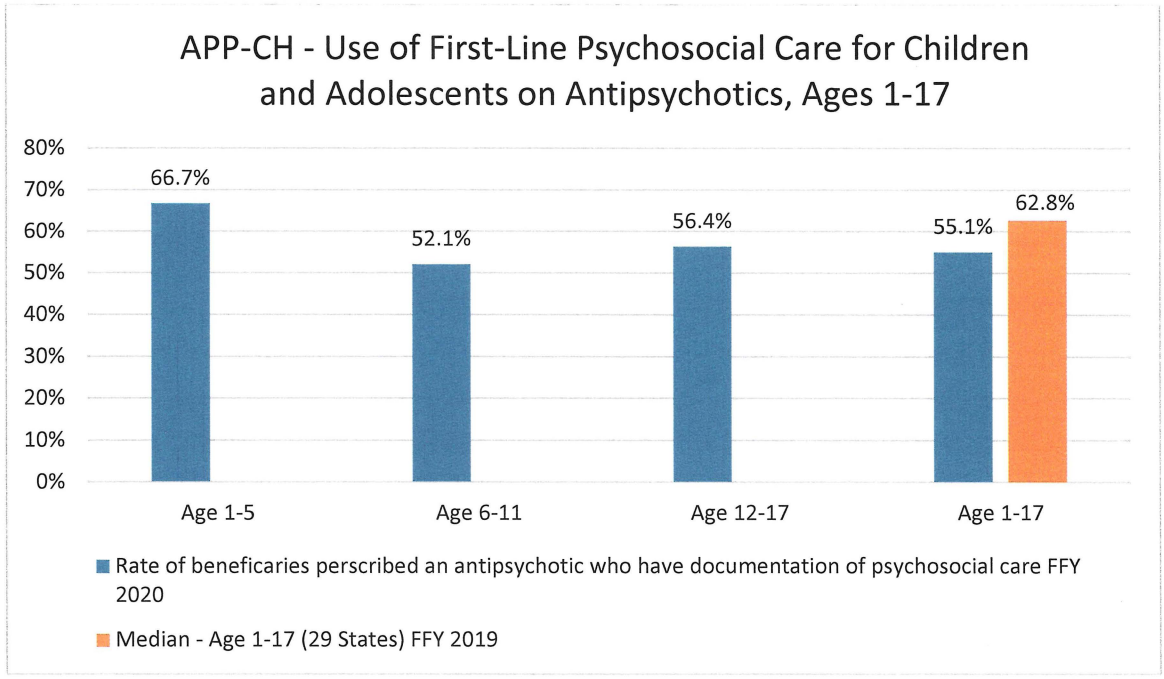
Behavioral Health Care





North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

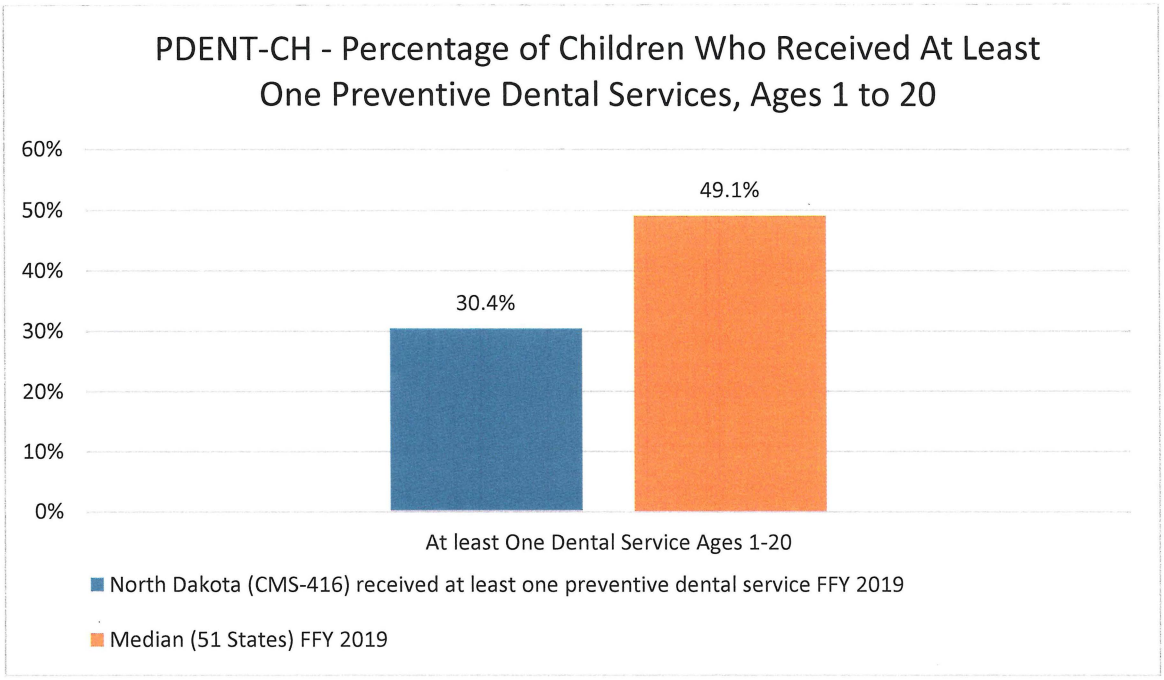


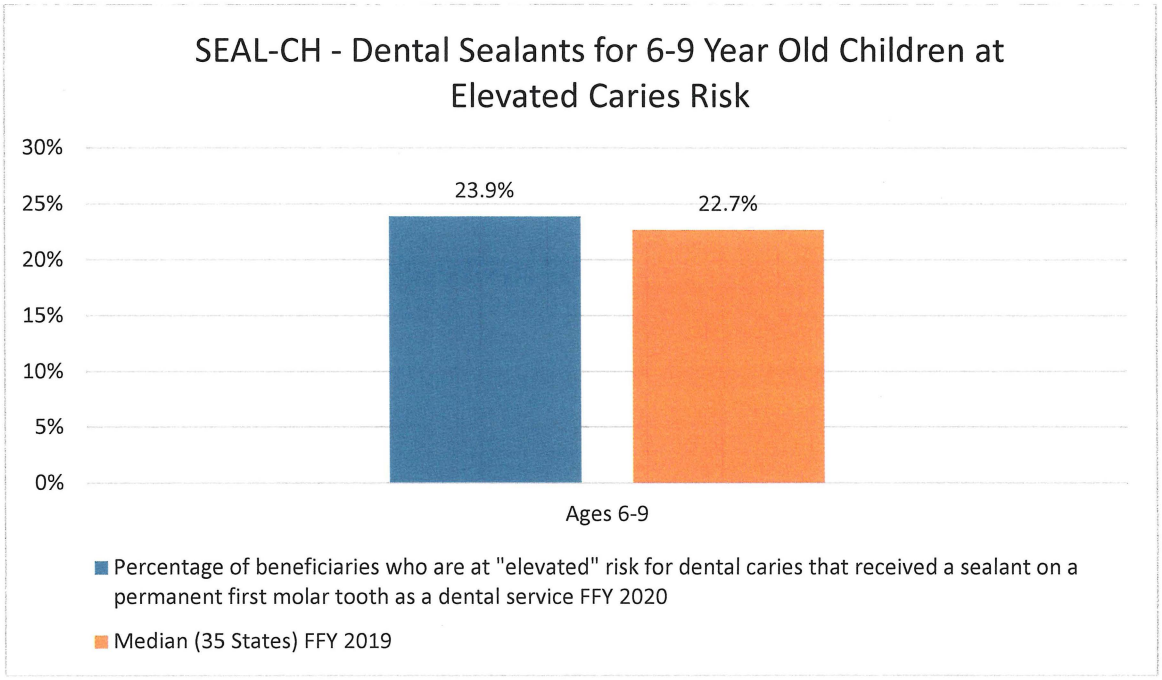


North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

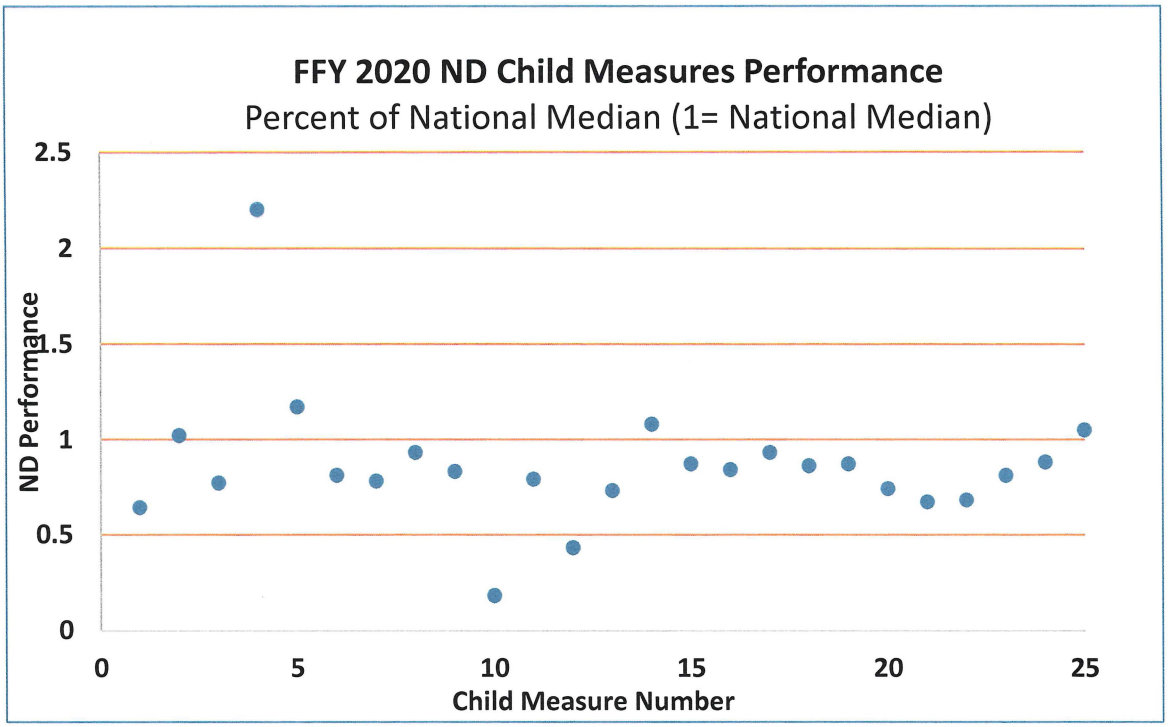
Dental and Oral Health Services

PDENT-CH Chart is for FFY 2019, data for FFY 2020 will be sent out in Spring 2021





North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020



North Dakota's Child Core Set:
Children's Health Care Quality Measures for Medicaid
Federal Fiscal Year 2020

Child Core Set							
Measure		2019	2020	2021	2022	2023	2024
Primary Care Access and Preventive Care							
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
CHL	Chlamydia Screening in Women Ages 16 to 20						
CIS	Childhood Immunization Status						
CDF	Screening for Depression and Follow-Up Plan: Ages 12 to 17						
W15	Well-Child Visits in the First 15 Months of Life						
IMA	Immunizations for Adolescents						
DEV	Developmental Screening in the First Three Years of Life						
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						
AWC	Adolescent Well-Care Visits						
Maternal and Perinatal Health							
PC02	PC-02: Cesarean Birth						
AUD	Audiological Diagnosis No Later Than 3 Months of Age						
LBW	Live Births Weighing Less Than 2,500 Grams						
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care						
CCP	Contraceptive Care – Postpartum Women Ages 15 to 20						
CCW	Contraceptive Care – All Women Ages 15 to 20						
Care of Acute and Chronic Conditions							
AMR	Asthma Medication Ratio Ages 5 to 18						
AMB	Ambulatory Care: Emergency Department (ED) Visits						
Behavioral Health Care							
ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication						
FUH	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17						
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics						
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics						
Dental and Oral Health Services							
DQA	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk						
CMS	Percentage of Eligibles Who Received Preventive Dental Services						
Experience of Care							
CPC	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Child Version (Medicaid)						

Reported
Not Reported

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/3/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 2:45 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Psychiatric Hospital and Residential Bed study
- Institutions for Mental Disorders
- Improving Care Coordination
- Transition to Community based care

Rosalie Etherington, Chief Clinic Dir(2:45 pm) testified about the Psychiatric Hospital and Residential Bed study #5296

Caprice Knapp, Medicaid Dir(3:05 pm) testified about the IMD #5270

Jeff Herman, CEO of Praire St. Johns (3:32 pm) testified about Care Coordination, oral testimony

Ty Hegland, CEO of Share House (3:46 pm) testified about Care Coordination, oral testimony

Arnie Strebe, CEO CFO of DHS (3:52 pm) testified about Amendment Review and Approval Process

Chair Nelson closed the meeting at 4:19 p.m.

Cole Fleck, Committee Clerk

INSTITUTE FOR MENTAL DISEASE (IMD)

House Appropriations | Human Resources Division

Representative Jon Nelson, Chairman

Psychiatric Hospital and Residential Bed Study Conclusions

Rosalie Etherington, Chief Clinics Officer, State Hospital Superintendent

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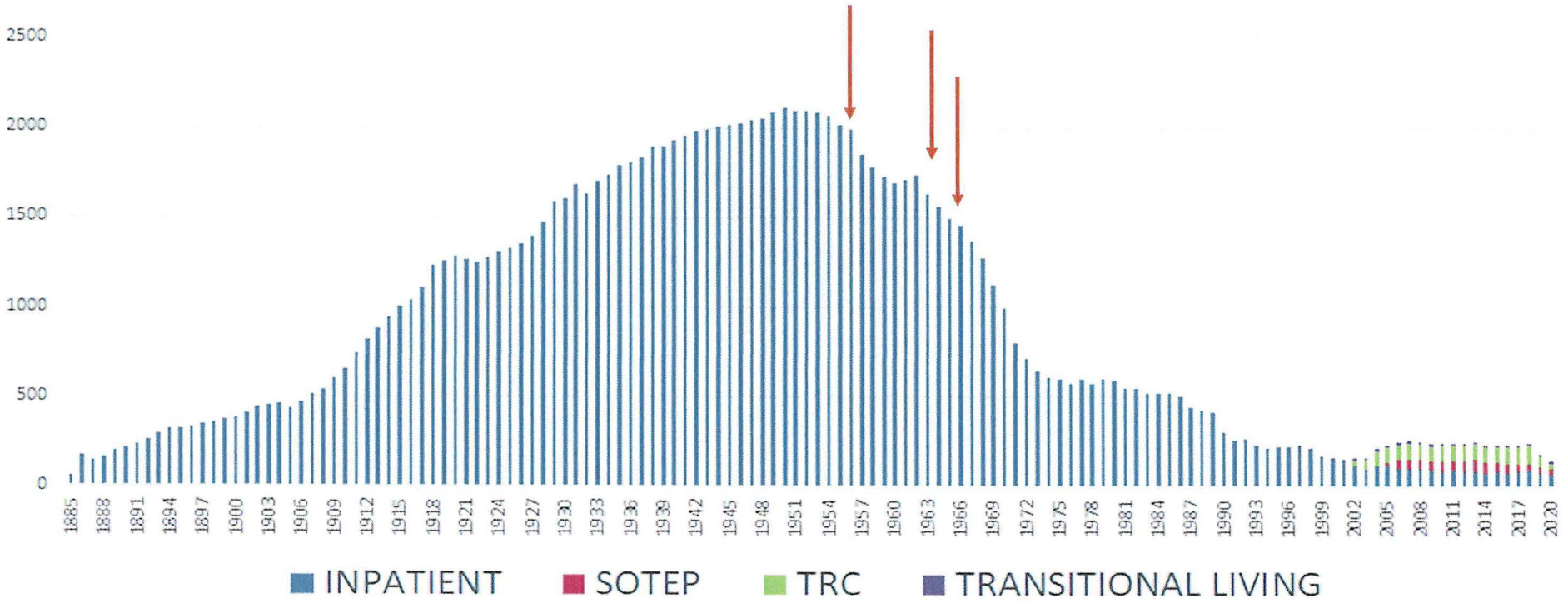
INSTITUTE FOR MENTAL DISEASE (IMD)

- An **IMD** is **defined** in federal statute as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

HISTORICAL CONTEXT

- Disincentivize the treatment in large institutions
- Shift the costs from the federal government onto states.

1963 COMMUNITY MENTAL HEALTH ACT
1965 IMD EXCUSION



PSYCHIATRIC HOSPITAL BED STUDY CONCLUSIONS

- North Dakota has sufficient psychiatric hospital beds
- North Dakota does not have signs of a hospital bed shortage
- Expansion of beds is counter to the expansion of community services
- No evidence regarding risks and benefits of mental health waivers

RESIDENTIAL BED STUDY CONCLUSIONS

- North Dakota has sufficient youth and adult residential beds
- Utilization rates of residential beds are higher than the national averages
- Residential beds are occupied with those that could be served elsewhere

BED STUDY ACTION STEPS



Thank you

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Institutions for Mental Diseases (IMDs) – Concept and Process Overview #5270

House Appropriations Human Resources, Chairman Nelson

Medical Services Division, Caprice Knapp – Director

February 3, 2021

NORTH Dakota | Human Services

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Background

An institution for mental diseases (IMD) is defined in section 1905(i) of the Social Security Act to mean a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an IMD. There are two exceptions to the IMD exclusion: 1) inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 and older in IMDs (42 CFR § 440.140), and 2) inpatient psychiatric hospital services for individuals under age 21, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility" (PRTF) (42 CFR § 440.160).

IMDs in North Dakota

In North Dakota, the following facilities are classified as IMDs: The State Hospital in Jamestown (140 beds); Prairie St. John's in Fargo (110 beds); ShareHouse in Fargo (87 beds); and Summit Prairie Recovery Center in Raleigh (36 beds).

'Waiving' the Prohibition of Medicaid Payment for IMD Services

Section 1115 of the Social Security Act gives the Secretary of the U.S. Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid law to give states additional flexibility to design and improve their programs.

Some states have received approval from CMS for 1115 waivers related to substance abuse disorder (SUD) treatment services provided in IMDs. In November 2018, CMS clarified that they will also approve 1115 waivers for services provided in IMDs that focus primarily on treatment for individuals with serious mental illness (SMI) or serious emotional disturbance (SED)[1]. States may choose to focus their 1115 waivers on SUD treatment, SMI/SED treatment, or both at the same time.

States have the flexibility to design 1115 demonstrations aimed at making significant improvements over the course of a five-year period. Compliance with the following goals and milestones is required.

Required Goals for SUD 1115 waiver:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

- Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

Required Milestones for SUD 1115 waiver:

- Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
- Widespread use of evidence-based, SUD-specific patient placement criteria;
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- Sufficient provider capacity at each level of care;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transitions between levels of care.

Required Goals for SMI/SED 1115 waiver:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Required Milestones for SMI/SED 1115 waiver:
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity’s accreditation requirements;

- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers);

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and

psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED;

Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model as well as consideration of a self-direction option for beneficiaries;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, to help determine appropriate level of care and length of stay;

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Other 1115 Waiver Requirements:

- Demonstrations must be "budget neutral" to the Federal government, which means that, during the project, federal Medicaid expenditures will not be more

than federal spending without the demonstration[2]. Calculations are based on per member, per month expenditures pre- and post-implementation for the targeted population [PMPM*Member Months]. Other methodologies may be accepted by CMS.

- Demonstrations must have implementation and evaluation plans approved by CMS.
- 1115 waivers do not allow for room and board payments unless the facility qualifies as an inpatient facility under section 1905(a) of the Social Security Act.
- States are required to have staff and/or contractual resources necessary to conduct independent and robust interim and final evaluations.

Other Considerations:

- Even if ND was approved for an 1115 waiver that would allow Medicaid to reimburse for treatment within an IMD, there would still be limits on the number of days that can be reimbursed (15 days per year for inpatient IMD; 30 days per year for residential IMD[3]). An 1115 waiver would apply only to traditional fee-for-service Medicaid.
- IMD reimbursement for the Medicaid Expansion group, which is currently operated as managed care, would not be included in an 1115 waiver. Federal managed care rules allow capitation payments to be made to a managed care organization (MCO) for a member aged 21 through 64 receiving inpatient treatment in an IMD if it is for psychiatric or SUD crisis residential services and the length of stay is no more than 15 days during the month of the capitation payment[4]. These services must also meet the requirements for 'in lieu of' services, meaning that the state has determined the IMD is medically appropriate and a cost effective substitute, the member is not required by the MCO to choose the IMD setting and the approved in lieu of services are considered in developing the component of the capitation rates that represents the covered services[5].
- There are a targeted number of IMD beds in the state that a waiver would open to Medicaid reimbursement. Also, since Medicaid is the only health care payer with a restriction on paying for IMD services and is the payer of last resort, other payers would pay before Medicaid.
- A waiver for IMDs would not expand eligibility or services. SUD and SMI/SED treatment can already be accessed by Medicaid members in settings not classified as IMDs. The only SUD treatment service that would be offered by an IMD is medically managed detoxification, which is a higher level of SUD treatment than most people need.
- Budget neutrality may be difficult to achieve, given the complex needs of the population who would be eligible for the waiver services, the infrastructure development requirements associated with the required goals and milestones, and the assumptions that are used to generate cost estimates. CMS monitors

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf
[4] https://www.law.cornell.edu/cfr/text/42/438.6
[5] https://www.law.cornell.edu/cfr/text/42/438.3

budget neutrality throughout the demonstration period and performs a formal adjudication at the end of the demonstration period to determine whether a state's actual spending has remained within the specified limit. During demonstration approval, the state must agree to limit their receipt of federal financial participation to the amounts indicated in the budget neutrality test and to return any funds they receive above those limits to CMS[6].

- In two Human Services Research Institute studies pursuit of an IMD waiver was not a recommendation.
- The milestones required to be addressed by states that implement 1115 waivers are broad and would require significant development of the behavioral health continuum.
- The US Government Accountability Office (GAO) found[7] that selected states' evaluations of these demonstrations had widespread, significant limitations that affected their usefulness in informing policy decisions. The limitations included gaps in reported evaluation results for important parts of the demonstrations. CMS is attempting to strengthen evaluation requirements and hold states accountable for meaningful and timely 1115 evaluation requirements.

<u>Examples</u>

Colorado's SUD 1115 waiver

- 2018 started the process, 2021 completed the process
- 2 FTEs allocated; unclear others that contribute to supporting roles.
- ~$500,000 year 1 and year 2; year 1 of implementation $174 million (inpatient and residential treatment)
- Post-implementation $1.58 million for consultants and IT systems (annually)

Virginia's 1115 waiver on Community Engagement, Premiums and Wellness Accounts, Housing and Employment Supports for High Need Enrollees

- 3 FTEs working 100%; 9 total from Compass Division chart (housing analyst, employment analyst, data analyst, wellness accounts analyst, finance analyst, Senior Advisor, Senior Program Analyst, Senior Policy Analyst)
- Manatt as a consultant to write the waiver; cost $3.495 million for Manatt
- Timeline- 2018 to December 2019 but an added 6 months after that to implement. Negotiate with CMS on budget neutrality, implementation plan, and evaluation plan.

[6] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf
[7] https://www.gao.gov/products/GAO-18-220

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/4/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 8:32 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Housing
- Social Determinates of Health
- Elements of Supportive Housing
- Economic Assistance
- Community Integration

Jessica Thomasson, DHS (8:33 am) testified about Housing and its role in Economic Health and Wellbeing #5407

Arnie Strebe, CEO CFO of DHS (8:40 am) testified about fact sheet process, oral testimony

Chair Nelson closed the meeting at 10:10 a.m.

Cole Fleck, Committee Clerk



House Appropriations | Human Resources
Division *Representative Jon Nelson, Chairman #5407*

Housing and its role in Economic Health and Wellbeing

February 3, 2021

NORTH Dakota | Human Services
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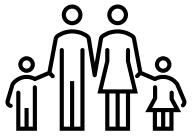
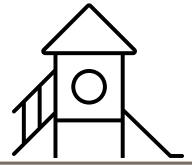
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



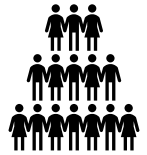
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

DHS AUTHORITY ESTABLISHED IN NDCC 50-06

Administration of human services programs related to:

- Children and families
- Individuals with developmental disabilities
- Aging services
- Behavioral health
- Economic assistance
- Medical service
- General assistance
- Child support

CHAPTER 50-06
DEPARTMENT OF HUMAN SERVICES

50-06-01. Definitions.
As used in this chapter, unless the context otherwise requires:

1. "Behavioral health" means the planning and implementation of preventive, consultative, diagnostic, treatment, crisis intervention, rehabilitative, and suicide prevention services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions.
2. "Behavioral health provider" means any licensed or accredited behavioral health provider in this state.
3. "Department" means the department of human services.
4. "Human services" means:
   a. A service or assistance provided to an individual or an individual's family in need of services or assistance, including child welfare services, economic assistance programs, medical services programs, and aging services programs, to assist the individual or the individual's family in achieving and maintaining basic self-sufficiency, including physical health, mental health, education, welfare, food and nutrition, and housing.
   b. A service or assistance provided, administered, or supervised by the department in accordance with chapter 50-06.
   c. Licensing duties as administered or supervised by the department or delegated by the department to a human service zone.

50-06-01.1. Department of human services to be substituted for public welfare board of North Dakota and social service board of North Dakota, members of board, and executive director.

When the terms "public welfare board of North Dakota", "social service board of North Dakota", "executive director of the public welfare board", "executive director of the social service board", "member of the public welfare board", or "member of the social service board", or any derivative of those terms which, when used in context indicates an intention to refer to those persons or that board, appear in the North Dakota Century Code, the term "department of human services", or the term "executive director of the department of human services", as the case may be, must be substituted therefor. It is the intent of the legislative assembly that the department of human services must be substituted for, shall take any action previously to be taken by, and shall perform any duties previously to be performed by the public welfare board of North Dakota or by the social service board of North Dakota.

The threads that run through every person's life

Foundations of Wellbeing are Interconnected



Economic Health

Having the resources you need to meet basic needs contributes to stability and is a foundation you can build on

Behavioral Health

Having good mental health and a healthy relationship with substances boosts your ability to weather life's storms

Physical Health

When you are in good physical health you can better navigate the activities of daily and community life

The stability that comes from good **economic** health can **improve behavioral** health.
The stability that comes from good **physical** and **behavioral** health **enables economic** health.

DHS Mission and Operating Principles

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.



Childhood experiences



Housing



Education



Social support



Family income



Employment



Our communities



Access to health services

Source: NHS Health Scotland



Jason needs a place to live.

Can I find a place that meets my needs?

- In the community where I want to live
- Right size for my household
- Accessible

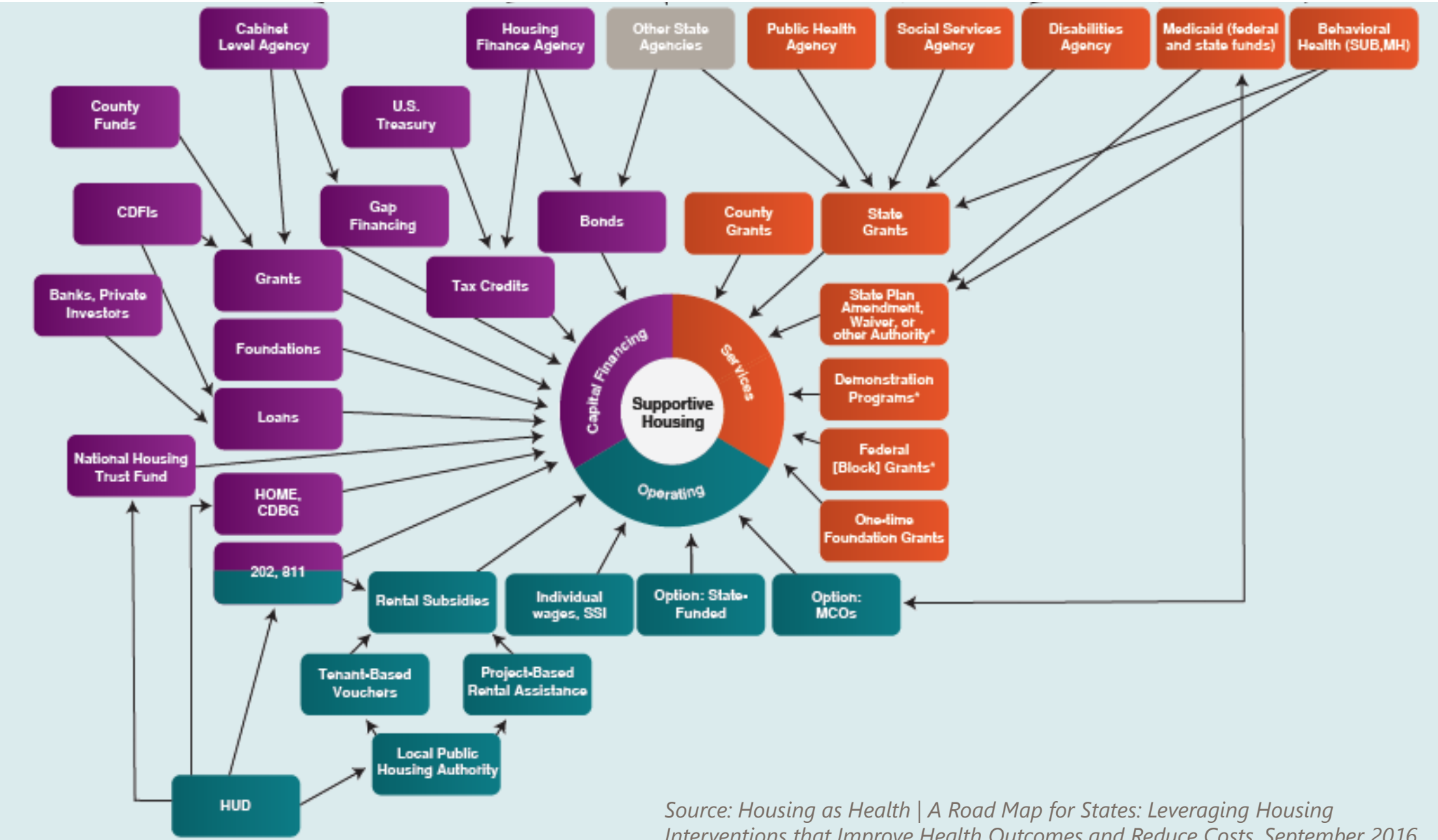
Can I afford to pay the cost of my housing?

- Rent or Mortgage
- Utilities
- Taxes
- Repairs

If things aren't going well, can I get help if I need it?

- Help with activities of daily living
- Personal care assistance
- Help managing your affairs
- Financial / budget / benefit counseling

Example of Partnerships involved in creating Supportive Housing



Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, September 2016

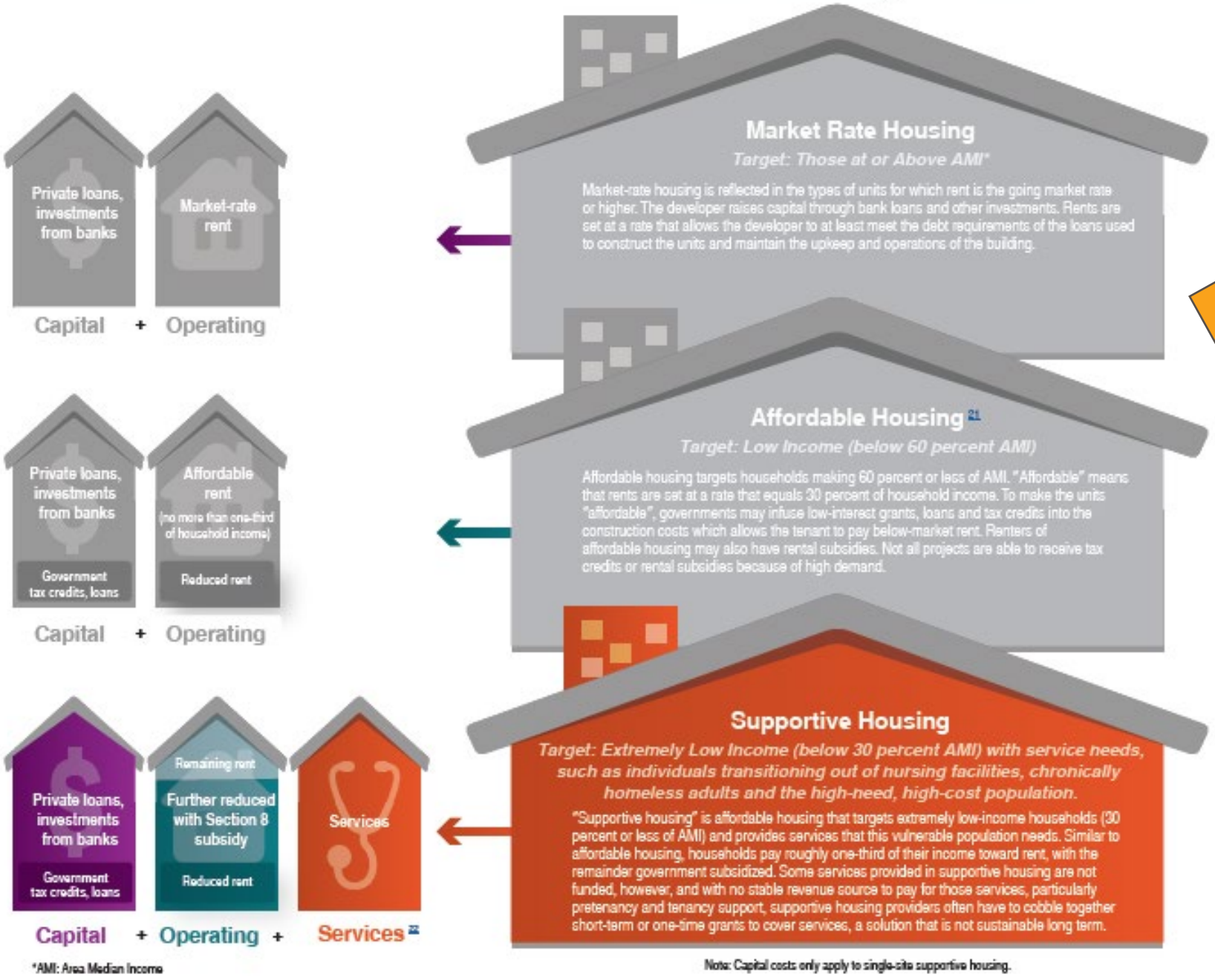
The Elements of Supportive Housing



The Challenge of Supportive Housing: Unlike Other Housing Models, Supportive Housing Must Encompass Services

Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, September 2016

Three Housing Models



Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, Sept 2016

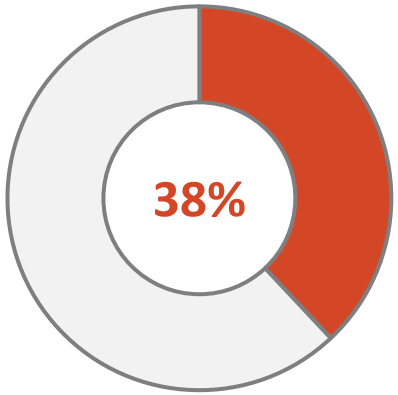
HOUSING SNAPSHOT - NORTH DAKOTA

$714-$972

40th percentile rents

Fair market rent (FMR) for a 2-bedroom apartment in ND varies from $714 - $972 (by region, 2018)

120,780



2 in 5 households

38% of North Dakotans are renters

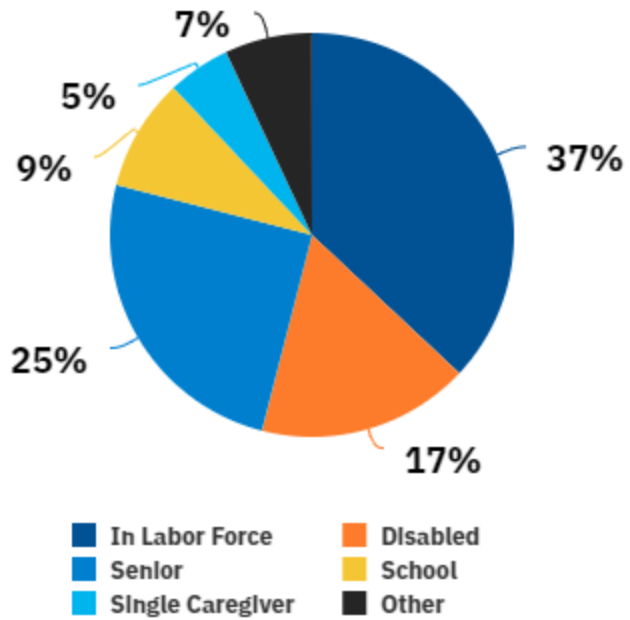
$26,140

30% of AMI

22% of renter households are considered extremely low income (30% AMI – state level)

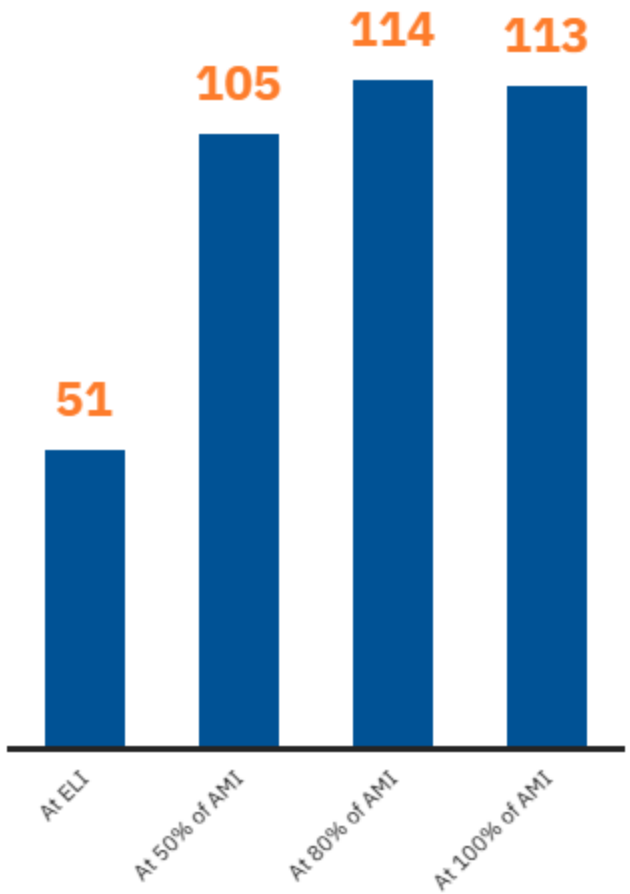
Which means a 4-person household earns a max of $26,140 (equal to a single wage of $12.56/hour)

EXTREMELY LOW INCOME RENTER HOUSEHOLDS



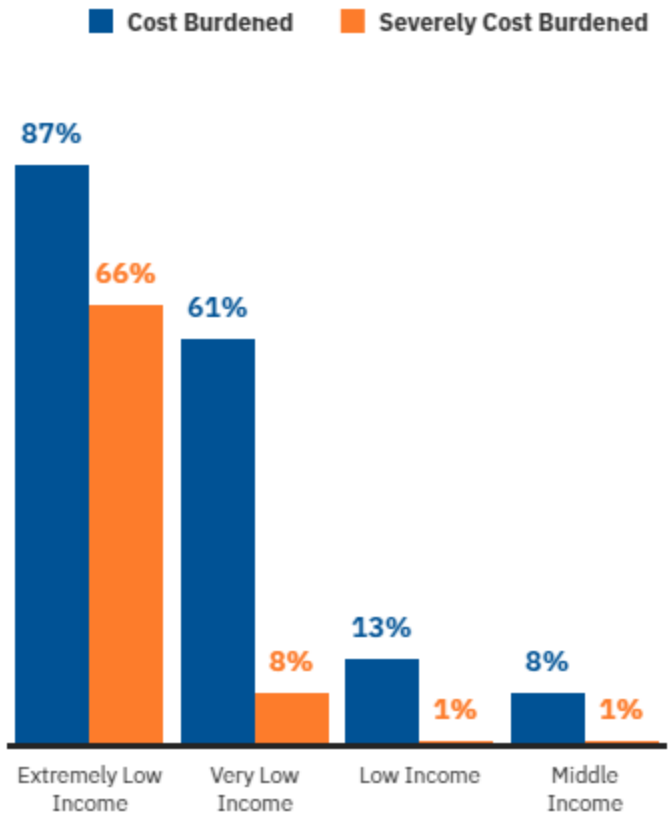
Note: Mutually exclusive categories applied in the following order: senior, disabled, in labor force, enrolled in school, single adult caregiver of a child under 7 or a person with a disability, and other. Fifteen percent of extremely low income renter households include a single adult caregiver, more than half of whom usually work more than 20 hours per week. Eleven percent of extremely low-income renter households are enrolled in school, 48% of whom usually work more than 20 hours per week.
Source: 2018 ACS PUMS.

AFFORDABLE AND AVAILABLE HOMES PER 100 RENTER HOUSEHOLDS



Source: NLIHC tabulations of 2018 ACS PUMS

HOUSING COST BURDEN BY INCOME GROUP



Note: Renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened.
Source: NLIHC tabulations of 2018 ACS PUMS

ECONOMIC ASSISTANCE

State Median Income for ND households 2020

Many federal assistance programs are designed to help individuals and families who earn less than 60% of State median income (SMI).

60% SMI is roughly equivalent to 200% of the federal poverty level.

	30% SMI		60% SMI		100% SMI	
Household Size	Annual Income	Hourly Wage	Annual Income	Hourly Wage	Annual Income	Hourly Wage
1	$ 15,720	$ 7.56	$ 31,440	$ 15.12	$ 52,400	$ 25.19
2	$ 20,562	$ 9.89	$ 41,124	$ 19.77	$ 68,540	$ 32.95
3	$ 25,398	$ 12.21	$ 50,796	$ 24.42	$ 84,660	$ 40.70
4	$ 30,234	$ 14.54	$ 60,468	$ 29.07	$ 100,780	$ 48.45
5	$ 35,070	$ 16.86	$ 70,140	$ 33.72	$ 116,900	$ 56.20
6	$ 39,912	$ 19.19	$ 79,824	$ 38.38	$ 133,040	$ 63.96
7	$ 40,818	$ 19.62	$ 81,636	$ 39.25	$ 136,060	$ 65.41
8	$ 41,724	$ 20.06	$ 83,448	$ 40.12	$ 139,080	$ 66.87

Hourly wage based on assumption of 2,080 hours of work / year (full time equivalent)

EVERY OCCUPATION HAS A DIFFERENT EARNING PROFILE, WHICH HELPS US UNDERSTAND WHO MAY BE ELIGIBLE FOR ASSISTANCE

Sampling of occupations by average wage (2019)

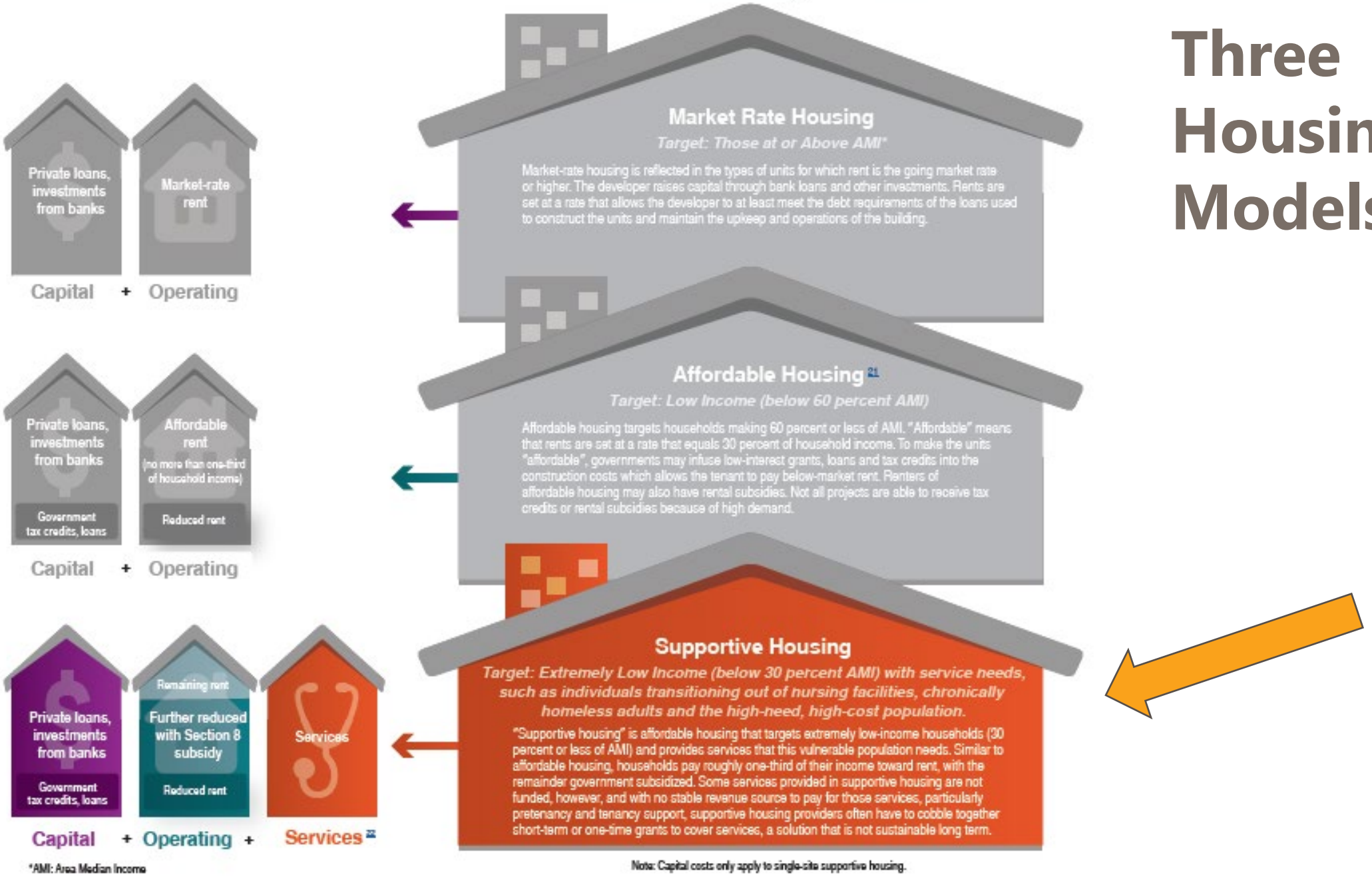




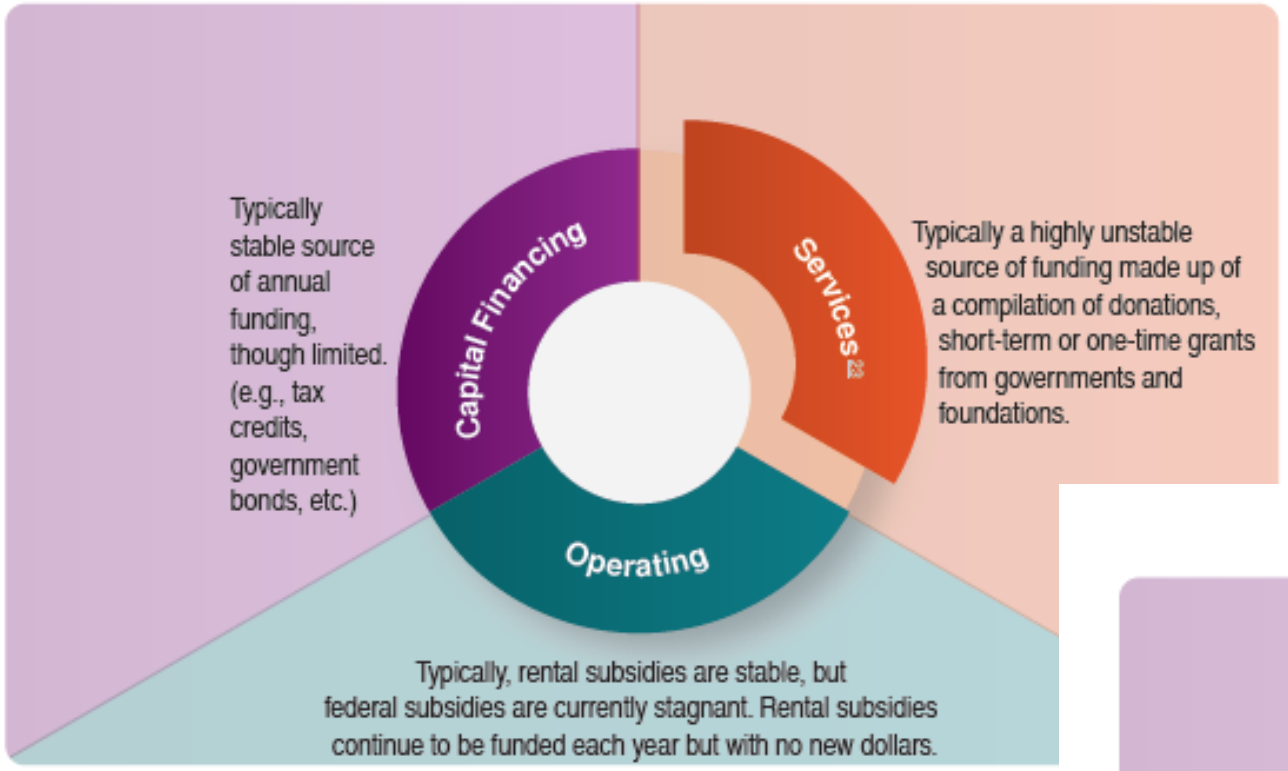


Less than $12 / hr	$12 - $20 / hour	$20 - $28 / hour	$28 - $35 / hour
Waiter/Waitress	Pharmacy tech	Carpenter	School counselor
Child care worker	Home health	Loan processor	Rotary drill oper
Dishwasher	PT assistant	Legal secretary	HR specialist
Bartender	Hair stylist	Correctional officers	Accountant
Cafeteria worker	Retail	Auto service tech	Real Estate Sales
Short order cook	Farmworker	Surgical tech	PR specialist
Cashiers	Restaurant cook	Roofer	Counselor
Clerical assistant	Data entry	Lic Practical Nurse	Registered Nurse
Personal care aide	EMTs & paramedics	Dental assistant	Computer network specialist
	Carpet installers	Firefighter	Construction supervisor
	Maintenance workers	Surgical assistant	Dental hygienist
	Nursing assistant	Clergy	Architecture occ
	Laborer	Social worker	Speech pathologist
	Substitute teacher	Police	
	Office/accounting clerk	Hotel manager	
	Light truck driver	Roustabout	
	Extraction helper	Heavy truck driver	

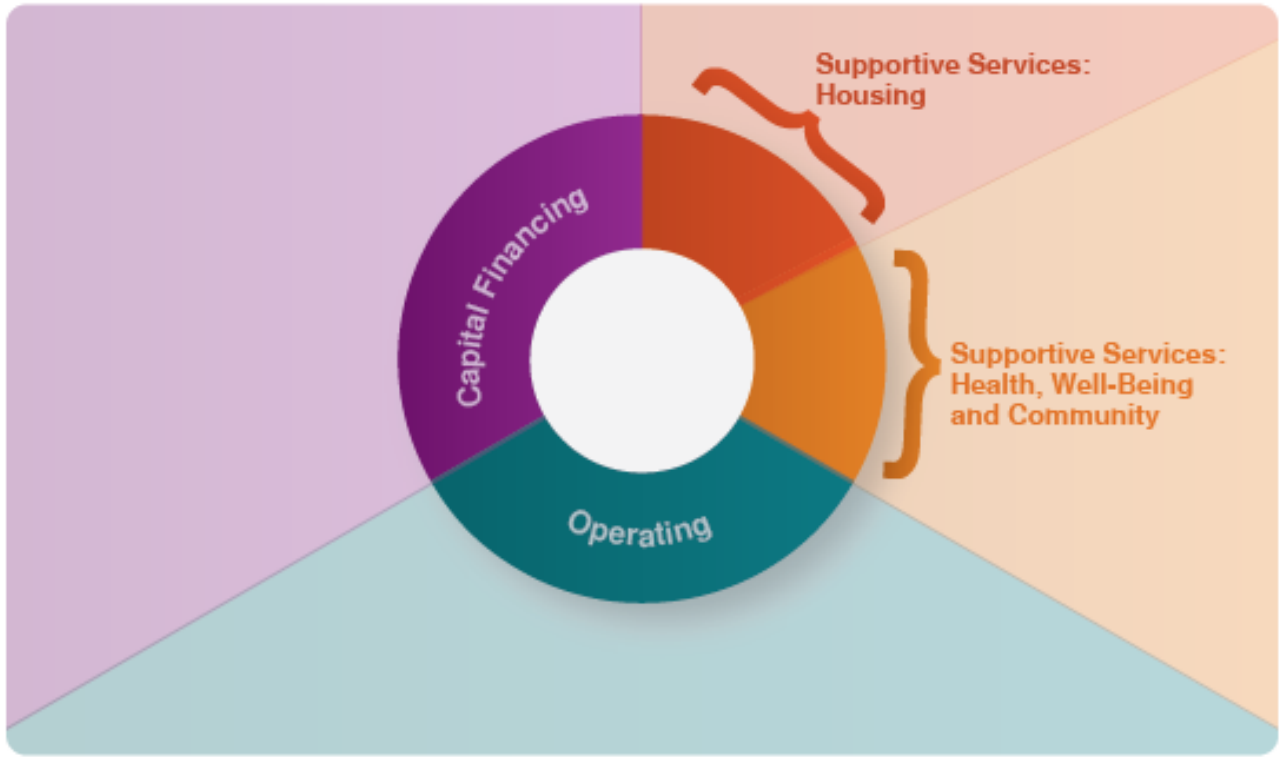
Three Housing Models



Supportive Housing Without Medicaid

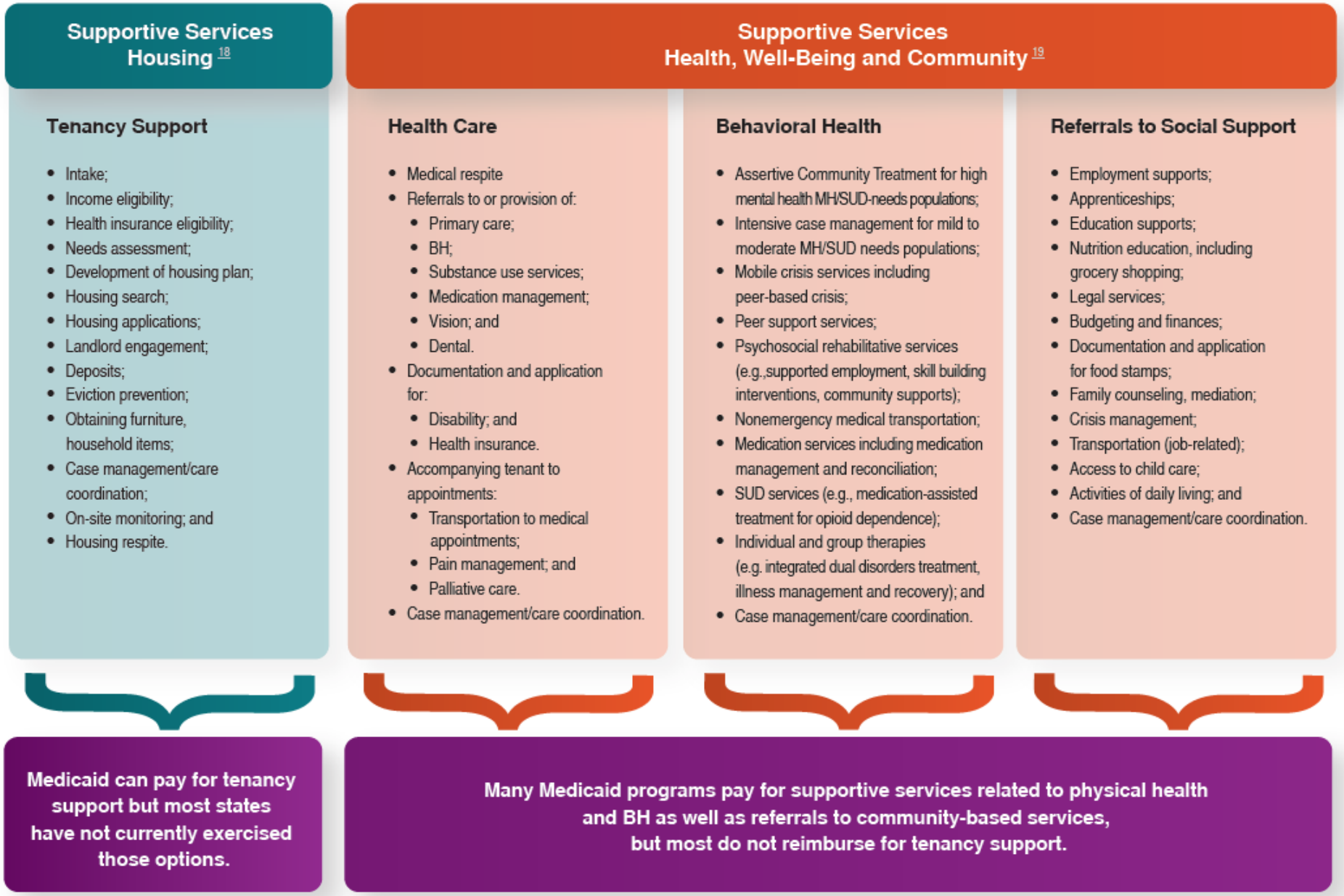


Supportive Housing With Medicaid



Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, Sept 2016

What are Supportive Services?



Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, Sept 2016

*Note: This list is not exhaustive but rather intended to serve as an example of the most commonly offered services.
For more information on supportive housing, see: https://www.usich.gov/solutions/housing/supportive-housing

Incorporate key elements of Behavioral Health Services that are integral to housing intervention

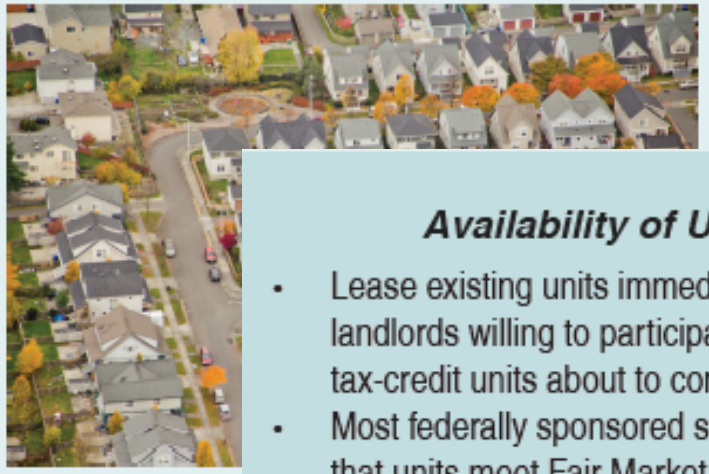


Source:
Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, September 2016

Two Different Supported Housing Models

Scattered Site

- Rental units located throughout the community;
- Apartments or single-family homes;
- Case managers may be mobile and provide services in the home, or patients can receive care at FQHCs or other partner facilities;
- Patients also referred to providers in their community;
- Little or no up-front capital investment; and
- Works well in communities well supplied with MH, BH and other service providers needed to effectively treat this population.



Availability of Units:

- Lease existing units immediately from landlords willing to participate, or identify tax-credit units about to come online.
- Most federally sponsored subsidies require that units meet Fair Market Rent guidelines and Section 8 inspection standards.

Single Site or Mixed Single Site

- Units located in a single building;
- Many services provided onsite by hired staff, through partnerships with providers or onsite at a provider facility;
- Depending on financing:
  - 100% units reserved as supportive housing
  - Percentage of units set aside as supportive housing, remainder reserved as market-rate housing for the general population
- Good option for cities with a shortage of affordable rental units to meet Fair Market Rent guidelines.



Availability of Units:

- Existing units are likely to be filled, with a low turnover rate.
- New units will need to be created through construction or rehabilitation.
- For this reason, scattered site complements single site nicely.

Source: Housing as Health | A Road Map for States: Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs, Sept 2016

KEY TERMS | DOJ SETTLEMENT
Most Integrated Setting

A *living environment* that allows individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

For Example

Single Family Home
Apartment
Townhome
Condominium
Farm or Ranch
Adult Foster Care
Living with family

SETTLEMENT AGREEMENT BETWEEN U.S. DOJ & STATE OF ND

Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective December 14, 2020

Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.



KEY TERMS | DOJ SETTLEMENT
Community Integration Mandate

Public entities are required to provide **community-based services** when:

- Community-based services are **appropriate** for the individual; and
- The individual **does not oppose** community-based treatment; and
- Community-based treatment can be **reasonably accommodated**, taking into account:
  - Resources available to the entity and
  - Needs of others receiving disability services.



KEY TERMS | DOJ SETTLEMENT
Permanent Supported Housing

Affordable, permanent housing coupled with housing supports and other community-based services. Individual lives in a private home alone, with family, significant other, or roommates of their choosing.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

Notes

- Tenants must have access to community provider for intermittent on-call, planned and back up community-based services
- Must be scattered site housing

KEY TERMS | DOJ SETTLEMENT

Integrated Housing

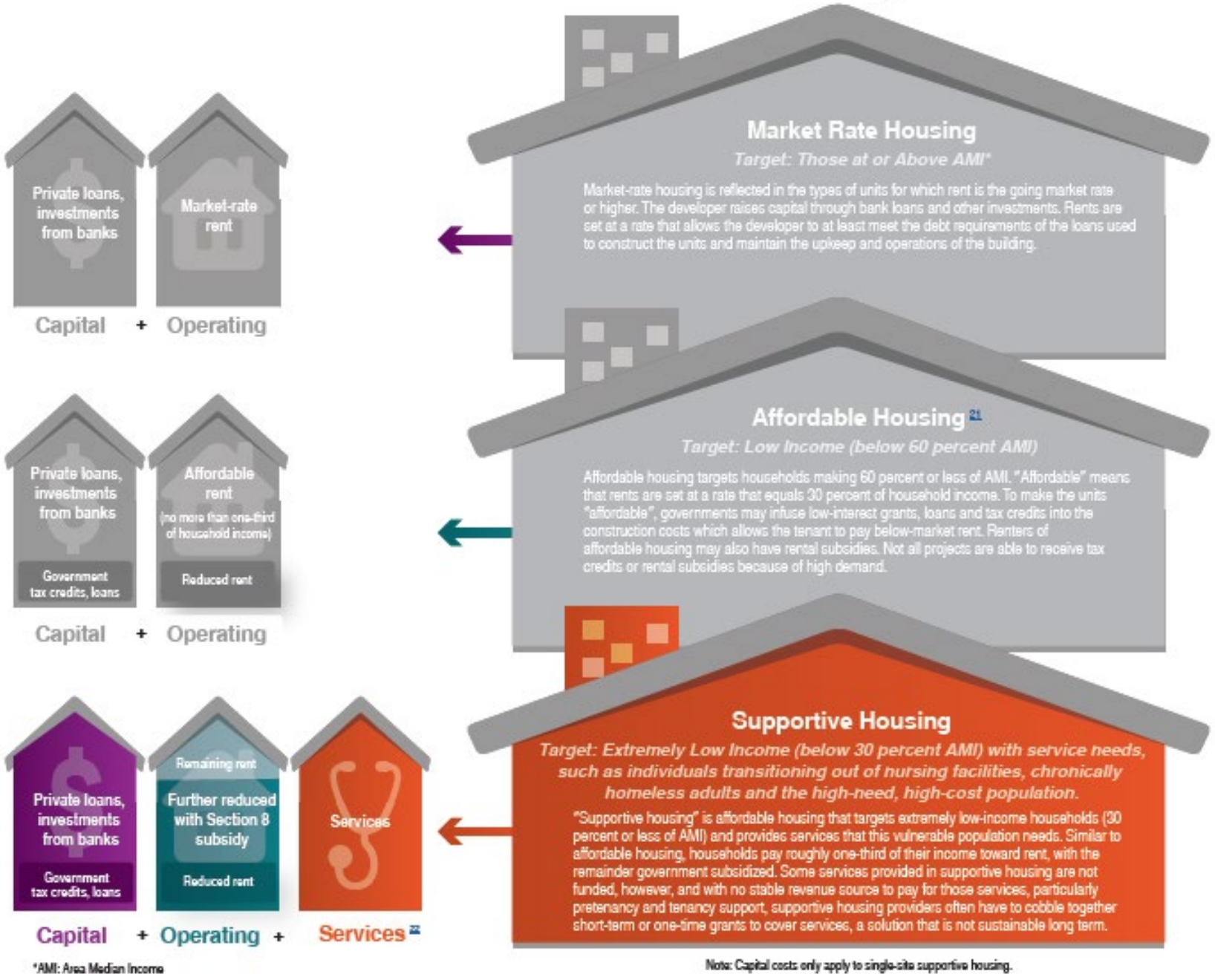
Housing **cannot be provided in** group homes, nursing facilities, boarding homes, residential care facilities or assisted living residences; or any building where more than 25% of the occupants are TPM.

Requires state to **provide** funding for **rental assistance** including reasonable expansion of existing capacity by funding and providing rental assistance to support permanent housing for TPM.

Requires state to **provide** for **assistance** with **identifying** housing, **coordinating** housing modifications, applying for subsidized housing, as well as help **preserving** tenancy if temporarily admitted to a Nursing Home.

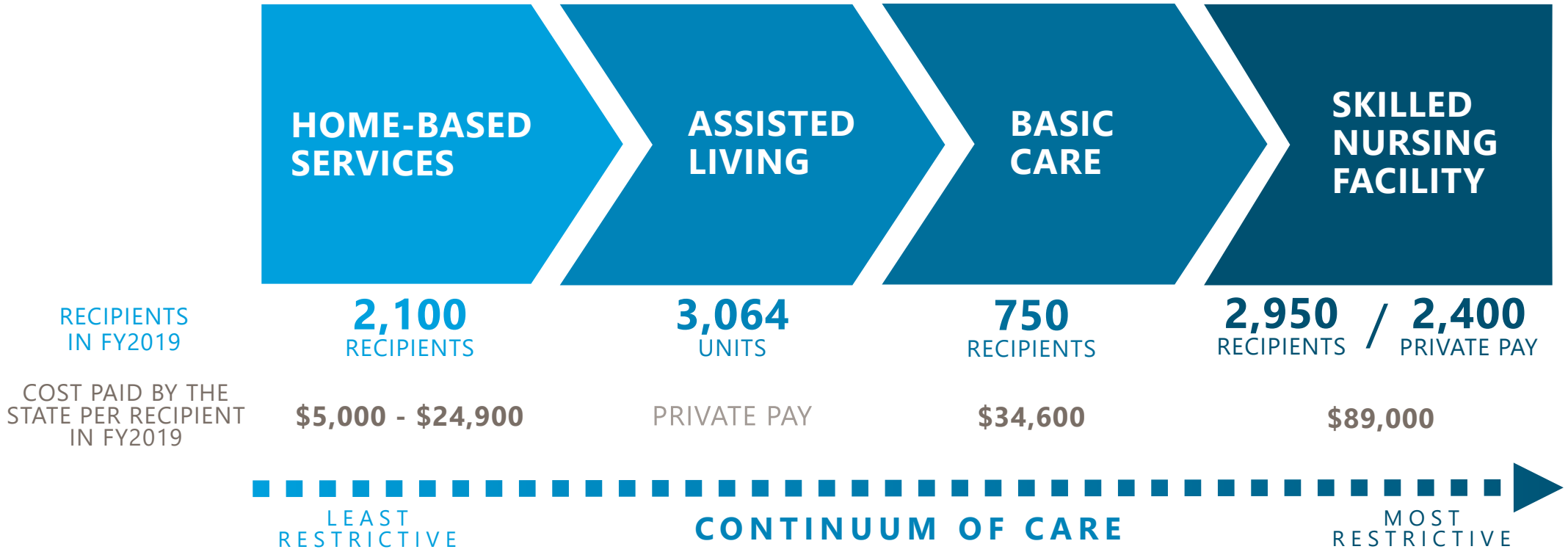
A Fourth Model

Integrated Housing Supports



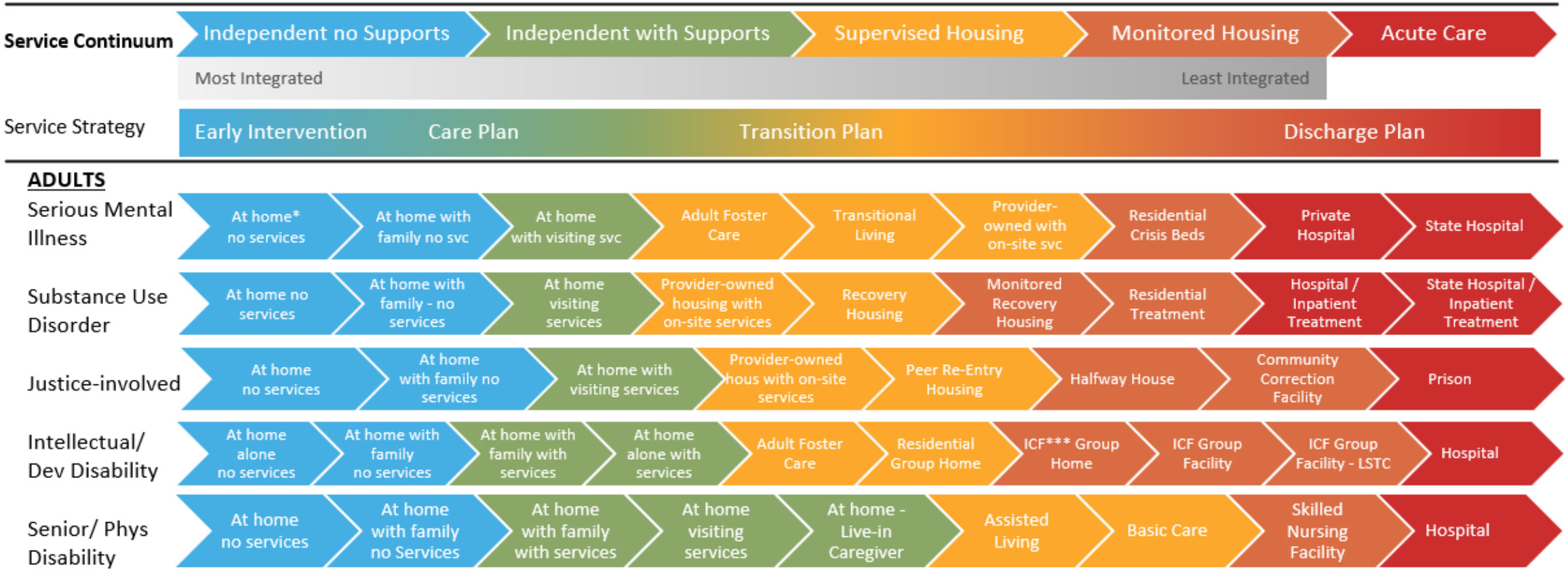
CONTINUUM OF CARE | DOJ SETTLEMENT

Long-term care services & supports



The Service Continuum - Adults

A critical concept defined

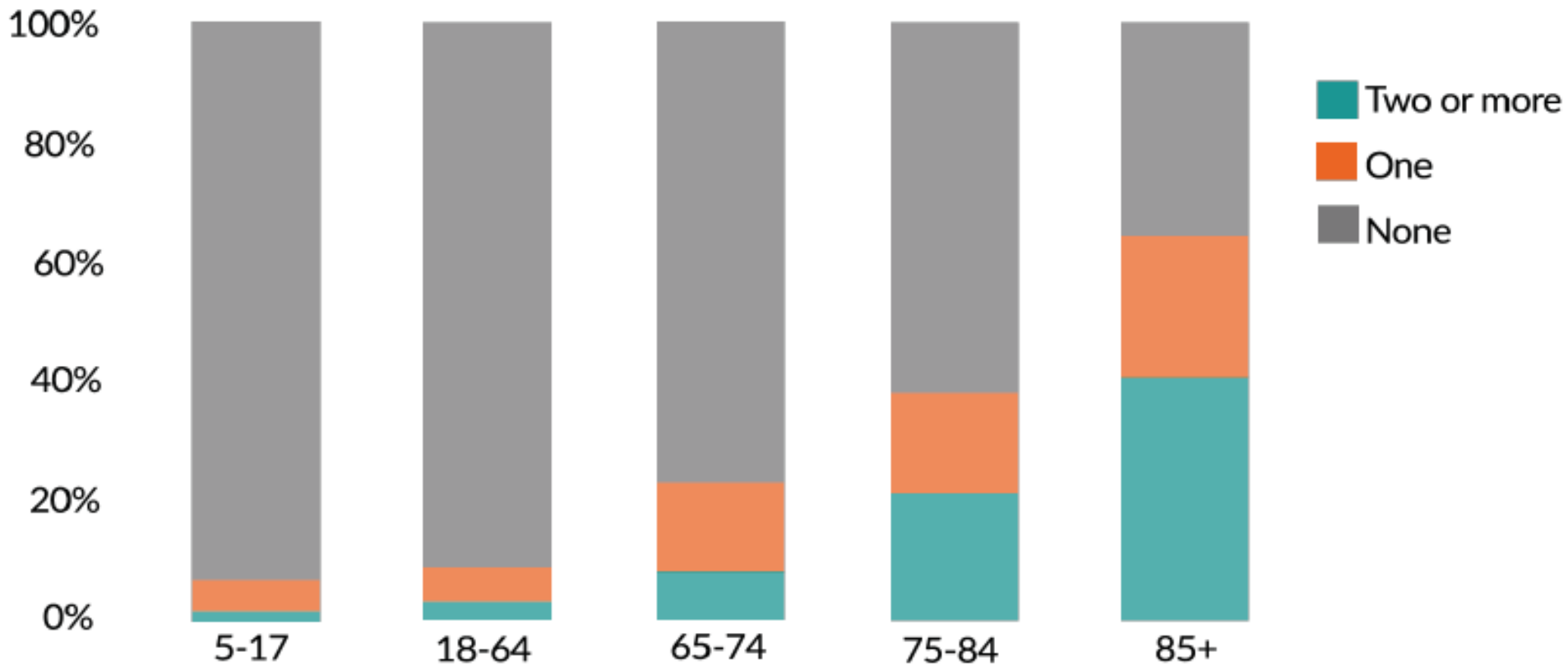


**Home = includes any type of home setting that is the responsibility of the individual (single family home, condo, apartment, mobile home)*

***Family = includes birth family, kin-caregiver, adopted family*

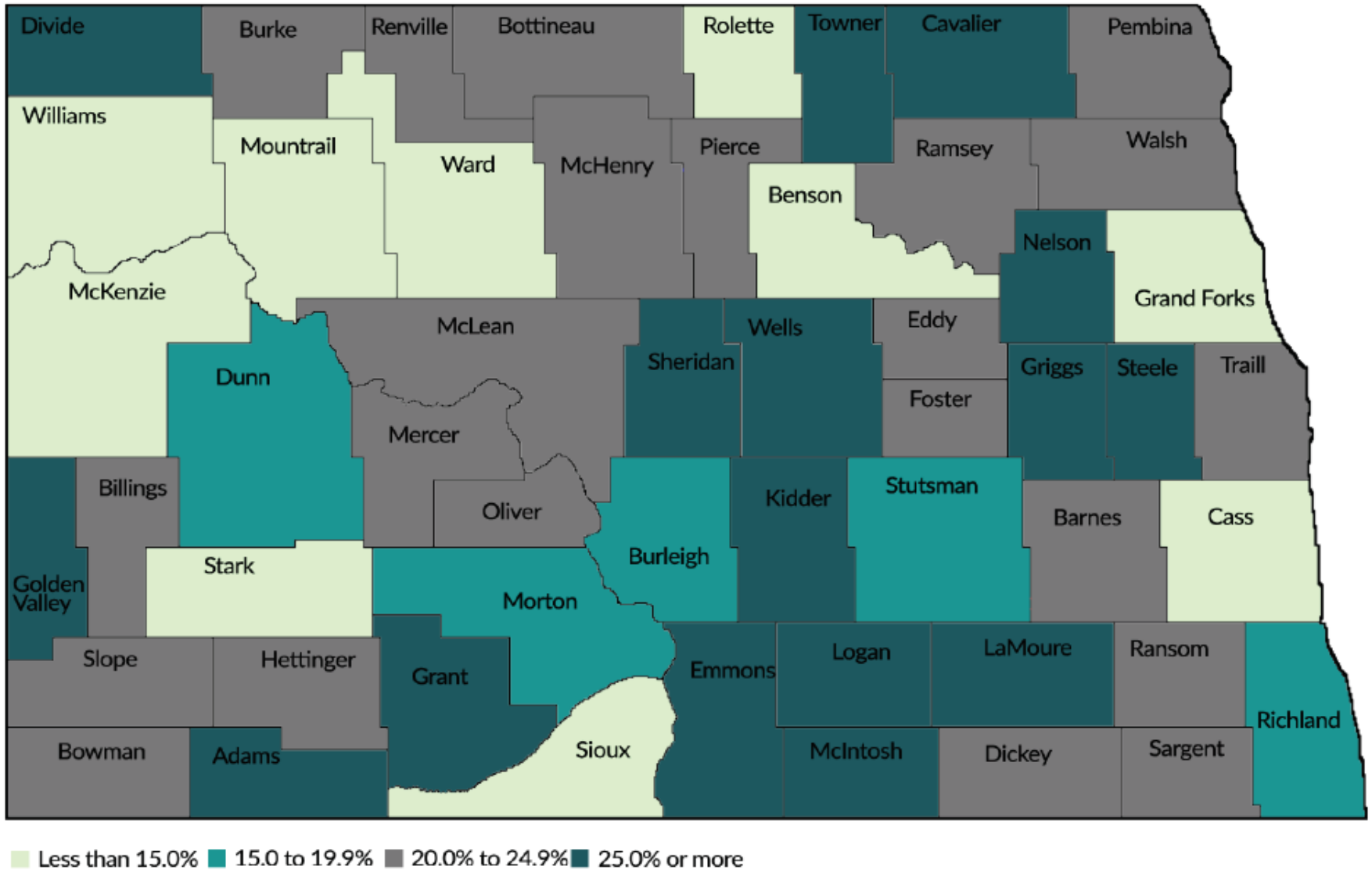
****ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)*

Individuals by Detailed Age and Number of Disabilities [18]



Source: "The Current State of Housing in North Dakota", 2020, p.18

Percent of Population Age 65+ [19]



Source: "The Current State of Housing in North Dakota", 2020, p.18

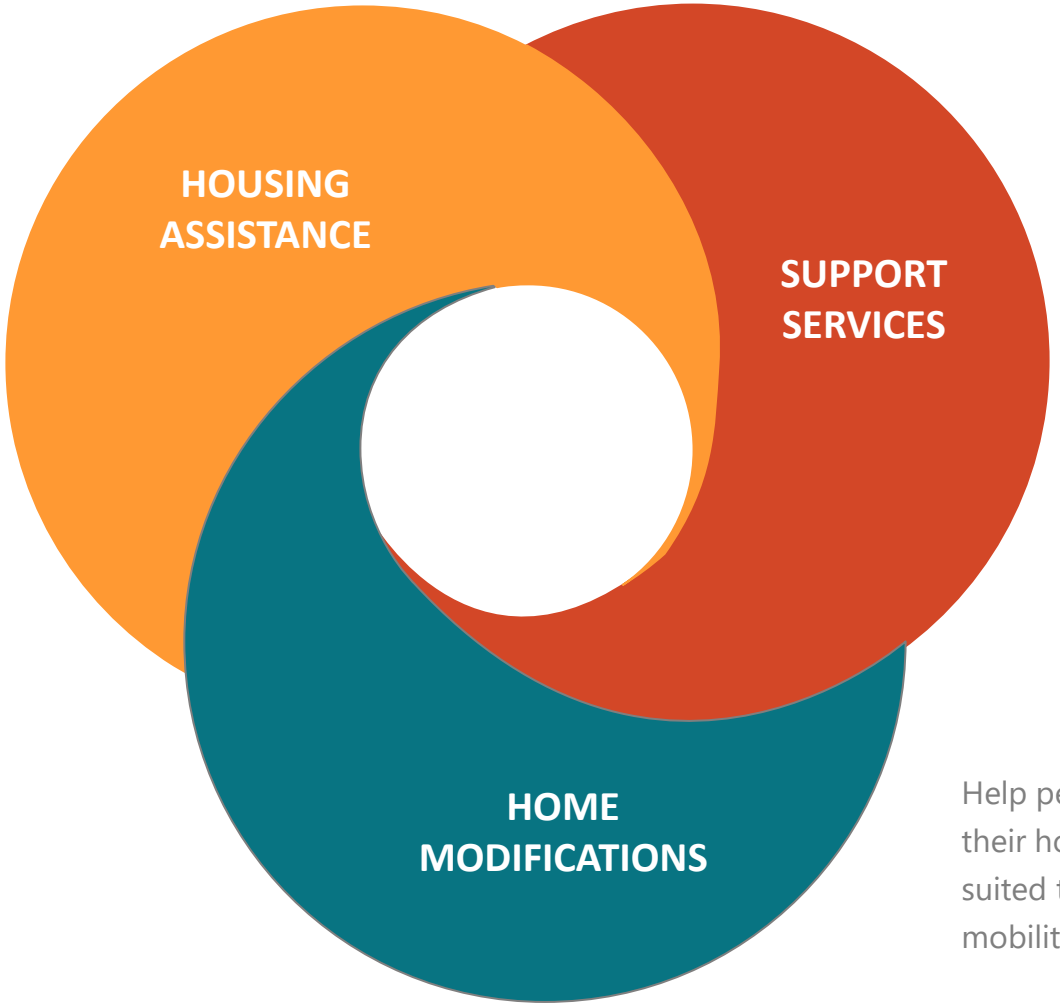
What do we need to do to help someone make an informed choice about how they may want to access services in the most integrated setting that is right for them?



Improve ability to live as independently as possible

Intersecting approaches can help preserve possibilities and assure choice

Provide housing assistance to remove affordability as a barrier to independent living.



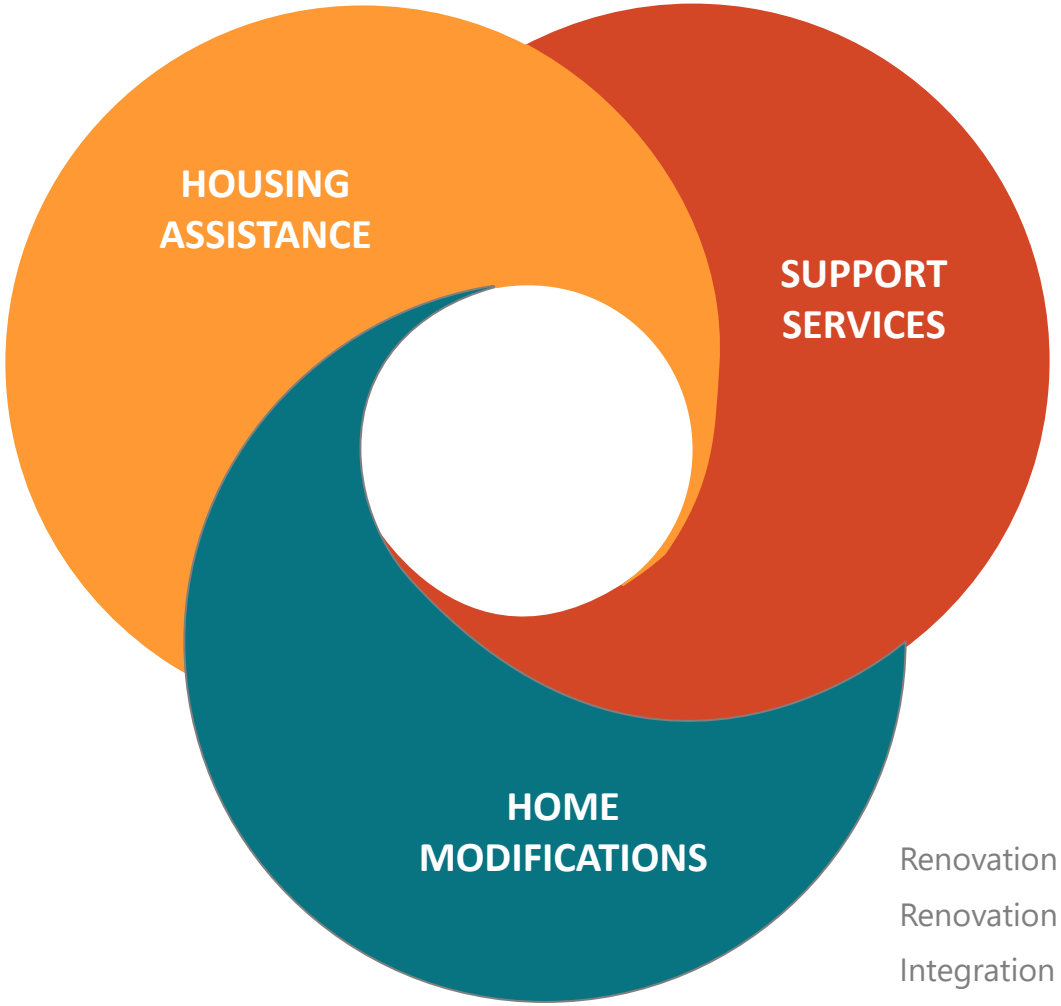
Home and community-based support services that provide the assistance necessary for someone to stay living independently.

Help people make modifications to their home to ensure that it is well suited to their changing health and mobility needs.

Improve ability to live as independently as possible

Intersecting approaches can help preserve possibilities and assure choice

Rental Assistance
Property Tax Assistance
Special Assessment Assistance
Utility assistance
Assistance with home repairs



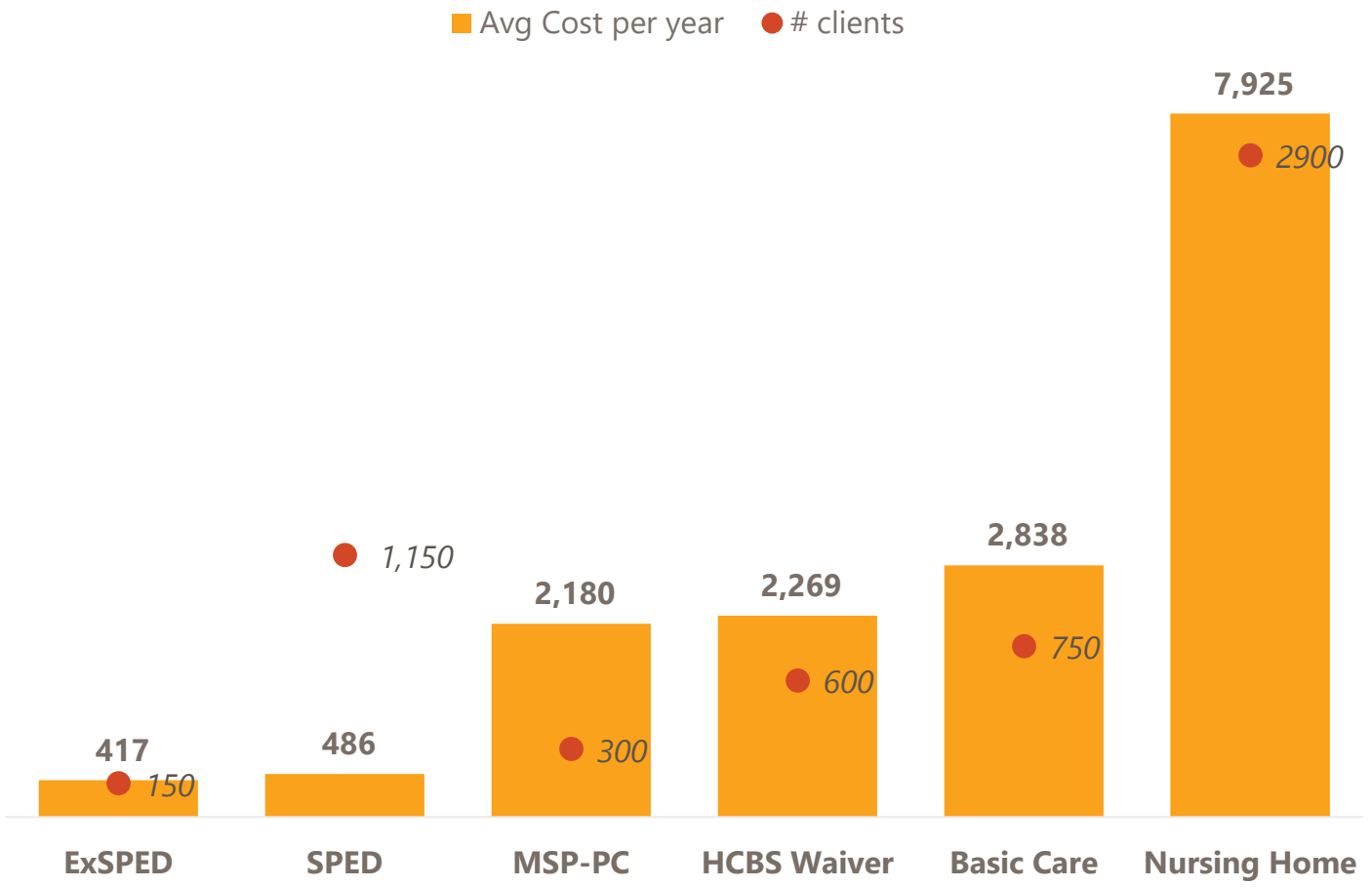
Personal Care
Medication Assistance
Meal Preparation
Shopping Assistance
Transportation Assistance
Companion Services
Preventative Health Care
Behavioral Health supports
Employment supports
Economic assistance
Budget planning
Care coordination

Renovation to address mobility
Renovation to address accessibility
Integration of assistive devices

What do we need to do to make sure we are delivering the right service in the right place at the right time?



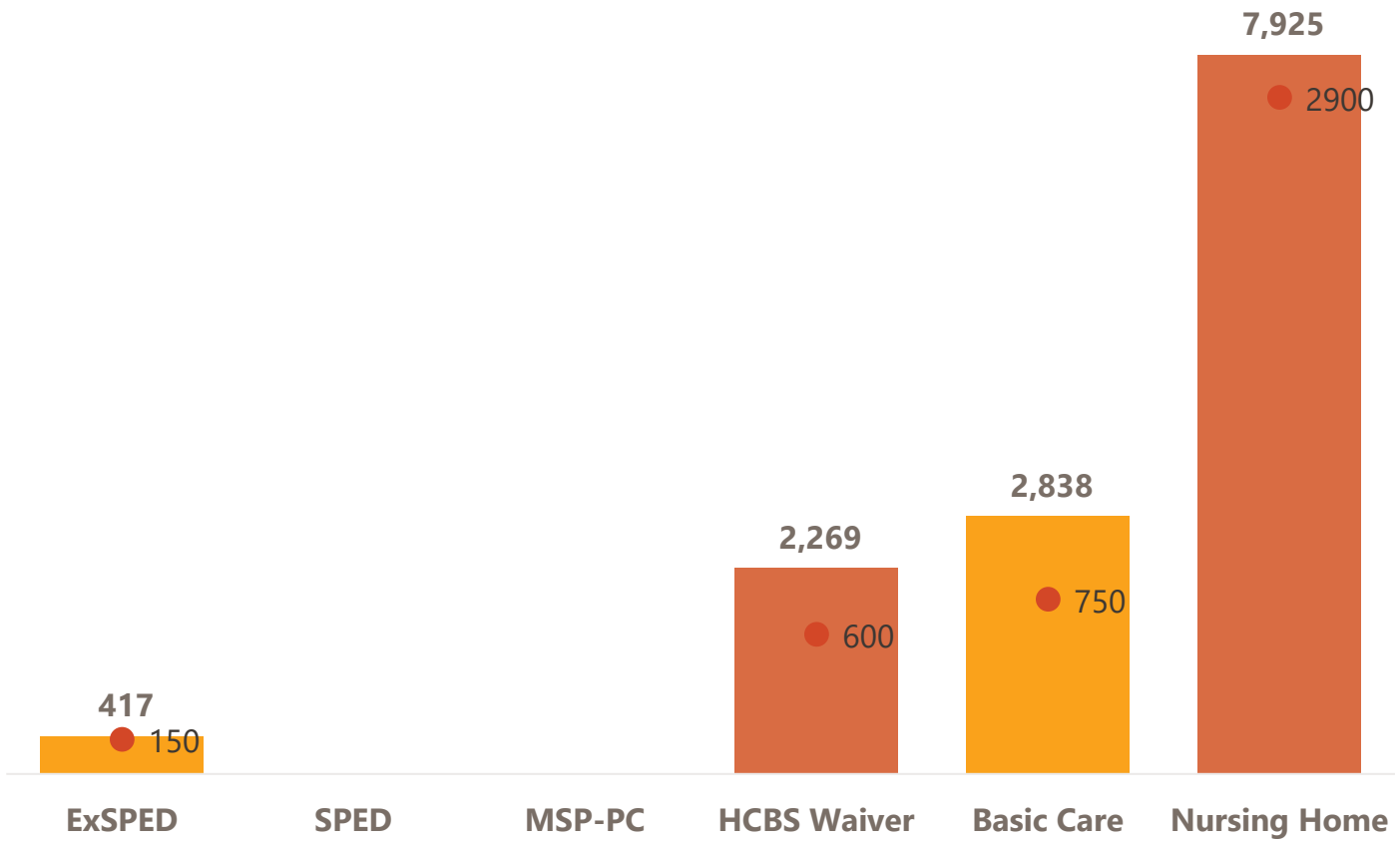
AGING & ADULT SERVICES
Cost per month per person per type of service – SFY20



Program Descriptions / Detail

- **Service Payments for the Elderly and Disabled (SPED):** Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- **Expanded SPED (Ex-SPED):** Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- **Home and community-based services (HCBS) waiver:** This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- **Medicaid State Plan personal care (MSP-PC):** Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

AGING & ADULT SERVICES
Cost month per person per type of service – SFY20



Types of Care with same criteria for eligibility *(level of care, assets, income)*

Expanded SPED = Basic Care

$417 / mo v $2,838 / mo

DIFFERENCE IN COST : $2,421

DIFFERENCE IN SVC :

Rent, Meals, Supervision

HCBS Waiver = Nursing Home

$2,269 / mo v $7,925 / mo

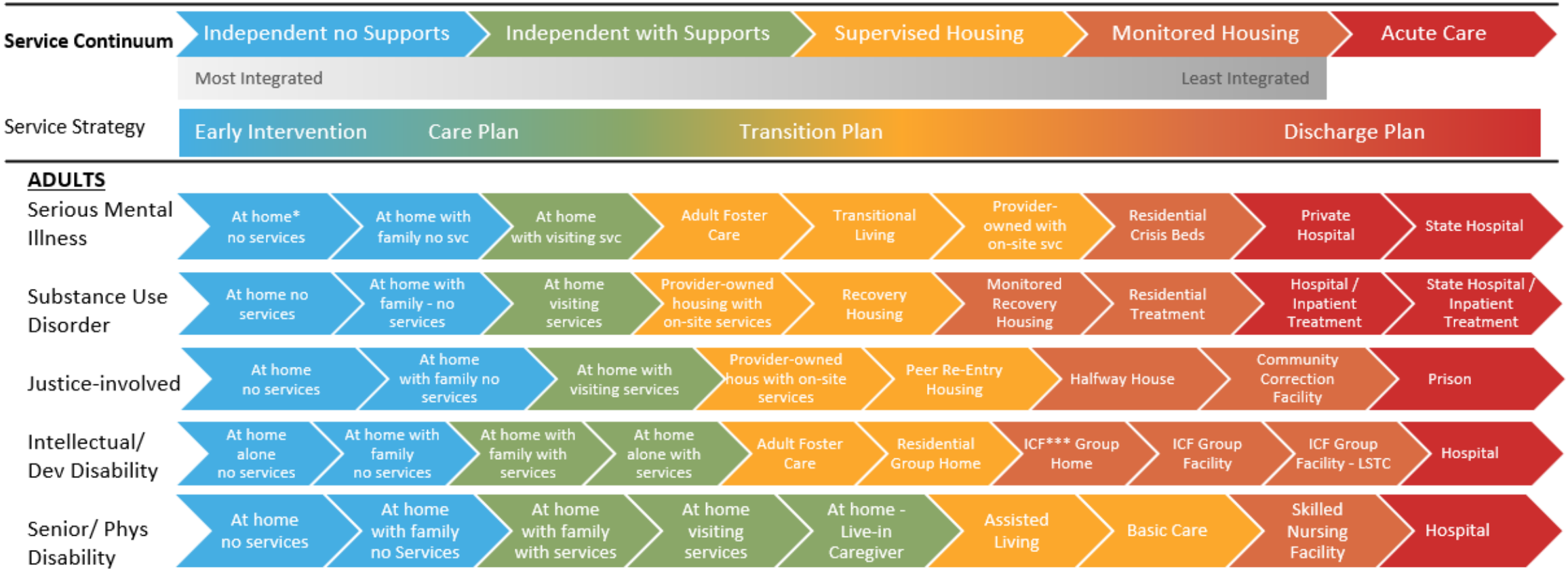
DIFFERENCE IN COST : $5,656

DIFFERENCE IN SVC :

Rent, Meals, Supervision, 24/7 Nursing

The Service Continuum - Adults

A critical concept defined



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****ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)*

What do we need to do to help someone find their way through a situation that threatens to push them into crisis, and instead help them find their way to stability.



DHS 19-21 BIENNIUM ACCOMPLISHMENTS & WORK IN PROGRESS

Improved access to effective services



Process Improvement & Redesign Efforts

- Long term care eligibility team
- Child Protective Service Redesign
- Human Service Zones
- Centralized approach to childcare licensing
- Move to functional teams for child support
- Electronic Visit Verification & case management systems



Treatment & Recovery Supports

- Medication Assisted Treatment
- Expanded use of SUD voucher
- Behavioral health crisis services



In-Community Services

- Peer supports, Companionship, and Adult Foster Care
- Social Determinants of Health via Medicaid (1915i)
- Centralized connection point for home & community-based svc (ADRL)
- Extended Free Through Recovery

Return
On
Investment



NORTH Dakota | Human Services

Be Legendary.™

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/8/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 10:30 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger		A
Strinden		A

Discussion Topics:

- Lutheran Social Services
- Early Childhood System Infrastructure
- Refugee Resettlement Program
- URM Foster Care

Sara Stolt (10:31 am) testified about Lutheran Social Services #6105

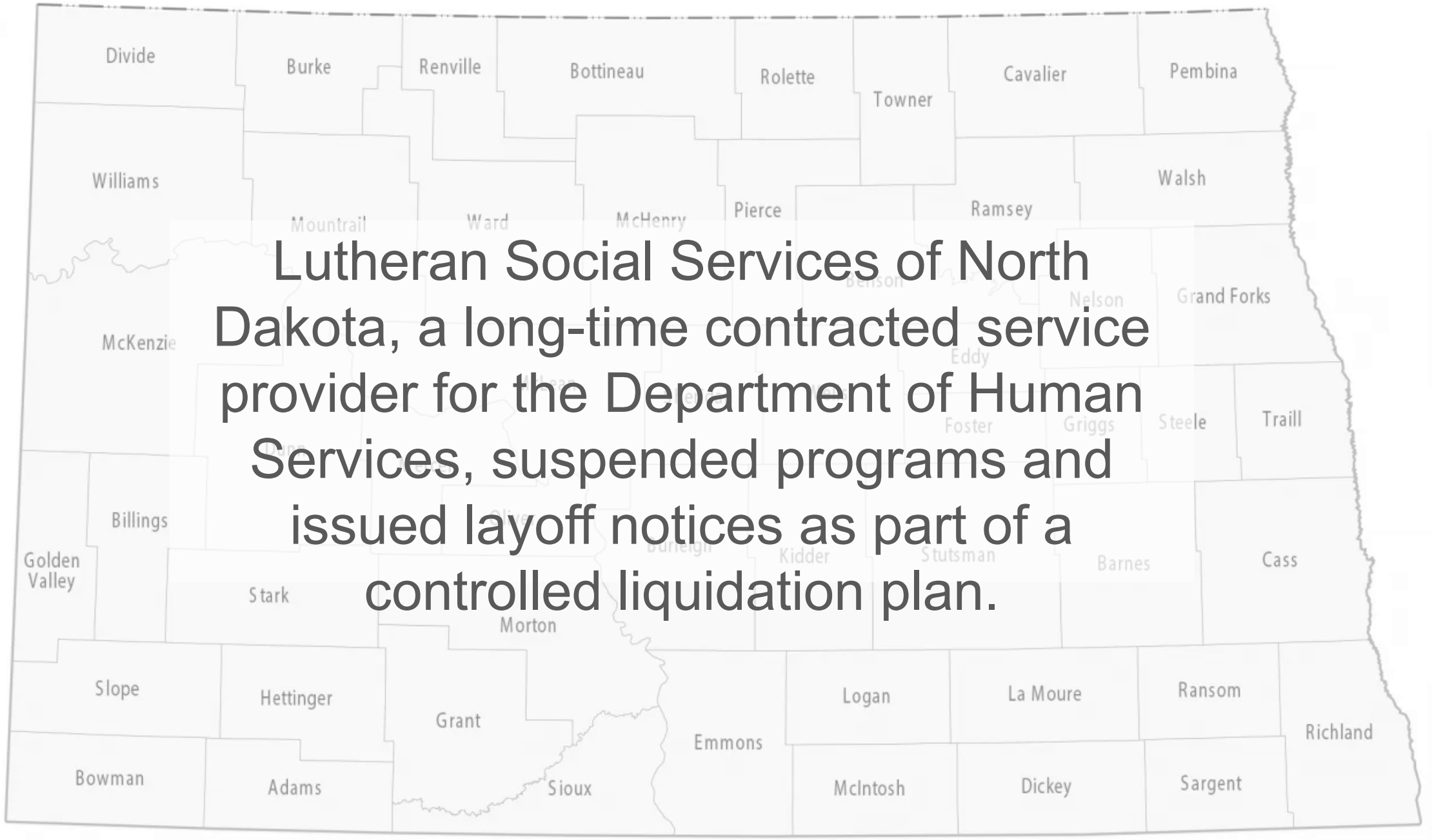
Chair Nelson closed the meeting at 11:14 a.m.

Cole Fleck, Committee Clerk

AN UPDATE RE THE MAINTENANCE OF CONTRACTED SERVICES FORMERLY PROVIDED BY LUTHERAN SOCIAL SERVICES OF NORTH DAKOTA

House Appropriations | Human Resources Subdivision
#6105

NORTH Dakota | Human Services
Be Legendary.™



Lutheran Social Services of North Dakota, a long-time contracted service provider for the Department of Human Services, suspended programs and issued layoff notices as part of a controlled liquidation plan.

Why did DHS establish a Work Group in this situation?

LSSND was contracted to provide several critical services on behalf of the state. The **state** has a **responsibility** to assure uninterrupted delivery of these services.

LSSND provided a wide array of human services n communities across North Dakota and, in many cases, was the **only provider** of a particular service in a community.

WORK GROUP GUIDING PRINCIPLES

- Minimize disruption of core services
- Ensure safety for children and adults receiving behavioral health and addiction/recovery services
- Transition core staff for state-required services to DHS temporarily, to allow for longer-term solutions to be identified
- Evaluate efficiency and effectiveness of contracted services to guide future procurement

EARLY CHILDHOOD SYSTEM INFRASTRUCTURE

Programs:
Child Care Aware
Bright & Early
Growing Futures

Coaching, training, workforce development, quality improvement for child care providers; parent resource and referral services

Funding:
Child Care Development Block Grant

Impact:
3 provider-oriented data systems; 33 staff



BEHAVIORAL HEALTH

Programs:
Project Renew
Crisis Counseling response line for behavioral health needs related to pandemic

Funding:
SAMHSA and FEMA Crisis Counseling Assistance

Impact:
5-7 staff temporarily connected to DHS to avoid interruption in availability of behavioral health crisis resource

Programs:
Gambler's Choice
Problem gambling prevention and treatment program to be made available to ND via State Lottery revenues

Funding:
State Special Funds (lottery)

Impact:
4 staff temporarily connected to DHS to avoid disruption in specialized addiction services



REFUGEE RESETTLEMENT COORDINATION

Programs:
Refugee Medical Assistance
Refugee Cash Assistance
Refugee Support Services

Wrap-around services for resettled refugees.

Funding:
Office of Refugee Resettlement (U.S. Dept of HHS)

Impact:
DHS re-assumes responsibility for state refugee coordination; 8-10 staff temporarily connected to DHS to facilitate program administration



URM FOSTER CARE

Programs:
Unaccompanied Refugee Minor (URM) Foster Care

Licensed foster care program that is fully federally funded to serve unaccompanied children

Funding:
Office of Refugee Resettlement

Impact:
7-9 staff temporarily connected to DHS to ensure continued service to 40 foster children in 25 licensed foster homes



TIMELINE

January 13-Present: DHS/LSSND Workgroup

January 15: Public notice of LSS ND closure

January 21: Public notice of DHS temporarily assuming early childhood infrastructure services

January 25: Public notice of DHS temporarily assuming responsibility for refugee resettlement

January 29: Notice of termination of state contracts

February 1: First set of employee / system transitions occur

March 1-31: Second set of employee / system transitions occur

NEXT STEPS

1. Finalize the operating budget and provide an amendment to HB 1012
2. Write the ND State Plan for Refugee Support Services and submit to ORR on February 22
3. Continue to transition staff
4. Fully operational March 31

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/8/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 2:54

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger		A
Strinden		A

Discussion Topics:

- Tomorrow's meeting

Chair Nelson (2:54 pm) discusses tomorrow's meeting

Chair Nelson closed the meeting at 2:55 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/15/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:03 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger		A
Strinden	P	

Discussion Topics:

- Amendment Review and Approval

Arnie Strebe (9:05 am) testified about the amendment approval process #6623

Rep Kreidt motioned to adopt the amendment for economic assistance

Rep Anderson seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for child support

Rep Mitskog seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for DD council

Rep Anderson seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for Children and Family Services

Rep Mitskog seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for Administration

Rep Strinden seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for Behavioral Health

Rep Anderson seconded the motion

Voice Vote motion carries

Rep Kreidt motioned to adopt the amendment for Section 25

Rep Strinden seconded the motion

Voice Vote motion carries

Chair Nelson closed the meeting at 10:28 a.m.

Cole Fleck, Committee Clerk

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
	2021-23 Base Level - Management	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362				
	2021-23 Ongoing Funding Changes - Management								
	2019 -21 Transfers and adjustments	(18.10)	(838,781)	(3,553,654)	(4,392,435)	(18.10)	(838,781)	(3,553,654)	(4,392,435)
	Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
	Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
	Retirement contribution increase		79,629	16,925	96,554		79,629	16,925	96,554
	Health insurance increase		3,903	830	4,733		3,903	830	4,733
	Subtotal Ongoing Funding Changes	(18.10)	(877,919)	(2,721,808)	(3,599,727)	(18.10)	(892,966)	(2,726,474)	(3,619,440)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
19		**Administration**								
20		Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
21		Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
22		Capital complex rent model change		474,286	-	474,286		474,286	-	474,286
23		Subtotal Administration	8.00	1,247,185	1,281,648	2,528,833	8.00	1,247,185	1,281,648	2,528,833

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
25		**Information Technology Services**								
26		Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
27		Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
28		Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
29		Early childhood data system		500,000		500,000		500,000		500,000
30		Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
31		Other funds reprioritizing			2,324,362	2,324,362			2,324,362	2,324,362
32		Subtotal ongoing funding changes	-	15,137,770	3,764,075	18,901,845	-	15,137,770	3,764,075	18,901,845

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	One-time funding items								
	Upgrade MMIS system		4,326,686	30,673,314	35,000,000		4,326,686	30,673,314	35,000,000
	Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
	Total one-time funding changes	-	19,326,686	45,673,314	65,000,000	-	19,326,686	45,673,314	65,000,000
	Amendments to consider								
	*Data automation						98,186	98,186	196,372
	*MMIS Tech Stack						600,000	1,800,000	2,400,000
	*IBM services - quality measures						11,344	34,031	45,375
	Section 15 - MMIS Tech Stack Carryover								-
	Section 16 SPACES Carryover								-
	Section 17 Child Care Licensing System Carryover								-
	Section 18 HIN Carryover								-
	Subtotal of Amendments to Consider	-	-	-	-	-	709,530	1,932,217	2,641,747
	Total Changes to Base Level Funding - Administration	(10.10)	34,833,722	47,997,229	82,830,951	(10.10)	35,528,205	49,924,780	85,452,985
	2021-23 Total Management Funding	97.85	$ 99,523,996	$ 138,018,317	$ 237,542,313	(10.10)	35,528,205	49,924,780	85,452,985

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
53		**2021-23 Base Level - Program and Policy**	383.25	$ 1,181,597,942	$ 2,232,568,138	$ 3,414,166,080				
54										
55		**2021-23 Ongoing Funding Changes**								
56		2019 - 21 Transfers and adjustments	257.22	22,005,318	23,196,444	45,201,762	257.22	22,005,318	23,196,444	45,201,762
57		Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
58		Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
59		Retirement contribution increase		304,799	262,848	567,647		304,799	262,848	567,647
60		Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
61		Provider inflationary increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
62		Federal Medicaid assistance percentage changes		(45,779,364)	45,779,364	-		(45,779,364)	45,779,364	-
63		Subtotal Ongoing Funding Changes	257.22	(6,464,232)	85,571,467	79,107,235	257.22	(6,443,756)	85,653,925	79,210,169
64										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	Economic Assistance								
	Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
	Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
	Subtotal Economic Assistance	-	2,741,868	11,659,728	14,401,596	-	2,741,868	11,659,728	14,401,596
	Amendments to consider								
	Emergency Rental Assistance December 2020 Congressional COVID-19 Relief				-			130,000,000	130,000,000
	Subtotal of Economic Assistance Amendments to Consider	-	-	-	-	-	-	130,000,000	130,000,000

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
75		**Child Support**								
76		Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
77		Savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
78		Subtotal Child Support	-	(67,509)	(449,573)	(517,082)	-	(67,509)	(449,573)	(517,082)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
80		**Medical Services**								
81		Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
82		Agency savings plan, including adjustments to Medicaid Expansion administration and rates		(2,578,722)	(6,846,085)	(9,424,807)		(975,780)	5,274,190	4,298,410
83		Medicaid Expansion	12.00	(9,146,630)	(73,787,030)	(82,933,660)	12.00	(10,749,572)	(85,907,305)	(96,656,877)
84		Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
85		Other fund reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
86		Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-		14,400,000	(14,400,000)	-
87		Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
88		Subtotal Medical Services	12.00	51,563,046	1,289,530	52,852,576	12.00	51,563,046	1,289,530	52,852,576
89										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
90		**Amendments to consider**											
91			*COVID-19 Vaccine admin/treatment								1,581,000	1,819,000	3,400,000
92			*DOJ Annual Nursing Facility Screening								50,000	150,000	200,000
93			*DOJ Path Contract Addition								16,465	49,395	65,860
94			Remove Tobacco Prevention and Control Trust Fund in HB 1012										-
95			Amend Community Health Trust Fund from $32,400,000 to $24,000,000 in HB 1012										-
96			Section 3 - Medicaid Expansion two year program extension										-
97			Section 4 - Medicaid Expansion to in house										-
98			Section 5 - Repeal consumer-directed health maintenances services										-
99			Section 12 - Medicaid Expansion MCO appropriation before transition in house										-
100			Section 14 - Health Homes										-
101			Section 27 - Utilization Rate Adjustments										-
102			Section 28 - Effective date for section 4										-
103			Section 29 - Expiration date for sections 3 & 12										-
104			Subtotal of Amendments to consider Medical Services		-	-	-	-		-	1,647,465	2,018,395	3,665,860
105													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
106		**Long-Term Care**								
107		Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
108		Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
109		Other funds reprioritization		-	(2,284,362)	(2,284,362)		-	(2,284,362)	(2,284,362)
110		Funding source change - Health care trust fund		1,000,000	(1,000,000)	-		1,000,000	(1,000,000)	-
111		Subtotal Long Term Care	-	33,348,100	33,234,093	66,582,193	-	33,348,100	33,234,093	66,582,193
112										
113		**Amendments to consider**								
114		Section 11 - Nursing Home Bed Reduction								-
115		Section 13 Nursing Home Rates								-
116		Remove Health Care Trust Fund in HB 1012								-
117		*DOJ Settlement: Supervision Rates						566,683	651,991	1,218,674
118		*DOJ Settlement: HCBS Family Personal Care						1,393,154	1,602,882	2,996,036
119		*DOJ Settlement: HCBS Non-Medical Transportation						85,557	44,248	129,805
120		*DOJ Settlement: HCBS Non-Medical Transportation Escort						152,158	10,075	162,233
121		Subtotal of Amendments to consider LTC	-	-	-	-	-	2,197,552	2,309,196	4,506,748
122										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
123		**DD Council**								
124		Continued program changes		-	124,949	124,949			124,949	124,949
125		Subtotal DD Council	-	-	124,949	124,949	-	-	124,949	124,949
126										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
127		**Aging Services**								
128		Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
129		Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
130		Subtotal Aging Services	-	(121,938)	2,220,821	2,098,883	-	(121,938)	2,220,821	2,098,883
131										
132		**Amendments to consider**								
133		*DOJ Settlement: Rental Assistance				-		300,000	-	300,000
134		*DOJ Settlement: Additional FTE					1.00		150,000	150,000
135		Ombudsman COVID-19 Congressional Relief							30,750	30,750
136		Vulnerable Adult Protective Services (VAPS) COVID-19 Congressional Relief							704,100	704,100
137		Senior Community Services Employment Program (SCSEP) Demonstration Grant							889,285	889,285
139		Subtotal of Aging Amendments to Consider	-	-	-	-	1.00	300,000	1,774,135	2,074,135
140										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
141		**Children and Family Services**								
142		Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
143		Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
144		Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
145		Subtotal Children and Family Services	-	(15,206,926)	(2,097,345)	(17,304,271)	-	(15,206,926)	(2,097,345)	(17,304,271)
146										
147		**Amendments to consider**								
151		Section 25 - QRTP rate setting process					-	-	-	-
152		Subtotal of CFS Amendments to Consider	-	-	-	-	-	-	-	-
153										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
154		**Behavioral Health Division**								
155		Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
156		Savings plan		(832,173)	-	(832,173)		(832,173)	-	(832,173)
157		Cost to Continue		5,427,067	-	5,427,067		5,427,067	-	5,427,067
158		Expanded substance use disorder voucher		9,000,000		9,000,000		9,000,000		9,000,000
159		Subtotal Behavioral Health Division	-	13,751,539	(1,957,536)	11,794,003	-	13,751,539	(1,957,536)	11,794,003
160										
161		**Amendments to consider**								
162		Section 8 - Allow for FTR Funding Transition								
163		Section 19 - School Behavioral Health Program carryover								
164		Section 20 - Behavioral Health Recovery Home grants carryover								
165		Section 24 Provider process and Outcome Measures								
166		Federal E-COVID Additional Award							2,859,649	
170		Subtotal of Behavioral Health Division Amendments to Consider	-	-	-	-	-	-	2,859,649	-
171										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
172		**Vocational Rehabilitation**											
173			Continued program changes			(416,293)	(381,081)	(797,374)			(416,293)	(381,081)	(797,374)
174			Agency savings plan:										
175			Centers for Independent Living State Match & Discretionary Funds Budget Error			(1,694,954)		(1,694,954)			(1,694,954)		(1,694,954)
176			Bottineau Ski Park			(109,000)	(91,000)	(200,000)			(109,000)	(91,000)	(200,000)
177			Subtotal Vocational Rehabilitation		-	(2,220,247)	(472,081)	(2,692,328)		-	(2,220,247)	(472,081)	(2,692,328)
178													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
179		**Developmental Disabilities**								
180		Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
181		Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
182		Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
183		Subtotal Developmental Disabilities	-	17,058,897	20,480,181	37,539,078	-	17,058,897	20,480,181	37,539,078
184										
185		**Amendments to consider**								
186		*Adjust Error for DD Crisis Beds					-	(30,156)	116,556	86,400
187		Subtotal of Developmental Disabilities Amendments to consider	-	-	-	-	-	(30,156)	116,556	86,400
188										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
189		**One-time funding items**											
190			Nursing facility payment methodology change			3,348,000	3,852,000	7,200,000			3,348,000	3,852,000	7,200,000
191			Nursing facility bed buyback program			3,300,000		3,300,000			3,300,000		3,300,000
192			Subtotal One-time funding changes		-	6,648,000	3,852,000	10,500,000		-	6,648,000	3,852,000	10,500,000
193													
194			Subtotal all ongoing funding changes		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
195													
196			Total Changes to Base Level Funding		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
197													
198		**2021-23 Total Funding - Program and Policy**			652.47	$ 1,282,628,540	$ 2,386,024,372	$ 3,668,652,912		270.22	$ 105,165,935	$ 292,616,623	$ 394,922,909
199													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
200		**2021-23 Base Level - Field Services**	1,599.03	$ 214,862,668	$ 127,314,955	$ 342,177,623				
201										
202		**2021-23 Ongoing Funding Changes**								
203		Transfers and adjustments	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)
204		Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
205		Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
206		Retirement contribution increase		1,003,529	108,416	1,111,945				-
207		Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
208		Provider inflationary increases		405,815		405,815		405,815		405,815
209		Subtotal Ongoing Funding Changes	(239.12)	(22,381,963)	(6,756,167)	(29,138,130)	(239.12)	(22,787,780)	(6,899,411)	(29,687,191)
210										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
211		**Human Service Centers**								
212		Continued program changes		6,007,961	(2,911,912)	3,096,049		6,007,961	(2,911,912)	3,096,049
213		Salary Underfunding		(2,891,071)		(2,891,071)		(2,891,071)		(2,891,071)
214		Cost and caseload changes		2,624,029	-	2,624,029		2,624,029	-	2,624,029
215		Civil sex offender treatment contract		917,004	-	917,004		917,004	-	917,004
216		Agency savings plan		(6,414,994)	-	(6,414,994)		(6,414,994)	-	(6,414,994)
217		Subtotal Human Service Centers	-	242,929	(2,911,912)	(2,668,983)	-	242,929	(2,911,912)	(2,668,983)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
219		**Institutions**								
220		Continued program changes		(2,447,261)	3,154,778	707,517		(2,447,261)	3,154,778	707,517
221		Salary Underfunding		(1,803,659)		(1,803,659)		(1,803,659)		(1,803,659)
222		LSTC Savings Plan Other than Adaptive Equipment	(14.50)	(5,991,785)	(6,549,550)	(12,541,335)	(14.50)	(6,134,400)	(6,714,398)	(12,848,798)
223		LSTC Savings Plan Adaptive Equipment		(142,615)	(164,086)	(306,701)		(142,615)	142,615	-
224		*LSTC Psychiatrist				-		183,040		183,040
225		State Hospital Savings Plan Other than 25 Bed Unit	(2.10)	49,025	(762)	48,263	(2.10)	49,025	-	49,025
226		State Hospital Savings Plan 25 Bed Unit	(14.00)	(1,775,792)	(345,100)	(2,120,892)				-
227		SOTEP Savings Plan	(1.00)	(143,450)		(143,450)	(1.00)	(143,450)		(143,450)
228		Subtotal Institutions	(31.60)	(12,255,537)	(3,904,720)	(16,160,257)	(17.60)	(10,439,320)	(3,417,005)	(13,856,325)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
230		**Amendments to consider**								
231		Section 21 - Conveyance of Land LSTC to Grafton Parks & Rec								
232		Section 22 - Capital Projects (Special Assessments and demolition at SH)								
233		Section 23 - New State Hospital								
234		Section 26 - Conveyance of Land at SH to National Guard								
235		Section 30 - Emergency clause for section 22 & 23								
236		Subtotal of Amendments to consider Institutions	-	-	-	-	-	-	-	-
237										
242		Total Changes to Base Level Funding	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)	(256.72)	(32,984,171)	(13,228,328)	(46,212,499)
243										
244		**2021-23 Total Funding - Field Services**	1,328.31	$ 180,468,097	$ 113,742,156	$ 294,210,253	(256.72)	$ (32,984,171)	$ (13,228,328)	$ (46,212,499)
245										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
246		**2021-23 Base Level - County Social Service Financing**	140.00	-	173,700,000	173,700,000				
247										
248		**2021-23 Ongoing Funding Changes**								
249		Base payroll changes			1,653,466	1,653,466			1,653,466	1,653,466
250		Salary increase		351,365	292,562	643,927		351,365	292,562	643,927
251		Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
252		Retirement contribution increase		72,382	60,269	132,651		72,382	60,269	132,651
253		Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
254		Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
255		Subtotal Ongoing Funding Changes	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	2,135,515	3,458,738
260										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
261		**Amendments to consider**								
262		Amend Human Service Finance Fund from 173,700,000 to 190,224,059 in HB 1012								
263		*Zone Employee salary increases & uncovered need					-	-	13,065,322	13,065,322
264		Subtotal of Amendments to consider - Zones	-	-	-	-	-	-	13,065,322	13,065,322
265										
266		Total Changes to Base Level Funding - County Social Service Zones	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	15,200,837	16,524,060
267										
268		**2021-23 Total Funding - County Social Service Financing**	143.00	1,323,223	175,835,515	177,158,738	3.00	1,323,223	15,200,837	16,524,060
269										
270		**2021-23 DHS HB 1012 Budget Total**	2,221.63	$ 1,563,943,856	$ 2,813,620,360	$ 4,377,564,216	6.40	$ 109,033,192	$ 344,513,912	$ 450,687,455
271										

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/17/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 3:45 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt		A
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Amendment Review and Approval

Rep Anderson motioned to adopt amendment and Rep Mitskog Seconded

Voice Vote (3:47 pm) do pass FTE's, motion carries

Arnie Strebe (3:52 pm) testified #6623

Donna Aukland (3:55 pm) testified #6623

Rep Schobinger moved to adopt and Rep Anderson Seconded

Voice Vote (4:09 pm) do pass Human Service Centers, motion carries

Rep Schobinger moved to adopt and Rep Mitskog Seconded

Voice Vote (4:10 pm) do pass Vocational Rehabilitation, motion carries

Rep Anderson moved to adopt and Rep Strinden Seconded

Voice Vote (4:22 pm) do pass institutions, motion carries

Rep Schobinger moved to adopt and Rep Anderson Seconded

Voice Vote (4:26 pm) do pass management. motion carries

Rep Schobinger moved to adopt and Rep Mitskog Seconded

Voice Vote (4:55 pm) do pass Information Technology Services, motion

carries

Rep Schobinger moved to adopt and Rep Anderson Seconded

Voice Vote (5:20 pm) do pass One Time Funding Items, motion carries

Rep Schobinger moved to adopt and Rep Anderson Seconded

Voice Vote (5:26 pm) do pass Ongoing Funding Changes, motion carries

Rep Schobinger moved to adopt and Rep Strinden Seconded

Voice Vote (5:40 pm) do pass Ongoing Funding Changes, motion carries

Chair Nelson closed the meeting at 5:42 p.m.

Cole Fleck, Committee Clerk

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
	2021-23 Base Level - Management	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362				
	2021-23 Ongoing Funding Changes - Management								
	2019 -21 Transfers and adjustments	(18.10)	(838,781)	(3,553,654)	(4,392,435)	(18.10)	(838,781)	(3,553,654)	(4,392,435)
	Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
	Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
	Retirement contribution increase		79,629	16,925	96,554		79,629	16,925	96,554
	Health insurance increase		3,903	830	4,733		3,903	830	4,733
	Subtotal Ongoing Funding Changes	(18.10)	(877,919)	(2,721,808)	(3,599,727)	(18.10)	(892,966)	(2,726,474)	(3,619,440)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
19		**Administration**								
20		Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
21		Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
22		Capital complex rent model change		474,286	-	474,286		474,286	-	474,286
23		Subtotal Administration	8.00	1,247,185	1,281,648	2,528,833	8.00	1,247,185	1,281,648	2,528,833

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
25		**Information Technology Services**								
26		Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
27		Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
28		Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
29		Early childhood data system		500,000		500,000		500,000		500,000
30		Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
31		Other funds reprioritizing			2,324,362	2,324,362			2,324,362	2,324,362
32		Subtotal ongoing funding changes	-	15,137,770	3,764,075	18,901,845	-	15,137,770	3,764,075	18,901,845

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	One-time funding items								
	Upgrade MMIS system		4,326,686	30,673,314	35,000,000		4,326,686	30,673,314	35,000,000
	Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
	Total one-time funding changes	-	19,326,686	45,673,314	65,000,000	-	19,326,686	45,673,314	65,000,000
	Amendments to consider								
	*Data automation						98,186	98,186	196,372
	*MMIS Tech Stack						600,000	1,800,000	2,400,000
	*IBM services - quality measures						11,344	34,031	45,375
	Section 15 - MMIS Tech Stack Carryover								-
	Section 16 SPACES Carryover								-
	Section 17 Child Care Licensing System Carryover								-
	Section 18 HIN Carryover								-
	Subtotal of Amendments to Consider	-	-	-	-	-	709,530	1,932,217	2,641,747
	Total Changes to Base Level Funding - Administration	(10.10)	34,833,722	47,997,229	82,830,951	(10.10)	35,528,205	49,924,780	85,452,985
	2021-23 Total Management Funding	97.85	$ 99,523,996	$ 138,018,317	$ 237,542,313	(10.10)	35,528,205	49,924,780	85,452,985

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
53		**2021-23 Base Level - Program and Policy**	383.25	$ 1,181,597,942	$ 2,232,568,138	$ 3,414,166,080				
54										
55		**2021-23 Ongoing Funding Changes**								
56		2019 - 21 Transfers and adjustments	257.22	22,005,318	23,196,444	45,201,762	257.22	22,005,318	23,196,444	45,201,762
57		Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
58		Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
59		Retirement contribution increase		304,799	262,848	567,647		304,799	262,848	567,647
60		Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
61		Provider inflationary increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
62		Federal Medicaid assistance percentage changes		(45,779,364)	45,779,364	-		(45,779,364)	45,779,364	-
63		Subtotal Ongoing Funding Changes	257.22	(6,464,232)	85,571,467	79,107,235	257.22	(6,443,756)	85,653,925	79,210,169
64										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	Economic Assistance								
	Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
	Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
	Subtotal Economic Assistance	-	2,741,868	11,659,728	14,401,596	-	2,741,868	11,659,728	14,401,596
	Amendments to consider								
	Emergency Rental Assistance December 2020 Congressional COVID-19 Relief				-			130,000,000	130,000,000
	Subtotal of Economic Assistance Amendments to Consider	-	-	-	-	-	-	130,000,000	130,000,000

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
75		**Child Support**								
76		Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
77		Savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
78		Subtotal Child Support	-	(67,509)	(449,573)	(517,082)	-	(67,509)	(449,573)	(517,082)

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
80		**Medical Services**								
81		Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
82		Agency savings plan, including adjustments to Medicaid Expansion administration and rates		(2,578,722)	(6,846,085)	(9,424,807)		(975,780)	5,274,190	4,298,410
83		Medicaid Expansion	12.00	(9,146,630)	(73,787,030)	(82,933,660)	12.00	(10,749,572)	(85,907,305)	(96,656,877)
84		Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
85		Other fund reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
86		Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-		14,400,000	(14,400,000)	-
87		Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
88		Subtotal Medical Services	12.00	51,563,046	1,289,530	52,852,576	12.00	51,563,046	1,289,530	52,852,576
89										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
90		**Amendments to consider**											
91			*COVID-19 Vaccine admin/treatment								1,581,000	1,819,000	3,400,000
92			*DOJ Annual Nursing Facility Screening								50,000	150,000	200,000
93			*DOJ Path Contract Addition								16,465	49,395	65,860
94			Remove Tobacco Prevention and Control Trust Fund in HB 1012										-
95			Amend Community Health Trust Fund from $32,400,000 to $24,000,000 in HB 1012										-
96			Section 3 - Medicaid Expansion two year program extension										-
97			Section 4 - Medicaid Expansion to in house										-
98			Section 5 - Repeal consumer-directed health maintenances services										-
99			Section 12 - Medicaid Expansion MCO appropriation before transition in house										-
100			Section 14 - Health Homes										-
101			Section 27 - Utilization Rate Adjustments										-
102			Section 28 - Effective date for section 4										-
103			Section 29 - Expiration date for sections 3 & 12										-
104			Subtotal of Amendments to consider Medical Services		-	-	-	-		-	1,647,465	2,018,395	3,665,860
105													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
106		**Long-Term Care**								
107		Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
108		Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
109		Other funds reprioritization		-	(2,284,362)	(2,284,362)		-	(2,284,362)	(2,284,362)
110		Funding source change - Health care trust fund		1,000,000	(1,000,000)	-		1,000,000	(1,000,000)	-
111		Subtotal Long Term Care	-	33,348,100	33,234,093	66,582,193	-	33,348,100	33,234,093	66,582,193
112										
113		**Amendments to consider**								
114		Section 11 - Nursing Home Bed Reduction								-
115		Section 13 Nursing Home Rates								-
116		Remove Health Care Trust Fund in HB 1012								-
117		*DOJ Settlement: Supervision Rates						566,683	651,991	1,218,674
118		*DOJ Settlement: HCBS Family Personal Care						1,393,154	1,602,882	2,996,036
119		*DOJ Settlement: HCBS Non-Medical Transportation						85,557	44,248	129,805
120		*DOJ Settlement: HCBS Non-Medical Transportation Escort						152,158	10,075	162,233
121		Subtotal of Amendments to consider LTC	-	-	-	-	-	2,197,552	2,309,196	4,506,748
122										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
123		**DD Council**								
124		Continued program changes		-	124,949	124,949			124,949	124,949
125		Subtotal DD Council	-	-	124,949	124,949	-	-	124,949	124,949
126										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
127		**Aging Services**								
128		Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
129		Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
130		Subtotal Aging Services	-	(121,938)	2,220,821	2,098,883	-	(121,938)	2,220,821	2,098,883
131										
132		**Amendments to consider**								
133		*DOJ Settlement: Rental Assistance				-		300,000	-	300,000
134		*DOJ Settlement: Additional FTE					1.00		150,000	150,000
135		Ombudsman COVID-19 Congressional Relief							30,750	30,750
136		Vulnerable Adult Protective Services (VAPS) COVID-19 Congressional Relief							704,100	704,100
137		Senior Community Services Employment Program (SCSEP) Demonstration Grant							889,285	889,285
139		Subtotal of Aging Amendments to Consider	-	-	-	-	1.00	300,000	1,774,135	2,074,135
140										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
141		**Children and Family Services**								
142		Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
143		Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
144		Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
145		Subtotal Children and Family Services	-	(15,206,926)	(2,097,345)	(17,304,271)	-	(15,206,926)	(2,097,345)	(17,304,271)
146										
147		**Amendments to consider**								
151		Section 25 - QRTP rate setting process					-	-	-	-
152		Subtotal of CFS Amendments to Consider	-	-	-	-	-	-	-	-
153										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
154		**Behavioral Health Division**								
155		Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
156		Savings plan		(832,173)	-	(832,173)		(832,173)	-	(832,173)
157		Cost to Continue		5,427,067	-	5,427,067		5,427,067	-	5,427,067
158		Expanded substance use disorder voucher		9,000,000		9,000,000		9,000,000		9,000,000
159		Subtotal Behavioral Health Division	-	13,751,539	(1,957,536)	11,794,003	-	13,751,539	(1,957,536)	11,794,003
160										
161		**Amendments to consider**								
162		Section 8 - Allow for FTR Funding Transition								
163		Section 19 - School Behavioral Health Program carryover								
164		Section 20 - Behavioral Health Recovery Home grants carryover								
165		Section 24 Provider process and Outcome Measures								
166		Federal E-COVID Additional Award							2,859,649	
170		Subtotal of Behavioral Health Division Amendments to Consider	-	-	-	-	-	-	2,859,649	-
171										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
172		**Vocational Rehabilitation**											
173			Continued program changes			(416,293)	(381,081)	(797,374)			(416,293)	(381,081)	(797,374)
174			Agency savings plan:										
175			Centers for Independent Living State Match & Discretionary Funds Budget Error			(1,694,954)		(1,694,954)			(1,694,954)		(1,694,954)
176			Bottineau Ski Park			(109,000)	(91,000)	(200,000)			(109,000)	(91,000)	(200,000)
177			Subtotal Vocational Rehabilitation		-	(2,220,247)	(472,081)	(2,692,328)		-	(2,220,247)	(472,081)	(2,692,328)
178													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
179		**Developmental Disabilities**								
180		Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
181		Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
182		Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
183		Subtotal Developmental Disabilities	-	17,058,897	20,480,181	37,539,078	-	17,058,897	20,480,181	37,539,078
184										
185		**Amendments to consider**								
186		*Adjust Error for DD Crisis Beds					-	(30,156)	116,556	86,400
187		Subtotal of Developmental Disabilities Amendments to consider	-	-	-	-	-	(30,156)	116,556	86,400
188										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
189		**One-time funding items**											
190			Nursing facility payment methodology change			3,348,000	3,852,000	7,200,000			3,348,000	3,852,000	7,200,000
191			Nursing facility bed buyback program			3,300,000		3,300,000			3,300,000		3,300,000
192			Subtotal One-time funding changes		-	6,648,000	3,852,000	10,500,000		-	6,648,000	3,852,000	10,500,000
193													
194			Subtotal all ongoing funding changes		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
195													
196			Total Changes to Base Level Funding		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
197													
198		**2021-23 Total Funding - Program and Policy**			652.47	$ 1,282,628,540	$ 2,386,024,372	$ 3,668,652,912		270.22	$ 105,165,935	$ 292,616,623	$ 394,922,909
199													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
200		**2021-23 Base Level - Field Services**	1,599.03	$ 214,862,668	$ 127,314,955	$ 342,177,623				
201										
202		**2021-23 Ongoing Funding Changes**								
203		Transfers and adjustments	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)
204		Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
205		Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
206		Retirement contribution increase		1,003,529	108,416	1,111,945				-
207		Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
208		Provider inflationary increases		405,815		405,815		405,815		405,815
209		Subtotal Ongoing Funding Changes	(239.12)	(22,381,963)	(6,756,167)	(29,138,130)	(239.12)	(22,787,780)	(6,899,411)	(29,687,191)
210										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
211		**Human Service Centers**								
212		Continued program changes		6,007,961	(2,911,912)	3,096,049		6,007,961	(2,911,912)	3,096,049
213		Salary Underfunding		(2,891,071)		(2,891,071)		(2,891,071)		(2,891,071)
214		Cost and caseload changes		2,624,029	-	2,624,029		2,624,029	-	2,624,029
215		Civil sex offender treatment contract		917,004	-	917,004		917,004	-	917,004
216		Agency savings plan		(6,414,994)	-	(6,414,994)		(6,414,994)	-	(6,414,994)
217		Subtotal Human Service Centers	-	242,929	(2,911,912)	(2,668,983)	-	242,929	(2,911,912)	(2,668,983)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
219		**Institutions**								
220		Continued program changes		(2,447,261)	3,154,778	707,517		(2,447,261)	3,154,778	707,517
221		Salary Underfunding		(1,803,659)		(1,803,659)		(1,803,659)		(1,803,659)
222		LSTC Savings Plan Other than Adaptive Equipment	(14.50)	(5,991,785)	(6,549,550)	(12,541,335)	(14.50)	(6,134,400)	(6,714,398)	(12,848,798)
223		LSTC Savings Plan Adaptive Equipment		(142,615)	(164,086)	(306,701)		(142,615)	142,615	-
224		*LSTC Psychiatrist				-		183,040		183,040
225		State Hospital Savings Plan Other than 25 Bed Unit	(2.10)	49,025	(762)	48,263	(2.10)	49,025	-	49,025
226		State Hospital Savings Plan 25 Bed Unit	(14.00)	(1,775,792)	(345,100)	(2,120,892)				-
227		SOTEP Savings Plan	(1.00)	(143,450)		(143,450)	(1.00)	(143,450)		(143,450)
228		Subtotal Institutions	(31.60)	(12,255,537)	(3,904,720)	(16,160,257)	(17.60)	(10,439,320)	(3,417,005)	(13,856,325)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
230		**Amendments to consider**								
231		Section 21 - Conveyance of Land LSTC to Grafton Parks & Rec								
232		Section 22 - Capital Projects (Special Assessments and demolition at SH)								
233		Section 23 - New State Hospital								
234		Section 26 - Conveyance of Land at SH to National Guard								
235		Section 30 - Emergency clause for section 22 & 23								
236		Subtotal of Amendments to consider Institutions	-	-	-	-	-	-	-	-
237										
242		Total Changes to Base Level Funding	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)	(256.72)	(32,984,171)	(13,228,328)	(46,212,499)
243										
244		**2021-23 Total Funding - Field Services**	1,328.31	$ 180,468,097	$ 113,742,156	$ 294,210,253	(256.72)	$ (32,984,171)	$ (13,228,328)	$ (46,212,499)
245										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
246		**2021-23 Base Level - County Social Service Financing**	140.00	-	173,700,000	173,700,000				
247										
248		**2021-23 Ongoing Funding Changes**								
249		Base payroll changes			1,653,466	1,653,466			1,653,466	1,653,466
250		Salary increase		351,365	292,562	643,927		351,365	292,562	643,927
251		Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
252		Retirement contribution increase		72,382	60,269	132,651		72,382	60,269	132,651
253		Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
254		Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
255		Subtotal Ongoing Funding Changes	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	2,135,515	3,458,738
260										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
261		**Amendments to consider**								
262		Amend Human Service Finance Fund from 173,700,000 to 190,224,059 in HB 1012								
263		*Zone Employee salary increases & uncovered need					-	-	13,065,322	13,065,322
264		Subtotal of Amendments to consider - Zones	-	-	-	-	-	-	13,065,322	13,065,322
265										
266		Total Changes to Base Level Funding - County Social Service Zones	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	15,200,837	16,524,060
267										
268		**2021-23 Total Funding - County Social Service Financing**	143.00	1,323,223	175,835,515	177,158,738	3.00	1,323,223	15,200,837	16,524,060
269										
270		**2021-23 DHS HB 1012 Budget Total**	2,221.63	$ 1,563,943,856	$ 2,813,620,360	$ 4,377,564,216	6.40	$ 109,033,192	$ 344,513,912	$ 450,687,455
271										

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/18/2021 am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 8:33 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Amendment Review and Approval Process

Arnie Strebe (8:35 am) testified #6623 #6938 #6939 #6940

Rep Kreidt moved to adopt amendment and Rep Anderson seconded Voice

Vote (8:52 am) do pass Institutions, motion carries

Caprice Knapp (8:55 am) testified #6623

Rep Schobinger moved to adopt amendment and Rep Strinden seconded

Voice Vote (9:24 am) do pass long term care, motion carries

Rep Kreidt moved to adopt amendment and Rep Anderson seconded

Voice Vote (9:26 am) do pass Field Services. motion carries

Rep Anderson moved to adopt amendment and Rep Kreidt seconded

Voice Vote (9:40 am) do pass aging Services. motion carries

Rep Kreidt moved to adopt amendment and Strinden seconded

Voice Vote (9:54 am) do pass Developmental Disabilities, motion carries

Chair Nelson closed the meeting at 9:56 a.m.

Cole Fleck, Committee Clerk

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
	2021-23 Base Level - Management	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362				
	2021-23 Ongoing Funding Changes - Management								
	2019 -21 Transfers and adjustments	(18.10)	(838,781)	(3,553,654)	(4,392,435)	(18.10)	(838,781)	(3,553,654)	(4,392,435)
	Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
	Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
	Retirement contribution increase		79,629	16,925	96,554		79,629	16,925	96,554
	Health insurance increase		3,903	830	4,733		3,903	830	4,733
	Subtotal Ongoing Funding Changes	(18.10)	(877,919)	(2,721,808)	(3,599,727)	(18.10)	(892,966)	(2,726,474)	(3,619,440)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
19		**Administration**								
20		Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
21		Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
22		Capital complex rent model change		474,286	-	474,286		474,286	-	474,286
23		Subtotal Administration	8.00	1,247,185	1,281,648	2,528,833	8.00	1,247,185	1,281,648	2,528,833

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
25		**Information Technology Services**								
26		Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
27		Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
28		Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
29		Early childhood data system		500,000		500,000		500,000		500,000
30		Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
31		Other funds reprioritizing			2,324,362	2,324,362			2,324,362	2,324,362
32		Subtotal ongoing funding changes	-	15,137,770	3,764,075	18,901,845	-	15,137,770	3,764,075	18,901,845

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	One-time funding items								
	Upgrade MMIS system		4,326,686	30,673,314	35,000,000		4,326,686	30,673,314	35,000,000
	Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
	Total one-time funding changes	-	19,326,686	45,673,314	65,000,000	-	19,326,686	45,673,314	65,000,000
	Amendments to consider								
	*Data automation						98,186	98,186	196,372
	*MMIS Tech Stack						600,000	1,800,000	2,400,000
	*IBM services - quality measures						11,344	34,031	45,375
	Section 15 - MMIS Tech Stack Carryover								-
	Section 16 SPACES Carryover								-
	Section 17 Child Care Licensing System Carryover								-
	Section 18 HIN Carryover								-
	Subtotal of Amendments to Consider	-	-	-	-	-	709,530	1,932,217	2,641,747
	Total Changes to Base Level Funding - Administration	(10.10)	34,833,722	47,997,229	82,830,951	(10.10)	35,528,205	49,924,780	85,452,985
	2021-23 Total Management Funding	97.85	$ 99,523,996	$ 138,018,317	$ 237,542,313	(10.10)	35,528,205	49,924,780	85,452,985

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
53		**2021-23 Base Level - Program and Policy**	383.25	$ 1,181,597,942	$ 2,232,568,138	$ 3,414,166,080				
54										
55		**2021-23 Ongoing Funding Changes**								
56		2019 - 21 Transfers and adjustments	257.22	22,005,318	23,196,444	45,201,762	257.22	22,005,318	23,196,444	45,201,762
57		Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
58		Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
59		Retirement contribution increase		304,799	262,848	567,647		304,799	262,848	567,647
60		Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
61		Provider inflationary increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
62		Federal Medicaid assistance percentage changes		(45,779,364)	45,779,364	-		(45,779,364)	45,779,364	-
63		Subtotal Ongoing Funding Changes	257.22	(6,464,232)	85,571,467	79,107,235	257.22	(6,443,756)	85,653,925	79,210,169
64										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	Economic Assistance								
	Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
	Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
	Subtotal Economic Assistance	-	2,741,868	11,659,728	14,401,596	-	2,741,868	11,659,728	14,401,596
	Amendments to consider								
	Emergency Rental Assistance December 2020 Congressional COVID-19 Relief				-			130,000,000	130,000,000
	Subtotal of Economic Assistance Amendments to Consider	-	-	-	-	-	-	130,000,000	130,000,000

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
75		**Child Support**								
76		Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
77		Savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
78		Subtotal Child Support	-	(67,509)	(449,573)	(517,082)	-	(67,509)	(449,573)	(517,082)

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
80		**Medical Services**								
81		Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
82		Agency savings plan, including adjustments to Medicaid Expansion administration and rates		(2,578,722)	(6,846,085)	(9,424,807)		(975,780)	5,274,190	4,298,410
83		Medicaid Expansion	12.00	(9,146,630)	(73,787,030)	(82,933,660)	12.00	(10,749,572)	(85,907,305)	(96,656,877)
84		Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
85		Other fund reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
86		Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-		14,400,000	(14,400,000)	-
87		Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
88		Subtotal Medical Services	12.00	51,563,046	1,289,530	52,852,576	12.00	51,563,046	1,289,530	52,852,576
89										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
90		**Amendments to consider**											
91			*COVID-19 Vaccine admin/treatment								1,581,000	1,819,000	3,400,000
92			*DOJ Annual Nursing Facility Screening								50,000	150,000	200,000
93			*DOJ Path Contract Addition								16,465	49,395	65,860
94			Remove Tobacco Prevention and Control Trust Fund in HB 1012										-
95			Amend Community Health Trust Fund from $32,400,000 to $24,000,000 in HB 1012										-
96			Section 3 - Medicaid Expansion two year program extension										-
97			Section 4 - Medicaid Expansion to in house										-
98			Section 5 - Repeal consumer-directed health maintenances services										-
99			Section 12 - Medicaid Expansion MCO appropriation before transition in house										-
100			Section 14 - Health Homes										-
101			Section 27 - Utilization Rate Adjustments										-
102			Section 28 - Effective date for section 4										-
103			Section 29 - Expiration date for sections 3 & 12										-
104			Subtotal of Amendments to consider Medical Services		-	-	-	-		-	1,647,465	2,018,395	3,665,860
105													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
106		**Long-Term Care**								
107		Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
108		Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
109		Other funds reprioritization		-	(2,284,362)	(2,284,362)		-	(2,284,362)	(2,284,362)
110		Funding source change - Health care trust fund		1,000,000	(1,000,000)	-		1,000,000	(1,000,000)	-
111		Subtotal Long Term Care	-	33,348,100	33,234,093	66,582,193	-	33,348,100	33,234,093	66,582,193
112										
113		**Amendments to consider**								
114		Section 11 - Nursing Home Bed Reduction								-
115		Section 13 Nursing Home Rates								-
116		Remove Health Care Trust Fund in HB 1012								-
117		*DOJ Settlement: Supervision Rates						566,683	651,991	1,218,674
118		*DOJ Settlement: HCBS Family Personal Care						1,393,154	1,602,882	2,996,036
119		*DOJ Settlement: HCBS Non-Medical Transportation						85,557	44,248	129,805
120		*DOJ Settlement: HCBS Non-Medical Transportation Escort						152,158	10,075	162,233
121		Subtotal of Amendments to consider LTC	-	-	-	-	-	2,197,552	2,309,196	4,506,748
122										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
123		**DD Council**								
124		Continued program changes		-	124,949	124,949			124,949	124,949
125		Subtotal DD Council	-	-	124,949	124,949	-	-	124,949	124,949
126										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
127		**Aging Services**								
128		Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
129		Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
130		Subtotal Aging Services	-	(121,938)	2,220,821	2,098,883	-	(121,938)	2,220,821	2,098,883
131										
132		**Amendments to consider**								
133		*DOJ Settlement: Rental Assistance				-		300,000	-	300,000
134		*DOJ Settlement: Additional FTE					1.00		150,000	150,000
135		Ombudsman COVID-19 Congressional Relief							30,750	30,750
136		Vulnerable Adult Protective Services (VAPS) COVID-19 Congressional Relief							704,100	704,100
137		Senior Community Services Employment Program (SCSEP) Demonstration Grant							889,285	889,285
139		Subtotal of Aging Amendments to Consider	-	-	-	-	1.00	300,000	1,774,135	2,074,135
140										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
141		**Children and Family Services**								
142		Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
143		Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
144		Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
145		Subtotal Children and Family Services	-	(15,206,926)	(2,097,345)	(17,304,271)	-	(15,206,926)	(2,097,345)	(17,304,271)
146										
147		**Amendments to consider**								
151		Section 25 - QRTP rate setting process					-	-	-	-
152		Subtotal of CFS Amendments to Consider	-	-	-	-	-	-	-	-
153										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
154		**Behavioral Health Division**								
155		Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
156		Savings plan		(832,173)	-	(832,173)		(832,173)	-	(832,173)
157		Cost to Continue		5,427,067	-	5,427,067		5,427,067	-	5,427,067
158		Expanded substance use disorder voucher		9,000,000		9,000,000		9,000,000		9,000,000
159		Subtotal Behavioral Health Division	-	13,751,539	(1,957,536)	11,794,003	-	13,751,539	(1,957,536)	11,794,003
160										
161		**Amendments to consider**								
162		Section 8 - Allow for FTR Funding Transition								
163		Section 19 - School Behavioral Health Program carryover								
164		Section 20 - Behavioral Health Recovery Home grants carryover								
165		Section 24 Provider process and Outcome Measures								
166		Federal E-COVID Additional Award							2,859,649	
170		Subtotal of Behavioral Health Division Amendments to Consider	-	-	-	-	-	-	2,859,649	-
171										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
172		**Vocational Rehabilitation**											
173			Continued program changes			(416,293)	(381,081)	(797,374)			(416,293)	(381,081)	(797,374)
174			Agency savings plan:										
175			Centers for Independent Living State Match & Discretionary Funds Budget Error			(1,694,954)		(1,694,954)			(1,694,954)		(1,694,954)
176			Bottineau Ski Park			(109,000)	(91,000)	(200,000)			(109,000)	(91,000)	(200,000)
177			Subtotal Vocational Rehabilitation		-	(2,220,247)	(472,081)	(2,692,328)		-	(2,220,247)	(472,081)	(2,692,328)
178													

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
179		**Developmental Disabilities**								
180		Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
181		Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
182		Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
183		Subtotal Developmental Disabilities	-	17,058,897	20,480,181	37,539,078	-	17,058,897	20,480,181	37,539,078
184										
185		**Amendments to consider**								
186		*Adjust Error for DD Crisis Beds					-	(30,156)	116,556	86,400
187		Subtotal of Developmental Disabilities Amendments to consider	-	-	-	-	-	(30,156)	116,556	86,400
188										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
189		**One-time funding items**											
190			Nursing facility payment methodology change			3,348,000	3,852,000	7,200,000			3,348,000	3,852,000	7,200,000
191			Nursing facility bed buyback program			3,300,000		3,300,000			3,300,000		3,300,000
192			Subtotal One-time funding changes		-	6,648,000	3,852,000	10,500,000		-	6,648,000	3,852,000	10,500,000
193													
194			Subtotal all ongoing funding changes		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
195													
196			Total Changes to Base Level Funding		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
197													
198		**2021-23 Total Funding - Program and Policy**			652.47	$ 1,282,628,540	$ 2,386,024,372	$ 3,668,652,912		270.22	$ 105,165,935	$ 292,616,623	$ 394,922,909
199													

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
200		**2021-23 Base Level - Field Services**	1,599.03	$ 214,862,668	$ 127,314,955	$ 342,177,623				
201										
202		**2021-23 Ongoing Funding Changes**								
203		Transfers and adjustments	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)
204		Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
205		Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
206		Retirement contribution increase		1,003,529	108,416	1,111,945				-
207		Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
208		Provider inflationary increases		405,815		405,815		405,815		405,815
209		Subtotal Ongoing Funding Changes	(239.12)	(22,381,963)	(6,756,167)	(29,138,130)	(239.12)	(22,787,780)	(6,899,411)	(29,687,191)
210										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
211		**Human Service Centers**								
212		Continued program changes		6,007,961	(2,911,912)	3,096,049		6,007,961	(2,911,912)	3,096,049
213		Salary Underfunding		(2,891,071)		(2,891,071)		(2,891,071)		(2,891,071)
214		Cost and caseload changes		2,624,029	-	2,624,029		2,624,029	-	2,624,029
215		Civil sex offender treatment contract		917,004	-	917,004		917,004	-	917,004
216		Agency savings plan		(6,414,994)	-	(6,414,994)		(6,414,994)	-	(6,414,994)
217		Subtotal Human Service Centers	-	242,929	(2,911,912)	(2,668,983)	-	242,929	(2,911,912)	(2,668,983)

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
219		**Institutions**								
220		Continued program changes		(2,447,261)	3,154,778	707,517		(2,447,261)	3,154,778	707,517
221		Salary Underfunding		(1,803,659)		(1,803,659)		(1,803,659)		(1,803,659)
222		LSTC Savings Plan Other than Adaptive Equipment	(14.50)	(5,991,785)	(6,549,550)	(12,541,335)	(14.50)	(6,134,400)	(6,714,398)	(12,848,798)
223		LSTC Savings Plan Adaptive Equipment		(142,615)	(164,086)	(306,701)		(142,615)	142,615	-
224		*LSTC Psychiatrist				-		183,040		183,040
225		State Hospital Savings Plan Other than 25 Bed Unit	(2.10)	49,025	(762)	48,263	(2.10)	49,025	-	49,025
226		State Hospital Savings Plan 25 Bed Unit	(14.00)	(1,775,792)	(345,100)	(2,120,892)				-
227		SOTEP Savings Plan	(1.00)	(143,450)		(143,450)	(1.00)	(143,450)		(143,450)
228		Subtotal Institutions	(31.60)	(12,255,537)	(3,904,720)	(16,160,257)	(17.60)	(10,439,320)	(3,417,005)	(13,856,325)

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
230		**Amendments to consider**								
231		Section 21 - Conveyance of Land LSTC to Grafton Parks & Rec								
232		Section 22 - Capital Projects (Special Assessments and demolition at SH)								
233		Section 23 - New State Hospital								
234		Section 26 - Conveyance of Land at SH to National Guard								
235		Section 30 - Emergency clause for section 22 & 23								
236		Subtotal of Amendments to consider Institutions	-	-	-	-	-	-	-	-
237										
242		Total Changes to Base Level Funding	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)	(256.72)	(32,984,171)	(13,228,328)	(46,212,499)
243										
244		**2021-23 Total Funding - Field Services**	1,328.31	$ 180,468,097	$ 113,742,156	$ 294,210,253	(256.72)	$ (32,984,171)	$ (13,228,328)	$ (46,212,499)
245										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
246		**2021-23 Base Level - County Social Service Financing**	140.00	-	173,700,000	173,700,000				
247										
248		**2021-23 Ongoing Funding Changes**								
249		Base payroll changes			1,653,466	1,653,466			1,653,466	1,653,466
250		Salary increase		351,365	292,562	643,927		351,365	292,562	643,927
251		Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
252		Retirement contribution increase		72,382	60,269	132,651		72,382	60,269	132,651
253		Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
254		Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
255		Subtotal Ongoing Funding Changes	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	2,135,515	3,458,738
260										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
261		**Amendments to consider**								
262		Amend Human Service Finance Fund from 173,700,000 to 190,224,059 in HB 1012								
263		*Zone Employee salary increases & uncovered need					-	-	13,065,322	13,065,322
264		Subtotal of Amendments to consider - Zones	-	-	-	-	-	-	13,065,322	13,065,322
265										
266		Total Changes to Base Level Funding - County Social Service Zones	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	15,200,837	16,524,060
267										
268		**2021-23 Total Funding - County Social Service Financing**	143.00	1,323,223	175,835,515	177,158,738	3.00	1,323,223	15,200,837	16,524,060
269										
270		**2021-23 DHS HB 1012 Budget Total**	2,221.63	$ 1,563,943,856	$ 2,813,620,360	$ 4,377,564,216	6.40	$ 109,033,192	$ 344,513,912	$ 450,687,455
271										

North Dakota Department of Human Services #6938
COVID Related Federal Awards and Expenses through 12/21/2020

Subdivision	Program	Federal Award/EC Approval	Paid as of 12/21/2020	Notes
Aging Services	Supportive Services	1,000,000	312	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	1,200,000	1,195,618	Project period ends 9/30/2021
Aging Services	Nutrition Services under Title III-C of the Older Americans Act	2,400,000	2,385,440	Project period ends 9/30/2021
Aging Services	Family Caregiver Support Program	500,000	460,574	Project period ends 9/30/2021
Aging Services	ADRL ACL Grant	305,454	41,094	Project period ends 9/30/2021
Aging Services	Ombudsman Program	100,000	62,388	Project period ends 9/30/2021
Aging Services	Senior Community Services Employment Program (SCSEP)	889,285	-	Project period ends 12/31/2022
Aging Services	Coronavirus Relief Funds from OMB: Nutrition Services	1,131,800	1,001,729	Coronavirus Relief Funds
Behavioral Health	Emergency Grant to Address Mental & Substance Use Disorders COVID-19 (SAMHSA)	2,000,000	135,136	Project period ends 8/19/2021
Behavioral Health	Crisis, Counseling, and Training Program (SAMHSA)	835,629	-	Project period ends 6/8/2021
Behavioral Health	Crisis Counseling Assistance and Training Program Grant, ISP	251,053	226,738	Project period ends 9/7/2020
Behavioral Health	Coronavirus Relief Funds from OMB: Community-based behavioral health services	1,700,000	-	Coronavirus Relief Funds
Children and Family Services	FMAP IV-E Foster Care & Sub Adopt	2,500,000	1,412,772	Paid is through 9/30/2020 - 6.2% increase
Children and Family Services	Family Violence Prevention and Services Grant	79,837	-	Project period ends 9/30/2021
Children and Family Services	Child Welfare Services State Grant	76,858	-	Project period ends 9/30/2021
Economic Assistance	SNAP - School Meals USDA Replacement	10,058,706	9,543,681	Paid is through Nov. 2020
Economic Assistance	SNAP Increased Benefits	25,752,708	23,795,212	Paid is through Nov. 2020
Economic Assistance	Child Care Development Fund (CCDF)	6,037,905	-	Project period ends 9/30/2023
Economic Assistance	Low Income Home Energy Assistance Program (LIHEAP)	5,176,454	2,144,286	Project period ends 9/30/2021
Economic Assistance	FEMA Share: Great Plains Food Bank pass through	430,200	464,670	FEMA is open ended during the declared emergency
Economic Assistance	Emergency Rent Bridge (Community Development Block Grant)	6,534,942	6,919	Awarded to Department of Commerce
Economic Assistance	Coronavirus Relief Funds from OMB: Childcare Emergency Operating Grant (CEOG)	48,850,000	46,758,287	Coronavirus Relief Funds
Economic Assistance	Coronavirus Relief Funds from OMB: Emergency Rent Bridge (Dept. ID 3080)	2,900,000	2,738,939	Coronavirus Relief Funds
HSC/Institution	Rural Stimulus Payment	3,445,927	1,875	
Management	Coronavirus Relief Funds from OMB: HVAC Air Purification systems for Skilled Nursing Facilities	2,600,000	738,387	Coronavirus Relief Funds
Medicaid Grants	FMAP for Traditional Medicaid, Long-Term Care, and Developmental Disabilities	85,000,000	47,520,244	Paid is through 9/30/2020 - 6.2% increase
Department of Human Services	Coronavirus Relief Funds from OMB: Human Service Zones expenses, agency PPE and telework expenses, temporary staff, Connect Karts, Consultants, LTC portable air purifiers, QSP PPE grants, Grocer EBT Grant, Great Plain Food Bank, Telehealth upgrades	3,922,111	1,477,906	Coronavirus Relief Funds
Department of Human Services	FEMA Share: Agency Expenses	-	69,403	FEMA is open ended during the declared emergency
		215,678,868.99	142,181,611	

Final award different than estimated award approved by Emergency Commission and Budget Section

Project	Appropriation					Turnback on Oct. 1, 2020	Paid to date (1/31/2021)	Remaining after 10/1/2020 Turnback	Operating Line	Notes
	May 2020	June 2020	August 2020	October 2020	TOTAL					
Childcare Emergency Operating Grant (CEOG)	19,200,000	9,600,000	12,050,000	8,000,000	48,850,000		48,870,865	(20,865)	Grants	Emergency resposne to temporarily support child care providers until the COVID-19 emergency ends.
Emergency Rent Bridge	2,500,000	-	-	400,000	2,900,000		3,036,330	(136,330)	Grants	Provide rental assistance to individuals at risk of eviction who are unable to make rental payments as
Connect Karts		100,000	-		100,000	-	96,986	3,014	Operating	Karts provide electronic devices that promote long term care residents to stay connected with families
Real time location system (RTLS), sanitation compliance, & geo	1,000,000		-		1,000,000	936,000	64,000	-	Operating	Three LTC facilities will pilot RTLS in their facilities. Provide funding for sanitiation complance.
Grocer Start Up Costs to Access to SNAP (EBT/Online/Delivery)			750,000		750,000	500,000	61,898	188,102	Grants	Funding to help offset start-up costs for 25-35 retailers who want to participate in SNAP
Community-based Behavioral Health Services				1,700,000	1,700,000		59,040	1,640,960	Grants	By providing community-based behavioral health services to individuals in their homes and
State Share of FEMA for Great Plains Food Bank			143,400	160,520	303,920	-	193,446	110,474	Operating	Requesting $143,400 to serve as the 25% match to the FEMA funds that are available to help the
DHS portable ionizers				100,000	100,000		-	100,000	HSC/Institutions	To be utilized in HSC group rooms, NDSH transitional living homes and medical clinic.
Portable Rapid Recovery Air Purification Systems for LTC				426,000	426,000		-	426,000	Grants	Assisted Living and Skilled Nursing Facilities to allow for portable rapid recovery air purfication
HVAC Air Purification systems for Skilled Nursing Facilities				2,600,000	2,600,000		2,531,663	68,337	Grants	Assist skilled nursing facilities in purchasing air purification systems that will reduce airborn bacteria in
Childcare Surveys				150,000	150,000		-	150,000	Operating	**Understanding the impact of COVID-19 on the child care needs of families with young children**
IT Programing Costs for Data Collection Surveys related to COVID-19	25,746	50,000	-		75,746		137,046	(61,300)	Operating	Surveys include DHS Daily surveys to collect facility information
Enhancements to existing program:										
Human Service Zones									County Social Service Finance	Relief Funds (CARES Act)
Overtime	100,000				100,000	-		100,000	County Social Service Finance	Expenditures estimated for zone operated social services.
COVID Leave	100,000				100,000	-		100,000	County Social Service Finance	
PPE	25,000				25,000	-		25,000	County Social Service Finance	
Telework costs	25,000				25,000	-		25,000	County Social Service Finance	
Program specific costs	30,000				30,000	-		30,000	County Social Service Finance	
Other Costs	5,000				5,000	-		5,000	County Social Service Finance	
Avatar telehealth Upgrades			111,000		111,000	-	-	111,000	HSC/Institutions	Telehealth desktop carts - 20 devices at $3,900 each total $78,000; digital stethoscope 20 devices at
Avatar additional forms			30,000		30,000	-	-	30,000	HSC/Institutions	Addition of forms needed on the Avatar myhealthpoint patient portal and needed for kiosk so
Telehealth Licenses	48,930				48,930	-	48,930	-	HSC/Institutions	$10,530 for 351 licenses for 3 months; $38,400 for 80 licenses for an additional 12
Psychological Testing Electronic Forms			22,000		22,000	-	-	22,000	HSC/Institutions	DHS administer one to several tests for each assessment and the purpose of those assessment are to
Nutrition Services	871,800			260,000	1,131,800	-	1,131,800	-	Operating	Estimated need due to COVID beyond FFRCA & CARES allotments - Funds are estimated to be fully
PPE Grants for Qualified Service Providers (QSP)		50,000			50,000	-	32,069	17,931	Grants	•Department is planning to implement enhanced requirements for QSPs as a result of the COVID-19
The New Workplace supporting and engaging team ND and our										
Polycom System Upgrades	240,000	60,000			300,000	-	-	300,000	HSC/Institutions	Update Polycom system at the NDSH and 4 human service centers to provide telehealth to clients and
NDSH Scrubs	2,000	1,232			3,232	-	3,908	(676)	HSC/Institutions	Purchase of 15 pairs of scrubs to work with COVID-19 positive individuals. $2K was approved in May
Commercial Washer/Dryer		5,000			5,000	574	1,750	2,676	HSC/Institutions	To isolate launder scrubs for the isolation unit at the State Hospital
Temp Staffing to manage the ERB program, VP3 program, sourcing and distribution of PPE, homeless shelter program, and data analysis related to DHS COVID-19 resposne & AGENCY PPE				700,000	700,000		626,587	73,413	Salaries	Funding at 100%, we are attempting to claim FEMA for these temps
Agency PPE				350,000	350,000		353,898	(3,898)	Operating	Funding at 100%, we are attempting to claim FEMA for these PPE and other operating costs related to
Telecommute Team Members	150,000				150,000	71,595	-	78,405	Operating	
Cell phones for clients at HSCs	48,000				48,000	-	27,018	20,982	HSC/Institutions	200 phones @ $40/month/phone for 6 months. Phones are for clients to stay in touch during covid
Workload increases	25,000				25,000	19,357	5,016	627	salaries	Workload increases provided to exempt, non-senior manager team members affected by COVID-19
Consultants	500,000				500,000	255,000	245,000	-	Operating	Hire consultant to work with DHS on efficiencies to move from paper to electronic, old process to
Stationary Temperature Taking Machines			84,000		84,000	-	84,000	-	HSC/Institutions	Will be automated machines placed at the entry of buildings to robotically take and record the
Temp Staff for HSC screeners			86,809		86,809	-	47,963	38,846	HSC/Institutions	Staff to screen employees and clients at the human service centers (2 per center). Each temp is
LSTC Ipads	2,800				2,800	2,800	-	-	HSC/Institutions	Ordered 7 Ipads for the living units/ These were purchased with NDIT CRF money.
	24,899,276	9,866,232	13,277,209	14,496,520	62,539,237	1,785,326	57,659,213	3,444,698		

Department of Human Servicesc #6939
Leases/Building Rent
For the 2019-2021 Biennium

STATE OWNED BUILDINGS								
LOCATION	Street Address	City	Sq Ft	Rate/ Sq Ft	Total Cost			
Judicial Wing - Capitol (Pay federal portion only)	600 E Boulevard Ave	Bismarck ND 58501	30,041	14.38	431,989.58			
SEHSC	2624 9th Ave S	Fargo ND 58103			-			
State Hospital	2605 Circle Dr	Jamestown ND 58401			-			
Life Skills & Transition Center	701 W 6th St	Grafton ND 58237			-			
Life Skills & Transition Center - NEHSC	701 W 6th St	Grafton ND 58237	9,434					

NON-STATE BUILDINGS								
LOCATION	Street Address	City	Sq Ft	Rate/ Sq Ft	Yearly Total Cost	Term	Expires	Notes
DHS North - HD Partners	3451 North 14th	Bismarck, ND 58501	24,000	8.84	212,160.00	48 Months	6/30/2020	1st of 5 renewals
Central Office - Job Service Building	1000 E Divide Avenue	Bismarck, ND 58501	10,710	15.00	160,650.00	27 months	6/30/2022	5 year renewal option
Central Office/WCHSC - Prairie Hills Plaza	1237 W Divide Avenue	Bismarck, ND 58501	64,286	17.41	1,119,374.00	2 years	6/30/2021	On 8th of 10 renewals
Child Support - Bismarck	Rosser and 5th Street	Bismarck, ND 58501	7,844	17.25	135,309.00	60 Months	6/30/2021	
Child Support - Devils Lake	1820 Walnut Street E,Suite 4	Devils Lake ND	4,800	11.50	55,200.00	2 years	6/30/2021	1 of 2 renewals
Child Support - Dickinson	132 Sims Street, Suite 202	Dickinson, ND 58601	2,158	12.51	26,996.58	5 years	6/30/2021	
Child Support - Fargo	4950 13th Avenue South	Fargo, ND	6,021	18.00	108,378.00	120 Months	6/30/2023	5 year renewal option
Child Support - Grand Forks	3001 A 32nd Ave S Suite 3	Grand Forks, ND 58201	3,900	19.75	77,025.00	77 months	11/30/2025	
Child Support - Jamestown	Lot 2 Block 1 Began's College Park	Jamestown, ND	2,941	10.00	29,410.00	24 months	6/30/2021	
Child Support - Minot	325 28th Avenue SW, Suite C	Minot, ND 58703	4,200	16.10	67,620.00	62 months	6/30/2020	5 year renwal option used
Child Support - Williston	206 E Broaddway Suites 103 & 113	Williston, ND 58801	664	7.80	5,179.20	24 months	9/30/2022	
Child Support - Work Force Safety & Insurance	1600 East Century Avenue Suite 5 & 7	Bismarck, ND 58501	9,251	16.00	148,016.00	2 years	6/30/2021	Unlimited renewals
Economic Assistance - Fritel Enterprise	208 Main Street	Rolette, ND	208	14.42	2,999.36	24 months	1/31/2022	1 of 1 renewal
Economic Assistance - Fritel Enterprise	302 Main Street Suite 103	Elgin ND 58533	108	60.00	6,480.00	12 months	10/31/2020	
Economic Assistance - Towner Health & Wellness	2 3rd Avenue SW	Towner, ND 58788	94	31.91	2,999.54	24 months	12/31/2020	1 of 2 renewals
NWHSC - Gray Building (Outreach)	109 5th Street SW	Watford City, ND	336	17.86	6,000.96	2 years	6/30/2021	3rd of 5 renewals
NWHSC - Metro 316	316 2nd Avenue West	Williston, ND 58801	28,579	16.48	470,981.92	2 years	6/30/2023	
NCHSC - Ortorro (Open Arms)	18 3rd St SE, Suite 300	Minot, ND 58701	3,121	14.23	44,411.83	2 years	6/30/2021	1st of 6 renewals
NCHSC - Mountrail	228 Eagle Drive	New Town ND 58763	215	5.58	1,200.00	2 years	6/30/2021	5 24 month renewals
NCHSC - Rugby (Outreach)	126 2nd Aveune	Rugby, ND 58368	950	9.48	9,006.00	30 months	6/30/2021	4 of 5 renewals
NCHSC - Minot Town & Country Investors	1050 South Broadway	Minot, ND 58701	50,911	10.82	550,857.02	2 years	6/30/2021	5 24 month renewals
NEHSC - Grand Forks County Commission	151 South 4th Street	Grand Forks, ND 58201	40,040	14.34	574,173.60	24 months	6/30/2021	9 24 month renewals
Authority	770 S 14th St,	Grand Forks, ND 58201	9,352	11.04	103,246.08	24 months	6/30/2021	5 of 5 renewals
NEHSC - Job Service (VR)	1501 29th Avenue South	Grand Forks, ND 58201	3,306	9.00	29,754.00	25 months	6/30/2021	0 of 4 renewal options
SEHSC - Capital Building Four (VR)	1655 43rd St South	Fargo, ND	6,450	19.93	128,548.50	2 years	6/30/2021	2nd of 10 renewals
SEHSC - Carlson Properties (MFP/Aging/CFS)	1401 32nd St South	Fargo, ND	1,882	13.90	26,159.80	24 months	6/30/2021	4th of 5 renewals
SEHSC - Dakota Pioneer (contracted)	631 1st Avenue North	Fargo, ND	2,043	10.54	21,533.22	24 months	6/30/2021	1 of 5 renewals
SEHSC - Liffrig Family Investments (Off Main)	1122 1st Avenue North	Fargo, ND	7,875	13.25	104,343.75	2 years	6/30/2021	7 of 10 renewals
SEHSC - Liffrig Family Investments (Off Main)	1122 1st Avenue North	Fargo, ND	1,254	12.36	15,499.44	14 Months	6/30/2021	1 of 5 renewals
LRHSC - Hamilton Enterprise Central	200 Hwy 2 SW	Devils Lake ND	18,236	13.00	237,068.00	118 months	6/30/2023	
LRHSC - Job Service (VR)	301 South College Drive	Devils Lake ND	950	0.57	541.50	25 Months	6/30/2021	0 of 4 renewal options
LRHSC - Paul Munro (Outreach)	1102 Main Avenue West	Rolla, ND	5,060	13.67	69,170.20	2 years	6/30/2023	
SCHSC - City/County Health District (Outreach)	415 2nd Avenue	Valley City, ND	1,749	9.00	15,737.67	13 months	6/30/2021	1st of 5 renewals
SCHSC - N & F Construction	520 3rd Street NW	Jamestown, ND	27,577	10.37	285,973.49	2 years	6/30/2021	8 of 9 renewals
BLHSC - Golden Valley/Billings County Social Services (Outreach)	67 1st SE	Beach, ND 58621	1,721	0.87	1,500.00	24 months	6/30/2021	3rd of 5 renewals
BLHSC - KD Builders (VR)	1674 15th Street West	Dickinson, ND 58601	2,022	16.00	32,352.00	5 years	6/30/2023	1 of 1 five year renewals
BLHSC - Community Action Partnership	990 3rd Ave W	Dickinson, ND 58601	320	13.45	4,304.00	24 months	6/30/2021	4 of 5 renewals
BLHSC - Driscoll Services LLC	1463 I-94 Business Loop	Dickinson, ND 58601	24,000	14.83	355,920.00	6 years	6/30/2026	1 additional 6 year term and 5 - 2 year renewals

These leases have been terminated or have not been budgeted in the 21-23 executive budget request
These leases do not expire at the end of the biennium

Life Skills and Transition Center Psychiatrist #6940

- At the present time, 88% of LSTC residents require consultation with a psychiatrist as part of their care.
- Psychiatry services are currently being provided by Dr. Hill, a psychiatrist employed at Northeast Human Service Center.
- He has historically provided approximately 4 hours of care to LSTC residents per week.
- He has been working with LSTC for 27 years. Dr. Hill specializes in serving people with developmental disabilities, which is a rare specialization in the field of psychiatry.
- Dr. Hill is retiring from NEHSC in June 2021.
- NEHSC intends to replace Dr. Hill with another full time psychiatrist.
- The needs for psychiatry services provided by NEHSC will make it difficult for the new hire to continue to serve LSTC.
- As such, LSTC is proposing to contract with Dr. Hill on an hourly basis, to ensure uninterrupted psychiatric care for LSTC residents. The contract provides approximately 8 hours of services to residents on site, to accommodate the increased need we expect to see due to LSTCs increased focus on providing crisis and stabilization services.
- Dr. Hill is willing to continue to provide this service to LSTC as proposed.
- His continued service to LSTC will help ensure LSTC maintains certifications and accreditation, particularly in terms of serving people with dual diagnoses and complex pharmacotherapy needs.
- The estimated cost of the psychiatric service contract for LSTC is $183,000.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/19/2021am
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 8:02 a.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Amendment Review and Approval

Arnie Strebe (8:03 am) testified #6623

Rep Strinden Motioned to amend to provide $25,000 for licensing accreditation services for small agencies. Rep Mitskog seconded

Voice Vote (8:11 am) Motion carried.

Rep Anderson Motioned to include home support in the retainer payment for the time that would coincide with the Federal Emergency the amount not to exceed $250,000. Rep Mitskog seconded

Voice Vote (8:20 am) Motion carried.

Rosalie Etherington (8:40 am) testified #6623

Rep Schobinger Moved to amend with the Developmental Disabilities Section. Seconded by Rep Kreidt. Voice Vote: Motion carried.

Representative Kriedt moved on line 226 to take the reduction of the FTE at the State Hospital. Rep. Mitskog seconded.

Voice Vote. Motion carried.

Rep Kreidt Moved the proposed amendments to institutions including section 21, 22, 26 and 30. Rep Mitskog seconded.

Voice Vote (8:57 am) Motion carried.

Rep Schobinger Motioned amend to include the State hospital new building funding and Rep Mitskog seconded

Roll Call Vote State Hospital:

Representative	Yea	Nay
Nelson		x
Kreidt		x
Andersen		x
Mitskog		x
Schobinger	x	
Strinden		x

1-5-0 Motion failed

Rep Mitskog Motioned a Legislative study the State Hospital treatment campus for the 21-23 interim with reports to the State Hospital board addressing the cost benefits or possible closing or building a new State Hospital. Rep Strinden seconded

Voice Vote (9:17 am) Motion carried.

Rep Mitskog Motioned to further amend by adding reporting to Legislators. Rep Strinden seconded

Roll Call Vote:

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger		x
Strinden	x	

5-1-0 Motion Carried.

Pam Sagness (9:25 am) testified #7004

Rep Kreidt motioned to amend Department of Human Services Savings plan and Rep Anderson seconded

Roll Call Vote

Representative	Yea	Nay
Nelson		x
Kreidt	x	
Andersen	x	
Mitskog		x
Schobinger		x
Strinden	x	

3-3-0 Motion failed.

Rep Kreidt Motioned move to restoring 85% of the Department of Human Services plan. and Rep Anderson seconded

Voice Vote (9:38 am) Motion carried.

Rep Kreidt Motioned for $5 million appropriations for deferred maintenance for State Hospital and authority to go to the emergency commission if necessary for additional funding and Rep Anderson seconded

Vote Voice (9:51 am) Motion carried.

Chair Nelson closed the meeting at 9:55 a.m.

Cole Fleck, Committee Clerk and Donna Whetham

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
	2021-23 Base Level - Management	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362				
	2021-23 Ongoing Funding Changes - Management								
	2019 -21 Transfers and adjustments	(18.10)	(838,781)	(3,553,654)	(4,392,435)	(18.10)	(838,781)	(3,553,654)	(4,392,435)
	Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
	Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
	Retirement contribution increase		79,629	16,925	96,554		79,629	16,925	96,554
	Health insurance increase		3,903	830	4,733		3,903	830	4,733
	Subtotal Ongoing Funding Changes	(18.10)	(877,919)	(2,721,808)	(3,599,727)	(18.10)	(892,966)	(2,726,474)	(3,619,440)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
19		**Administration**								
20		Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
21		Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
22		Capital complex rent model change		474,286	-	474,286		474,286	-	474,286
23		Subtotal Administration	8.00	1,247,185	1,281,648	2,528,833	8.00	1,247,185	1,281,648	2,528,833

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
25		**Information Technology Services**								
26		Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
27		Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
28		Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
29		Early childhood data system		500,000		500,000		500,000		500,000
30		Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
31		Other funds reprioritizing			2,324,362	2,324,362			2,324,362	2,324,362
32		Subtotal ongoing funding changes	-	15,137,770	3,764,075	18,901,845	-	15,137,770	3,764,075	18,901,845

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	One-time funding items								
	Upgrade MMIS system		4,326,686	30,673,314	35,000,000		4,326,686	30,673,314	35,000,000
	Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
	Total one-time funding changes	-	19,326,686	45,673,314	65,000,000	-	19,326,686	45,673,314	65,000,000
	Amendments to consider								
	*Data automation						98,186	98,186	196,372
	*MMIS Tech Stack						600,000	1,800,000	2,400,000
	*IBM services - quality measures						11,344	34,031	45,375
	Section 15 - MMIS Tech Stack Carryover								-
	Section 16 SPACES Carryover								-
	Section 17 Child Care Licensing System Carryover								-
	Section 18 HIN Carryover								-
	Subtotal of Amendments to Consider	-	-	-	-	-	709,530	1,932,217	2,641,747
	Total Changes to Base Level Funding - Administration	(10.10)	34,833,722	47,997,229	82,830,951	(10.10)	35,528,205	49,924,780	85,452,985
	2021-23 Total Management Funding	97.85	$ 99,523,996	$ 138,018,317	$ 237,542,313	(10.10)	35,528,205	49,924,780	85,452,985

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
53		**2021-23 Base Level - Program and Policy**	383.25	$ 1,181,597,942	$ 2,232,568,138	$ 3,414,166,080				
54										
55		**2021-23 Ongoing Funding Changes**								
56		2019 - 21 Transfers and adjustments	257.22	22,005,318	23,196,444	45,201,762	257.22	22,005,318	23,196,444	45,201,762
57		Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
58		Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
59		Retirement contribution increase		304,799	262,848	567,647		304,799	262,848	567,647
60		Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
61		Provider inflationary increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
62		Federal Medicaid assistance percentage changes		(45,779,364)	45,779,364	-		(45,779,364)	45,779,364	-
63		Subtotal Ongoing Funding Changes	257.22	(6,464,232)	85,571,467	79,107,235	257.22	(6,443,756)	85,653,925	79,210,169
64										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	Economic Assistance								
	Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
	Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
	Subtotal Economic Assistance	-	2,741,868	11,659,728	14,401,596	-	2,741,868	11,659,728	14,401,596
	Amendments to consider								
	Emergency Rental Assistance December 2020 Congressional COVID-19 Relief				-			130,000,000	130,000,000
	Subtotal of Economic Assistance Amendments to Consider	-	-	-	-	-	-	130,000,000	130,000,000

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
75		**Child Support**								
76		Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
77		Savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
78		Subtotal Child Support	-	(67,509)	(449,573)	(517,082)	-	(67,509)	(449,573)	(517,082)

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
80		**Medical Services**								
81		Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
82		Agency savings plan, including adjustments to Medicaid Expansion administration and rates		(2,578,722)	(6,846,085)	(9,424,807)		(975,780)	5,274,190	4,298,410
83		Medicaid Expansion	12.00	(9,146,630)	(73,787,030)	(82,933,660)	12.00	(10,749,572)	(85,907,305)	(96,656,877)
84		Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
85		Other fund reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
86		Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-		14,400,000	(14,400,000)	-
87		Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
88		Subtotal Medical Services	12.00	51,563,046	1,289,530	52,852,576	12.00	51,563,046	1,289,530	52,852,576
89										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
90		**Amendments to consider**											
91			*COVID-19 Vaccine admin/treatment								1,581,000	1,819,000	3,400,000
92			*DOJ Annual Nursing Facility Screening								50,000	150,000	200,000
93			*DOJ Path Contract Addition								16,465	49,395	65,860
94			Remove Tobacco Prevention and Control Trust Fund in HB 1012										-
95			Amend Community Health Trust Fund from $32,400,000 to $24,000,000 in HB 1012										-
96			Section 3 - Medicaid Expansion two year program extension										-
97			Section 4 - Medicaid Expansion to in house										-
98			Section 5 - Repeal consumer-directed health maintenances services										-
99			Section 12 - Medicaid Expansion MCO appropriation before transition in house										-
100			Section 14 - Health Homes										-
101			Section 27 - Utilization Rate Adjustments										-
102			Section 28 - Effective date for section 4										-
103			Section 29 - Expiration date for sections 3 & 12										-
104			Subtotal of Amendments to consider Medical Services		-	-	-	-		-	1,647,465	2,018,395	3,665,860
105													

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
106		**Long-Term Care**								
107		Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
108		Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
109		Other funds reprioritization		-	(2,284,362)	(2,284,362)		-	(2,284,362)	(2,284,362)
110		Funding source change - Health care trust fund		1,000,000	(1,000,000)	-		1,000,000	(1,000,000)	-
111		Subtotal Long Term Care	-	33,348,100	33,234,093	66,582,193	-	33,348,100	33,234,093	66,582,193
112										
113		**Amendments to consider**								
114		Section 11 - Nursing Home Bed Reduction								-
115		Section 13 Nursing Home Rates								-
116		Remove Health Care Trust Fund in HB 1012								-
117		*DOJ Settlement: Supervision Rates						566,683	651,991	1,218,674
118		*DOJ Settlement: HCBS Family Personal Care						1,393,154	1,602,882	2,996,036
119		*DOJ Settlement: HCBS Non-Medical Transportation						85,557	44,248	129,805
120		*DOJ Settlement: HCBS Non-Medical Transportation Escort						152,158	10,075	162,233
121		Subtotal of Amendments to consider LTC	-	-	-	-	-	2,197,552	2,309,196	4,506,748
122										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
123		**DD Council**								
124		Continued program changes		-	124,949	124,949			124,949	124,949
125		Subtotal DD Council	-	-	124,949	124,949	-	-	124,949	124,949
126										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
127		**Aging Services**								
128		Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
129		Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
130		Subtotal Aging Services	-	(121,938)	2,220,821	2,098,883	-	(121,938)	2,220,821	2,098,883
131										
132		**Amendments to consider**								
133		*DOJ Settlement: Rental Assistance				-		300,000	-	300,000
134		*DOJ Settlement: Additional FTE					1.00		150,000	150,000
135		Ombudsman COVID-19 Congressional Relief							30,750	30,750
136		Vulnerable Adult Protective Services (VAPS) COVID-19 Congressional Relief							704,100	704,100
137		Senior Community Services Employment Program (SCSEP) Demonstration Grant							889,285	889,285
139		Subtotal of Aging Amendments to Consider	-	-	-	-	1.00	300,000	1,774,135	2,074,135
140										

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
141		**Children and Family Services**								
142		Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
143		Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
144		Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
145		Subtotal Children and Family Services	-	(15,206,926)	(2,097,345)	(17,304,271)	-	(15,206,926)	(2,097,345)	(17,304,271)
146										
147		**Amendments to consider**								
151		Section 25 - QRTP rate setting process					-	-	-	-
152		Subtotal of CFS Amendments to Consider	-	-	-	-	-	-	-	-
153										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
154		**Behavioral Health Division**								
155		Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
156		Savings plan		(832,173)	-	(832,173)		(832,173)	-	(832,173)
157		Cost to Continue		5,427,067	-	5,427,067		5,427,067	-	5,427,067
158		Expanded substance use disorder voucher		9,000,000		9,000,000		9,000,000		9,000,000
159		Subtotal Behavioral Health Division	-	13,751,539	(1,957,536)	11,794,003	-	13,751,539	(1,957,536)	11,794,003
160										
161		**Amendments to consider**								
162		Section 8 - Allow for FTR Funding Transition								
163		Section 19 - School Behavioral Health Program carryover								
164		Section 20 - Behavioral Health Recovery Home grants carryover								
165		Section 24 Provider process and Outcome Measures								
166		Federal E-COVID Additional Award							2,859,649	
170		Subtotal of Behavioral Health Division Amendments to Consider	-	-	-	-	-	-	2,859,649	-
171										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
172		**Vocational Rehabilitation**											
173			Continued program changes			(416,293)	(381,081)	(797,374)			(416,293)	(381,081)	(797,374)
174			Agency savings plan:										
175			Centers for Independent Living State Match & Discretionary Funds Budget Error			(1,694,954)		(1,694,954)			(1,694,954)		(1,694,954)
176			Bottineau Ski Park			(109,000)	(91,000)	(200,000)			(109,000)	(91,000)	(200,000)
177			Subtotal Vocational Rehabilitation		-	(2,220,247)	(472,081)	(2,692,328)		-	(2,220,247)	(472,081)	(2,692,328)
178													

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
179		**Developmental Disabilities**								
180		Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
181		Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
182		Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
183		Subtotal Developmental Disabilities	-	17,058,897	20,480,181	37,539,078	-	17,058,897	20,480,181	37,539,078
184										
185		**Amendments to consider**								
186		*Adjust Error for DD Crisis Beds					-	(30,156)	116,556	86,400
187		Subtotal of Developmental Disabilities Amendments to consider	-	-	-	-	-	(30,156)	116,556	86,400
188										

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
189		**One-time funding items**											
190			Nursing facility payment methodology change			3,348,000	3,852,000	7,200,000			3,348,000	3,852,000	7,200,000
191			Nursing facility bed buyback program			3,300,000		3,300,000			3,300,000		3,300,000
192			Subtotal One-time funding changes		-	6,648,000	3,852,000	10,500,000		-	6,648,000	3,852,000	10,500,000
193													
194			Subtotal all ongoing funding changes		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
195													
196			Total Changes to Base Level Funding		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
197													
198		**2021-23 Total Funding - Program and Policy**			652.47	$ 1,282,628,540	$ 2,386,024,372	$ 3,668,652,912		270.22	$ 105,165,935	$ 292,616,623	$ 394,922,909
199													

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Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
200		**2021-23 Base Level - Field Services**	1,599.03	$ 214,862,668	$ 127,314,955	$ 342,177,623				
201										
202		**2021-23 Ongoing Funding Changes**								
203		Transfers and adjustments	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)
204		Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
205		Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
206		Retirement contribution increase		1,003,529	108,416	1,111,945				-
207		Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
208		Provider inflationary increases		405,815		405,815		405,815		405,815
209		Subtotal Ongoing Funding Changes	(239.12)	(22,381,963)	(6,756,167)	(29,138,130)	(239.12)	(22,787,780)	(6,899,411)	(29,687,191)
210										

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
211		**Human Service Centers**								
212		Continued program changes		6,007,961	(2,911,912)	3,096,049		6,007,961	(2,911,912)	3,096,049
213		Salary Underfunding		(2,891,071)		(2,891,071)		(2,891,071)		(2,891,071)
214		Cost and caseload changes		2,624,029	-	2,624,029		2,624,029	-	2,624,029
215		Civil sex offender treatment contract		917,004	-	917,004		917,004	-	917,004
216		Agency savings plan		(6,414,994)	-	(6,414,994)		(6,414,994)	-	(6,414,994)
217		Subtotal Human Service Centers	-	242,929	(2,911,912)	(2,668,983)	-	242,929	(2,911,912)	(2,668,983)

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
219		**Institutions**								
220		Continued program changes		(2,447,261)	3,154,778	707,517		(2,447,261)	3,154,778	707,517
221		Salary Underfunding		(1,803,659)		(1,803,659)		(1,803,659)		(1,803,659)
222		LSTC Savings Plan Other than Adaptive Equipment	(14.50)	(5,991,785)	(6,549,550)	(12,541,335)	(14.50)	(6,134,400)	(6,714,398)	(12,848,798)
223		LSTC Savings Plan Adaptive Equipment		(142,615)	(164,086)	(306,701)		(142,615)	142,615	-
224		*LSTC Psychiatrist				-		183,040		183,040
225		State Hospital Savings Plan Other than 25 Bed Unit	(2.10)	49,025	(762)	48,263	(2.10)	49,025	-	49,025
226		State Hospital Savings Plan 25 Bed Unit	(14.00)	(1,775,792)	(345,100)	(2,120,892)				-
227		SOTEP Savings Plan	(1.00)	(143,450)		(143,450)	(1.00)	(143,450)		(143,450)
228		Subtotal Institutions	(31.60)	(12,255,537)	(3,904,720)	(16,160,257)	(17.60)	(10,439,320)	(3,417,005)	(13,856,325)

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
230		**Amendments to consider**								
231		Section 21 - Conveyance of Land LSTC to Grafton Parks & Rec								
232		Section 22 - Capital Projects (Special Assessments and demolition at SH)								
233		Section 23 - New State Hospital								
234		Section 26 - Conveyance of Land at SH to National Guard								
235		Section 30 - Emergency clause for section 22 & 23								
236		Subtotal of Amendments to consider Institutions	-	-	-	-	-	-	-	-
237										
242		Total Changes to Base Level Funding	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)	(256.72)	(32,984,171)	(13,228,328)	(46,212,499)
243										
244		**2021-23 Total Funding - Field Services**	1,328.31	$ 180,468,097	$ 113,742,156	$ 294,210,253	(256.72)	$ (32,984,171)	$ (13,228,328)	$ (46,212,499)
245										

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
246		**2021-23 Base Level - County Social Service Financing**	140.00	-	173,700,000	173,700,000				
247										
248		**2021-23 Ongoing Funding Changes**								
249		Base payroll changes			1,653,466	1,653,466			1,653,466	1,653,466
250		Salary increase		351,365	292,562	643,927		351,365	292,562	643,927
251		Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
252		Retirement contribution increase		72,382	60,269	132,651		72,382	60,269	132,651
253		Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
254		Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
255		Subtotal Ongoing Funding Changes	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	2,135,515	3,458,738
260										

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	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
261		**Amendments to consider**								
262		Amend Human Service Finance Fund from 173,700,000 to 190,224,059 in HB 1012								
263		*Zone Employee salary increases & uncovered need					-	-	13,065,322	13,065,322
264		Subtotal of Amendments to consider - Zones	-	-	-	-	-	-	13,065,322	13,065,322
265										
266		Total Changes to Base Level Funding - County Social Service Zones	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	15,200,837	16,524,060
267										
268		**2021-23 Total Funding - County Social Service Financing**	143.00	1,323,223	175,835,515	177,158,738	3.00	1,323,223	15,200,837	16,524,060
269										
270		**2021-23 DHS HB 1012 Budget Total**	2,221.63	$ 1,563,943,856	$ 2,813,620,360	$ 4,377,564,216	6.40	$ 109,033,192	$ 344,513,912	$ 450,687,455
271										

Division	Description	Executive Budget Request General Fund Savings	Savings if Amended	Notes	Action	Remaining Contract Total for Provider
Behavioral Health	Reduce **Parent to Parent** - 1915i Realignment	(11,250)	(5,625)	Not Direct Service - 15% reduction of total	Restore to 85% of $75,000	69,375
Behavioral Health	Reduce **Brain Injury - Resource Facilitation** (NDBIN) - 1915i realignment	(279,247)	(83,774)	Not Direct Service - 15% reduction of total	Restore to 85% of $558,494	474,720
Behavioral Health	Reduce peer support certification	(13,590)	(13,590)	no vendor	No vendor - virtual training, reduced travel, etc.	N/A
Behavioral Health	Reduce Peer support pilot	(15,000)	15,000	no vendor	1-time start-up last session	N/A
Children and Family Services	**Family Voices** - Reduce Family Peer Support (Family Health Info & Ed Ctr) - 1915i re-alignment	(99,999)	(26,250)	Not Direct Service - 15% reduction of total	Restore to 85% of $175,000	148,750
Human Service Center	Reduce **Prairie Harvest** Mental Health contract - 1915i re-alignment	(1,414,800)	(1,061,100)	All tenants pay rent; NEHSC gives services; remaining $ support until 1915i efficient	Maintain 50% reduction. Other similar providers receive between $280,000-$500,000.	1,644,260
Total DHS Savings Plan		**(1,833,886)**	**(1,175,339)**			**2,337,105**

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/19/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 3:09 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Amendment Review and Approval Process

Arnie Strebe (3:10 pm) testified #6623

Pam Sagness (3:12 pm) testified #6623

Rep Kreidt moved to amend behavioral health funding transfers

Rep Mitskog Seconded

Voice Vote (3:15 pm) Motion Carries

Rep Kreidt moved to amend- behavioral health exemptions

Rep Mitskog Seconded

Voice Vote (3:16 pm) Motion Carries

Rep Strinden move to amend behavioral health exemption

Rep Anderson Seconded

Voice Vote (3:17 pm) Motion Carries

Rep Kreidt moved to amend behavioral health provider process and outcome measures

Rep Strinden Seconded

Voice Vote (3:18 pm) Motion Carries

Rep Kreidt moved to amend SUD vouchers

Rep Anderson Seconded

Roll Call Vote (3:48 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger		x
Strinden		x

Motion Carries 4-2-0

Caprice Knapp (3:49 pm) testified #6623

Rep Kreidt move to amend traditional Medicaid

Rep Mitskog Seconded

Voice Vote (4:22 pm) Motion Carries

Rep Schobinger moved to pass amendment 21.0271.01001

Rep Strinden Seconded

Roll Call Vote (4:30 pm)

Representative	Yea	Nay
Nelson		x
Kreidt		x
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Motion Carries 4-2-0

Rep Kreidt move to amend Medicaid expiation; reduce by 25 million dollars or a 4% reduction to the total appropriation

Rep Mitskog Seconded

Roll Call Vote (4:41 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen		x
Mitskog	x	
Schobinger		x
Strinden		x

Motion Fails 3-3-0

Tim Blasl (4:45 pm) testified orally

Rep Mitskog move to amend Medicaid expiation, option 2 (transparency)

Rep Kreidt Seconded

Roll Call Vote (4:47 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

Motion Carries 6-0-0

Rep Kreidt moved to amend Medicaid expiation; option 3 (packages for every under 21)

Rep Anderson Seconded

Roll Call Vote (4:57 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger		x
Strinden	x	

Motion Caries 5-1-0

Rep Mitskog move to amend Medicaid expansion; option 4 (reimbursement for behavioral health)

Rep Kreidt Seconded

Roll Call Vote (4:57 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen		x
Mitskog	x	
Schobinger		
Strinden		x

Motion Carries 3-2-1

Rep Mitskog move to amend DD services

Rep Strinden Seconded

Roll Call Vote (5:07 pm)

Representative	Yea	Nay
Nelson		x
Kreidt		x
Andersen		x
Mitskog	x	
Schobinger		
Strinden	x	

Motion Fails 2-3-1

Rep Strinden move to amend Disorder Vouchers

Rep Mitskog Seconded

Roll Call Vote (5:13 pm)

Representative	Yea	Nay
Nelson		x
Kreidt		x
Andersen		x
Mitskog	x	
Schobinger		
Strinden	x	

Motion Fails 2-3-1

Rep Kreidt moved to amend section 12

Rep Anderson Seconded

Voice Vote (5:18 pm) Motion Carries

Rep Kreidt moved to amend 1 and 1 inflators

Rep Anderson Seconded

Voice Vote (5:23 pm) Motion Carries

Rep Kreidt moved to amend; reduce units to 450 and reduce amount to 28 hundred

Rep Anderson Seconded

Voice Vote (5:25 pm) Motion Carries

Rep Kreidt moved to amend; for overall operation of the Department of human services a reduction 6 ½%

Rep Anderson Seconded

Voice Vote (5:29 pm) Motion Carries

Rep Kreidt move to amend; strike the health homes piece from the budget bill (Section 14)

Rep Mitskog Seconded

Voice Vote (5:30 pm) Motion Carries

Rep Kreidt Move to amend; $2 incentive reinstated for the 1.6 million

Rep Anderson Seconded

Voice Vote (5:32 pm) Motion Carries

Rep Kreidt Move to amend; grant 333 thousand dollars less than the 8 million dollars

Rep Anderson Seconded

Voice Vote (5:35 pm) Motion Carries

Chair Nelson closed the meeting at 5:38 p.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Representative Schobinger
January 18, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to amend and reenact section 50-24.1-37 of the North Dakota Century Code, relating to the Medicaid expansion program"

Page 4, after line 16, insert:

"**SECTION 9. AMENDMENT.** Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021 -~~ Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment removes the sunset clause for the Medicaid Expansion program and continues the program in its current form.

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
	2021-23 Base Level - Management	107.95	$ 64,690,274	$ 90,021,088	$ 154,711,362				
	2021-23 Ongoing Funding Changes - Management								
	2019 -21 Transfers and adjustments	(18.10)	(838,781)	(3,553,654)	(4,392,435)	(18.10)	(838,781)	(3,553,654)	(4,392,435)
	Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
	Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
	Retirement contribution increase		79,629	16,925	96,554		79,629	16,925	96,554
	Health insurance increase		3,903	830	4,733		3,903	830	4,733
	Subtotal Ongoing Funding Changes	(18.10)	(877,919)	(2,721,808)	(3,599,727)	(18.10)	(892,966)	(2,726,474)	(3,619,440)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
19		**Administration**								
20		Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
21		Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
22		Capital complex rent model change		474,286	-	474,286		474,286	-	474,286
23		Subtotal Administration	8.00	1,247,185	1,281,648	2,528,833	8.00	1,247,185	1,281,648	2,528,833

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
25		**Information Technology Services**								
26		Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
27		Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
28		Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
29		Early childhood data system		500,000		500,000		500,000		500,000
30		Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
31		Other funds reprioritizing			2,324,362	2,324,362			2,324,362	2,324,362
32		Subtotal ongoing funding changes	-	15,137,770	3,764,075	18,901,845	-	15,137,770	3,764,075	18,901,845

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	One-time funding items								
	Upgrade MMIS system		4,326,686	30,673,314	35,000,000		4,326,686	30,673,314	35,000,000
	Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
	Total one-time funding changes	-	19,326,686	45,673,314	65,000,000	-	19,326,686	45,673,314	65,000,000
	Amendments to consider								
	*Data automation						98,186	98,186	196,372
	*MMIS Tech Stack						600,000	1,800,000	2,400,000
	*IBM services - quality measures						11,344	34,031	45,375
	Section 15 - MMIS Tech Stack Carryover								-
	Section 16 SPACES Carryover								-
	Section 17 Child Care Licensing System Carryover								-
	Section 18 HIN Carryover								-
	Subtotal of Amendments to Consider	-	-	-	-	-	709,530	1,932,217	2,641,747
	Total Changes to Base Level Funding - Administration	(10.10)	34,833,722	47,997,229	82,830,951	(10.10)	35,528,205	49,924,780	85,452,985
	2021-23 Total Management Funding	97.85	$ 99,523,996	$ 138,018,317	$ 237,542,313	(10.10)	35,528,205	49,924,780	85,452,985

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
53		**2021-23 Base Level - Program and Policy**	383.25	$ 1,181,597,942	$ 2,232,568,138	$ 3,414,166,080				
54										
55		**2021-23 Ongoing Funding Changes**								
56		2019 - 21 Transfers and adjustments	257.22	22,005,318	23,196,444	45,201,762	257.22	22,005,318	23,196,444	45,201,762
57		Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
58		Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
59		Retirement contribution increase		304,799	262,848	567,647		304,799	262,848	567,647
60		Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
61		Provider inflationary increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
62		Federal Medicaid assistance percentage changes		(45,779,364)	45,779,364	-		(45,779,364)	45,779,364	-
63		Subtotal Ongoing Funding Changes	257.22	(6,464,232)	85,571,467	79,107,235	257.22	(6,443,756)	85,653,925	79,210,169
64										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments		
	Economic Assistance								
	Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
	Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
	Subtotal Economic Assistance	-	2,741,868	11,659,728	14,401,596	-	2,741,868	11,659,728	14,401,596
	Amendments to consider								
	Emergency Rental Assistance December 2020 Congressional COVID-19 Relief				-			130,000,000	130,000,000
	Subtotal of Economic Assistance Amendments to Consider	-	-	-	-	-	-	130,000,000	130,000,000

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
75		**Child Support**								
76		Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
77		Savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
78		Subtotal Child Support	-	(67,509)	(449,573)	(517,082)	-	(67,509)	(449,573)	(517,082)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
80		**Medical Services**								
81		Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
82		Agency savings plan, including adjustments to Medicaid Expansion administration and rates		(2,578,722)	(6,846,085)	(9,424,807)		(975,780)	5,274,190	4,298,410
83		Medicaid Expansion	12.00	(9,146,630)	(73,787,030)	(82,933,660)	12.00	(10,749,572)	(85,907,305)	(96,656,877)
84		Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
85		Other fund reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
86		Funding source change - community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	-		14,400,000	(14,400,000)	-
87		Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
88		Subtotal Medical Services	12.00	51,563,046	1,289,530	52,852,576	12.00	51,563,046	1,289,530	52,852,576
89										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
90		**Amendments to consider**											
91			*COVID-19 Vaccine admin/treatment								1,581,000	1,819,000	3,400,000
92			*DOJ Annual Nursing Facility Screening								50,000	150,000	200,000
93			*DOJ Path Contract Addition								16,465	49,395	65,860
94			Remove Tobacco Prevention and Control Trust Fund in HB 1012										-
95			Amend Community Health Trust Fund from $32,400,000 to $24,000,000 in HB 1012										-
96			Section 3 - Medicaid Expansion two year program extension										-
97			Section 4 - Medicaid Expansion to in house										-
98			Section 5 - Repeal consumer-directed health maintenances services										-
99			Section 12 - Medicaid Expansion MCO appropriation before transition in house										-
100			Section 14 - Health Homes										-
101			Section 27 - Utilization Rate Adjustments										-
102			Section 28 - Effective date for section 4										-
103			Section 29 - Expiration date for sections 3 & 12										-
104			Subtotal of Amendments to consider Medical Services		-	-	-	-		-	1,647,465	2,018,395	3,665,860
105													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
106		**Long-Term Care**								
107		Agency Savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
108		Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
109		Other funds reprioritization		-	(2,284,362)	(2,284,362)		-	(2,284,362)	(2,284,362)
110		Funding source change - Health care trust fund		1,000,000	(1,000,000)	-		1,000,000	(1,000,000)	-
111		Subtotal Long Term Care	-	33,348,100	33,234,093	66,582,193	-	33,348,100	33,234,093	66,582,193
112										
113		**Amendments to consider**								
114		Section 11 - Nursing Home Bed Reduction								-
115		Section 13 Nursing Home Rates								-
116		Remove Health Care Trust Fund in HB 1012								-
117		*DOJ Settlement: Supervision Rates						566,683	651,991	1,218,674
118		*DOJ Settlement: HCBS Family Personal Care						1,393,154	1,602,882	2,996,036
119		*DOJ Settlement: HCBS Non-Medical Transportation						85,557	44,248	129,805
120		*DOJ Settlement: HCBS Non-Medical Transportation Escort						152,158	10,075	162,233
121		Subtotal of Amendments to consider LTC	-	-	-	-	-	2,197,552	2,309,196	4,506,748
122										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
123		**DD Council**								
124		Continued program changes		-	124,949	124,949			124,949	124,949
125		Subtotal DD Council	-	-	124,949	124,949	-	-	124,949	124,949
126										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
127		**Aging Services**								
128		Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
129		Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
130		Subtotal Aging Services	-	(121,938)	2,220,821	2,098,883	-	(121,938)	2,220,821	2,098,883
131										
132		**Amendments to consider**								
133		*DOJ Settlement: Rental Assistance				-		300,000	-	300,000
134		*DOJ Settlement: Additional FTE					1.00		150,000	150,000
135		Ombudsman COVID-19 Congressional Relief							30,750	30,750
136		Vulnerable Adult Protective Services (VAPS) COVID-19 Congressional Relief							704,100	704,100
137		Senior Community Services Employment Program (SCSEP) Demonstration Grant							889,285	889,285
139		Subtotal of Aging Amendments to Consider	-	-	-	-	1.00	300,000	1,774,135	2,074,135
140										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
141		**Children and Family Services**								
142		Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
143		Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
144		Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
145		Subtotal Children and Family Services	-	(15,206,926)	(2,097,345)	(17,304,271)	-	(15,206,926)	(2,097,345)	(17,304,271)
146										
147		**Amendments to consider**								
151		Section 25 - QRTP rate setting process					-	-	-	-
152		Subtotal of CFS Amendments to Consider	-	-	-	-	-	-	-	-
153										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
154		**Behavioral Health Division**								
155		Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
156		Savings plan		(832,173)	-	(832,173)		(832,173)	-	(832,173)
157		Cost to Continue		5,427,067	-	5,427,067		5,427,067	-	5,427,067
158		Expanded substance use disorder voucher		9,000,000		9,000,000		9,000,000		9,000,000
159		Subtotal Behavioral Health Division	-	13,751,539	(1,957,536)	11,794,003	-	13,751,539	(1,957,536)	11,794,003
160										
161		**Amendments to consider**								
162		Section 8 - Allow for FTR Funding Transition								
163		Section 19 - School Behavioral Health Program carryover								
164		Section 20 - Behavioral Health Recovery Home grants carryover								
165		Section 24 Provider process and Outcome Measures								
166		Federal E-COVID Additional Award							2,859,649	
170		Subtotal of Behavioral Health Division Amendments to Consider	-	-	-	-	-	-	2,859,649	-
171										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
172		**Vocational Rehabilitation**											
173			Continued program changes			(416,293)	(381,081)	(797,374)			(416,293)	(381,081)	(797,374)
174			Agency savings plan:										
175			Centers for Independent Living State Match & Discretionary Funds Budget Error			(1,694,954)		(1,694,954)			(1,694,954)		(1,694,954)
176			Bottineau Ski Park			(109,000)	(91,000)	(200,000)			(109,000)	(91,000)	(200,000)
177			Subtotal Vocational Rehabilitation		-	(2,220,247)	(472,081)	(2,692,328)		-	(2,220,247)	(472,081)	(2,692,328)
178													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
179		**Developmental Disabilities**								
180		Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
181		Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
182		Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
183		Subtotal Developmental Disabilities	-	17,058,897	20,480,181	37,539,078	-	17,058,897	20,480,181	37,539,078
184										
185		**Amendments to consider**								
186		*Adjust Error for DD Crisis Beds					-	(30,156)	116,556	86,400
187		Subtotal of Developmental Disabilities Amendments to consider	-	-	-	-	-	(30,156)	116,556	86,400
188										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	F	G	H	I	J	K	L	M	N	O	P	Q	R
5					21 -23 Executive Budget Recommendation (EBR)					21 - 23 HB 1012 Proposed Amendments			
6	Recom. Time Required				FTE Positions	General Fund	Other Funds	Total		FTE Positions	General Fund	Other Funds	Total
189		**One-time funding items**											
190			Nursing facility payment methodology change			3,348,000	3,852,000	7,200,000			3,348,000	3,852,000	7,200,000
191			Nursing facility bed buyback program			3,300,000		3,300,000			3,300,000		3,300,000
192			Subtotal One-time funding changes		-	6,648,000	3,852,000	10,500,000		-	6,648,000	3,852,000	10,500,000
193													
194			Subtotal all ongoing funding changes		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
195													
196			Total Changes to Base Level Funding		269.22	101,030,598	153,456,234	254,486,832		270.22	105,165,935	292,616,623	394,922,909
197													
198		**2021-23 Total Funding - Program and Policy**			652.47	$ 1,282,628,540	$ 2,386,024,372	$ 3,668,652,912		270.22	$ 105,165,935	$ 292,616,623	$ 394,922,909
199													

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
200		**2021-23 Base Level - Field Services**	1,599.03	$ 214,862,668	$ 127,314,955	$ 342,177,623				
201										
202		**2021-23 Ongoing Funding Changes**								
203		Transfers and adjustments	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)	(239.12)	(21,166,537)	(19,642,790)	(40,809,327)
204		Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
205		Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
206		Retirement contribution increase		1,003,529	108,416	1,111,945				-
207		Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
208		Provider inflationary increases		405,815		405,815		405,815		405,815
209		Subtotal Ongoing Funding Changes	(239.12)	(22,381,963)	(6,756,167)	(29,138,130)	(239.12)	(22,787,780)	(6,899,411)	(29,687,191)
210										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
211		**Human Service Centers**								
212		Continued program changes		6,007,961	(2,911,912)	3,096,049		6,007,961	(2,911,912)	3,096,049
213		Salary Underfunding		(2,891,071)		(2,891,071)		(2,891,071)		(2,891,071)
214		Cost and caseload changes		2,624,029	-	2,624,029		2,624,029	-	2,624,029
215		Civil sex offender treatment contract		917,004	-	917,004		917,004	-	917,004
216		Agency savings plan		(6,414,994)	-	(6,414,994)		(6,414,994)	-	(6,414,994)
217		Subtotal Human Service Centers	-	242,929	(2,911,912)	(2,668,983)	-	242,929	(2,911,912)	(2,668,983)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
219		**Institutions**								
220		Continued program changes		(2,447,261)	3,154,778	707,517		(2,447,261)	3,154,778	707,517
221		Salary Underfunding		(1,803,659)		(1,803,659)		(1,803,659)		(1,803,659)
222		LSTC Savings Plan Other than Adaptive Equipment	(14.50)	(5,991,785)	(6,549,550)	(12,541,335)	(14.50)	(6,134,400)	(6,714,398)	(12,848,798)
223		LSTC Savings Plan Adaptive Equipment		(142,615)	(164,086)	(306,701)		(142,615)	142,615	-
224		*LSTC Psychiatrist				-		183,040		183,040
225		State Hospital Savings Plan Other than 25 Bed Unit	(2.10)	49,025	(762)	48,263	(2.10)	49,025	-	49,025
226		State Hospital Savings Plan 25 Bed Unit	(14.00)	(1,775,792)	(345,100)	(2,120,892)				-
227		SOTEP Savings Plan	(1.00)	(143,450)		(143,450)	(1.00)	(143,450)		(143,450)
228		Subtotal Institutions	(31.60)	(12,255,537)	(3,904,720)	(16,160,257)	(17.60)	(10,439,320)	(3,417,005)	(13,856,325)

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
230		**Amendments to consider**								
231		Section 21 - Conveyance of Land LSTC to Grafton Parks & Rec								
232		Section 22 - Capital Projects (Special Assessments and demolition at SH)								
233		Section 23 - New State Hospital								
234		Section 26 - Conveyance of Land at SH to National Guard								
235		Section 30 - Emergency clause for section 22 & 23								
236		Subtotal of Amendments to consider Institutions	-	-	-	-	-	-	-	-
237										
242		Total Changes to Base Level Funding	(270.72)	(34,394,571)	(13,572,799)	(47,967,370)	(256.72)	(32,984,171)	(13,228,328)	(46,212,499)
243										
244		**2021-23 Total Funding - Field Services**	1,328.31	$ 180,468,097	$ 113,742,156	$ 294,210,253	(256.72)	$ (32,984,171)	$ (13,228,328)	$ (46,212,499)
245										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
246		**2021-23 Base Level - County Social Service Financing**	140.00	-	173,700,000	173,700,000				
247										
248		**2021-23 Ongoing Funding Changes**								
249		Base payroll changes			1,653,466	1,653,466			1,653,466	1,653,466
250		Salary increase		351,365	292,562	643,927		351,365	292,562	643,927
251		Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
252		Retirement contribution increase		72,382	60,269	132,651		72,382	60,269	132,651
253		Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
254		Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
255		Subtotal Ongoing Funding Changes	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	2,135,515	3,458,738
260										

HB 1012 Review Approval Worksheet

Legislative Base budget | EBR Proposed Sections HB | Add req beyond EBR

	Recom. Time Required		FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
			21 -23 Executive Budget Recommendation (EBR)				21 - 23 HB 1012 Proposed Amendments			
261		**Amendments to consider**								
262		Amend Human Service Finance Fund from 173,700,000 to 190,224,059 in HB 1012								
263		*Zone Employee salary increases & uncovered need					-	-	13,065,322	13,065,322
264		Subtotal of Amendments to consider - Zones	-	-	-	-	-	-	13,065,322	13,065,322
265										
266		Total Changes to Base Level Funding - County Social Service Zones	3.00	1,323,223	2,135,515	3,458,738	3.00	1,323,223	15,200,837	16,524,060
267										
268		**2021-23 Total Funding - County Social Service Financing**	143.00	1,323,223	175,835,515	177,158,738	3.00	1,323,223	15,200,837	16,524,060
269										
270		**2021-23 DHS HB 1012 Budget Total**	2,221.63	$ 1,563,943,856	$ 2,813,620,360	$ 4,377,564,216	6.40	$ 109,033,192	$ 344,513,912	$ 450,687,455
271										

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
2/22/2021 pm
House Appropriations Human Resources

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 4:01 p.m.

Representative	Present	Absent
Nelson	P	
Kreidt	P	
Andersen	P	
Mitskog	P	
Schobinger	P	
Strinden	P	

Discussion Topics:

- Amendment Review and Approval Process

Brady Larson (4:03 pm) testified orally

Rep Kreidt move amendment 21.0271.01003

Rep Mitskog Seconded

Roll Call Vote (4:45 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

6-0-0 Motion carried.

Rep Kreidt Made a motioned for a do pass as amended

Rep Schobinger Seconded

Roll Call Vote (4:46 pm)

Representative	Yea	Nay
Nelson	x	
Kreidt	x	
Andersen	x	
Mitskog	x	
Schobinger	x	
Strinden	x	

6-0-0 Motion carried.

Chair Nelson closed the meeting at 4:47 p.m.

Cole Fleck, Committee Clerk and Donna Whetham

Prepared by the Legislative Council staff for
the House Appropriations - Human Resources
Division Committee
February 22, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to create and enact a new section to chapter 50-06 of the North Dakota Century Code, relating to substance use disorder treatment voucher system grants; to amend and reenact sections 50-06-42 and 50-24.1-37 of the North Dakota Century Code, relating to the substance use disorder voucher program and the Medicaid expansion program; to repeal section 50-24.1-18.1 of the North Dakota Century Code, relating to consumer-directed health maintenance services"

Page 1, line 2, replace "and" with "to provide legislative intent;"

Page 1, line 2, after "report" insert "; to provide for a study; to provide for a transfer; to provide for the conveyance of land; to provide an application; to provide an effective date; to provide an expiration date; and to declare an emergency"

Page 1, replace lines 12 through 19 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
Total general fund	$64,690,274	$26,569,097	$91,259,371"

Page 1, remove lines 22 through 24

Page 2, replace lines 1 through 7 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000	0	10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
Total general fund	$1,181,597,942	$112,586,136	$1,294,184,078"

Page 2, replace lines 10 through 16 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
Total general fund	$214,862,668	($31,262,297)	$183,600,371"

Page 2, replace lines 19 through 24 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
Total general fund	$0	$1,311,724	$1,311,724"

Page 2, remove lines 27 through 30

Page 3, replace lines 1 and 2 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$109,204,660	$1,570,355,544
Grant total special funds	2,623,604,181	287,500,058	2,911,104,239
Grant total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Full-time equivalent positions	2,230.23	1.60	2,231.83"

Page 3, line 3, after "**FUNDING**" insert "**- EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY**"

Page 3, line 4, after "biennium" insert "and the one-time funding items included in the appropriation in section 1 of this Act"

Page 3, replace line 6 with:

"Technology projects	$13,785,658	$67,641,747"

Page 3, replace lines 11 through 14 with:

"State hospital study	200,000	300,000
Medicaid system consultant	0	300,000
Nursing facility payment methodology	0	7,200,000
Total all funds	$22,068,926	$75,441,747
Less estimated income	20,556,323	51,607,531
Total general fund	$1,512,603	$23,834,216

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a political subdivision for the state share of costs relating to the purchase of a fire truck, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services shall discontinue any agreement with a political subdivision for fire

protection services and may not enter any future agreement with a political subdivision for fire protection services."

Page 4, after line 2, insert:

"**SECTION 6. FULL-TIME EQUIVALENT POSITION - AGING SERVICES.** Section 1 of this Act includes one full-time equivalent position for the administration of services resulting from a federal department of justice lawsuit settlement. This position is authorized only for the biennium beginning July 1, 2021, and ending June 30, 2023, and may not be included in the department's base budget for the biennium beginning July 1, 2023, and ending June 30, 2025."

Page 4, line 4, replace "$173,700,000" with "$187,385,888"

Page 4, remove lines 7 through 10

Page 4, line 12, replace "$32,400,000" with "$24,000,000"

Page 4, line 16, after "fund" insert "and $1,150,538 from federal funds"

Page 4, after line 16, insert:

"**SECTION 10. CAPITAL PAYMENTS.** During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to expend funds for the payment of special assessments at the state hospital and life skills and transition center.

SECTION 11. STATE HOSPITAL - CAPITAL PROJECTS - EMERGENCY COMMISSION APPROVAL. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to proceed with the demolition of the chapel and employee building and associated tunnels at the state hospital. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act. The department may transfer funds for the demolition of the identified buildings and associated tunnels and for emergency capital projects. Notwithstanding section 54-27-12, the department of human services may spend up to $5,000,000 for emergency projects under this section and may seek emergency commission approval to spend more than $5,000,000 under this section.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through December 31, 2021. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 13. EXPENDITURES MAY NOT EXCEED APPROPRIATION - NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $621,362,568, of which $288,313,216 is from the general fund, for nursing home payments for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 14. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Substance use disorder treatment voucher system grants.

1. A licensed substance abuse treatment program, excluding regional human service centers and hospital or medical clinic-based programs for medical management of withdrawal, may apply for a competitive substance use disorder treatment voucher system grant. A licensed substance abuse treatment program is eligible for a one-time grant award. To receive a grant, a licensed substance abuse treatment program must:

   a. Submit an application in the form and manner prescribed by the department;

   b. Enter into a grant agreement with the department;

   c. Use grant funds for a licensed substance abuse treatment program with less than seventeen beds in an underserved area, as determined by the department, in the state's substance abuse treatment system;

   d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

   e. Provide and disclose information needed to comply with the department's data collection requirements; and

   f. Operate in compliance with grant requirements.

2. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

3. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program, including ending or reducing the operation of the substance use disorder treatment services in the underserved area.

4. The department may not collect property, equipment, or supplies purchased with grant funds from the licensed substance abuse treatment program after successful completion of the terms of the grant.

5. The grant term must be for five years.

SECTION 15. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, and hospital- or medical clinic-based programs for medical management of withdrawal. Services eligible for the voucher program include only those levels of care recognized by the American society of

addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

2. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than thirty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for nonresidential outpatient and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 16. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021 -~~ Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 17. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021 -~~ Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

~~5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 18. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 19. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton parks and recreation department. The department of human services may convey a portion of two parcels of land commonly referred to as "the bowl" on the terms and conditions determined appropriate by the department and the attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 20. LEASE OF LAND - STATE HOSPITAL. The department of human services and national guard may enter an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to construct a new training and storage facility.

SECTION 21. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 22. IN-HOME SUPPORT SERVICES - DEVELOPMENTAL DISABILITIES WAIVER. The department of human services shall add in-home support services to the appendix K application submitted by the department to the centers for Medicare and Medicaid services for the developmental disability services waiver for the COVID-19 emergency. Funding for in-home support services under the appendix K application may not exceed $250,000 during the COVID-19 emergency.

SECTION 23. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation approved by the sixty-seventh legislative assembly.

SECTION 24. COMMUNITY BEHAVIORAL HEALTH PROGRAM. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department may transfer funds for the continuation of the community behavioral health program pursuant to subsection 2 of section 54-23.3-10.

SECTION 25. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 26. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 27. EXEMPTION. The amount appropriated for the development of the child care licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the child care licensing and data system during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 28. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 29. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavioral health pilot projects during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 30. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 31. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITY RATES. The appropriation in section 1 of this Act includes adjustments to reimbursement rates for developmental disability service providers. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly if funding provided for developmental disability provider payments is not sufficient to pay actual expenses.

SECTION 32. STATE HOSPITAL TREATMENT CAMPUS - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall conduct a study and prepare a report. The report must provide a cost-benefit analysis and available options and address the feasibility and desirability of closing the state hospital, renovating the state hospital, or building a new treatment campus to meet the health care needs of the state. Before October 1, 2022, the department of human services shall provide a report to the legislative management regarding the results of the study. Subdivision 3 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the report and recommendation.

SECTION 33. BEHAVIORAL HEALTH SERVICES - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services shall study the feasibility and desirability of implementing behavioral health services for the medical assistance expansion program through an administrative services organization. Subdivision 2 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the study and to develop a plan to implement behavioral health services for the medical assistance expansion program through an administrative services organization. The department of human services shall provide reports to the legislative management regarding the status and results of the study.

SECTION 34. EFFECTIVE DATE. Section 17 of this Act becomes effective January 1, 2022.

SECTION 35. EXPIRATION DATE. Section 14 of this Act is effective through July 1, 2027, and after that date is ineffective.

SECTION 36. EXPIRATION DATE. Section 16 of this Act is effective through December 31, 2021, and after that date is ineffective.

SECTION 37. EMERGENCY. Section 3 of this Act is declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Base Budget	House Changes	House Version
DHS - Management			
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85
DHS - Program/Policy			
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67
DHS - County Social Services Financing			
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00
DHS - Field Services			
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31
Bill total			
Total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Less estimated income	2,623,604,181	287,500,058	2,911,104,239
General fund	$1,461,150,884	$109,204,660	$1,570,355,544
FTE	2,230.23	1.60	2,231.83

House Bill No. 1012 - DHS - Management - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85

Department 326 - DHS - Management - Detail of House Changes

	Adjusts Funding for Management[1]	Total House Changes
Salaries and wages	($890,281)	($890,281)
Operating expenses	77,342,233	77,342,233
Capital assets	25,000	25,000
Total all funds	$76,476,952	$76,476,952
Less estimated income	49,907,855	49,907,855
General fund	$26,569,097	$26,569,097
FTE	(10.10)	(10.10)

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and other budget adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Adjusts funding for base payroll changes		(508,525)	732,079	223,554
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		370,808	77,346	448,154
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,903	830	4,733
Reduces funding for overall agency operations		(8,405,193)		(8,405,193)
Administration				
Adds funding for continued program changes		341,831	841,290	1,183,121
Adjusts funding for the agency savings plan	8.00	431,068	440,358	871,426
Information Technology Services				
Adds funding for increased data processing costs and other program changes		14,822,924	4,401,791	19,224,715
Adjusts funding for the agency savings plan		(4,396,355)	(3,012,157)	(7,408,512)
Adds funding for technology services and repairs		4,010,886		4,010,886
Adds funding for an early childhood data system		500,000		500,000
Adds funding for Microsoft Office 365 expenses		200,315	50,079	250,394
Reprioritzes other funds from other agency budget areas for information technology costs			2,324,362	2,324,362
	(10.10)	$6,532,881	$2,302,324	$8,835,205
One-Time Funding Items				
Adds funding for the first phase of upgrading the Medicaid Management Information System (MMIS)		$4,326,686	$30,673,314	$35,000,000
Adds funding for the child welfare technology project		15,000,000	15,000,000	30,000,000
Adds funding for data automation services		98,186	98,186	196,372

Adds funding for the MMIS tech stack project		600,000	1,800,000	2,400,000
Adds funding for quality measures services		11,344	34,031	45,375
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747
Total changes to base level funding	(10.10)	$26,569,097	$49,907,855	$76,476,952

House Bill No. 1012 - DHS - Program/Policy - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000		10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - Medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67

Department 328 - DHS - Program/Policy - Detail of House Changes

	Adjusts Funding for Program and Policy[1]	Total House Changes
Salaries and wages	$50,364,134	$50,364,134
Operating expenses	15,702,927	15,702,927
Capital assets		
Grants	9,311,450	9,311,450
Grants - Medical assistance	273,030,980	273,030,980
Total all funds	$348,409,491	$348,409,491
Less estimated income	235,823,355	235,823,355
General fund	$112,586,136	$112,586,136
FTE	265.42	265.42

[1] The following adjustments are made to program and policy:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	257.22	$22,005,318	$23,196,444	$45,201,762
Adjusts funding for base payroll changes		2,029,128	624,013	2,653,141
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		1,501,257	1,359,427	2,860,684
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		17,084	14,732	31,816
Adds funding for 1 percent annual provider inflation increases		13,478,022	14,417,097	27,895,119
Adjusts funding based on anticipated changes to the state's federal medical assistance percentage to 52.40 percent for federal		(45,779,364)	45,779,364	0

fiscal year 2021 and 53.50 percent for federal fiscal year 2022				
Economic Assistance				
Adjusts funding for continued program changes		(210,585)	3,276,939	3,066,354
Adjusts funding for anticipated cost and caseload changes		2,952,453	8,382,789	11,335,242
Child Support				
Adjusts funding for continued program changes		36,397	(91,785)	(55,388)
Adjusts funding for agency savings plan		(103,906)	(357,788)	(461,694)
Medical Services				
Adjusts funding for continued program changes		2,493,060	5,504,976	7,998,036
Adjusts funding for agency savings plan excluding changes to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746
Adjusts funding for anticipated cost and caseload changes		55,976,251	100,813,594	156,789,845
Reprioritizes other funds for the dental access program for information technology costs			(40,000)	(40,000)
Adjusts the source of funding from the tobacco prevention and control trust fund ($6 million) and community health trust fund ($8.4 million) to the general fund		14,400,000	(14,400,000)	0
Reduces funding to underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Adds funding for vaccines for Medicaid recipients		1,581,000	1,819,000	3,400,000
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		66,465	199,395	265,860
Transfers 19- and 20-year old individuals in Medicaid Expansion to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)
Adjusts estimated Medicaid utilization rates for inpatient and outpatient hospital		(176,553)	(202,213)	(378,766)
Restores funding related to per member per month payments		769,869	882,371	1,652,240
Long-Term Care				
Adjusts funding for agency savings plan		(7,871,872)	(960,285)	(8,832,157)
Restores funding removed for the basic care program		5,300,000		5,300,000
Adjusts funding for anticipated cost and caseload changes		40,219,972	37,478,740	77,698,712
Reprioritizes other funds for the basic care			(2,284,362)	(2,284,362)

program for information technology costs				
Adjusts the source of funding from the health care trust fund to the general fund		1,000,000	(1,000,000)	0
Adjusts funding for estimated utilization rates		(9,395,558)	(9,429,807)	(18,825,365)
Provides $1,000,000 of funds from the health care trust fund and $1,150,538 of federal funding authority for nursing home operating margins			2,150,538	2,150,538
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		2,197,552	2,309,196	4,506,748
Developmental Disabilities Council				
Adjusts funding for continued program changes			124,949	124,949
Aging Services				
Adjusts funding for continued program changes		126,302	2,384,246	2,510,548
Adjusts funding for the agency savings plan		(248,240)	(163,425)	(411,665)
Adds 1 FTE position and funding for services to be provided due to a Department of Justice lawsuit settlement	1.00	300,000	150,000	450,000
Adds funding for Senior Community Services Employment Program demonstration grant			889,285	889,285
Children and Family Services				
Adjusts funding for continued program changes		3,172,228	(394,323)	2,777,905
Adjusts funding for agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Restores a portion of funding removed due to 1915i realignment of funding		73,750		73,750
Adjusts funding for anticipated cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Transfers early childhood program funding and FTE positions from DPI as provided in House Bill No. 1416	3.00	300,000	400,000	700,000
Adds funding for an early childhood grant program as provided in House Bill No. 1466	3.70	5,458,910		5,458,910
Behavioral Health Division				
Adjusts funding for continued program changes		156,645	(1,957,536)	(1,800,891)
Adjusts funding for agency savings plan		(832,173)		(832,173)
Restores a portion of funding removed due to 1915i realignment of funding		372,611		372,611
Adjusts funding for anticipated cost and caseload changes		5,427,067		5,427,067

Adds funding for the substance use disorder voucher program to provide total funding of $15.3 million		7,000,000		7,000,000
Vocational Rehabilitation				
Adjusts funding for continued program changes		(416,293)	(381,081)	(797,374)
Adjusts funding for agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Restores funding removed for Centers for Independent Living and a ski park grant		1,803,954	91,000	1,894,954
Developmental Disabilities				
Adjusts funding for continued program changes		(11,821)	163,017	151,196
Adjusts funding for agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)
Adjusts funding for anticipated cost and caseload changes		19,323,007	22,244,014	41,567,021
Adds funding for small agency accreditation costs		25,000		25,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491
One-Time Funding Items				
Adds funding for changes associated with the implementation of a new nursing payment methodology		$3,348,000	$3,852,000	$7,200,000
Adds funding for a study to implement behavioral health services for the medical assistance expansion program through an administrative services organization		150,000	150,000	300,000
Total one-time funding items	0.00	$3,498,000	$4,002,000	$7,500,000
Total changes to base level funding	265.42	$112,586,136	$235,823,355	$348,409,491

House Bill No. 1012 - DHS - County Social Services Financing - House Action

	Base Budget	House Changes	House Version
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of House Changes

	Adjusts Funding for County Social Services[1]	Total House Changes
County social services	$16,451,515	$16,451,515
Total all funds	$16,451,515	$16,451,515
Less estimated income	15,139,791	15,139,791
General fund	$1,311,724	$1,311,724
FTE	3.00	3.00

[1] Funding is adjusted for county social services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adds funding for base payroll changes			$1,653,466	$1,653,466
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		$412,248	291,785	704,033
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,287	2,737	6,024
Adjusts funding for continued program changes		896,189	(372,192)	523,997
Adds 3 FTE home- and community-based services staff	3.00		498,673	498,673
Adds funding to provide salary increases to zone employees consistent with state employee salary increases			3,975,941	3,975,941
Adds funding for zone operations			9,089,381	9,089,381
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515

House Bill No. 1012 - DHS - Field Services - House Action

	Base Budget	House Changes	House Version
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31

Department 349 - DHS - Field Services - Detail of House Changes

	Adjusts Funding for Field Services[1]	Total House Changes
Human service centers	($37,774,523)	($37,774,523)
Institutions	(6,858,717)	(6,858,717)
Total all funds	($44,633,240)	($44,633,240)
Less estimated income	(13,370,943)	(13,370,943)
General fund	($31,262,297)	($31,262,297)
FTE	(256.72)	(256.72)

[1] Funding for field services is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Adjusts funding for base payroll changes		(7,659,868)	12,248,626	4,588,758
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		5,572,943	489,043	6,061,986
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		59,867	5,710	65,577
Adds funding for 1 percent annual inflationary adjustments for providers		405,815		405,815
Human Service Centers				
Adjusts funding for continued program changes		3,116,890	(2,911,912)	204,978
Adjusts funding for anticipated cost and caseload changes		2,624,029		2,624,029
Adds funding for a civil sex offender treatment contract		917,004		917,004
Adjusts funding for agency savings plan		(6,414,994)		(6,414,994)
Restores a portion of funding removed for 1915i plan realignment		1,362,299		1,362,299
Institutions				
Adjusts funding for continued program changes		(4,250,920)	3,154,778	(1,096,142)
Adjusts funding for agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)
Restores the 25 beds at the State Hospital removed in the agency savings plan to provide a total of 100 staffed beds	14.00	1,775,792	345,100	2,120,892
Adds funding for psychiatry transition costs at the Life Skills and Transition Center		100,000		100,000
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)
One-Time Funding				
Adds funding for consultant costs for a State Hospital complex study		$300,000		$300,000
Total one-time funding changes	0.00	$300,000	$0	$300,000
Total changes to base level funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)

House Bill No. 1012 - Other Changes - House Action

This amendment also:

- Provides a 2019-21 biennium deficiency appropriation from the DHS operating fund for a grant to a political subdivision for costs to purchase a fire truck.
- Identifies 1 FTE position in the Aging Services Division for administration of services relating to a federal

Department of Justice lawsuit settlement as being authorized for only the 2021-23 biennium.

- Adjusts sections to identify the amount of funding provided from the human service finance fund, community health trust fund, and health care trust fund.
- Removes a section relating to funding provided from the tobacco prevention and control trust fund.
- Authorizes capital projects and payments at the State Hospital and Life Skills and Transition Center.
- Specifies the use of funding for the substance use disorder voucher program.
- Provides Medicaid Expansion expenditures may not exceed appropriations for the program.
- Provides expenditures for nursing facility payments may not exceed appropriations for the payments.
- Repeals the sunset clause on the Medicaid Expansion program, transfers 19- and 20-year old program recipients to a fee-for-service arrangement, and removes privacy requirements regarding provider reimbursement rates.
- Repeals Section 50-24.1-18.1 which relates to consumer-directed health maintenance services.
- Authorizes the conveyance of land at the Life Skills and Transition Center and authorizes the lease of land at the State Hospital.
- Requires providers receiving funding from DHS to submit process and outcome measures.
- Requires DHS to include in-home support services in the Appendix K application the department submits to the Centers for Medicare and Medicaid Services.
- Requires DHS to adopt rules to establish a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers.
- Authorizes DHS to transfer funds between line items to provide additional funding for the community behavioral health program.
- Provides exemptions to allow DHS to continue prior biennium appropriations into the 2021-23 biennium for various projects.
- Provides legislative intent that DHS seek a deficiency appropriation if funding for developmental disability rates is not sufficient to cover program expenses.
- Provides for DHS to conduct a study of the State Hospital complex.
- Provides for DHS to conduct a study of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1012
2/23/2021

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

7:24 Chairman Delzer- Opened the meeting for HB 1012

Attendance	P/A
Representative Jeff Delzer	P
Representative Keith Kempenich	P
Representative Bert Anderson	P
Representative Larry Bellew	P
Representative Tracy Boe	P
Representative Mike Brandenburg	P
Representative Michael Howe	P
Representative Gary Kreidt	P
Representative Bob Martinson	P
Representative Lisa Meier	P
Representative Alisa Mitskog	P
Representative Corey Mock	P
Representative David Monson	P
Representative Mike Nathe	P
Representative Jon O. Nelson	P
Representative Mark Sanford	P
Representative Mike Schatz	P
Representative Jim Schmidt	P
Representative Randy A. Schobinger	P
Representative Michelle Strinden	P
Representative Don Vigesaa	P

Discussion Topics:

- Budget
- Amendment

7:25 Representative Jon O. Nelson Explains the budget and the amendment 21.0271.01003

8:25 Representative Jon O. Nelson Makes a motion to adopt amendment

Representative Kreidt Second

Further Discussion

8:26 Voice Vote- Motion carries

Committee Discussion

8:29 Representative Kreidt- Explains his amendment 21.0271.01012, adds the sunset back into the bill

Representative Kreidt-Makes a motion to adopt the amendment

Representative Jon O. Nelson-Second

Further discussion

8:34 Roll Call Vote was taken;

Representatives	Vote
Representative Jeff Delzer	Y
Representative Keith Kempenich	Y
Representative Bert Anderson	Y
Representative Larry Bellew	Y
Representative Tracy Boe	Y
Representative Mike Brandenburg	Y
Representative Michael Howe	Y
Representative Gary Kreidt	Y
Representative Bob Martinson	N
Representative Lisa Meier	Y
Representative Alisa Mitskog	N
Representative Corey Mock	N
Representative David Monson	Y
Representative Mike Nathe	N
Representative Jon O. Nelson	Y
Representative Mark Sanford	N
Representative Mike Schatz	Y
Representative Jim Schmidt	N
Representative Randy A. Schobinger	N
Representative Michelle Strinden	Y
Representative Don Vigesaa	Y

Motion Carries 14-7-0

Representative Jon O. Nelson Makes a motion for a Do Pass as Amended

Representative Kreidt Second

Further discussion

8:36 Roll Call Vote was taken;

Representatives	Vote
Representative Jeff Delzer	Y
Representative Keith Kempenich	Y
Representative Bert Anderson	Y
Representative Larry Bellew	N
Representative Tracy Boe	Y
Representative Mike Brandenburg	Y
Representative Michael Howe	Y
Representative Gary Kreidt	Y
Representative Bob Martinson	Y
Representative Lisa Meier	Y
Representative Alisa Mitskog	Y
Representative Corey Mock	Y
Representative David Monson	Y
Representative Mike Nathe	Y
Representative Jon O. Nelson	Y
Representative Mark Sanford	Y
Representative Mike Schatz	N
Representative Jim Schmidt	Y
Representative Randy A. Schobinger	Y
Representative Michelle Strinden	Y
Representative Don Vigesaa	Y

Motion Carries 19-2-0 Representative Jon O. Nelson will carry the bill

Additional written testimony: No written testimony

8:37 Chairman Delzer- Closes the meeting for HB 1012

Risa Berube,

House Appropriations Committee Clerk

21.0271.01003
Title.

Fiscal No. 1

Prepared by the Legislative Council staff for
the House Appropriations - Human Resources
Division Committee
February 22, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to create and enact a new section to chapter 50-06 of the North Dakota Century Code, relating to substance use disorder treatment voucher system grants; to amend and reenact sections 50-06-42 and 50-24.1-37 of the North Dakota Century Code, relating to the substance use disorder voucher program and the Medicaid expansion program; to repeal section 50-24.1-18.1 of the North Dakota Century Code, relating to consumer-directed health maintenance services"

Page 1, line 2, replace "and" with "to provide legislative intent;"

Page 1, line 2, after "report" insert "; to provide for a study; to provide for a transfer; to provide for the conveyance of land; to provide an application; to provide an effective date; to provide an expiration date; and to declare an emergency"

Page 1, replace lines 12 through 19 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
Total general fund	$64,690,274	$26,569,097	$91,259,371"

Page 1, remove lines 22 through 24

Page 2, replace lines 1 through 7 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000	0	10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
Total general fund	$1,181,597,942	$112,586,136	$1,294,184,078"

Page 2, replace lines 10 through 16 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
Total general fund	$214,862,668	($31,262,297)	$183,600,371"

Page 2, replace lines 19 through 24 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
Total general fund	$0	$1,311,724	$1,311,724"

Page 2, remove lines 27 through 30

Page 3, replace lines 1 and 2 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$109,204,660	$1,570,355,544
Grant total special funds	2,623,604,181	287,500,058	2,911,104,239
Grant total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Full-time equivalent positions	2,230.23	1.60	2,231.83"

Page 3, line 3, after "**FUNDING**" insert "**- EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY**"

Page 3, line 4, after "biennium" insert "and the one-time funding items included in the appropriation in section 1 of this Act"

Page 3, replace line 6 with:

"Technology projects	$13,785,658	$67,641,747"

Page 3, replace lines 11 through 14 with:

"State hospital study	200,000	300,000
Medicaid system consultant	0	300,000
Nursing facility payment methodology	0	7,200,000
Total all funds	$22,068,926	$75,441,747
Less estimated income	20,556,323	51,607,531
Total general fund	$1,512,603	$23,834,216

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a political subdivision for the state share of costs relating to the purchase of a fire truck, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services shall discontinue any agreement with a political subdivision for fire

protection services and may not enter any future agreement with a political subdivision for fire protection services."

Page 4, after line 2, insert:

"**SECTION 6. FULL-TIME EQUIVALENT POSITION - AGING SERVICES.** Section 1 of this Act includes one full-time equivalent position for the administration of services resulting from a federal department of justice lawsuit settlement. This position is authorized only for the biennium beginning July 1, 2021, and ending June 30, 2023, and may not be included in the department's base budget for the biennium beginning July 1, 2023, and ending June 30, 2025."

Page 4, line 4, replace "$173,700,000" with "$187,385,888"

Page 4, remove lines 7 through 10

Page 4, line 12, replace "$32,400,000" with "$24,000,000"

Page 4, line 16, after "fund" insert "and $1,150,538 from federal funds"

Page 4, after line 16, insert:

"**SECTION 10. CAPITAL PAYMENTS.** During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to expend funds for the payment of special assessments at the state hospital and life skills and transition center.

SECTION 11. STATE HOSPITAL - CAPITAL PROJECTS - EMERGENCY COMMISSION APPROVAL. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to proceed with the demolition of the chapel and employee building and associated tunnels at the state hospital. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act. The department may transfer funds for the demolition of the identified buildings and associated tunnels and for emergency capital projects. Notwithstanding section 54-27-12, the department of human services may spend up to $5,000,000 for emergency projects under this section and may seek emergency commission approval to spend more than $5,000,000 under this section.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through December 31, 2021. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 13. EXPENDITURES MAY NOT EXCEED APPROPRIATION - NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $621,362,568, of which $288,313,216 is from the general fund, for nursing home payments for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 14. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Substance use disorder treatment voucher system grants.

1. A licensed substance abuse treatment program, excluding regional human service centers and hospital or medical clinic-based programs for medical management of withdrawal, may apply for a competitive substance use disorder treatment voucher system grant. A licensed substance abuse treatment program is eligible for a one-time grant award. To receive a grant, a licensed substance abuse treatment program must:

   a. Submit an application in the form and manner prescribed by the department;

   b. Enter into a grant agreement with the department;

   c. Use grant funds for a licensed substance abuse treatment program with less than seventeen beds in an underserved area, as determined by the department, in the state's substance abuse treatment system;

   d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

   e. Provide and disclose information needed to comply with the department's data collection requirements; and

   f. Operate in compliance with grant requirements.

2. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

3. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program, including ending or reducing the operation of the substance use disorder treatment services in the underserved area.

4. The department may not collect property, equipment, or supplies purchased with grant funds from the licensed substance abuse treatment program after successful completion of the terms of the grant.

5. The grant term must be for five years.

SECTION 15. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, and hospital- or medical clinic-based programs for medical management of withdrawal. Services eligible for the voucher program include only those levels of care recognized by the American society of

addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

2. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than thirty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for nonresidential outpatient and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 16. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021 -~~ Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 17. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021 -~~ Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

~~5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 18. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 19. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton parks and recreation department. The department of human services may convey a portion of two parcels of land commonly referred to as "the bowl" on the terms and conditions determined appropriate by the department and the attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 20. LEASE OF LAND - STATE HOSPITAL. The department of human services and national guard may enter an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to construct a new training and storage facility.

SECTION 21. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 22. IN-HOME SUPPORT SERVICES - DEVELOPMENTAL DISABILITIES WAIVER. The department of human services shall add in-home support services to the appendix K application submitted by the department to the centers for Medicare and Medicaid services for the developmental disability services waiver for the COVID-19 emergency. Funding for in-home support services under the appendix K application may not exceed $250,000 during the COVID-19 emergency.

SECTION 23. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation approved by the sixty-seventh legislative assembly.

SECTION 24. COMMUNITY BEHAVIORAL HEALTH PROGRAM. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department may transfer funds for the continuation of the community behavioral health program pursuant to subsection 2 of section 54-23.3-10.

SECTION 25. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 26. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 27. EXEMPTION. The amount appropriated for the development of the child care licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the child care licensing and data system during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 28. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 29. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavioral health pilot projects during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 30. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 31. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITY RATES. The appropriation in section 1 of this Act includes adjustments to reimbursement rates for developmental disability service providers. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly if funding provided for developmental disability provider payments is not sufficient to pay actual expenses.

SECTION 32. STATE HOSPITAL TREATMENT CAMPUS - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall conduct a study and prepare a report. The report must provide a cost-benefit analysis and available options and address the feasibility and desirability of closing the state hospital, renovating the state hospital, or building a new treatment campus to meet the health care needs of the state. Before October 1, 2022, the department of human services shall provide a report to the legislative management regarding the results of the study. Subdivision 3 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the report and recommendation.

SECTION 33. BEHAVIORAL HEALTH SERVICES - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services shall study the feasibility and desirability of implementing behavioral health services for the medical assistance expansion program through an administrative services organization. Subdivision 2 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the study and to develop a plan to implement behavioral health services for the medical assistance expansion program through an administrative services organization. The department of human services shall provide reports to the legislative management regarding the status and results of the study.

SECTION 34. EFFECTIVE DATE. Section 17 of this Act becomes effective January 1, 2022.

SECTION 35. EXPIRATION DATE. Section 14 of this Act is effective through July 1, 2027, and after that date is ineffective.

SECTION 36. EXPIRATION DATE. Section 16 of this Act is effective through December 31, 2021, and after that date is ineffective.

SECTION 37. EMERGENCY. Section 3 of this Act is declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Base Budget	House Changes	House Version
DHS - Management			
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85
DHS - Program/Policy			
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67
DHS - County Social Services Financing			
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00
DHS - Field Services			
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31
Bill total			
Total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Less estimated income	2,623,604,181	287,500,058	2,911,104,239
General fund	$1,461,150,884	$109,204,660	$1,570,355,544
FTE	2,230.23	1.60	2,231.83

House Bill No. 1012 - DHS - Management - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85

Department 326 - DHS - Management - Detail of House Changes

	Adjusts Funding for Management[1]	Total House Changes
Salaries and wages	($890,281)	($890,281)
Operating expenses	77,342,233	77,342,233
Capital assets	25,000	25,000
Total all funds	$76,476,952	$76,476,952
Less estimated income	49,907,855	49,907,855
General fund	$26,569,097	$26,569,097
FTE	(10.10)	(10.10)

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and other budget adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Adjusts funding for base payroll changes		(508,525)	732,079	223,554
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		370,808	77,346	448,154
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,903	830	4,733
Reduces funding for overall agency operations		(8,405,193)		(8,405,193)
Administration				
Adds funding for continued program changes		341,831	841,290	1,183,121
Adjusts funding for the agency savings plan	8.00	431,068	440,358	871,426
Information Technology Services				
Adds funding for increased data processing costs and other program changes		14,822,924	4,401,791	19,224,715
Adjusts funding for the agency savings plan		(4,396,355)	(3,012,157)	(7,408,512)
Adds funding for technology services and repairs		4,010,886		4,010,886
Adds funding for an early childhood data system		500,000		500,000
Adds funding for Microsoft Office 365 expenses		200,315	50,079	250,394
Reprioritzes other funds from other agency budget areas for information technology costs			2,324,362	2,324,362
	(10.10)	$6,532,881	$2,302,324	$8,835,205
One-Time Funding Items				
Adds funding for the first phase of upgrading the Medicaid Management Information System (MMIS)		$4,326,686	$30,673,314	$35,000,000
Adds funding for the child welfare technology project		15,000,000	15,000,000	30,000,000
Adds funding for data automation services		98,186	98,186	196,372

Adds funding for the MMIS tech stack project		600,000	1,800,000	2,400,000
Adds funding for quality measures services		11,344	34,031	45,375
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747
Total changes to base level funding	(10.10)	$26,569,097	$49,907,855	$76,476,952

House Bill No. 1012 - DHS - Program/Policy - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000		10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - Medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67

Department 328 - DHS - Program/Policy - Detail of House Changes

	Adjusts Funding for Program and Policy[1]	Total House Changes
Salaries and wages	$50,364,134	$50,364,134
Operating expenses	15,702,927	15,702,927
Capital assets		
Grants	9,311,450	9,311,450
Grants - Medical assistance	273,030,980	273,030,980
Total all funds	$348,409,491	$348,409,491
Less estimated income	235,823,355	235,823,355
General fund	$112,586,136	$112,586,136
FTE	265.42	265.42

[1] The following adjustments are made to program and policy:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	257.22	$22,005,318	$23,196,444	$45,201,762
Adjusts funding for base payroll changes		2,029,128	624,013	2,653,141
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		1,501,257	1,359,427	2,860,684
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		17,084	14,732	31,816
Adds funding for 1 percent annual provider inflation increases		13,478,022	14,417,097	27,895,119
Adjusts funding based on anticipated changes to the state's federal medical assistance percentage to 52.40 percent for federal		(45,779,364)	45,779,364	0

fiscal year 2021 and 53.50 percent for federal fiscal year 2022				
Economic Assistance				
Adjusts funding for continued program changes		(210,585)	3,276,939	3,066,354
Adjusts funding for anticipated cost and caseload changes		2,952,453	8,382,789	11,335,242
Child Support				
Adjusts funding for continued program changes		36,397	(91,785)	(55,388)
Adjusts funding for agency savings plan		(103,906)	(357,788)	(461,694)
Medical Services				
Adjusts funding for continued program changes		2,493,060	5,504,976	7,998,036
Adjusts funding for agency savings plan excluding changes to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746
Adjusts funding for anticipated cost and caseload changes		55,976,251	100,813,594	156,789,845
Reprioritizes other funds for the dental access program for information technology costs			(40,000)	(40,000)
Adjusts the source of funding from the tobacco prevention and control trust fund ($6 million) and community health trust fund ($8.4 million) to the general fund		14,400,000	(14,400,000)	0
Reduces funding to underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Adds funding for vaccines for Medicaid recipients		1,581,000	1,819,000	3,400,000
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		66,465	199,395	265,860
Transfers 19- and 20-year old individuals in Medicaid Expansion to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)
Adjusts estimated Medicaid utilization rates for inpatient and outpatient hospital		(176,553)	(202,213)	(378,766)
Restores funding related to per member per month payments		769,869	882,371	1,652,240
Long-Term Care				
Adjusts funding for agency savings plan		(7,871,872)	(960,285)	(8,832,157)
Restores funding removed for the basic care program		5,300,000		5,300,000
Adjusts funding for anticipated cost and caseload changes		40,219,972	37,478,740	77,698,712
Reprioritizes other funds for the basic care			(2,284,362)	(2,284,362)

program for information technology costs				
Adjusts the source of funding from the health care trust fund to the general fund		1,000,000	(1,000,000)	0
Adjusts funding for estimated utilization rates		(9,395,558)	(9,429,807)	(18,825,365)
Provides $1,000,000 of funds from the health care trust fund and $1,150,538 of federal funding authority for nursing home operating margins			2,150,538	2,150,538
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		2,197,552	2,309,196	4,506,748
Developmental Disabilities Council				
Adjusts funding for continued program changes			124,949	124,949
Aging Services				
Adjusts funding for continued program changes		126,302	2,384,246	2,510,548
Adjusts funding for the agency savings plan		(248,240)	(163,425)	(411,665)
Adds 1 FTE position and funding for services to be provided due to a Department of Justice lawsuit settlement	1.00	300,000	150,000	450,000
Adds funding for Senior Community Services Employment Program demonstration grant			889,285	889,285
Children and Family Services				
Adjusts funding for continued program changes		3,172,228	(394,323)	2,777,905
Adjusts funding for agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Restores a portion of funding removed due to 1915i realignment of funding		73,750		73,750
Adjusts funding for anticipated cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Transfers early childhood program funding and FTE positions from DPI as provided in House Bill No. 1416	3.00	300,000	400,000	700,000
Adds funding for an early childhood grant program as provided in House Bill No. 1466	3.70	5,458,910		5,458,910
Behavioral Health Division				
Adjusts funding for continued program changes		156,645	(1,957,536)	(1,800,891)
Adjusts funding for agency savings plan		(832,173)		(832,173)
Restores a portion of funding removed due to 1915i realignment of funding		372,611		372,611
Adjusts funding for anticipated cost and caseload changes		5,427,067		5,427,067

Adds funding for the substance use disorder voucher program to provide total funding of $15.3 million		7,000,000		7,000,000
Vocational Rehabilitation				
Adjusts funding for continued program changes		(416,293)	(381,081)	(797,374)
Adjusts funding for agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Restores funding removed for Centers for Independent Living and a ski park grant		1,803,954	91,000	1,894,954
Developmental Disabilities				
Adjusts funding for continued program changes		(11,821)	163,017	151,196
Adjusts funding for agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)
Adjusts funding for anticipated cost and caseload changes		19,323,007	22,244,014	41,567,021
Adds funding for small agency accreditation costs		25,000		25,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491
One-Time Funding Items				
Adds funding for changes associated with the implementation of a new nursing payment methodology		$3,348,000	$3,852,000	$7,200,000
Adds funding for a study to implement behavioral health services for the medical assistance expansion program through an administrative services organization		150,000	150,000	300,000
Total one-time funding items	0.00	$3,498,000	$4,002,000	$7,500,000
Total changes to base level funding	265.42	$112,586,136	$235,823,355	$348,409,491

House Bill No. 1012 - DHS - County Social Services Financing - House Action

	Base Budget	House Changes	House Version
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of House Changes

	Adjusts Funding for County Social Services[1]	Total House Changes
County social services	$16,451,515	$16,451,515
Total all funds	$16,451,515	$16,451,515
Less estimated income	15,139,791	15,139,791
General fund	$1,311,724	$1,311,724
FTE	3.00	3.00

[1] Funding is adjusted for county social services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adds funding for base payroll changes			$1,653,466	$1,653,466
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		$412,248	291,785	704,033
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,287	2,737	6,024
Adjusts funding for continued program changes		896,189	(372,192)	523,997
Adds 3 FTE home- and community-based services staff	3.00		498,673	498,673
Adds funding to provide salary increases to zone employees consistent with state employee salary increases			3,975,941	3,975,941
Adds funding for zone operations			9,089,381	9,089,381
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515

House Bill No. 1012 - DHS - Field Services - House Action

	Base Budget	House Changes	House Version
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31

Department 349 - DHS - Field Services - Detail of House Changes

	Adjusts Funding for Field Services[1]	Total House Changes
Human service centers	($37,774,523)	($37,774,523)
Institutions	(6,858,717)	(6,858,717)
Total all funds	($44,633,240)	($44,633,240)
Less estimated income	(13,370,943)	(13,370,943)
General fund	($31,262,297)	($31,262,297)
FTE	(256.72)	(256.72)

[1] Funding for field services is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Adjusts funding for base payroll changes		(7,659,868)	12,248,626	4,588,758
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		5,572,943	489,043	6,061,986
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		59,867	5,710	65,577
Adds funding for 1 percent annual inflationary adjustments for providers		405,815		405,815
Human Service Centers				
Adjusts funding for continued program changes		3,116,890	(2,911,912)	204,978
Adjusts funding for anticipated cost and caseload changes		2,624,029		2,624,029
Adds funding for a civil sex offender treatment contract		917,004		917,004
Adjusts funding for agency savings plan		(6,414,994)		(6,414,994)
Restores a portion of funding removed for 1915i plan realignment		1,362,299		1,362,299
Institutions				
Adjusts funding for continued program changes		(4,250,920)	3,154,778	(1,096,142)
Adjusts funding for agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)
Restores the 25 beds at the State Hospital removed in the agency savings plan to provide a total of 100 staffed beds	14.00	1,775,792	345,100	2,120,892
Adds funding for psychiatry transition costs at the Life Skills and Transition Center		100,000		100,000
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)
One-Time Funding				
Adds funding for consultant costs for a State Hospital complex study		$300,000		$300,000
Total one-time funding changes	0.00	$300,000	$0	$300,000
Total changes to base level funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)

House Bill No. 1012 - Other Changes - House Action

This amendment also:

- Provides a 2019-21 biennium deficiency appropriation from the DHS operating fund for a grant to a political subdivision for costs to purchase a fire truck.
- Identifies 1 FTE position in the Aging Services Division for administration of services relating to a federal

Department of Justice lawsuit settlement as being authorized for only the 2021-23 biennium.

- Adjusts sections to identify the amount of funding provided from the human service finance fund, community health trust fund, and health care trust fund.
- Removes a section relating to funding provided from the tobacco prevention and control trust fund.
- Authorizes capital projects and payments at the State Hospital and Life Skills and Transition Center.
- Specifies the use of funding for the substance use disorder voucher program.
- Provides Medicaid Expansion expenditures may not exceed appropriations for the program.
- Provides expenditures for nursing facility payments may not exceed appropriations for the payments.
- Repeals the sunset clause on the Medicaid Expansion program, transfers 19- and 20-year old program recipients to a fee-for-service arrangement, and removes privacy requirements regarding provider reimbursement rates.
- Repeals Section 50-24.1-18.1 which relates to consumer-directed health maintenance services.
- Authorizes the conveyance of land at the Life Skills and Transition Center and authorizes the lease of land at the State Hospital.
- Requires providers receiving funding from DHS to submit process and outcome measures.
- Requires DHS to include in-home support services in the Appendix K application the department submits to the Centers for Medicare and Medicaid Services.
- Requires DHS to adopt rules to establish a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers.
- Authorizes DHS to transfer funds between line items to provide additional funding for the community behavioral health program.
- Provides exemptions to allow DHS to continue prior biennium appropriations into the 2021-23 biennium for various projects.
- Provides legislative intent that DHS seek a deficiency appropriation if funding for developmental disability rates is not sufficient to cover program expenses.
- Provides for DHS to conduct a study of the State Hospital complex.
- Provides for DHS to conduct a study of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.

Prepared by the Legislative Council staff for
Representative J. Nelson
February 22, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to amend and reenact section 50-24.1-37 of the North Dakota Century Code, relating to the Medicaid expansion program"

Page 1, line 2, after "exemption" insert "; to provide an effective date"

Page 4, after line 16, insert:

"**SECTION 9. AMENDMENT.** Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, ~~2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 10. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, 2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

~~5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 11. EFFECTIVE DATE. Section 10 of this Act becomes effective January 1, 2022."

Renumber accordingly

DP 2/23/21
1 of 18

21.0271.01013
Title.02000
Fiscal No. 2

Prepared by the Legislative Council staff for
the House Appropriations Committee
February 23, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to create and enact a new section to chapter 50-06 of the North Dakota Century Code, relating to substance use disorder treatment voucher system grants; to amend and reenact sections 50-06-42 and 50-24.1-37 of the North Dakota Century Code, relating to the substance use disorder voucher program and the Medicaid expansion program; to repeal section 50-24.1-18.1 of the North Dakota Century Code, relating to consumer-directed health maintenance services"

Page 1, line 2, replace "and" with "to provide a statement of legislative intent;"

Page 1, line 2, after "report" insert "; to provide for a study; to provide for a transfer; to provide for the conveyance of land; to provide an application; to provide an effective date; to provide an expiration date; and to declare an emergency"

Page 1, replace lines 12 through 19 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
Total general fund	$64,690,274	$26,569,097	$91,259,371"

Page 1, remove lines 22 through 24

Page 2, replace lines 1 through 7 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000	0	10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
Total general fund	$1,181,597,942	$112,586,136	$1,294,184,078"

Page 2, replace lines 10 through 16 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
Total general fund	$214,862,668	($31,262,297)	$183,600,371"

Page 2, replace lines 19 through 24 with:

DP 4/23/21
2118

"

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
Total general fund	$0	$1,311,724	$1,311,724"

Page 2, remove lines 27 through 30

Page 3, replace lines 1 and 2 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$109,204,660	$1,570,355,544
Grant total special funds	2,623,604,181	287,500,058	2,911,104,239
Grant total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Full-time equivalent positions	2,230.23	1.60	2,231.83"

Page 3, line 3, after "**FUNDING**" insert "**- EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY**"

Page 3, line 4, after "biennium" insert "and the one-time funding items included in the appropriation in section 1 of this Act"

Page 3, replace line 6 with:

"Technology projects	$13,785,658	$67,641,747"

Page 3, replace lines 11 through 14 with:

"State hospital study	200,000	300,000
Medicaid system consultant	0	300,000
Nursing facility payment methodology	0	7,200,000
Total all funds	$22,068,926	$75,441,747
Less estimated income	20,556,323	51,607,531
Total general fund	$1,512,603	$23,834,216

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a political subdivision for the state share of costs relating to the purchase of a fire truck, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services shall discontinue any agreement with a political subdivision for fire protection services and may not enter any future agreement with a political subdivision for fire protection services."

Page 4, after line 2, insert:

"**SECTION 6. FULL-TIME EQUIVALENT POSITION - AGING SERVICES.** Section 1 of this Act includes one full-time equivalent position for the administration of services resulting from a federal department of justice lawsuit settlement. This position is authorized only for the biennium beginning July 1, 2021, and ending June 30, 2023, and may not be included in the department's base budget for the biennium beginning July 1, 2023, and ending June 30, 2025."

Page 4, line 4, replace "$173,700,000" with "$187,385,888"

Page 4, remove lines 7 through 10

Page 4, line 12, replace "$32,400,000" with "$24,000,000"

Page 4, line 16, after "fund" insert "and $1,150,538 from federal funds"

Page 4, after line 16, insert:

"**SECTION 10. CAPITAL PAYMENTS.** During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to expend funds for the payment of special assessments at the state hospital and life skills and transition center.

SECTION 11. STATE HOSPITAL - CAPITAL PROJECTS - EMERGENCY COMMISSION APPROVAL. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to proceed with the demolition of the chapel and employee building and associated tunnels at the state hospital. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act. The department may transfer funds for the demolition of the identified buildings and associated tunnels and for emergency capital projects. Notwithstanding section 54-27-12, the department of human services may spend up to $5,000,000 for emergency projects under this section and may seek emergency commission approval to spend more than $5,000,000 under this section.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid

program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through December 31, 2021. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 13. EXPENDITURES MAY NOT EXCEED APPROPRIATION - NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $621,362,568, of which $288,313,216 is from the general fund, for nursing home payments for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 14. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Substance use disorder treatment voucher system grants.

1. A licensed substance abuse treatment program, excluding regional human service centers and hospital or medical clinic-based programs for medical management of withdrawal, may apply for a competitive substance use disorder treatment voucher system grant. A licensed substance abuse treatment program is eligible for a one-time grant award. To receive a grant, a licensed substance abuse treatment program shall:

   a. Submit an application in the form and manner prescribed by the department;

   b. Enter a grant agreement with the department;

   c. Use grant funds for a licensed substance abuse treatment program with fewer than seventeen beds in an underserved area, as determined by the department, in the state's substance abuse treatment system;

   d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

   e. Provide and disclose information needed to comply with the department's data collection requirements; and

   f. Operate in compliance with grant requirements.

2. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

3. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program, including ending or reducing the operation of the substance use disorder treatment services in the underserved area.

4. The department may not collect property, equipment, or supplies purchased with grant funds from the licensed substance abuse treatment program after successful completion of the terms of the grant.

5. The grant term must be for five years.

SECTION 15. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, and hospital- or medical clinic-based programs for medical management of withdrawal. Services eligible for the voucher program

include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

2. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than thirty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for nonresidential outpatient and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 16. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, ~~2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 17. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, 2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

~~5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 18. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 19. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton parks and recreation department. The department of human services may convey a portion of two parcels of land commonly referred to as "the bowl" on the terms and conditions determined appropriate by the department and the attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 20. LEASE OF LAND - STATE HOSPITAL. The department of human services and national guard may enter an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to construct a new training and storage facility.

SECTION 21. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 22. IN-HOME SUPPORT SERVICES - DEVELOPMENTAL DISABILITIES WAIVER. The department of human services shall add in-home support services to the appendix K application submitted by the department to the centers for Medicare and Medicaid services for the developmental disability services waiver for the COVID-19 emergency. Funding for in-home support services under the appendix K application may not exceed $250,000 during the COVID-19 emergency.

SECTION 23. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation approved by the sixty-seventh legislative assembly.

SECTION 24. COMMUNITY BEHAVIORAL HEALTH PROGRAM. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department may transfer funds for the continuation of the community behavioral health program pursuant to subsection 2 of section 54-23.3-10.

SECTION 25. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 26. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 27. EXEMPTION. The amount appropriated for the development of the child care licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the child care licensing and data system during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 28. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 29. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavioral health pilot projects during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 30. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 31. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITY RATES. The appropriation in section 1 of this Act includes adjustments to reimbursement rates for developmental disability service providers. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly if funding provided for developmental disability provider payments is not sufficient to pay actual expenses.

SECTION 32. STATE HOSPITAL TREATMENT CAMPUS - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall conduct a study and prepare a report. The report must provide a cost-benefit analysis and available options and address the feasibility and desirability of closing the state hospital, renovating the state hospital, or building a new treatment campus to meet the health care needs of the state. Before October 1, 2022, the department of human services shall provide a report to the legislative management regarding the results of the study. Subdivision 3 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the report and recommendation.

SECTION 33. BEHAVIORAL HEALTH SERVICES - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services shall study the feasibility and desirability of implementing behavioral health services for the medical assistance expansion program through an administrative services organization. Subdivision 2 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the study and to develop a plan to implement behavioral health services for the medical assistance expansion program through an administrative services organization. The department of human services shall provide reports to the legislative management regarding the status and results of the study.

SECTION 34. EFFECTIVE DATE. Section 17 of this Act becomes effective January 1, 2022.

SECTION 35. EXPIRATION DATE. Section 14 of this Act is effective through July 1, 2027, and after that date is ineffective.

SECTION 36. EMERGENCY. Section 3 of this Act is declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Base Budget	House Changes	House Version
DHS - Management			
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85
DHS - Program/Policy			
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67
DHS - County Social Services Financing			
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00
DHS - Field Services			
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31
Bill total			
Total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Less estimated income	2,623,604,181	287,500,058	2,911,104,239
General fund	$1,461,150,884	$109,204,660	$1,570,355,544
FTE	2,230.23	1.60	2,231.83

House Bill No. 1012 - DHS - Management - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85

Department 326 - DHS - Management - Detail of House Changes

	Adjusts Funding for Management[1]	Total House Changes
Salaries and wages	($890,281)	($890,281)
Operating expenses	77,342,233	77,342,233
Capital assets	25,000	25,000
Total all funds	$76,476,952	$76,476,952
Less estimated income	49,907,855	49,907,855
General fund	$26,569,097	$26,569,097
FTE	(10.10)	(10.10)

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and other budget adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Adjusts funding for base payroll changes		(508,525)	732,079	223,554
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		370,808	77,346	448,154
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,903	830	4,733
Reduces funding for overall agency operations		(8,405,193)		(8,405,193)
Administration				
Adds funding for continued program changes		341,831	841,290	1,183,121
Adjusts funding for the agency savings plan	8.00	431,068	440,358	871,426
Information Technology Services				
Adds funding for increased data processing costs and other program changes		14,822,924	4,401,791	19,224,715
Adjusts funding for the agency savings plan		(4,396,355)	(3,012,157)	(7,408,512)
Adds funding for technology services and repairs		4,010,886		4,010,886
Adds funding for an early childhood data system		500,000		500,000
Adds funding for Microsoft Office 365 expenses		200,315	50,079	250,394
Reprioritzes other funds from other agency budget areas for information technology costs			2,324,362	2,324,362
	(10.10)	$6,532,881	$2,302,324	$8,835,205
One-Time Funding Items				
Adds funding for the first phase of upgrading the Medicaid Management Information System (MMIS)		$4,326,686	$30,673,314	$35,000,000
Adds funding for the child welfare technology project		15,000,000	15,000,000	30,000,000
Adds funding for data automation services		98,186	98,186	196,372

Adds funding for the MMIS tech stack project		600,000	1,800,000	2,400,000
Adds funding for quality measures services		11,344	34,031	45,375
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747
Total changes to base level funding	(10.10)	$26,569,097	$49,907,855	$76,476,952

House Bill No. 1012 - DHS - Program/Policy - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000		10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - Medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67

Department 328 - DHS - Program/Policy - Detail of House Changes

	Adjusts Funding for Program and Policy[1]	Total House Changes
Salaries and wages	$50,364,134	$50,364,134
Operating expenses	15,702,927	15,702,927
Capital assets		
Grants	9,311,450	9,311,450
Grants - Medical assistance	273,030,980	273,030,980
Total all funds	$348,409,491	$348,409,491
Less estimated income	235,823,355	235,823,355
General fund	$112,586,136	$112,586,136
FTE	265.42	265.42

[1] The following adjustments are made to program and policy:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	257.22	$22,005,318	$23,196,444	$45,201,762
Adjusts funding for base payroll changes		2,029,128	624,013	2,653,141
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		1,501,257	1,359,427	2,860,684
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		17,084	14,732	31,816
Adds funding for 1 percent annual provider inflation increases		13,478,022	14,417,097	27,895,119
Adjusts funding based on anticipated changes to the state's federal medical assistance percentage to 52.40 percent for federal fiscal		(45,779,364)	45,779,364	0

year 2021 and 53.50 percent for federal fiscal year 2022				
Economic Assistance				
Adjusts funding for continued program changes		(210,585)	3,276,939	3,066,354
Adjusts funding for anticipated cost and caseload changes		2,952,453	8,382,789	11,335,242
Child Support				
Adjusts funding for continued program changes		36,397	(91,785)	(55,388)
Adjusts funding for agency savings plan		(103,906)	(357,788)	(461,694)
Medical Services				
Adjusts funding for continued program changes		2,493,060	5,504,976	7,998,036
Adjusts funding for agency savings plan excluding changes to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746
Adjusts funding for anticipated cost and caseload changes		55,976,251	100,813,594	156,789,845
Reprioritizes other funds for the dental access program for information technology costs			(40,000)	(40,000)
Adjusts the source of funding from the tobacco prevention and control trust fund ($6 million) and community health trust fund ($8.4 million) to the general fund		14,400,000	(14,400,000)	0
Reduces funding to underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Adds funding for vaccines for Medicaid recipients		1,581,000	1,819,000	3,400,000
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		66,465	199,395	265,860
Transfers 19- and 20-year old individuals in Medicaid Expansion to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)
Adjusts estimated Medicaid utilization rates for inpatient and outpatient hospital		(176,553)	(202,213)	(378,766)
Restores funding related to per member per month payments		769,869	882,371	1,652,240
Long-Term Care				
Adjusts funding for agency savings plan		(7,871,872)	(960,285)	(8,832,157)
Restores funding removed for the basic care program		5,300,000		5,300,000
Adjusts funding for anticipated cost and caseload changes		40,219,972	37,478,740	77,698,712
Reprioritizes other funds for the basic care program for information technology costs			(2,284,362)	(2,284,362)
Adjusts the source of funding from the health care trust fund to the general fund		1,000,000	(1,000,000)	0

Adjusts funding for estimated utilization rates		(9,395,558)	(9,429,807)	(18,825,365)
Provides $1,000,000 of funds from the health care trust fund and $1,150,538 of federal funding authority for nursing home operating margins			2,150,538	2,150,538
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		2,197,552	2,309,196	4,506,748
Developmental Disabilities Council				
Adjusts funding for continued program changes			124,949	124,949
Aging Services				
Adjusts funding for continued program changes		126,302	2,384,246	2,510,548
Adjusts funding for the agency savings plan		(248,240)	(163,425)	(411,665)
Adds 1 FTE position and funding for services to be provided due to a Department of Justice lawsuit settlement	1.00	300,000	150,000	450,000
Adds funding for Senior Community Services Employment Program demonstration grant			889,285	889,285
Children and Family Services				
Adjusts funding for continued program changes		3,172,228	(394,323)	2,777,905
Adjusts funding for agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Restores a portion of funding removed due to 1915i realignment of funding		73,750		73,750
Adjusts funding for anticipated cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Transfers early childhood program funding and FTE positions from DPI as provided in House Bill No. 1416	3.00	300,000	400,000	700,000
Adds funding for an early childhood grant program as provided in House Bill No. 1466	3.70	5,458,910		5,458,910
Behavioral Health Division				
Adjusts funding for continued program changes		156,645	(1,957,536)	(1,800,891)
Adjusts funding for agency savings plan		(832,173)		(832,173)
Restores a portion of funding removed due to 1915i realignment of funding		372,611		372,611
Adjusts funding for anticipated cost and caseload changes		5,427,067		5,427,067
Adds funding for the substance use disorder voucher program to provide total funding of $15.3 million		7,000,000		7,000,000
Vocational Rehabilitation				
Adjusts funding for continued program changes		(416,293)	(381,081)	(797,374)

Adjusts funding for agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Restores funding removed for Centers for Independent Living and a ski park grant		1,803,954	91,000	1,894,954
Developmental Disabilities				
Adjusts funding for continued program changes		(11,821)	163,017	151,196
Adjusts funding for agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)
Adjusts funding for anticipated cost and caseload changes		19,323,007	22,244,014	41,567,021
Adds funding for small agency accreditation costs		25,000		25,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491
One-Time Funding Items				
Adds funding for changes associated with the implementation of a new nursing payment methodology		$3,348,000	$3,852,000	$7,200,000
Adds funding for a study to implement behavioral health services for the medical assistance expansion program through an administrative services organization		150,000	150,000	300,000
Total one-time funding items	0.00	$3,498,000	$4,002,000	$7,500,000
Total changes to base level funding	265.42	$112,586,136	$235,823,355	$348,409,491

House Bill No. 1012 - DHS - County Social Services Financing - House Action

	Base Budget	House Changes	House Version
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of House Changes

	Adjusts Funding for County Social Services[1]	Total House Changes
County social services	$16,451,515	$16,451,515
Total all funds	$16,451,515	$16,451,515
Less estimated income	15,139,791	15,139,791
General fund	$1,311,724	$1,311,724
FTE	3.00	3.00

[1] Funding is adjusted for county social services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adds funding for base payroll changes			$1,653,466	$1,653,466
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		$412,248	291,785	704,033
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,287	2,737	6,024
Adjusts funding for continued program changes		896,189	(372,192)	523,997
Adds 3 FTE home- and community-based services staff	3.00		498,673	498,673
Adds funding to provide salary increases to zone employees consistent with state employee salary increases			3,975,941	3,975,941
Adds funding for zone operations			9,089,381	9,089,381
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515

House Bill No. 1012 - DHS - Field Services - House Action

	Base Budget	House Changes	House Version
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31

Department 349 - DHS - Field Services - Detail of House Changes

	Adjusts Funding for Field Services[1]	Total House Changes
Human service centers	($37,774,523)	($37,774,523)
Institutions	(6,858,717)	(6,858,717)
Total all funds	($44,633,240)	($44,633,240)
Less estimated income	(13,370,943)	(13,370,943)
General fund	($31,262,297)	($31,262,297)
FTE	(256.72)	(256.72)

[1] Funding for field services is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Adjusts funding for base payroll changes		(7,659,868)	12,248,626	4,588,758
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		5,572,943	489,043	6,061,986

Adds funding for health insurance premium increases from $1,427 to $1,429 per month		59,867	5,710	65,577
Adds funding for 1 percent annual inflationary adjustments for providers		405,815		405,815
Human Service Centers				
Adjusts funding for continued program changes		3,116,890	(2,911,912)	204,978
Adjusts funding for anticipated cost and caseload changes		2,624,029		2,624,029
Adds funding for a civil sex offender treatment contract		917,004		917,004
Adjusts funding for agency savings plan		(6,414,994)		(6,414,994)
Restores a portion of funding removed for 1915i plan realignment		1,362,299		1,362,299
Institutions				
Adjusts funding for continued program changes		(4,250,920)	3,154,778	(1,096,142)
Adjusts funding for agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)
Restores the 25 beds at the State Hospital removed in the agency savings plan to provide a total of 100 staffed beds	14.00	1,775,792	345,100	2,120,892
Adds funding for psychiatry transition costs at the Life Skills and Transition Center		100,000		100,000
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)
One-Time Funding				
Adds funding for consultant costs for a State Hospital complex study		$300,000		$300,000
Total one-time funding changes	0.00	$300,000	$0	$300,000
Total changes to base level funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)

House Bill No. 1012 - Other Changes - House Action

This amendment also:

- Provides a 2019-21 biennium deficiency appropriation from the DHS operating fund for a grant to a political subdivision for costs to purchase a fire truck.
- Identifies 1 FTE position in the Aging Services Division for administration of services relating to a federal Department of Justice lawsuit settlement as being authorized for only the 2021-23 biennium.
- Adjusts sections to identify the amount of funding provided from the human service finance fund, community health trust fund, and health care trust fund.
- Removes a section relating to funding provided from the tobacco prevention and control trust fund.
- Authorizes capital projects and payments at the State Hospital and Life Skills and Transition Center.
- Specifies the use of funding for the substance use disorder voucher program.
- Provides Medicaid Expansion expenditures may not exceed appropriations for the program.
- Provides expenditures for nursing facility payments may not exceed appropriations for the payments.
- Extends the sunset clause on the Medicaid Expansion program, transfers 19- and 20-year old program recipients to a fee-for-service arrangement, and removes privacy requirements regarding provider reimbursement rates.
- Repeals Section 50-24.1-18.1 which relates to consumer-directed health maintenance services.
- Authorizes the conveyance of land at the Life Skills and Transition Center and authorizes the lease of land at

the State Hospital.

- Requires providers receiving funding from DHS to submit process and outcome measures.
- Requires DHS to include in-home support services in the Appendix K application the department submits to the Centers for Medicare and Medicaid Services.
- Requires DHS to adopt rules to establish a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers.
- Authorizes DHS to transfer funds between line items to provide additional funding for the community behavioral health program.
- Provides exemptions to allow DHS to continue prior biennium appropriations into the 2021-23 biennium for various projects.
- Provides legislative intent that DHS seek a deficiency appropriation if funding for developmental disability rates is not sufficient to cover program expenses.
- Provides for DHS to conduct a study of the State Hospital complex.
- Provides for DHS to conduct a study of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.

REPORT OF STANDING COMMITTEE

HB 1012: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (19 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1012 was placed on the Sixth order on the calendar.

Page 1, line 2, after "services" insert "; to create and enact a new section to chapter 50-06 of the North Dakota Century Code, relating to substance use disorder treatment voucher system grants; to amend and reenact sections 50-06-42 and 50-24.1-37 of the North Dakota Century Code, relating to the substance use disorder voucher program and the Medicaid expansion program; to repeal section 50-24.1-18.1 of the North Dakota Century Code, relating to consumer-directed health maintenance services"

Page 1, line 2, replace "and" with "to provide a statement of legislative intent;"

Page 1, line 2, after "report" insert "; to provide for a study; to provide for a transfer; to provide for the conveyance of land; to provide an application; to provide an effective date; to provide an expiration date; and to declare an emergency"

Page 1, replace lines 12 through 19 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
Total general fund	$64,690,274	$26,569,097	$91,259,371"

Page 1, remove lines 22 through 24

Page 2, replace lines 1 through 7 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000	0	10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
Total general fund	$1,181,597,942	$112,586,136	$1,294,184,078"

Page 2, replace lines 10 through 16 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
Total general fund	$214,862,668	($31,262,297)	$183,600,371"

Page 2, replace lines 19 through 24 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,451,515	$190,151,515

Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
Total general fund	$0	$1,311,724	$1,311,724"

Page 2, remove lines 27 through 30

Page 3, replace lines 1 and 2 with:

"

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$109,204,660	$1,570,355,544
Grant total special funds	2,623,604,181	287,500,058	2,911,104,239
Grant total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Full-time equivalent positions	2,230.23	1.60	2,231.83"

Page 3, line 3, after "**FUNDING**" insert "**- EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY**"

Page 3, line 4, after "biennium" insert "and the one-time funding items included in the appropriation in section 1 of this Act"

Page 3, replace line 6 with:

"Technology projects	$13,785,658	$67,641,747"

Page 3, replace lines 11 through 14 with:

"State hospital study	200,000	300,000
Medicaid system consultant	0	300,000
Nursing facility payment methodology	0	7,200,000
Total all funds	$22,068,926	$75,441,747
Less estimated income	20,556,323	51,607,531
Total general fund	$1,512,603	$23,834,216

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a political subdivision for the state share of costs relating to the purchase of a fire truck, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services shall discontinue any agreement with a political subdivision for fire protection services and may not enter any future agreement with a political subdivision for fire protection services."

Page 4, after line 2, insert:

"**SECTION 6. FULL-TIME EQUIVALENT POSITION - AGING SERVICES.** Section 1 of this Act includes one full-time equivalent position for the administration of services resulting from a federal department of justice lawsuit settlement. This position is authorized only for the biennium beginning July 1, 2021, and ending

June 30, 2023, and may not be included in the department's base budget for the biennium beginning July 1, 2023, and ending June 30, 2025."

Page 4, line 4, replace "$173,700,000" with "$187,385,888"

Page 4, remove lines 7 through 10

Page 4, line 12, replace "$32,400,000" with "$24,000,000"

Page 4, line 16, after "fund" insert "and $1,150,538 from federal funds"

Page 4, after line 16, insert:

"**SECTION 10. CAPITAL PAYMENTS.** During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to expend funds for the payment of special assessments at the state hospital and life skills and transition center.

SECTION 11. STATE HOSPITAL - CAPITAL PROJECTS - EMERGENCY COMMISSION APPROVAL. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to proceed with the demolition of the chapel and employee building and associated tunnels at the state hospital. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act. The department may transfer funds for the demolition of the identified buildings and associated tunnels and for emergency capital projects. Notwithstanding section 54-27-12, the department of human services may spend up to $5,000,000 for emergency projects under this section and may seek emergency commission approval to spend more than $5,000,000 under this section.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through December 31, 2021. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 13. EXPENDITURES MAY NOT EXCEED APPROPRIATION - NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $621,362,568, of which $288,313,216 is from the general fund, for nursing home payments for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 14. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Substance use disorder treatment voucher system grants.

1. A licensed substance abuse treatment program, excluding regional human service centers and hospital or medical clinic-based programs for medical management of withdrawal, may apply for a competitive substance use disorder treatment voucher system grant. A licensed substance abuse treatment program is eligible for a one-time grant award. To receive a grant, a licensed substance abuse treatment program shall:

   a. Submit an application in the form and manner prescribed by the department;

   b. Enter a grant agreement with the department;

   c. Use grant funds for a licensed substance abuse treatment program with fewer than seventeen beds in an underserved area, as

determined by the department, in the state's substance abuse treatment system;

d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

e. Provide and disclose information needed to comply with the department's data collection requirements; and

f. Operate in compliance with grant requirements.

2. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

3. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program, including ending or reducing the operation of the substance use disorder treatment services in the underserved area.

4. The department may not collect property, equipment, or supplies purchased with grant funds from the licensed substance abuse treatment program after successful completion of the terms of the grant.

5. The grant term must be for five years.

SECTION 15. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, and hospital- or medical clinic-based programs for medical management of withdrawal. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

2. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

a. No more than thirty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

b. The remaining appropriation must be allocated for nonresidential outpatient and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 16. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, ~~2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 17. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective through July 31, 2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by

bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

~~5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 18. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 19. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton parks and recreation department. The department of human services may convey a portion of two parcels of land commonly referred to as "the bowl" on the terms and conditions determined appropriate by the department and the attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 20. LEASE OF LAND - STATE HOSPITAL. The department of human services and national guard may enter an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to construct a new training and storage facility.

SECTION 21. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 22. IN-HOME SUPPORT SERVICES - DEVELOPMENTAL DISABILITIES WAIVER. The department of human services shall add in-home support services to the appendix K application submitted by the department to the centers for Medicare and Medicaid services for the developmental disability services waiver for the COVID-19 emergency. Funding for in-home support services under the appendix K application may not exceed $250,000 during the COVID-19 emergency.

SECTION 23. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation approved by the sixty-seventh legislative assembly.

SECTION 24. COMMUNITY BEHAVIORAL HEALTH PROGRAM. Pursuant to section 4 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department may transfer funds for the continuation of the community behavioral health program pursuant to subsection 2 of section 54-23.3-10.

SECTION 25. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 26. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 27. EXEMPTION. The amount appropriated for the development of the child care licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the child care licensing and data system during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 28. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 29. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavioral health pilot projects during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 30. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 31. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITY RATES. The appropriation in section 1 of this Act includes adjustments to reimbursement rates for developmental disability service providers. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly if funding provided for developmental disability provider payments is not sufficient to pay actual expenses.

SECTION 32. STATE HOSPITAL TREATMENT CAMPUS - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall conduct a study and prepare a report. The report must provide a cost-benefit analysis and available options and address the feasibility and desirability of closing the state hospital, renovating the state hospital, or building a new treatment campus to meet the health care needs of the state. Before October 1, 2022, the department of human services shall provide a report to the legislative management regarding the results of

the study. Subdivision 3 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the report and recommendation.

SECTION 33. BEHAVIORAL HEALTH SERVICES - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services shall study the feasibility and desirability of implementing behavioral health services for the medical assistance expansion program through an administrative services organization. Subdivision 2 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the study and to develop a plan to implement behavioral health services for the medical assistance expansion program through an administrative services organization. The department of human services shall provide reports to the legislative management regarding the status and results of the study.

SECTION 34. EFFECTIVE DATE. Section 17 of this Act becomes effective January 1, 2022.

SECTION 35. EXPIRATION DATE. Section 14 of this Act is effective through July 1, 2027, and after that date is ineffective.

SECTION 36. EMERGENCY. Section 3 of this Act is declared to be an emergency measure."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of House Action

	Base Budget	House Changes	House Version
DHS - Management			
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85
DHS - Program/Policy			
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67
DHS - County Social Services Financing			
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00
DHS - Field Services			
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31
Bill total			
Total all funds	$4,084,755,065	$396,704,718	$4,481,459,783
Less estimated income	2,623,604,181	287,500,058	2,911,104,239
General fund	$1,461,150,884	$109,204,660	$1,570,355,544
FTE	2,230.23	1.60	2,231.83

House Bill No. 1012 - DHS - Management - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$20,222,500	($890,281)	$19,332,219
Operating expenses	134,438,862	77,342,233	211,781,095
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$76,476,952	$231,188,314
Less estimated income	90,021,088	49,907,855	139,928,943
General fund	$64,690,274	$26,569,097	$91,259,371
FTE	107.95	(10.10)	97.85

Department 326 - DHS - Management - Detail of House Changes

	Adjusts Funding for Management[1]	Total House Changes
Salaries and wages	($890,281)	($890,281)
Operating expenses	77,342,233	77,342,233
Capital assets	25,000	25,000
Total all funds	$76,476,952	$76,476,952
Less estimated income	49,907,855	49,907,855
General fund	$26,569,097	$26,569,097
FTE	(10.10)	(10.10)

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and other budget adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Adjusts funding for base payroll changes		(508,525)	732,079	223,554
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		370,808	77,346	448,154
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,903	830	4,733
Reduces funding for overall agency operations		(8,405,193)		(8,405,193)
Administration				
Adds funding for continued program changes		341,831	841,290	1,183,121
Adjusts funding for the agency savings plan	8.00	431,068	440,358	871,426
Information Technology Services				
Adds funding for increased data processing costs and other program changes		14,822,924	4,401,791	19,224,715
Adjusts funding for the agency savings plan		(4,396,355)	(3,012,157)	(7,408,512)
Adds funding for technology services and repairs		4,010,886		4,010,886
Adds funding for an early childhood data system		500,000		500,000
Adds funding for Microsoft Office 365 expenses		200,315	50,079	250,394
Reprioritzes other funds from other agency budget areas for information technology costs			2,324,362	2,324,362
	(10.10)	$6,532,881	$2,302,324	$8,835,205

One-Time Funding Items				
Adds funding for the first phase of upgrading the Medicaid Management Information System (MMIS)		$4,326,686	$30,673,314	$35,000,000
Adds funding for the child welfare technology project		15,000,000	15,000,000	30,000,000
Adds funding for data automation services		98,186	98,186	196,372
Adds funding for the MMIS tech stack project		600,000	1,800,000	2,400,000
Adds funding for quality measures services		11,344	34,031	45,375
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747
Total changes to base level funding	(10.10)	$26,569,097	$49,907,855	$76,476,952

House Bill No. 1012 - DHS - Program/Policy - House Action

	Base Budget	House Changes	House Version
Salaries and wages	$68,994,873	$50,364,134	$119,359,007
Operating expenses	150,961,583	15,702,927	166,664,510
Capital assets	10,000		10,000
Grants	452,041,904	9,311,450	461,353,354
Grants - Medical assistance	2,742,157,720	273,030,980	3,015,188,700
Total all funds	$3,414,166,080	$348,409,491	$3,762,575,571
Less estimated income	2,232,568,138	235,823,355	2,468,391,493
General fund	$1,181,597,942	$112,586,136	$1,294,184,078
FTE	383.25	265.42	648.67

Department 328 - DHS - Program/Policy - Detail of House Changes

	Adjusts Funding for Program and Policy[1]	Total House Changes
Salaries and wages	$50,364,134	$50,364,134
Operating expenses	15,702,927	15,702,927
Capital assets		
Grants	9,311,450	9,311,450
Grants - Medical assistance	273,030,980	273,030,980
Total all funds	$348,409,491	$348,409,491
Less estimated income	235,823,355	235,823,355
General fund	$112,586,136	$112,586,136
FTE	265.42	265.42

[1] The following adjustments are made to program and policy:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	257.22	$22,005,318	$23,196,444	$45,201,762
Adjusts funding for base payroll changes		2,029,128	624,013	2,653,141
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		1,501,257	1,359,427	2,860,684
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		17,084	14,732	31,816
Adds funding for 1 percent annual provider inflation		13,478,022	14,417,097	27,895,119

increases				
Adjusts funding based on anticipated changes to the state's federal medical assistance percentage to 52.40 percent for federal fiscal year 2021 and 53.50 percent for federal fiscal year 2022		(45,779,364)	45,779,364	0
Economic Assistance				
Adjusts funding for continued program changes		(210,585)	3,276,939	3,066,354
Adjusts funding for anticipated cost and caseload changes		2,952,453	8,382,789	11,335,242
Child Support				
Adjusts funding for continued program changes		36,397	(91,785)	(55,388)
Adjusts funding for agency savings plan		(103,906)	(357,788)	(461,694)
Medical Services				
Adjusts funding for continued program changes		2,493,060	5,504,976	7,998,036
Adjusts funding for agency savings plan excluding changes to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746
Adjusts funding for anticipated cost and caseload changes		55,976,251	100,813,594	156,789,845
Reprioritizes other funds for the dental access program for information technology costs			(40,000)	(40,000)
Adjusts the source of funding from the tobacco prevention and control trust fund ($6 million) and community health trust fund ($8.4 million) to the general fund		14,400,000	(14,400,000)	0
Reduces funding to underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)
Adds funding for vaccines for Medicaid recipients		1,581,000	1,819,000	3,400,000
Adds funding for services to be provided due to a Department of Justice lawsuit settlement		66,465	199,395	265,860
Transfers 19- and 20-year old individuals in Medicaid Expansion to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)
Adjusts estimated Medicaid utilization rates for inpatient and outpatient hospital		(176,553)	(202,213)	(378,766)
Restores funding related to per member per month payments		769,869	882,371	1,652,240
Long-Term Care				
Adjusts funding for agency savings plan		(7,871,872)	(960,285)	(8,832,157)
Restores funding removed for the basic care program		5,300,000		5,300,000
Adjusts funding for anticipated cost and caseload changes		40,219,972	37,478,740	77,698,712
Reprioritizes other funds for the basic care program for information technology costs			(2,284,362)	(2,284,362)
Adjusts the source of funding from the health care trust fund to the general fund		1,000,000	(1,000,000)	0
Adjusts funding for estimated utilization rates		(9,395,558)	(9,429,807)	(18,825,365)
Provides $1,000,000 of funds from the health care trust fund and $1,150,538 of federal funding authority for nursing home operating margins			2,150,538	2,150,538

Adds funding for services to be provided due to a Department of Justice lawsuit settlement		2,197,552	2,309,196	4,506,748
Developmental Disabilities Council				
Adjusts funding for continued program changes			124,949	124,949
Aging Services				
Adjusts funding for continued program changes		126,302	2,384,246	2,510,548
Adjusts funding for the agency savings plan		(248,240)	(163,425)	(411,665)
Adds 1 FTE position and funding for services to be provided due to a Department of Justice lawsuit settlement	1.00	300,000	150,000	450,000
Adds funding for Senior Community Services Employment Program demonstration grant			889,285	889,285
Children and Family Services				
Adjusts funding for continued program changes		3,172,228	(394,323)	2,777,905
Adjusts funding for agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)
Restores a portion of funding removed due to 1915i realignment of funding		73,750		73,750
Adjusts funding for anticipated cost and caseload changes		(6,187,819)	6,025,058	(162,761)
Transfers early childhood program funding and FTE positions from DPI as provided in House Bill No. 1416	3.00	300,000	400,000	700,000
Adds funding for an early childhood grant program as provided in House Bill No. 1466	3.70	5,458,910		5,458,910
Behavioral Health Division				
Adjusts funding for continued program changes		156,645	(1,957,536)	(1,800,891)
Adjusts funding for agency savings plan		(832,173)		(832,173)
Restores a portion of funding removed due to 1915i realignment of funding		372,611		372,611
Adjusts funding for anticipated cost and caseload changes		5,427,067		5,427,067
Adds funding for the substance use disorder voucher program to provide total funding of $15.3 million		7,000,000		7,000,000
Vocational Rehabilitation				
Adjusts funding for continued program changes		(416,293)	(381,081)	(797,374)
Adjusts funding for agency savings plan		(1,803,954)	(91,000)	(1,894,954)
Restores funding removed for Centers for Independent Living and a ski park grant		1,803,954	91,000	1,894,954
Developmental Disabilities				
Adjusts funding for continued program changes		(11,821)	163,017	151,196
Adjusts funding for agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)

Adjusts funding for anticipated cost and caseload changes		19,323,007	22,244,014	41,567,021
Adds funding for small agency accreditation costs		25,000		25,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491
One-Time Funding Items				
Adds funding for changes associated with the implementation of a new nursing payment methodology		$3,348,000	$3,852,000	$7,200,000
Adds funding for a study to implement behavioral health services for the medical assistance expansion program through an administrative services organization		150,000	150,000	300,000
Total one-time funding items	0.00	$3,498,000	$4,002,000	$7,500,000
Total changes to base level funding	265.42	$112,586,136	$235,823,355	$348,409,491

House Bill No. 1012 - DHS - County Social Services Financing - House Action

	Base Budget	House Changes	House Version
County social services	$173,700,000	$16,451,515	$190,151,515
Total all funds	$173,700,000	$16,451,515	$190,151,515
Less estimated income	173,700,000	15,139,791	188,839,791
General fund	$0	$1,311,724	$1,311,724
FTE	140.00	3.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of House Changes

	Adjusts Funding for County Social Services[1]	Total House Changes
County social services	$16,451,515	$16,451,515
Total all funds	$16,451,515	$16,451,515
Less estimated income	15,139,791	15,139,791
General fund	$1,311,724	$1,311,724
FTE	3.00	3.00

[1] Funding is adjusted for county social services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adds funding for base payroll changes			$1,653,466	$1,653,466
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		$412,248	291,785	704,033
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		3,287	2,737	6,024
Adjusts funding for continued program changes		896,189	(372,192)	523,997
Adds 3 FTE home- and community-based services staff	3.00		498,673	498,673
Adds funding to provide salary increases to zone			3,975,941	3,975,941

employees consistent with state employee salary increases				
Adds funding for zone operations			9,089,381	9,089,381
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515

House Bill No. 1012 - DHS - Field Services - House Action

	Base Budget	House Changes	House Version
Human service centers	$204,701,143	($37,774,523)	$166,926,620
Institutions	137,476,480	(6,858,717)	130,617,763
Total all funds	$342,177,623	($44,633,240)	$297,544,383
Less estimated income	127,314,955	(13,370,943)	113,944,012
General fund	$214,862,668	($31,262,297)	$183,600,371
FTE	1,599.03	(256.72)	1,342.31

Department 349 - DHS - Field Services - Detail of House Changes

	Adjusts Funding for Field Services[1]	Total House Changes
Human service centers	($37,774,523)	($37,774,523)
Institutions	(6,858,717)	(6,858,717)
Total all funds	($44,633,240)	($44,633,240)
Less estimated income	(13,370,943)	(13,370,943)
General fund	($31,262,297)	($31,262,297)
FTE	(256.72)	(256.72)

[1] Funding for field services is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Adjusts funding for 2019-21 biennium line item transfers and budget adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Adjusts funding for base payroll changes		(7,659,868)	12,248,626	4,588,758
Adds funding for salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250		5,572,943	489,043	6,061,986
Adds funding for health insurance premium increases from $1,427 to $1,429 per month		59,867	5,710	65,577
Adds funding for 1 percent annual inflationary adjustments for providers		405,815		405,815
Human Service Centers				
Adjusts funding for continued program changes		3,116,890	(2,911,912)	204,978
Adjusts funding for anticipated cost and caseload changes		2,624,029		2,624,029
Adds funding for a civil sex offender treatment contract		917,004		917,004
Adjusts funding for agency savings plan		(6,414,994)		(6,414,994)
Restores a portion of funding removed for 1915i plan realignment		1,362,299		1,362,299
Institutions				
Adjusts funding for continued program changes		(4,250,920)	3,154,778	(1,096,142)
Adjusts funding for agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)

Restores the 25 beds at the State Hospital removed in the agency savings plan to provide a total of 100 staffed beds	14.00	1,775,792	345,100	2,120,892
Adds funding for psychiatry transition costs at the Life Skills and Transition Center		100,000		100,000
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)
One-Time Funding				
Adds funding for consultant costs for a State Hospital complex study		$300,000		$300,000
Total one-time funding changes	0.00	$300,000	$0	$300,000
Total changes to base level funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)

House Bill No. 1012 - Other Changes - House Action

This amendment also:

- Provides a 2019-21 biennium deficiency appropriation from the DHS operating fund for a grant to a political subdivision for costs to purchase a fire truck.
- Identifies 1 FTE position in the Aging Services Division for administration of services relating to a federal Department of Justice lawsuit settlement as being authorized for only the 2021-23 biennium.
- Adjusts sections to identify the amount of funding provided from the human service finance fund, community health trust fund, and health care trust fund.
- Removes a section relating to funding provided from the tobacco prevention and control trust fund.
- Authorizes capital projects and payments at the State Hospital and Life Skills and Transition Center.
- Specifies the use of funding for the substance use disorder voucher program.
- Provides Medicaid Expansion expenditures may not exceed appropriations for the program.
- Provides expenditures for nursing facility payments may not exceed appropriations for the payments.
- Extends the sunset clause on the Medicaid Expansion program, transfers 19- and 20-year old program recipients to a fee-for-service arrangement, and removes privacy requirements regarding provider reimbursement rates.
- Repeals Section 50-24.1-18.1 which relates to consumer-directed health maintenance services.
- Authorizes the conveyance of land at the Life Skills and Transition Center and authorizes the lease of land at the State Hospital.
- Requires providers receiving funding from DHS to submit process and outcome measures.
- Requires DHS to include in-home support services in the Appendix K application the department submits to the Centers for Medicare and Medicaid Services.
- Requires DHS to adopt rules to establish a new ratesetting process and requirements for foster care maintenance rates for qualified residential treatment providers.
- Authorizes DHS to transfer funds between line items to provide additional funding for the community behavioral health program.
- Provides exemptions to allow DHS to continue prior biennium appropriations into the 2021-23 biennium for various projects.
- Provides legislative intent that DHS seek a deficiency appropriation if funding for

developmental disability rates is not sufficient to cover program expenses.

- Provides for DHS to conduct a study of the State Hospital complex.
- Provides for DHS to conduct a study of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.

2021 SENATE APPROPRIATIONS

HB 1012

Department 325 - Department of Human Services
House Bill No. 1012

Executive Budget Comparison to Prior Biennium Appropriations

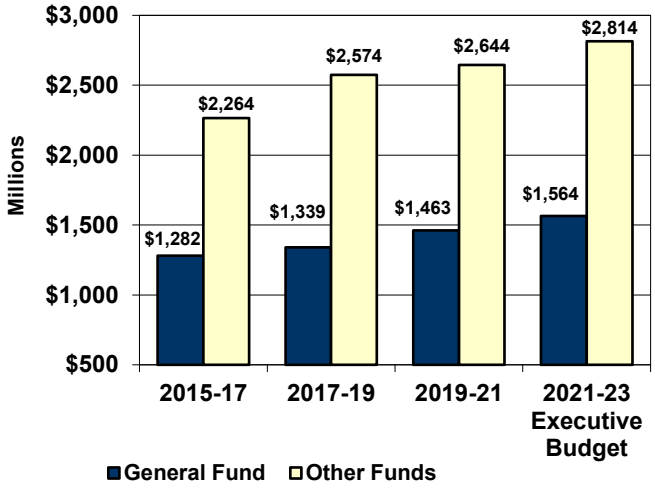
	FTE Positions	General Fund	Other Funds	Total
2021-23 Executive Budget	2,221.63	$1,563,943,856	$2,813,620,360	$4,377,564,216
2019-21 Legislative Appropriations[1]	2,230.23	1,462,663,487	2,644,160,504	4,106,823,991
Increase (Decrease)	(8.60)	$101,280,369	$169,459,856	$270,740,225

[1]The 2019-21 biennium agency appropriation amounts have not been adjusted for additional Coronavirus (COVID-19) spending authority of $215,186,966 resulting from Emergency Commission action during the 2019-21 biennium.

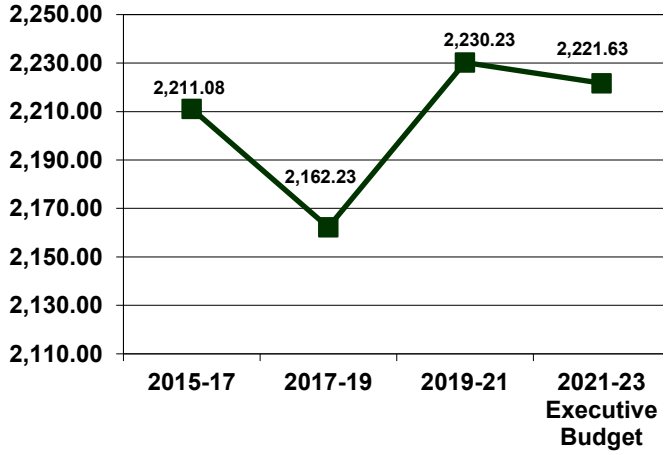
Ongoing and One-Time General Fund Appropriations

	Ongoing General Fund Appropriation	One-Time General Fund Appropriation	Total General Fund Appropriation
2021-23 Executive Budget	$1,537,969,170	$25,974,686	$1,563,943,856
2019-21 Legislative Appropriations	1,461,150,884	1,512,603	1,462,663,487
Increase (Decrease)	$76,818,286	$24,462,083	$101,280,369

Agency Funding



FTE Positions



Executive Budget Comparison to Base Level

	General Fund	Other Funds	Total
2021-23 Executive Budget	$1,563,943,856	$2,813,620,360	$4,377,564,216
2021-23 Base Level	1,461,150,884	2,623,604,181	4,084,755,065
Increase (Decrease)	$102,792,972	$190,016,179	$292,809,151

First House Action

Attached is a comparison worksheet detailing first house changes to base level funding and the executive budget.

Executive Budget Highlights
(With First House Changes in Bold)

DEPARTMENTWIDE

1. Provides funding for state employee salary and benefit increases, of which $9,368,646 is for salary increases, $108,150 is for health insurance increases, and $1,908,797 is for retirement contribution increases. **The House added funding for salary adjustments of 1.5 percent per year with a $100 minimum and $250 maximum monthly increase and increases in health insurance premiums from $1,427 to $1,429 per month. The House did not add funding for retirement contribution increases**.	$8,737,712	$2,647,881	$11,385,593

2. Underfunds salaries and wages by $4,694,730 from the general fund in anticipation of savings from **vacant positions and employee turnover**	($4,694,730)	$0	($4,694,730)
3. Adjusts funding to reduce general fund support for traditional Medicaid ($50,919,245) and increase general fund support for Medicaid Expansion ($3,916,989) and the children's health insurance program ($1,222,892) due to changes in the state's federal medical assistance percentage (FMAP)	($45,779,364)	$45,779,364	$0
4. Adds funding for **cost, caseload, and utilization changes,** including $156,789,851 for medical services, $77,698,712 for long-term care, and $41,567,021 for developmental disabilities (DD). **The House adjusted estimated utilization rates for the medical services and long-term care programs.**	$124,345,846	$174,944,195	$299,290,041
5. Provides a 1 percent **inflationary increase** for human service providers during each year of the 2021-23 biennium	$13,883,837	$14,417,097	$28,300,934
6. Reduces ongoing funding appropriated during the 2019-21 biennium from the community health trust fund from $32.4 million to $24 million and replaces ongoing funding provided from the tobacco prevention and control trust fund ($6 million) and health care trust fund ($1 million). **The House added $1 million of funding from the health care trust fund and matching federal funds of $1,150,538 for nursing home operating margin adjustments.**	$15,400,000	($15,400,000)	$0
7. Adds funding for the Capitol grounds agency rent proposal. **The House did not add funding for the agency rent proposal.**	$474,286	$0	$474,286
8. Adds funding for Microsoft Office 365 expenses	$200,315	$50,079	$250,394
9. Adds ongoing funding to develop an early childhood integrated data system	$500,000	$0	$500,000
10. Provides **one-time funding** to replace the child welfare management and payments system	$15,000,000	$15,000,000	$30,000,000
11. Provides **one-time funding** to modernize the Medicaid management information system	$4,326,686	$30,673,314	$35,000,000
PROGRAM AND POLICY			
Medical services			
12. Provides $1,477.4 million for medical services, of which $385.2 million is from the general fund, an increase in total of $63.7 million, or 4.5 percent, compared to the 2019-21 biennium appropriation of $1,413.7 million. The executive budget:			
• Provides $623.8 million for Medicaid Expansion grants, of which $73.5 million is from the general fund, a decrease in total of $10.9 million, or 1.7 percent, compared to the 2019-21 biennium appropriation of $634.7 million, of which $64.1 million is from the general fund. The executive budget adds 12 FTE positions to transfer the administration of Medicaid Expansion to the department and changes the payment rates from commercial rates to fee-for-service rates. **The House did not transfer the administration of the Medicaid Expansion program to the department and did not change the commercial rate structure.**	$9,400,000	($20,300,000)	($10,900,000)
• Underfunds Medicaid grants	($9,580,913)	($9,955,925)	($19,536,838)
Long-term care			
13. Provides $822.6 million for **long-term care**, of which $404.2 million is from the general fund, an increase in total of $85.2 million, or 11.6 percent, compared to the 2019-21 biennium appropriation of $737.4 million. The executive budget:			
• Reprioritizes agency special funds by transferring $2.3 million from the basic care program to information technology services			
• Adds **one-time funding** to transition to a new nursing facility payment methodology	$3,348,000	$3,852,000	$7,200,000

• Adds **one-time funding** for a nursing bed buyback program to buy back approximately 250 licensed nursing home beds. **The House did not add funding for the nursing bed buyback program.**	$3,300,000	$0	$3,300,000
Developmental disabilities			
14. Provides $739.3 million for DD, of which $344.8 million is from the general fund, an increase in total of $68.1 million, or 10.1 percent, compared to the 2019-21 biennium appropriation of $671.2 million. The executive budget:			
• Adds funding for **equipment over $5,000**, which includes tymp machines ($10,000)	$979	$9,021	$10,000
• Adjusts department budget reporting by transferring certain FTE positions and funding relating to DD duties from the human service centers to the Developmental Disabilities Division			
Vocational rehabilitation			
15. Provides $37.7 million for vocational rehabilitation services, of which $7.3 million is from the general fund, an increase in total of $11 million, or 41.2 percent, compared to the 2019-21 biennium appropriation of $26.7 million. The executive budget:			
• Adjusts department budget reporting by transferring certain FTE positions and funding relating to vocational rehabilitation duties from the human service centers to the Vocational Rehabilitation Division			
Aging services			
16. Provides $34.5 million for aging services, of which $12.4 million is from the general fund, an increase in total of $9.3 million, or 36.9 percent, compared to the 2019-21 biennium appropriation of $25.2 million. The executive budget:			
• Adjusts department budget reporting by transferring certain FTE positions and funding relating to aging services duties from the human service centers to the Aging Services Division			
Behavioral health services			
17. Provides $85 million for behavioral health services, of which $36.7 million is from the general fund, an increase in total of $12.6 million, or 17.4 percent, compared to the 2019-21 biennium appropriation of $72.4 million. The executive budget:			
• Increases funding for the substance use disorder voucher program from $8 million to $17 million. **The House increased funding for the voucher program to $15 million and provided for $3 million of the funds to be distributed as facility grants in underserved areas of the state.**	$9,000,000	$0	$9,000,000
Economic assistance			
18. Provides $275 million for economic assistance, of which $11.9 million is from the general fund, an increase in total of $13.1 million, or 5 percent, compared to the 2019-21 biennium appropriation of $261.9 million. Major program changes include:			
• Provides $34.7 million for **child care assistance**, of which $5.6 million is from the general fund, an increase of $6.9 million, or 24.8 percent, compared to the 2019-21 biennium appropriation of $27.8 million	$2,952,579	$3,970,653	$6,923,232
• Increases federal funding for the **supplemental nutrition assistance program (SNAP)** or food stamp benefits to provide a total of $168 million, an increase of $2.8 million, or 1.7 percent, compared to the 2019-21 biennium appropriation of $165.2 million	$0	$2,760,000	$2,760,000
• Increases federal funding for the **low-income home energy assistance program (LIHEAP)** to provide a total of $36.1 million, an increase of $1.6 million, or	$0	$1,634,000	$1,634,000

4.6 percent, compared to the 2019-21 biennium appropriation of $34.5 million

Children and family services

19. Provides $165.6 million for children and family services, of which $72 million is from the general fund, a decrease in total of $10.6 million, or 6.0 percent, compared to the 2019-21 biennium appropriation of $176.2 million. The executive budget:

    - Transfers certain FTE positions and funding relating to children and family services duties from the human service center budget to the Children and Family Services Division

INSTITUTIONS

20. Provides $126.7 million for institutions, of which $84.3 million is from the general fund, a decrease in total of $17.7 million, or 24.2 percent, compared to the 2019-21 biennium appropriation of $144.4 million. Major items in the executive budget relating to institutions are as follows:

State Hospital

21. Authorizes the construction of a new **state behavioral health hospital and clinic** through a public-private partnership. **The House did not authorize the construction of a new state behavioral health hospital and clinic.**

22. Provides funding for **extraordinary repairs** as follows: $1,292,499 $0 $1,292,499

Sidewalk repairs	$35,000
Roof repairs	28,000
Door lock replacement	85,000
Auto shop oil interceptor	18,000
Oil control and steam valves	45,800
Water main valve replacement	6,500
Flooring updates	197,672
Paint client rooms	29,750
Sewer line cleanout	7,750
Penal fixture hook and cleanout pins	18,000
Boiler control upgrade	209,000
Remove water treatment loop	85,000
Automation control upgrades	235,750
Tuck pointing	291,277
Total	$1,292,499

23. Provides funding for **equipment over $5,000**, which includes: $60,800 $0 $60,800

Utility vehicle	$28,000
Pressure washer	6,800
Floor scrubber	7,500
Camera equipment replacement	18,500
Total	$60,800

Life Skills and Transition Center

24. Provides funding for **extraordinary repairs**, as follows: $637,106 $0 $637,106

Asbestos abatement	$30,000
Concrete work and repairs	156,760
Cottage repairs	25,000
Level cemetery markers	20,000
Painting	30,000
Skylight repairs	76,500
Parking lot maintenance	60,000
Tunnel repairs	25,000
Door repair and replacement	65,000
Flooring	90,000
Elevator pit coating	19,096
Colette fitness building roof	39,750
Total	$637,106

25. Provides funding for **equipment over $5,000**, which includes:	$208,055	$0	$208,055

Dishwasher	$90,000
Security cameras	38,727
Mower/blower	31,765
Utility vehicle	22,135
Floor scrubber	5,200
Washing machines	14,228
Gym divider	6,000
Total	$208,055

HUMAN SERVICE CENTERS

26. Provides $167.5 million for human service centers, of which $96.2 million is from the general fund, a decrease in total of $37.2 million, or 18.2 percent, compared to the 2019-21 biennium appropriation of $204.7 million. The executive budget:			
• Adds funding to contract with a private service provider for civil sex offender treatment	$917,004	$0	$917,004
• Adds funding for **extraordinary repairs** at the southeast human service center, which includes $80,000 for an air unit replacement	$80,000	$0	$80,000
• Transfers 238.12 FTE positions to program and policy and management to adjust the budget reporting for the department			

COUNTY SOCIAL SERVICES

27. Transfers $174.4 from the tax relief fund to the human service finance fund and appropriates the funding, along with funding from the general fund and other funds, for costs associated with the state takeover of county social services expenses. The transfer from the tax relief fund is an increase of $680,767 from the 2019-21 biennium transfer. **The House provided for a transfer of $187.4 million from the tax relief fund to the human service finance fund.**	$1,323,223	$2,135,515	$3,458,738
28. Adds 3 FTE home- and community-based case management staff	$0	$498,673	$498,673

Other Sections in House Bill No. 1012

Deficiency appropriation - Section 3 appropriates $333,333 from the Department of Human Services (DHS) operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a fire truck.

Transfers - Section 4 authorizes DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1.

Transfers - Section 5 authorizes DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.

Aging Services FTE position - Section 6 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.

Human service finance fund - Section 7 identifies $187,385,888 of the appropriation for the county social and human service project is from the human service finance fund.

Community health trust fund - Section 8 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.

Health care trust fund - Section 9 identifies $1 million from the health care trust fund and $1,150,538 from federal funds is for nursing facility operating margin adjustments.

Capital projects and payments - Section 10 authorizes DHS to pay special assessments at the State Hospital and Life Skills and Transition Center. Section 11 authorizes the demolition of the chapel and employee building at the State Hospital and allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.

Medicaid Expansion appropriations - Section 12 provides DHS may not spend more for the Medicaid Expansion program than the amount appropriated in the bill with certain exceptions.

Nursing facility appropriations - Section 13 provides DHS may not spend more for nursing facility payments than the amount appropriated in the bill.

Substance use disorder voucher program - Sections 14 and 15 create a new substance use disorder voucher facility grant program and provide that no more than 30 percent of funding for service grants may be used for residential services.

Medicaid Expansion - Sections 16 and 17 amend North Dakota Century Code Section 50-24.1-37 to extend the sunset clause on the Medicaid Expansion program. Section 17 provides effective January 1, 2022, 19 and 20 year old recipients are transitioned to a fee for service arrangement and provider reimbursement rates are not confidential.

Personal care - Section 18 repeals Section 50-24.1-18.1 relating to personal care services for eligible medical assistance recipients.

Conveyance of land - Section 19 authorizes DHS to convey land at the Life Skills and Transition Center to the Grafton Parks and Recreation Department.

Lease of land - Section 20 authorizes DHS and the Adjutant General to enter an agreement to lease up to 20 acres of property at the State Hospital for a National Guard training and storage facility.

Provider outcomes - Section 21 requires providers that receive funding from DHS to submit process and outcome measures.

Developmental disabilities in-home support services - Section 22 directs DHS to include in-home supports to be included in the Appendix K application submitted to the Centers for Medicare and Medicaid Services for the developmental disability waiver.

Qualified residential treatment providers - Section 23 requires DHS to adopt rules establishing a ratesetting process and other requirements for foster care maintenance rates for qualified residential treatment providers.

Community behavioral health program - Section 24 authorizes DHS to use line item transfers to provide funding for the community behavioral health program.

Carryover authority - Sections 25 through 30 allow DHS to continue unexpended appropriations for various projects into the 2021-23 biennium.

Developmental disability provider rates - Section 31 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if developmental disability provider funding is not sufficient to pay actual expenses.

State Hospital complex study - Section 32 provides for DHS to conduct a study of the State Hospital complex and to provide a report to the Legislative Management regarding the results of the study.

Medicaid Expansion behavioral health services - Section 33 provides for DHS to conduct a study of the feasibility and desirability of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.

Continuing Appropriations

Child support collection and disbursement - Section 14-09-25 - Allows the department to receive child support payments and provide the funds to the custodial parent or appropriate governmental entity for those custodial parents receiving governmental assistance.

Child support improvement account - Section 50-09-15.1 - Allows the department to receive federal child support incentive funds and spend the funds in accordance with its business plan to improve the child support collection process.

Child support cooperative agreements - Section 50-09-33 - Allows the department to accept federal funds and other income generated by the department under a cooperative agreement with an Indian tribe for child support enforcement services for hiring staff and payment of other expenses as necessary for carrying out the department's duties under the agreement.

Transition to independence - Section 50-06-34 - Allows the department to receive grants and other sources of funding for the development of a program for services to transition-aged youth at risk.

Deficiency Appropriation

Section 3 of the bill appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.

Estimated Unspent General Fund Appropriation Authority (Turnback)

The 2021-23 executive budget recommendation includes estimated unspent general fund appropriation authority of $92.5 million for DHS for the 2019-21 biennium.

Significant Audit Findings

The June 30, 2019, State Auditor report for the Department of Human Services identified the following audit findings:

- Payments after death (prior audit finding) - A total of $108,425 may have been paid in Medicaid benefits for medical services billed for services dated after a beneficiary's date of death.
- Child care correction orders not resolved (prior audit finding) - Child care providers are operating without proper reinspection of correction orders, potentially jeopardizing the health and safety of children.
- Monitoring child care providers with memorandums of understanding (prior audit finding) - The department is not properly monitoring child care providers operating under a memorandum of understanding agreement resulting in increased risks to the health and safety of children when in child care.

- Failure to timely contact suspected victims of child abuse and neglect (prior audit finding) - Prior audit recommendations have not been implemented which may cause a child to stay in an at-risk environment susceptible to abuse or neglect for an additional amount of time.
- Not performing quality assurance for child protection services (prior audit finding) - Without sufficient monitoring procedures the department is unable to ensure that services will protect the health and welfare of children.
- Confirmed child abusers not listed on index (prior audit finding) - Background check search results of the child abuse and neglect index may be inaccurate.
- Financial errors - The department reported incorrect financial information for the state's comprehensive annual financial report.
- Medicaid drug rebate system errors (prior audit finding) - There is increased potential for fraud and errors to occur and be undetected within the Medicaid drug rebate program.

Major Related Legislation

House Bill No. 1065 - Nursing home bed moratorium - Amends Section 23-16-01.1 to adjust provisions relating to the nursing home bed moratorium.

House Bill No. 1066 - Accreditation of human service centers - Amends Section 50-06-05.2 to require DHS to request appropriations to ensure maintenance of the accreditation of human service centers and allows accreditation to be used as a basis for licensing in lieu of adopted rules for the operation of the centers.

House Bill No. 1076 - Children's Cabinet membership - Amends Section 50-06-43.1 to allow the chairman of the Legislative Management to appoint a member of the Legislative Assembly as the presiding officer of the Children's Cabinet.

House Bill No. 1090 - Nursing home payment methodology - Amends various sections to adjust the payment methodology of nursing homes.

House Bill No. 1247 - Department of Health and Human Services - Merges the State Department of Health into the Department of Human Services to create a new Department of Health and Human Services.

House Bill No. 1332 - Nursing home bed moratorium - Amends Section 23-16-01.1 to extend the moratoria on basic care and nursing facility bed capacity.

House Bill No. 1394 - Federal coronavirus relief funding - Appropriates federal COVID-19 relief funding anticipated to be received by state agencies.

House Bill No. 1395 - Federal coronavirus relief fund - Reallocates federal coronavirus relief funds previously authorized by the Emergency Commission and Budget Section.

House Bill No. 1402 - Substance use disorder voucher program - Authorizes an out-of-state substance use disorder treatment program located in a bordering state to participate in the voucher program to provide services to underserved areas of the state.

House Bill No. 1407 - Tribal health care coordination fund - Increases from 60 to 70 percent, the amount of eligible funding to be deposited in the tribal health care coordination fund.

House Bill No. 1416 - Early childhood duties - Transfers early childhood education duties from the Department of Public Instruction to DHS.

House Bill No. 1466 - Early childhood education grant program - Establishes a new grant program within DHS to provide grants for early childhood education programs.

Senate Bill No. 2014 - Health care trust fund - Amends Section 6-09.16-03 to remove the transfer of principal and interest from loan payments from the long-term care facility loan fund to the health care trust fund.

Senate Bill No. 2083 - Child abuse - Amends various sections relating to reporting and duties relating to child abuse.

Senate Bill No. 2085 - Medical services program adjustments - Amends various sections relating to the medical assistance program, including eligibility of Medicaid waivers for in-home services, services provided by advanced practice nurses, and payment methods for medical assistance providers.

Senate Bill No. 2086 - County social and human service project - Amends various sections relating to the county social and human service project, including the duties of counties and human service zones, payments to human service zones, and the process to inform county commissioners regarding options to transition zone employees to state employment, and transfers 16 FTE foster care licensing positions from zone employment to state employment.

Senate Bill No. 2087 - Medical assistance prior authorization - Amends Section 50-24.6-04 relating to prior authorization of medications for the medical assistance program.

Senate Bill No. 2088 - Adoption assistance - Amends Sections 50-28-02 and 50-09-02.2 relating to adoption assistance for children with special needs and payments to adoptive parents.

Senate Bill No. 2089 - Housing stabilization assistance and autism spectrum disorder voucher program - Amends Section 50-06-05.1 relating to housing stabilization assistance and repeals Section 50-06-32.1 to eliminate the autism spectrum disorder voucher program.

Senate Bill No. 2135 - Report on department quality - Requires DHS to provide a report to the Legislative Management before July 1, 2022, regarding the department's quality strategy.

Senate Bill No. 2161 - Behavioral health bed management system - Requires DHS to establish and maintain a registry of mental health providers in the state and establish and maintain a behavioral health bed management system for public and private providers.

Senate Bill No. 2199 - Interstate contracts for treatment - Amends Section 25-03.1-34.2 relating to DHS entering contracts with neighboring states for the treatment of mental illness or substance use disorders.

Senate Bill No. 2205 - Medicaid coverage for interpreter services - Requires DHS to cover interpreter services costs needed for individuals in the Medicaid program receiving medical services.

Senate Bill No. 2256 - Study of developmental disability services - Provides for a Legislative Management study of developmental disability services in the state and provides a $150,000 general fund appropriation to DHS to contract with a consultant for the study.

Senate Bill No. 2275 - **Task force on prevention of sexual abuse of children** - Provides a general fund appropriation of $281,715 for a grant to the task force on prevention of sexual abuse of children.

Department of Human Services - Budget No. 325
House Bill No. 1012

	FTE	General Fund	Other Funds	Total
2021-23 Base Level				
Management	107.95	$64,690,274	$90,021,088	$154,711,362
Program and Policy	383.25	1,181,597,942	2,232,568,138	3,414,166,080
Field Services	1,599.03	214,862,668	127,314,955	342,177,623
County Social Services	140.00	0	173,700,000	173,700,000
Total 2021-23 Base Level	2,230.23	$1,461,150,884	$2,623,604,181	$4,084,755,065

House Adjustments to Base Level	**FTE**	**General Fund**	**Other Funds**	**Total**
Management	(10.10)	$26,569,097	$49,907,855	$76,476,952
Program and Policy	265.42	112,586,136	235,823,355	348,409,491
Field Services	(256.72)	(31,262,297)	(13,370,943)	(44,633,240)
County Social Services	3.00	1,311,724	15,139,791	16,451,515
Total Adjustments	1.60	$109,204,660	$287,500,058	$396,704,718

2021-23 House Version	**FTE**	**General Fund**	**Other Funds**	**Total**
Management	97.85	$91,259,371	$139,928,943	$231,188,314
Program and Policy	648.67	1,294,184,078	2,468,391,493	3,762,575,571
Field Services	1,342.31	183,600,371	113,944,012	297,544,383
County Social Services	143.00	1,311,724	188,839,791	190,151,515
Total 2021-23 House Version	2,231.83	$1,570,355,544	$2,911,104,239	$4,481,459,783

DHS - Management - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation				House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	107.95	$64,690,274	$90,021,088	$154,711,362	107.95	$64,690,274	$90,021,088	$154,711,362
2021-23 Ongoing Funding Changes								
2019-21 transfers and adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)	(18.10)	($838,781)	($3,553,654)	($4,392,435)
Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554
Salary increase		385,855	82,012	467,867		370,808	77,346	448,154
Retirement contribution increase		79,629	16,925	96,554				0
Health insurance increase		3,903	830	4,733		3,903	830	4,733
Reduce funding for operating				0		(8,405,193)		(8,405,193)
Administration								
Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121
Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426
Capitol complex rent model change		474,286		474,286				0
Information Technology Services								
Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715
Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)
Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886
Early childhood data system		500,000		500,000		500,000		500,000
Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394
Other funds reprioritization			2,324,362	2,324,362			2,324,362	2,324,362
Total ongoing funding changes	(10.10)	$15,507,036	$2,323,915	$17,830,951	(10.10)	$6,532,881	$2,302,324	$8,835,205
One-time funding items								
Upgrade MMIS system		$4,326,686	$30,673,314	$35,000,000		$4,326,686	$30,673,314	$35,000,000
Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000
Data automation						98,186	98,186	196,372
MMIS tech stack						600,000	1,800,000	2,400,000
Quality measures services						11,344	34,031	45,375
Total one-time funding changes	0.00	$19,326,686	$45,673,314	$65,000,000	0.00	$20,036,216	$47,605,531	$67,641,747
Total Changes to Base Level Funding	(10.10)	$34,833,722	$47,997,229	$82,830,951	(10.10)	$26,569,097	$49,907,855	$76,476,952
2021-23 Total Funding	97.85	$99,523,996	$138,018,317	$237,542,313	97.85	$91,259,371	$139,928,943	$231,188,314
Total ongoing changes as a percentage of base level	*(9.4%)*	*24.0%*	*2.6%*	*11.5%*	*(9.4%)*	*10.1%*	*2.6%*	*5.7%*
Total changes as a percentage of base level	*(9.4%)*	*53.8%*	*53.3%*	*53.5%*	*(9.4%)*	*41.1%*	*55.4%*	*49.4%*

DHS - Program and Policy - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation				House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080
2021-23 Ongoing Funding Changes								
2019-21 transfers and adjustments	257.22	$22,005,318	$23,196,444	$45,201,762	257.22	$22,005,318	$23,196,444	$45,201,762
Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141
Salary increase		1,480,781	1,276,969	2,757,750		1,501,257	1,359,427	2,860,684
Retirement contribution increase		304,799	262,848	567,647				0
Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816
Provider inflation increases		13,478,022	14,417,097	27,895,119		13,478,022	14,417,097	27,895,119
Federal medical assistance percentage changes		(45,779,364)	45,779,364	0		(45,779,364)	45,779,364	0
Economic Assistance								
Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354
Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242
Child Support								
Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)
Agency savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)
Medical Services								
Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036
Agency savings plan, excluding adjustments to Medicaid Expansion administration and rates	12.00	(11,725,352)	(80,633,115)	(92,358,467)		(999,112)	5,250,858	4,251,746
Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845
Other funds reprioritization			(40,000)	(40,000)			(40,000)	(40,000)
Funding source change - Community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	0		14,400,000	(14,400,000)	0
Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)
Medicaid COVID-19 vaccine				0		1,581,000	1,819,000	3,400,000
DOJ settlement services				0		66,465	199,395	265,860
Medicaid Expansion - 19 and 20 year olds to fee for service				0	0.50	(2,413,379)	(2,745,227)	(5,158,606)
Adjust estimated utilization rates				0		(176,553)	(202,213)	(378,766)
Restore per member per month payment				0		769,869	882,371	1,652,240
Long-Term Care								
Agency savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)
Restore funding for basic care program				0		5,300,000		5,300,000
Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712
Other funds reprioritization			(2,284,362)	(2,284,362)			(2,284,362)	(2,284,362)
Funding source change - Health care trust fund		1,000,000	(1,000,000)	0		1,000,000	(1,000,000)	0
Adjustment for utilization rates				0		(9,395,558)	(9,429,807)	(18,825,365)
Provide funding from health care trust fund				0			2,150,538	2,150,538
DOJ settlement services				0		2,197,552	2,309,196	4,506,748

DD Council								
Continued program changes			124,949	124,949			124,949	124,949
Aging Services								
Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548
Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)
DOJ settlement agreement				0	1.00	300,000	150,000	450,000
Senior community employment grant				0			889,285	889,285
Children and Family Services								
Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905
Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)
Restore portion of 1915i realignment				0		73,750		73,750
Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)
Transfer early childhood program				0	3.00	300,000	400,000	700,000
Early childhood grant program				0	3.70	5,458,910		5,458,910
Behavioral Health Division								
Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)
Agency savings plan		(832,173)		(832,173)		(832,173)		(832,173)
Restore portion of 1915i realignment				0		372,611		372,611
Grant cost and caseload changes		5,427,067		5,427,067		5,427,067		5,427,067
Expand substance use disorder voucher		9,000,000		9,000,000		7,000,000		7,000,000
Vocational Rehabilitation								
Continued program changes		(416,293)	(381,081)	(797,374)		(416,293)	(381,081)	(797,374)
Agency savings plan		(1,803,954)	(91,000)	(1,894,954)		(1,803,954)	(91,000)	(1,894,954)
Restore CIL and ski park funds				0		1,803,954	91,000	1,894,954
Developmental Disabilities								
Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196
Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)
Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021
Small agency accreditation costs				0		25,000		25,000
Total ongoing funding changes	269.22	$94,382,598	$149,604,234	$243,986,832	265.42	$109,088,136	$231,821,355	$340,909,491
One-time funding items:								
Nursing facility payment methodology change		$3,348,000	$3,852,000	$7,200,000		$3,348,000	$3,852,000	$7,200,000
Nursing facility bed buyback program		3,300,000		3,300,000				0
ASO management consultant				0		150,000	150,000	300,000
Total one-time funding changes		$6,648,000	$3,852,000	$10,500,000	0.00	$3,498,000	$4,002,000	$7,500,000
Total Changes to Base Level Funding	269.22	$101,030,598	$153,456,234	$254,486,832	265.42	$112,586,136	$235,823,355	$348,409,491
2021-23 Total Funding	652.47	$1,282,628,540	$2,386,024,372	$3,668,652,912	648.67	$1,294,184,078	$2,468,391,493	$3,762,575,571
Total ongoing changes as a percentage of base level	*70.2%*	*8.0%*	*6.7%*	*7.1%*	*69.3%*	*9.2%*	*10.4%*	*10.0%*
Total changes as a percentage of base level	*70.2%*	*8.6%*	*6.9%*	*7.5%*	*69.3%*	*9.5%*	*10.6%*	*10.2%*

DHS - Field Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation				House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	1,599.03	$214,862,668	$127,314,955	$342,177,623	1,599.03	$214,862,668	$127,314,955	$342,177,623
2021-23 Ongoing Funding Changes								
2019-21 transfers and adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)
Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758
Salary increase		4,975,231	523,871	5,499,102		5,572,943	489,043	6,061,986
Retirement contribution increase		1,003,529	108,416	1,111,945				0
Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577
Provider inflationary increases		405,815		405,815		405,815		405,815
Human Service Centers								
Continued program changes		3,116,890	(2,911,912)	204,978		3,116,890	(2,911,912)	204,978
Cost and caseload changes		2,624,029		2,624,029		2,624,029		2,624,029
Civil sex offender treatment contract		917,004		917,004		917,004		917,004
Agency savings plan		(6,414,994)		(6,414,994)		(6,414,994)		(6,414,994)
Restore portion of 1915i realignment				0		1,362,299		1,362,299
Institutions								
Continued program changes		(4,250,920)	3,154,778	(1,096,142)		(4,250,920)	3,154,778	(1,096,142)
Agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)
Restore State Hospital beds				0	14.00	1,775,792	345,100	2,120,892
LSTC psychiatrist				0		100,000		100,000
Total ongoing funding changes	(270.72)	($34,394,571)	($13,572,799)	($47,967,370)	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)
One-time funding items								
State Hospital complex study				$0		$300,000		$300,000
Total one-time funding changes	0.00	$0	$0	$0	0.00	$300,000	$0	$300,000
Total Changes to Base Level Funding	(270.72)	($34,394,571)	($13,572,799)	($47,967,370)	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)
2021-23 Total Funding	1,328.31	$180,468,097	$113,742,156	$294,210,253	1,342.31	$183,600,371	$113,944,012	$297,544,383
Total ongoing changes as a percentage of base level	*(16.9%)*	*(16.0%)*	*(10.7%)*	*(14.0%)*	*(16.1%)*	*(14.7%)*	*(10.5%)*	*(13.1%)*
Total changes as a percentage of base level	*(16.9%)*	*(16.0%)*	*(10.7%)*	*(14.0%)*	*(16.1%)*	*(14.5%)*	*(10.5%)*	*(13.0%)*

DHS - County Social Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	Executive Budget Recommendation				House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	140.00	$0	$173,700,000	$173,700,000	140.00	$0	$173,700,000	$173,700,000
2021-23 Ongoing Funding Changes								
Base payroll changes			$1,653,466	$1,653,466			$1,653,466	$1,653,466
Salary increase		$351,365	292,562	643,927		412,248	291,785	704,033
Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024
Retirement contribution increase		72,382	60,269	132,651				0
Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997
Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673
Zone employee salary increase							3,975,941	3,975,941
Additional zone operations funding							9,089,381	9,089,381
Total ongoing funding changes	3.00	$1,323,223	$2,135,515	$3,458,738	3.00	$1,311,724	$15,139,791	$16,451,515
One-time funding items								
No one-time funding items				$0				$0
Total one-time funding changes	0.00	$0	$0	$0	0.00	$0	$0	$0
Total Changes to Base Level Funding	3.00	$1,323,223	$2,135,515	$3,458,738	3.00	$1,311,724	$15,139,791	$16,451,515
2021-23 Total Funding	143.00	$1,323,223	$175,835,515	$177,158,738	143.00	$1,311,724	$188,839,791	$190,151,515
Total ongoing changes as a percentage of base level	*2.1%*		*1.2%*	*2.0%*	*2.1%*		*8.7%*	*9.5%*
Total changes as a percentage of base level	*2.1%*		*1.2%*	*2.0%*	*2.1%*		*8.7%*	*9.5%*

Department of Human Services - Budget No. 325
House Bill No. 1012
Other Sections

	Executive Budget Recommendation	House Version
Deficiency appropriation	Not included	Section 3 appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.
Line item transfers	Section 6 would allow DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 7 would allow DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.	Section 4 allows DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 5 allows DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.
Aging Services FTE position	Not included	Section 6 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.
Human service finance fund	Section 9 would identify $174,380,767 of the recommended appropriation for the county social and human service project is from the human service finance fund.	Section 7 identifies $187,385,888 of the appropriation for the county social and human service project is from the human service finance fund.
Community health trust fund	Section 8 would identify $24 million of the recommended appropriation for the Medical Services Division is from the community health trust fund.	Section 8 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.
Health care trust fund	Not included	Section 9 identifies $1 million of the appropriation for long-term care is from the health care trust fund for nursing facility operating margin adjustments.
Capital projects and payments	Section 21 would authorize the payment of special assessments at the State Hospital and Life Skills and Transition Center and would authorize the demolition of the chapel and employee building at the State Hospital. The section would also allow DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.	Section 10 authorizes the payment of special assessments at the State Hospital and Life Skills and Transition Center. Section 11 authorizes the demolition of the chapel and employee building at the State Hospital. The section also allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.
Medicaid Expansion appropriations	Section 11 would provide DHS may not spend more for the Medicaid Expansion program than the amount appropriated in the bill with certain exceptions.	Section 12 provides DHS may not spend more for the Medicaid Expansion program than the amount appropriated in the bill with certain exceptions.
Nursing facility appropriations	Section 12 would provide DHS may not spend more for nursing facility payments than the amount appropriated in the bill.	Section 13 provides DHS may not spend more for nursing facility payments than the amount appropriated in the bill.
Substance use disorder voucher program	Not included	Sections 14 and 15 create a new substance use disorder voucher facility grant program and provide that no more than 30 percent of funding for service grants may be used for residential services.
Medicaid Expansion	Section 3 would amend North Dakota Century Code Section 50-24.1-37 to extend the expiration date for the Medicaid Expansion program to June 30, 2022. Section 4 would provide for the Medicaid Expansion program to be a fee-for-service program administered by DHS effective July 1, 2022.	Sections 16 and 17 amend North Dakota Century Code Section 50-24.1-37 to extend the sunset clause on the Medicaid Expansion program. Section 17 provides effective January 1, 2022, 19 and 20 year old recipients are transitioned to a fee for service arrangement and provider reimbursement rates are not confidential.
Personal care	Section 5 would repeal Section 50-24.1-18.1 relating to personal care services for eligible medical assistance recipients.	Section 18 repeals Section 50-24.1-18.1 relating to personal care services for eligible medical assistance recipients.

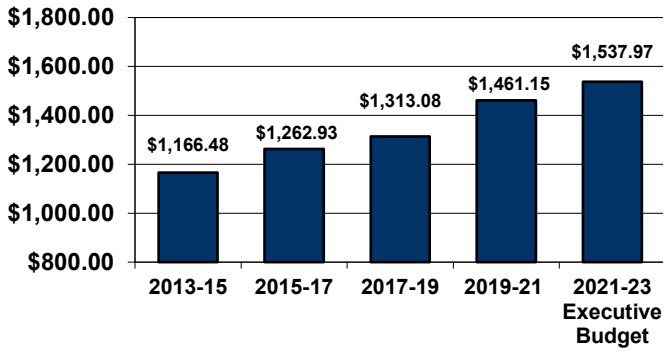
Conveyance of land	Section 20 would authorize DHS to convey land at the Life Skills and Transition Center to the Grafton Parks and Recreation Department.	Section 19 authorizes DHS to convey land at the Life Skills and Transition Center to the Grafton Parks and Recreation Department.
Lease of land at State Hospital	Section 25 would provide legislative intent that DHS and the Adjutant General enter an agreement to lease up to 20 acres of property at the State Hospital for a National Guard training and storage center.	Section 20 authorizes DHS and the Adjutant General to enter an agreement to lease up to 20 acres of property at the State Hospital for a National Guard training and storage facility.
Provider outcomes	Section 23 would require providers that receive funding from DHS to submit process and outcome measures.	Section 21 requires providers that receive funding from DHS to submit process and outcome measures.
Developmental disabilities in-home supports	Not included	Section 22 directs DHS to include in-home supports to be included in the Appendix K application submitted to the Centers for Medicare and Medicaid Services for the developmental disability waiver.
Residential treatment providers	Section 24 would require DHS to adopt rules establishing a ratesetting process and other requirements for foster care maintenance rates for qualified residential treatment providers.	Section 23 requires DHS to adopt rules establishing a ratesetting process and other requirements for foster care maintenance rates for qualified residential treatment providers.
Community behavioral health program	Not included	Section 24 authorizes DHS to use line item transfers to provide funding for the community behavioral health program.
Carryover authority	Sections 14 through 19 would allow DHS to continue unexpended appropriations for various projects into the 2021-23 biennium.	Sections 25 through 30 allow DHS to continue unexpended appropriations for various projects into the 2021-23 biennium.
Legislative intent - Developmental disability provider rates	Not included	Section 31 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if developmental disability provider funding is not sufficient to pay actual expenses.
State Hospital complex study	Not included	Section 32 provides for DHS to conduct a study of the State Hospital complex and to provide a report to the Legislative Management regarding the results of the study.
Medicaid Expansion behavioral health services	Not included	Section 33 provides for DHS to conduct a study of the feasibility and desirability of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.
Nursing home bed reduction	Section 10 would appropriate $3.3 million from the general fund to provide incentives to nursing facilities to reduce licensed bed capacity.	Not included
Health home for individuals with chronic conditions	Section 13 would require DHS to develop a plan to implement a state Medicaid option to provide coordinated care through a health home for individuals with a chronic condition.	Not included
State Hospital facility	Section 22 would authorize DHS to enter a public-private partnership for the purpose of constructing a new State Hospital facility.	Not included

Department 325 - Department of Human Services

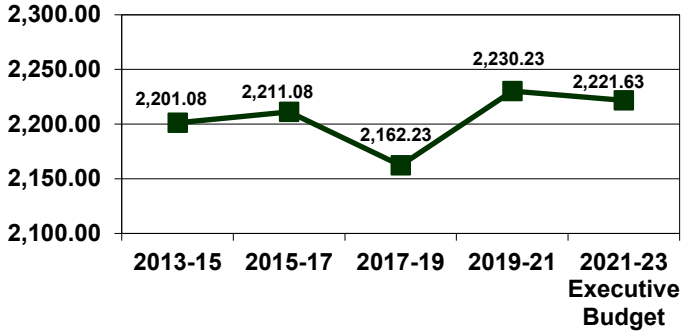
Historical Appropriations Information

Ongoing General Fund Appropriations Since 2013-15

Ongoing General Fund Appropriations (in Millions)



FTE Positions



Ongoing General Fund Appropriations					
	2013-15	2015-17	2017-19	2019-21	2021-23 Executive Budget
Ongoing general fund appropriations	$1,166,482,508	$1,262,925,021	$1,313,081,350	$1,461,150,884	$1,537,969,170
Increase (decrease) from previous biennium	N/A	$96,442,513	$50,156,329	$148,069,534	$76,818,286
Percentage increase (decrease) from previous biennium	N/A	8.3%	4.0%	11.3%	5.3%
Cumulative percentage increase (decrease) from 2013-15 biennium	N/A	8.3%	12.6%	25.3%	31.8%

Major Increases (Decreases) in Ongoing General Fund Appropriations

2015-17 Biennium

1.	Added state matching funds due to changes in FMAP	$3,584,150
2.	Added funding for the state's share of Medicaid Expansion costs	$8,187,466
3.	Provided a 3 percent inflationary increase for providers for the 1st year of the biennium	$24,727,201
4.	Added funding of $19,312,165 for property tax relief to counties for costs previously paid by counties for child welfare programs, the SPED programs, and technology costs; and $3.9 million for grants to counties that have imposed an emergency human service levy	$23,212,165
5.	Transferred the high-risk sex offender treatment program to the Department of Corrections and Rehabilitation	($2,290,297)
6.	Added funding for physical, occupational, and speech therapy service provider rate increase to a 50 percent fee schedule	$468,629
7.	Added funding for Medicare drug clawback payments to reflect a premium rate increase	$2,183,214
8.	Added funding for basic care provider payment changes	$704,148
9.	Added funding for senior meals program	$502,300
10.	Added funding to establish and administer a substance abuse voucher system	$375,000

2017-19 Biennium

1.	Removed 33 FTE positions from the department	($3,127,902)
2.	Reduced funding for staff overtime	($1,082,857)
3.	Adjusted funding for child care assistance eligibility	($2,160,357)
4.	Adjusted the professional fee schedule to 100 percent of Medicare and provided other policy changes	($10,612,966)
5.	Added funding to continue Medicaid Expansion for 19 and 20 year olds as managed care	$1,653,008

6.	Changed a portion of funding sources for various programs from the general fund to the community health trust fund ($18,000,000) and the tobacco prevention and control trust fund ($22,175,000)	($40,175,000)
7.	Added funding for nursing home operating margin, rebasing, and incentives	$1,783,181
8.	Added funding for money follows the person grants	$527,954
9.	Added funding to increase the autism waiver maximum age to 11 years old	$183,609
10.	Reduced funding for vacant positions and employee turnover at institutions	($3,250,499)

2019-21 Biennium

1.	Added funding for provider inflationary increases of 2 percent the 1st year of the biennium and 2.5 percent the 2nd year of the biennium	$30,155,090
2.	Adjusted funding for anticipated changes in the regular FMAP	($25,682,840)
3.	Adjusted funding for anticipated changes in the FMAP for Medicaid Expansion ($20,254,376) and the children's health insurance program ($6,152,757)	$26,407,133
4.	Added funding for grant cost and caseload changes	$51,128,377
5.	Replaced funding provided in the 2017-19 biennium from the tobacco prevention and control trust fund	$34,175,000
6.	Replaced one-time funding provided in the 2017-19 biennium for Medicaid Expansion commercial rates	$13,300,000
7.	Adjusted funding sources to use funding from the community health trust fund rather than the general fund	($32,400,000)
8.	Added funding for the free through recovery program to provide services to individuals outside of the corrections system	$4,000,000
9.	Added funding to expand crisis services	$4,096,174
10.	Added funding for the substance use disorder voucher program	$3,053,523

2021-23 Biennium (Executive Budget Recommendation)

1.	Adds funding for cost, caseload, and utilization changes, including $156,789,851 for medical services, $77,698,712 for long-term care, and $41,567,021 for developmental disabilities. **The House adjusted estimated utilization rates for the medical services and long-term care programs.**	$124,345,846
2.	Underfunds salaries and wages by $4,694,730 from the general fund in anticipation of savings from vacant positions and employee turnover	($4,694,730)
3.	Reduces ongoing funding appropriated during the 2019-21 biennium from the community health trust fund from $32.4 million to $24 million and replaces ongoing funding provided from the health care trust fund ($1 million). **The House added $1 million of funding from the health care trust fund and matching federal funds of $1,150,538 for nursing home operating margin adjustments.**	$15,400,000
4.	Provides a 1 percent inflationary increase for human service providers during each year of the 2021-23 biennium	$13,883,837
5.	Increases funding for the substance use disorder voucher program from $8 million to $17 million. **The House increased funding for the voucher program to $15 million and provided for $3 million of the funds to be distributed as facility grants in underserved areas of the state.**	$9,000,000
6.	Adjusts funding to reduce general fund support for traditional Medicaid ($50,919,245) and increase general fund support for Medicaid Expansion ($3,916,989) and the children's health insurance program ($1,222,892) due to changes in the state's FMAP	($45,779,364)
7.	Underfunds Medicaid grants	($9,580,913)
8.	Adds funding to contract with a private service provider for civil sex offender treatment	$917,004
9.	Adds funding for the Capitol grounds agency rent proposal. **The House did not add funding for the agency rent proposal.**	$474,286
10.	Adds ongoing funding to develop an early childhood integrated data system	$500,000

GOVERNOR'S RECOMMENDATION FOR THE DEPARTMENT OF HUMAN SERVICES AS SUBMITTED BY THE OFFICE OF MANAGEMENT AND BUDGET

SECTION 1. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from special funds derived from federal funds and other income, to the department of human services for the purpose of defraying the expenses of its various divisions, for the biennium beginning July 1, 2021, and ending June 30, 2023, as follows:

Subdivision 1.

MANAGEMENT

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and Wages	$ 16,939,176	$ 2,509,310	$ 19,448,486
Operating Expenses	133,329,751	84,689,076	218,018,827
Capital Assets	50,000	25,000	75,000
Total All Funds	$150,318,927	$87,223,386	$237,542,313
Less Estimated Income	86,467,434	51,550,883	138,018,317
Total General Fund	$ 63,851,493	$35,672,503	$ 99,523,996

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and Wages	$ 111,785,293	$ 7,772,728	$ 119,558,021
Operating Expenses	155,887,808	9,993,200	165,881,008
Capital Assets	10,000	0	10,000
Grants	449,002,998	6,686,742	455,689,740
Grant – Medical Assistance	2,742,681,743	184,832,400	2,927,514,143
Total All Funds	$3,459,367,842	$209,285,070	$3,668,652,912
Less Estimated Income	2,255,764,582	130,259,790	2,386,024,372
Total General Fund	$1,203,603,260	$ 79,025,280	$1,282,628,540

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human Service Centers	$162,984,547	$ 4,533,765	$167,518,312
Institutions	138,383,749	(11,691,808)	126,691,941
Total All Funds	$301,368,296	($ 7,158,043)	$294,210,253
Less Estimated Income	107,672,165	6,069,991	113,742,156
Total General Fund	$193,696,131	($13,228,034)	$180,468,097

Subdivision 4.

PROPERTY TAX RELIEF

	Base Level	Adjustments or Enhancements	Appropriation
County Social Services	$173,700,000	$3,458,738	$177,158,738
Total All Funds	$173,700,000	$3,458,738	$177,158,738
Less Estimated Income	173,700,000	2,135,515	175,835,515
Total General Fund	$ 0	$1,323,223	$ 1,323,223

Subdivision 5.

BILL TOTAL

	Base Level	Adjustments or Enhancements	Appropriation
Grand Total General Fund	$1,461,150,884	$102,792,972	$1,563,943,856
Grand Total Special Funds	2,623,604,181	190,016,179	2,813,620,360
Grand Total All Funds	$4,084,755,065	$292,809,151	$4,377,564,216
Full-time Equivalent Positions	2,230.23	(8.60)	2,221.63

SECTION 2. ONE-TIME FUNDING - EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY. The following amounts reflect the one-time funding items approved by the sixty- sixth legislative assembly for the 2019-21 biennium and the 2021-23 biennium one-time funding items included in section 1 of this Act:

One-Time Funding Description	2019-21	2021-23
Technology Projects	$13,785,658	$ 0
Capital Projects – Life Skills and Transition Center	4,277,165	0
Capital Projects – State Hospital	2,493,500	0
Medically Complex Children Provider Funding Adjustment	977,603	0
Hyperbaric Oxygen Therapy Grant	335,000	0
State Hospital Study	200,000	0
MMIS Modernization	0	35,000,000
Nursing Facility Payment Reform	0	7,200,000
Nursing Home Bed Buy Back	0	3,300,000
Frame/CCIPS Replacement	0	30,000,000
Total All Funds	$22,068,926	$75,500,000
Less Estimated Income	20,556,323	49,525,314
Total General Fund	$1,512,603	$25,974,686

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 3. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Effective ~~January~~August 1, ~~2020~~2021, through ~~July 31~~June 30, ~~2021~~2022 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.
4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even- numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.

5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 4. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion ~~- Legislative management report~~. (Effective ~~January~~July 1, ~~2020~~2022, through July 31, ~~2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. ~~Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.~~
4. ~~The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even- numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~
5. ~~Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.~~

SECTION 5. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 6. FUNDING TRANSFERS - EXCEPTION - AUTHORIZATION. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022, any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 7. FUNDING TRANSFERS - EXCEPTION - AUTHORIZATION. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority from line items within subdivisions 1, 2, and 3 of section 1 of this Act to subdivision 4 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022 any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 8. ESTIMATED INCOME - COMMUNITY HEALTH TRUST FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $24,000,000 from the community health trust fund for defraying expenses in the medical services division.

SECTION 9. ESTIMATED INCOME - HUMAN SERVICE FINANCE FUND. The estimated income line item in subdivision 4 of section 1 of this Act includes the sum of $174,380,767 from the human service finance fund for state-paid economic assistance and social and human services.

SECTION 10. APPROPRIATION – NURSING HOME BED REDUCTION. There is appropriated the sum of $3,300,000, from the general fund or so much of the sum as may be necessary, to the department of human services for the purpose of providing incentives to nursing homes to reduce licensed nursing facility bed capacity for the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 11. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM.

1. Subdivision 2 of section 1 of this Act includes the sum of $325,521,229, of which $36,606,115 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021 and ending June 30, 2022. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:
   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $5,120,064 included in subdivision 2 of section 1 of this Act.
   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $34,364,628 included in subdivision 2 of section 1 of this Act.
2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.
3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.
4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.
5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.
6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through June 30, 2022. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

SECTION 12. EXPENDITURES MAY NOT EXCEED APPROPRIATION – NURSING HOME RATES. Subdivision 2 of section 1 of this Act includes the sum of $635,373,451, of which $296,019,558 is from the general fund, for nursing home rates for the biennium beginning July 1, 2021 and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.

SECTION 13. HEALTH HOMES - REPORT TO LEGISLATIVE MANAGEMENT. During the biennium beginning July 1, 2021 and ending June 30, 2023, the department of human services shall develop a plan to implement, in accordance with section 1945 of the Social Security Act, health homes to coordinate care for people with Medicaid who have chronic conditions during the biennium beginning July 1, 2023 and ending June 30, 2025. Prior to October 1, 2022, the department shall report to the legislative management on the implementation plan.

SECTION 14. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54- 44.1-11. Any unexpended funds from these appropriations approved under section 54-44.1-11 are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 15. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54- 44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 16. EXEMPTION. The amount appropriated for the development of the childcare licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019- 21 biennium are available for the completion of the childcare licensing and data system during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 17. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the health information network during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 18. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavior health pilot projects during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 19. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 20. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to Grafton Parks and Recreation. The department may convey a portion of two parcels of land commonly referred to as “the bowl” on the terms and conditions determined appropriate by the department and the attorney general. Section 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 21. CAPITAL PROJECTS AND PAYMENTS. During the period beginning with the effective date of this Act, and ending June 30, 2023, the department of human services is authorized to expend funds for the following capital projects and payments:

1. The payment of special assessments at the state hospital and life skills and transition center; and
2. The demolition of the chapel and employee building and associated tunnels at the state hospital.

Notwithstanding sections 54-16-04 and 54-27-12, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021 and ending June 30, 2023, as requested by the department of human services for the department to expend funds on the demolition of the identified buildings and associated tunnels and for emergency capital projects. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department of human services shall report to the

budget section after June 30, 2022 any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 22. STATE HOSPITAL BUILDING PROJECTS. The department of human services is authorized to construct a new state hospital on the property owned by the state of North Dakota, in Stutsman County, near or on state hospital's current campus. The new state hospital may include space for the operation of the regional human service center. The department of human services shall utilize chapter 48-02.1 and have a private operator to build, transfer, and operate the facility through a development agreement on leased property owned by the state of North Dakota. The continuing cost to support the new state hospital through a development agreement must be included in the department of human services' 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 23. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021 and ending June 30, 2023.

SECTION 24. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new rate setting process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation received by the sixty-seventh legislative assembly.

SECTION 25. LEGISLATIVE INTENT – CONVEYANCE OF LAND. It is the intent of the sixty-seventh legislative assembly that the department of human services and national guard enter into an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to build a new training and storage center.

SECTION 26. EFFECTIVE DATE. Section 4 of this Act becomes effective on July 1, 2022.

SECTION 27. EXPIRATION DATE. Sections 3 and 11 of this Act is effective through June 30, 2022 and after that date is ineffective.

SECTION 28. EMERGENCY. Sections 21 and 22 of this Act are declared to be an emergency measure.

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/9/2021 AM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 8:31 A.M.

Senators present: **Holmberg, Krebsbach, Wanzek, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman. Senator Bekkedahl** was absent.

Discussion Topics:

- DHS Administration
- Behavioral Health
- Medical Services

Chris Jones, Executive Director, Department of Human Services, testified neutrally and submitted testimony #8077.

Pamela Sagness, Director of Behavioral Health Division, Department of Human Services, testified neutrally and submitted testimony #8226 and #8231.

Caprice Knapp, Director of Medical Services Division, Department of Human Services, testified in favor and submitted testimony #8211 and #8259.

Josh Askvig, State Director, AARP North Dakota, testified in favor and submitted testimony #8029 and #8030.

Carlotta McCleary, Executive Director, Mental Health America North Dakota, testified in favor and submitted testimony #8296.

Trina Gress, Community Options, testified in opposition and submitted testimony #7976.

Brad DeJong, Senior Partner, Eide Bailly, testified in favor and submitted testimony #8304

Senator Holmberg closed the hearing at 12:14 p.m.

Rose Laning, Committee Clerk



8077

HOUSE BILL 1012

Senate Appropriations

Senator Ray Holmberg, Chairman

OVERVIEW/MANAGEMENT BUDGET

Chris Jones, Executive Director

NORTH Dakota | Human Services

Be Legendary.™

DHS MISSION AND OPERATING PRINCIPLES

Provide quality, efficient, and effective human services, which improve the lives of people



- Services and care should be provided **as close to home as possible**
- Services should be **provided consistently across service areas** to promote equity of access and citizen focus of delivery

- Services should be administered to **optimize** for a given cost **the number served** at a service **level aligned to need**
- Investments and funding in DHS should **maximize ROI for the most vulnerable** through safety net services
- Cost-effectiveness should be considered holistically, acknowledging **potential unintended consequences** and **alignment between state and federal priorities**

- Services should help vulnerable North Dakotans of all ages maintain or enhance quality of life by:
- Supporting **access to the social determinants of health**: economic stability, housing, education, food, community, and health care
- **Mitigating threats** to quality of life such as lack of financial resources, emotional crises, disabling conditions, or inability to protect oneself

DEPARTMENT OF HUMAN SERVICES

Quality services, Proven results, Closer to home

1. Base decisions on **quality**, **efficiency**, and **effectiveness**.

   Find success in a resource-constrained environment.

   Make **reductions** in some areas **and investments** in others to optimize outcomes.

2. The state has **enough treatment beds**. Investing in **earlier interventions** can help **avoid crisis**.

   Right service. Right place. Right time.

   Serving people in **lowest level of care necessary** will return **better outcomes**.

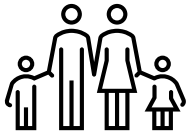
   To deliver services closer to home, **all** have to be **willing to change** how they do business – DHS can't do this alone.

3. How we **pay** for services should be **fair** and **equitable** across systems.

   Inequity in rates **affects** people's ability to **access** services - providers often prioritize more lucrative payment opportunities

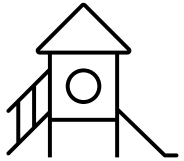
   Demonstrate value to taxpayers. **Value** equals **high quality cost efficient care**.

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



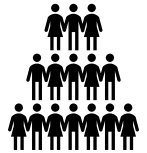
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

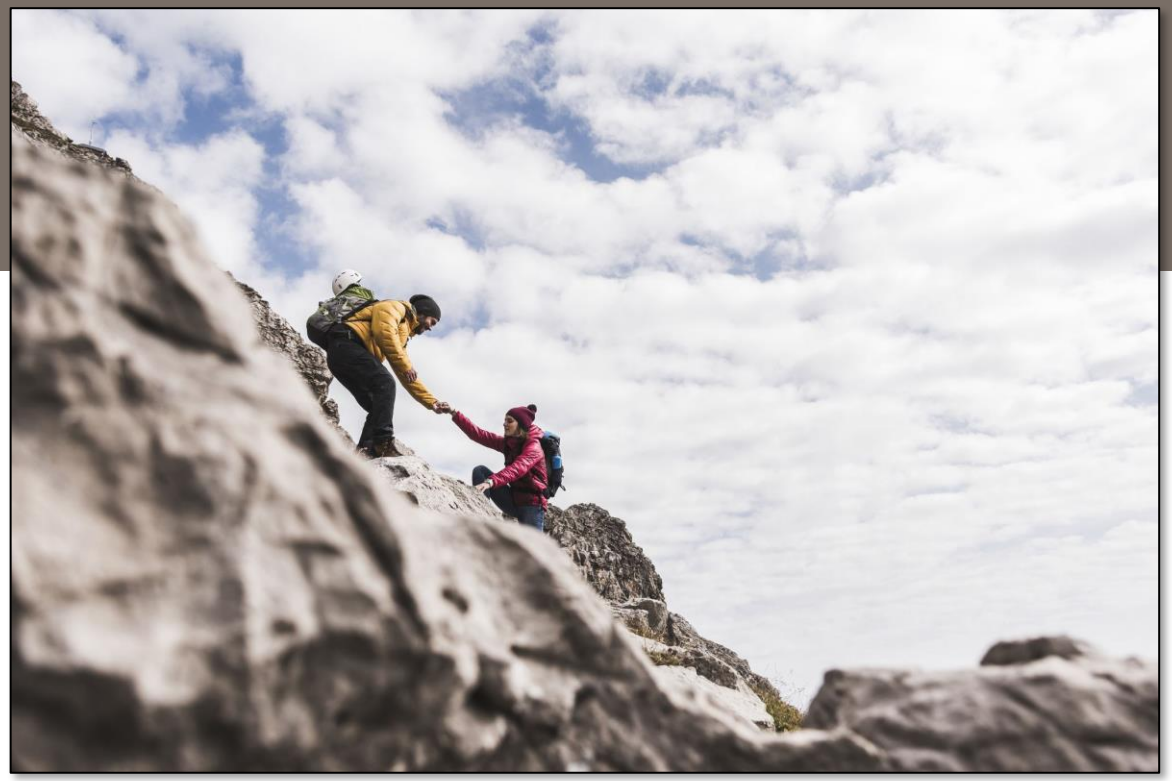
Economic Health | Behavioral Health | Physical Health

DHS FTE CHANGES

Department of Human Services
21-23 FTE Count

Division	Current Budget	Executive Budget Changes	To House	House Changes	To Senate
Total FTE	2,230.23	(8.60)	2,221.63	10.20	2,231.83

WHO WE ARE



Administration

- Human Resources
- Legal Services
- Fiscal
- Logistics Management – New 19-21
- Strategic Communications – New 19-21
- Information Technology

We support the people who serve the people

HOUSE CHANGES TO ADMINISTRATION

- Employee Compensation and Retirement
- Reduction of 6.5% Operating
  - $8.4 million in general fund reduction
    - $8,089,759 to Information Technology
    - $315,434 to other administration
    - Reduces ability to provide quality services to the citizens of ND



Contact Information

Chris Jones, Executive Director
Department of Human Services
Phone: 701.328.2538
Email: cdjones@nd.gov



NORTH Dakota | Behavioral Health
Be Legendary.™ HUMAN SERVICES



House Bill 1012
Senate Appropriations
Senator Holmberg, Chairman

Behavioral Health Division
Pamela Sagness, Director

1

1

What is Behavioral Health?

A state of mental/emotional being and/or choices and actions that affect **WELLNESS**.

- Preventing and treating depression and anxiety
- Preventing and treating substance use disorder or other addictions
- Supporting recovery
- Creating healthy communities
- Promoting overall well-being

2

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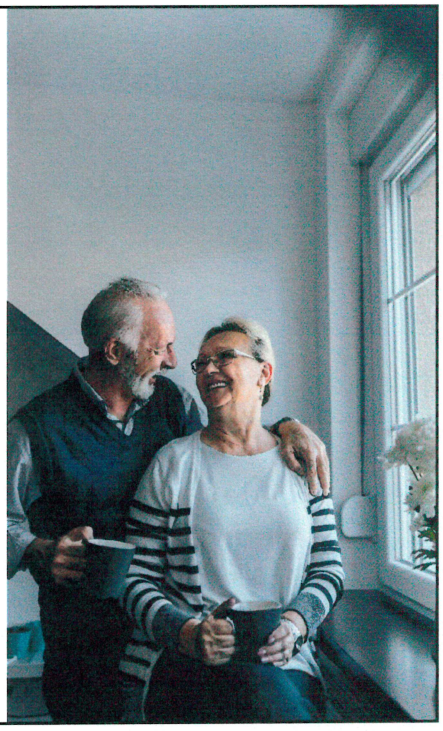
3

Why is Behavioral Health Important?

Persons with behavioral health disorders die, on average, about *5 years earlier* than persons without these disorders.

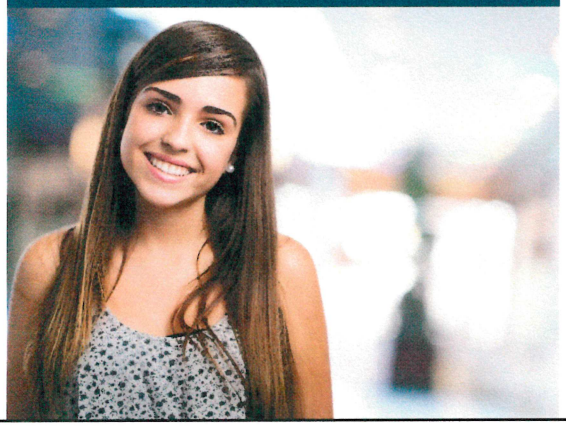
Persons with serious mental illness (SMI) are now dying *25 years earlier* than the general population

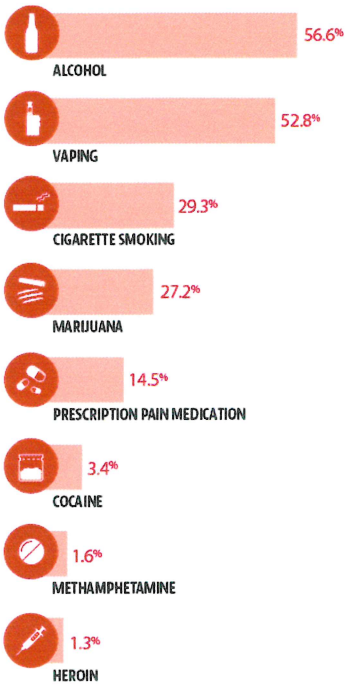


(Druss BG, et al. Understanding Excess Mortality in Persons With Mental Illness: 17-Year Follow Up of a Nationally Representative US Survey. Medical Care 2011; 49(6), 599–604.)

4

ND Youth Lifetime Substance Use
(High School Students)





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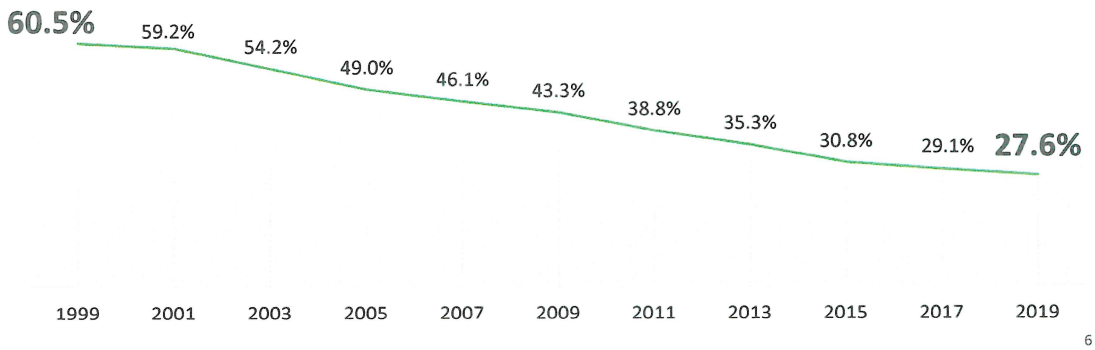
Prevention Works!

Current Alcohol Use (past 30 days) among ND High School Students

Youth Risk Behavior Survey



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Youth Suicide
(High School Students; past 12 months)



7

7

Adult Substance Use
(Age 18+; past 30 days)







	BINGE ALCOHOL USE*	TOBACCO	MARIJUANA	ILLICIT DRUGS (other than marijuana)
NORTH DAKOTA	34.1%	28.3%	7.9%	3.1%
UNITED STATES	26.5%	23.7%	10.2%	3.4%

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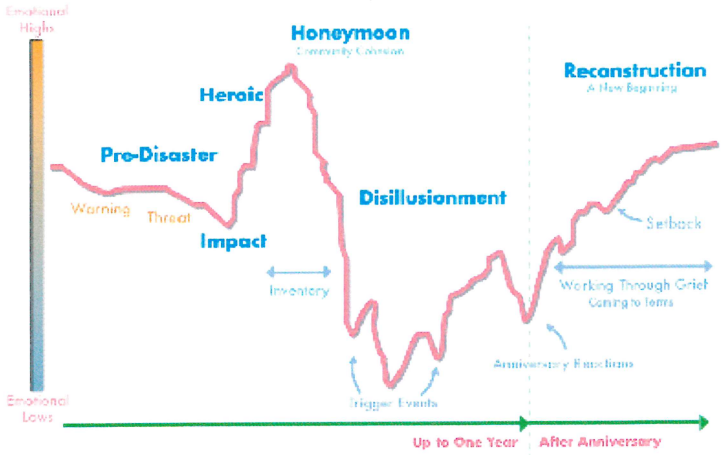
Disaster Impacts to Behavioral Health



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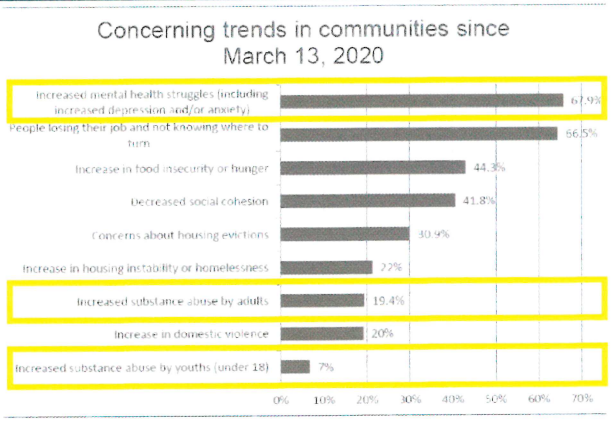
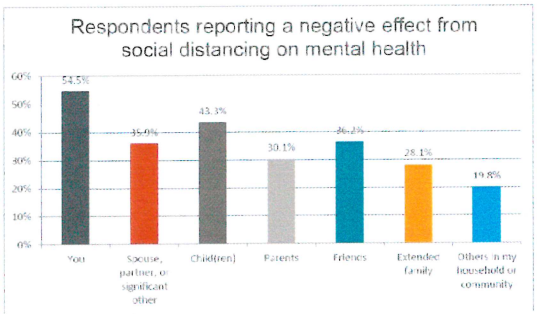
COVID-19 Impacts on Behavioral Health

ND Dept. of Commerce Survey May 2020



Respondents Reporting Negative Effect on Mental Health



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NORTH Dakota | Behavioral Health
HUMAN SERVICES
BEHAVIORAL HEALTH
IN NORTH DAKOTA
DATA BOOK 2021
BEHAVIORAL HEALTH DATA BOOKLET
All data resources are available at
www.behavioralhealth.nd.gov/data.

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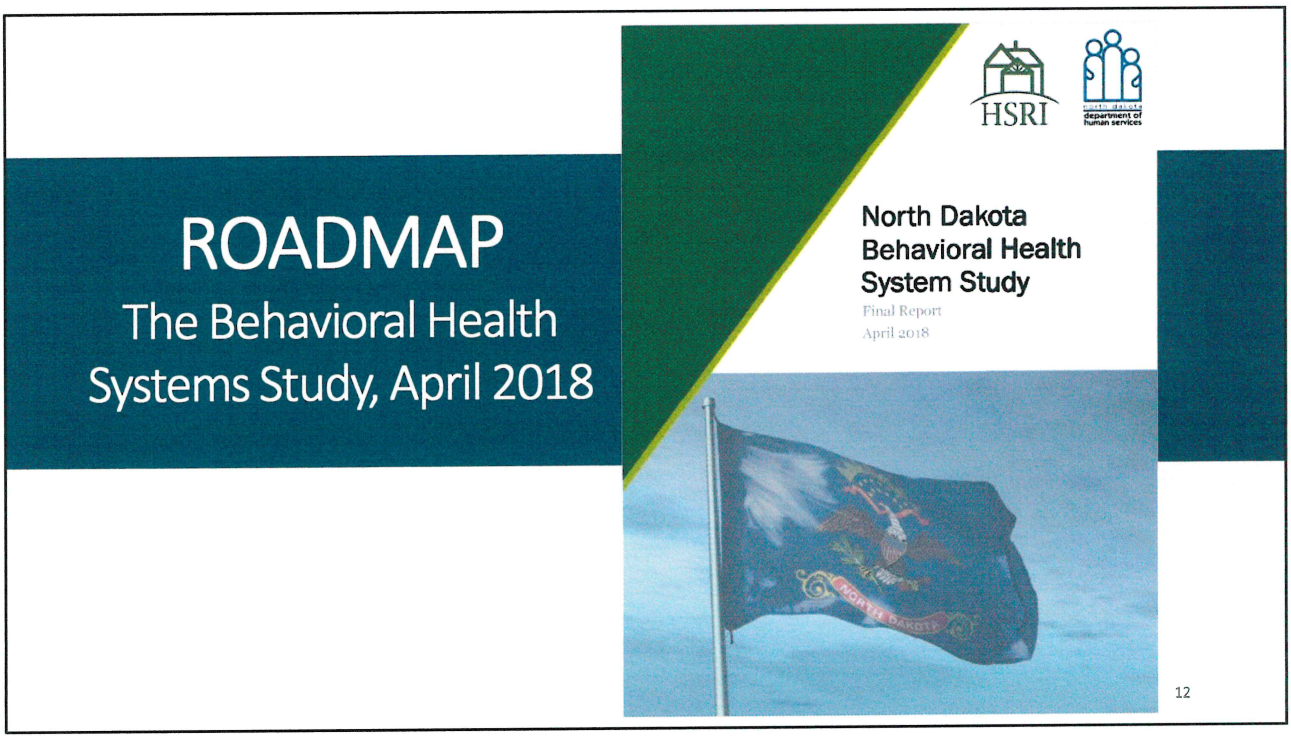
ROADMAP
The Behavioral Health
Systems Study, April 2018
HSRI
department of human services
North Dakota
Behavioral Health
System Study
Final Report
April 2018
12

12

North Dakota Behavioral Health System Study RECOMMENDATIONS

The 250-page report provides more than 65 recommendations in 13 categories.

1. Develop a comprehensive implementation plan
2. Invest in prevention and early intervention
3. Ensure all North Dakotans have timely access to behavioral health services
4. Expand outpatient and community-based service array
5. Enhance and streamline system of care for children and youth
6. Continue to implement/refine criminal justice strategy
7. Engage in targeted efforts to recruit/retain competent behavioral health workforce
8. Expand the use of tele-behavioral health
9. Ensure the system reflects its values of person-centeredness, cultural competence, trauma-informed approaches
10. Encourage and support the efforts of communities to promote high-quality services
11. Partner with tribal nations to increase health equity
12. Diversify and enhance funding for behavioral health
13. Conduct ongoing, system-side data-driven monitoring of needs and access

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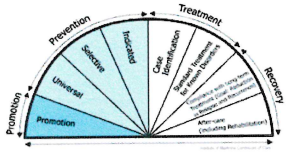
Keys to Reforming North Dakota's Behavioral Health System



Support the full Continuum of Care



Increase Community-Based Services



Prevent Criminal Justice Involvement for Individuals with a Behavioral Health Condition

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KEY INITIATIVES

Behavioral Health

NORTH Dakota Be Legendary.™ | Behavioral Health HUMAN SERVICES

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During the 2019 legislative session, North Dakota lawmakers authorized the Department of Human Services (Department) to create a Medicaid 1915(i) State Plan Amendment.

The amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.

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1915i State Plan Amendment



The amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.

Individual Eligibility	Services
• The individual is age 0+; and • The individual is currently enrolled in ND Medicaid or Medicaid Expansion; and • The individual resides in and will receive services in a setting meeting the federal home and community-based setting requirements, and • The individual has a mental illness, substance use disorder or traumatic brain injury diagnosis The individual has a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting, as evidenced by a complex score of 50 or higher on the WHODAS 2.0.	• Care Coordination • Training and Supports for Unpaid Caregivers • Community Transitional Services • Benefits Planning • Non-Medical Transportation • Respite • Prevocational Training • Supported Education • Supported Employment • Housing Support Services • Family Peer Support • Peer Support

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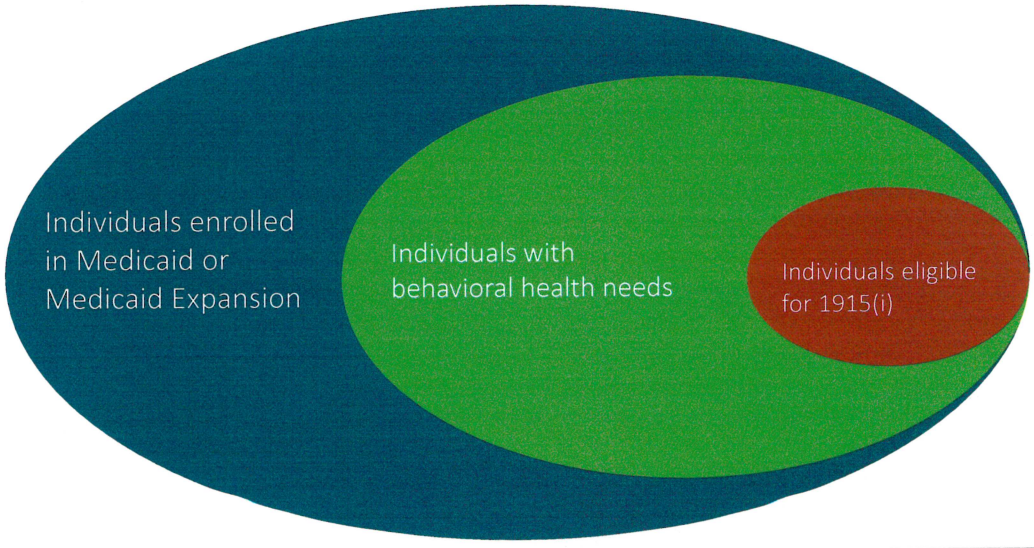
Population Served



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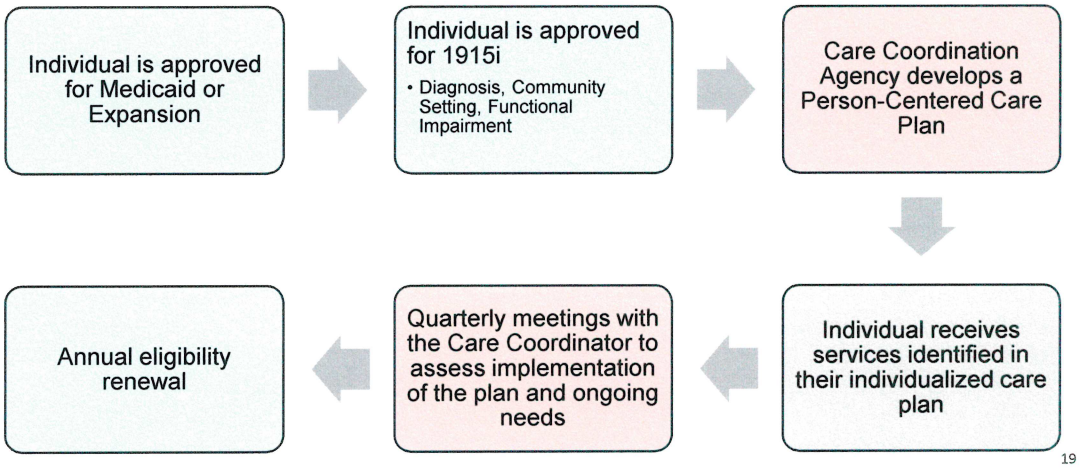
Process



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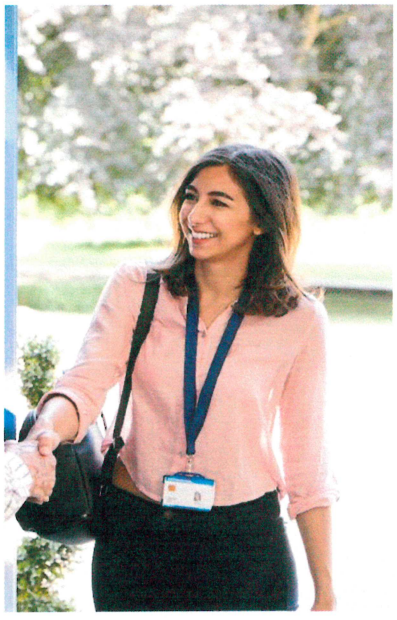
The Care Coordination Role

- 1915(i) Care Coordination Service are provided by enrolled 1915(i) Care Coordination Providers. Care Coordinators could be employed by the state, private providers/ community organizations.
- The Care Coordination Role is responsible for the development of the Person-centered Plan of Care and supporting the individual with accessing the greater community to meet the individual's overall needs. This includes:
  - Ensuring continuity of care including collaborating with existing systems and services.
  - Connecting individual to additional 1915(i) Services through the development of the person-centered plan of care.
  - Building informal supports network in the individual's community.
  - Providing services that are equitable and culturally competent.
  - Empowering individuals by upholding practice that promotes individual choice, rights and responsibilities.



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Example 1: Community Behavioral Health Provider

NOW

- $1,000,000 **general** fund/biennium
- 60 individuals served at any one time/biennium
  - 50% qualify for Medicaid
  - 25% qualify for 1915i (15)
- Individuals receive support services 24/7

FUTURE

- 15 individuals (qualify for 1915i) - Provider reimbursed for person-centered services based on individuals need

EXAMPLE →

- *An individual receives 2 hours of Care Coordination/3 days a week/biennium = $50,918.40*
  - *For 15 individuals = **$763,776***
- *An individual receives Peer Support 4 hours/week/biennium = $12,280.32*
  - *For 13 individuals = **$159,644.16***
- *An individual receives Supported Housing 1 hour/day/5 days a week = $21,819.20*
  - *For 12 individuals = **$261,830.40***
- *An individual receives Supported Employment 3 hours/week/biennium = $13,091.52*
  - *For 4 individuals = **$52,366.08***
- *Total amount billed to the provider = **$1,237,616.64***
  - *$618,808.32 general funds/biennium for the 15 individuals serviced*

In current budget most providers continue to receive 50% of the original amount - $500,000

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Outcomes of 1915i Implementation

- Individuals with highest need receive services that are more robust and targeted to their specific needs (person-centered).
- By leveraging other funds, the state is investing less funding yet providing more service to individuals with a behavioral health condition and providing opportunities for providers to expand services.
- Providers are able to bill for the specific services they are providing which allows greater opportunity to expand services and increase revenue.
- Behavioral health on par with health & sustainable.

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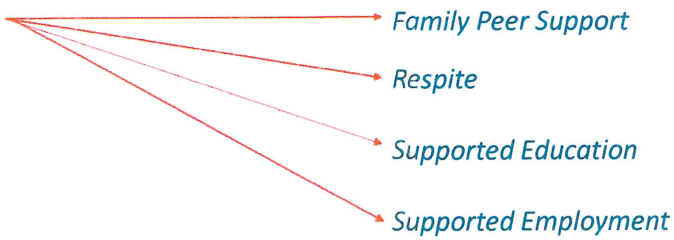
Example 2: School

FUTURE

EXAMPLE →

- *School-Based Care Coordinator*
  30 hours/40 weeks/biennium =
  $195,840



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Supporting Families

FUTURE

- ***Student struggles are often related to family issues.***
- ***Connecting family members to services can be significant for student success.***

EXAMPLE →

A family experiences homelessness due to parental mental illness. Connecting to care coordination providers of adult services will be vital.

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Expanded Behavioral Health Workforce

- 1915i services are provided by non-traditional behavioral health professionals
- Potential to improve access for workforce in rural areas
- Effectiveness of lived experience
- Career growth opportunities

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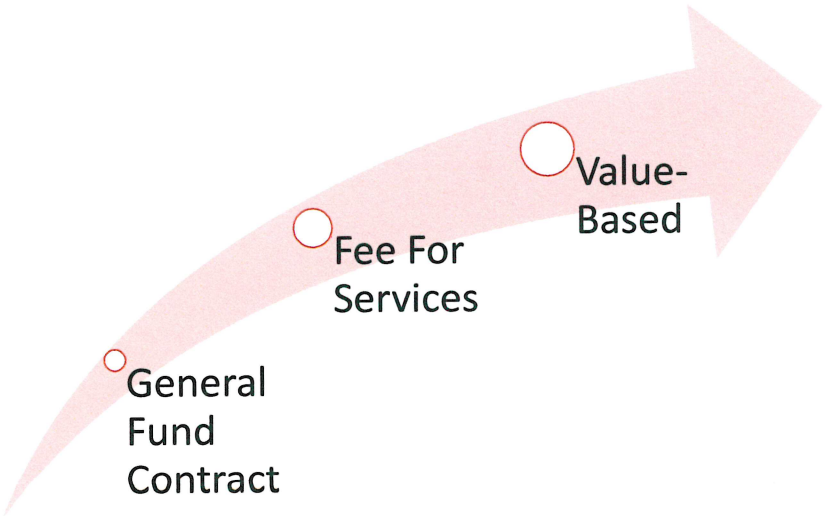
Reimbursement Roadmap



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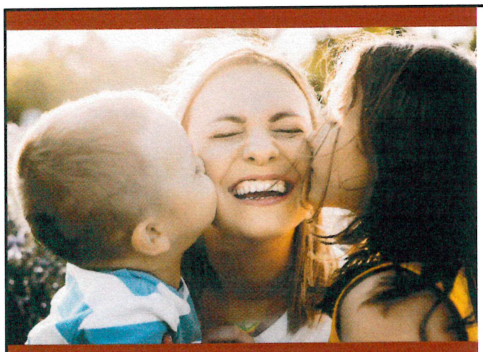

1915i Provider Enrollment

PROVIDERS ENROLLED

As of March 5, 2021

Candor Professional Services
- 1 individual provider

Community Options
- 41 individual providers

6 group providers approved; no individual providers enrolled yet
- Poppy's Promise
- Veridian Fiscal Solutions
- Keeping the Promise
- ShareHouse
- PATH North Dakota
- Success Unlimited

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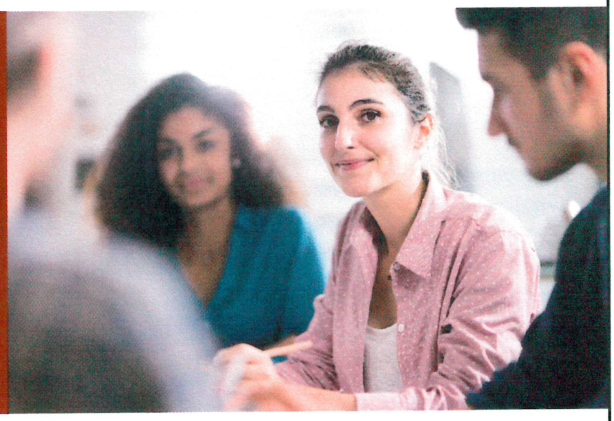
PROVIDER RESOURCES



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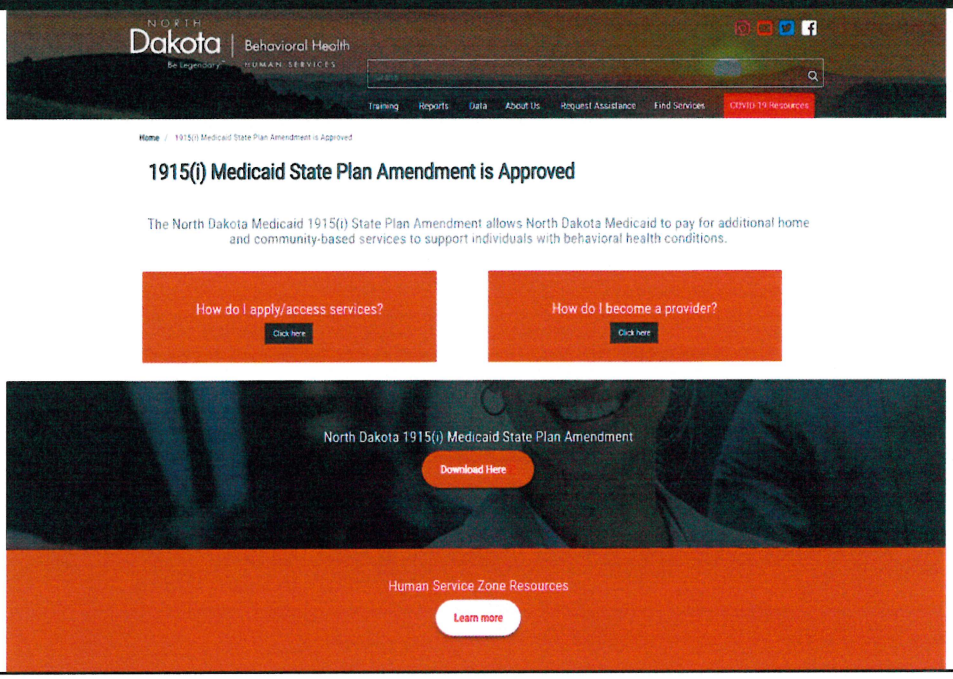
www.behavioralhealth.nd.gov/1915(i)



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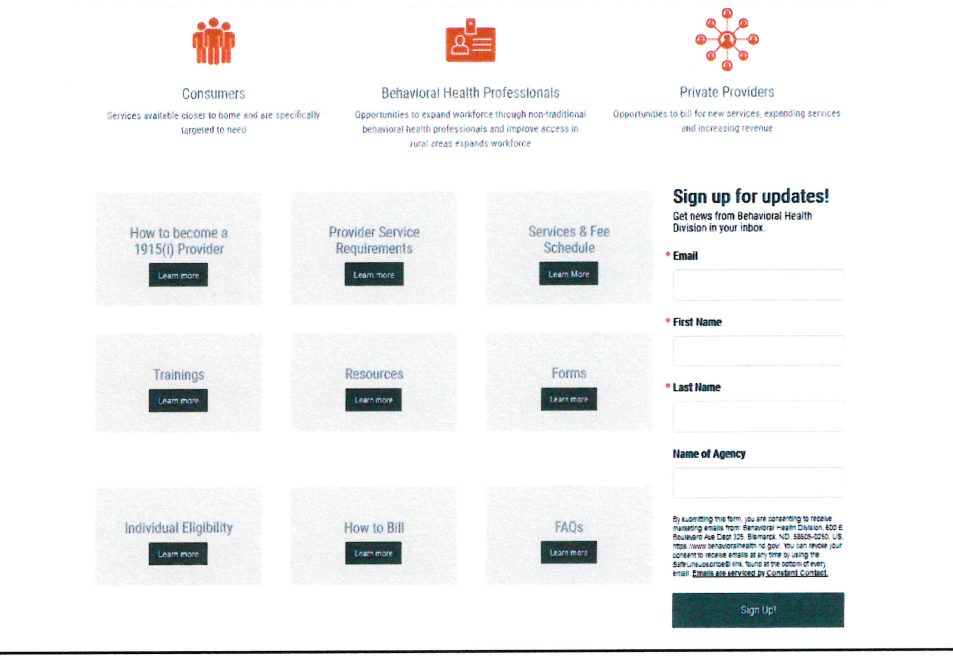
www.behavioralhealth.nd.gov/1915(i)



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Technical Assistance Calls for 1915(i) Providers

Medical Services and Behavioral Health Divisions are offering Technical Assistance for 1915(i) providers through a series of calls every Wednesday, beginning January 20, 2021, 1-2pm.
When

This training is offered online, every Wednesday from 1-2pm CT.

www.behavioralhealth.nd.gov/1915i/resources

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Substance Use Disorder (SUD) Voucher

21 Substance Use Disorder Treatment Programs are providing services through the SUD Voucher.

4,200+ individuals have been approved since inception of the SUD Voucher program.

GOALS: Improve access to quality services

	2015-2017	2017-2019	2019-2021
TOTAL BUDGET	$575,000	$4,917,087	$7,997,294
AMOUNT EXPENDED	$252,293.85	$8,288,293.05	$10,060,494.86 (as of March 3, 2021)

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Changes/Expansion

65th Legislative Session (2017)

Methadone maintenance was added as a covered service, effective July 1, 2017 **(HB 1012)**

66th Legislative Session (2019)

Providers who access the SUD Voucher were **expanded to public agencies** (i.e., public health and tribal agencies) who hold a substance abuse treatment program license - not including Human Service Centers. **(HB 1105)**

Eligibility age was changed from 18 to 14 years old, effective July 1, 2020. **(SB 2175)**

67th Legislative Session (2021)

House Bill 1402 is **proposed to allow providers in border states** to access the SUD Voucher for North Dakota citizens

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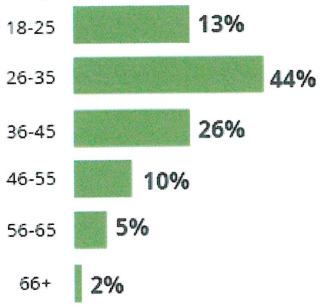
Substance Use Disorder (SUD) Voucher

From July 1, 2019 through Sept. 30, 2020, approximately 2,296 individuals have received services.

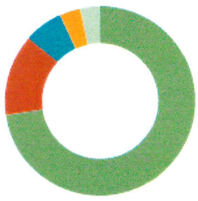
Gender

43.4% 56.6%

Age

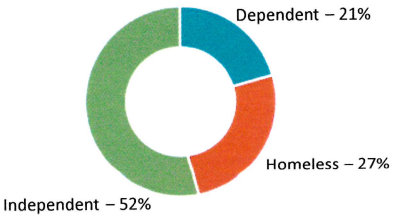


Race



- White - **73%**
- American Indian or Alaska Native - **19%**
- Black or African American - **5%**
- Hispanic or Latino - **3%**
- More than one race reported - **3%**
- Native Hawaiian or Other Pacific Islander - **0%**
- Asian - **0%**
- Prefer not to answer - **0%**

Living Environment



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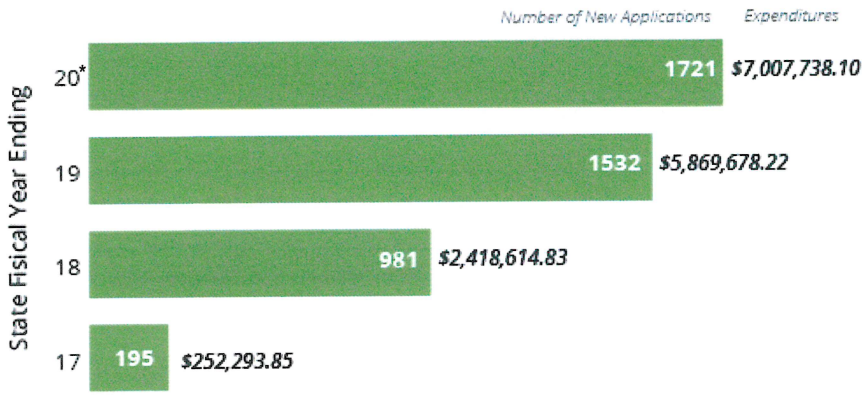
Program Participant Growth and Expenditures



*New applications closed July 1, 2020.

35

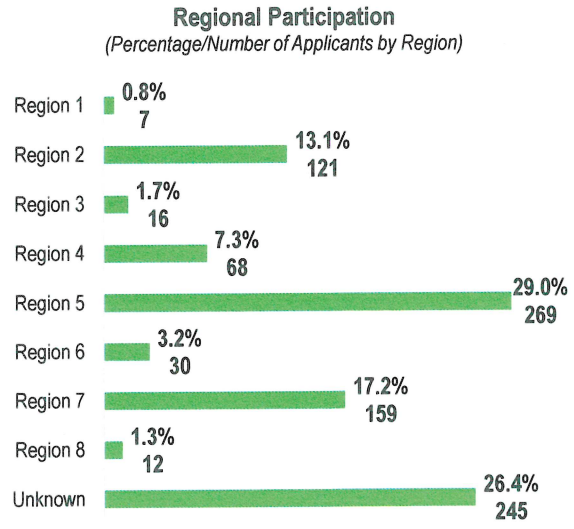
Appropriation and Expenditures

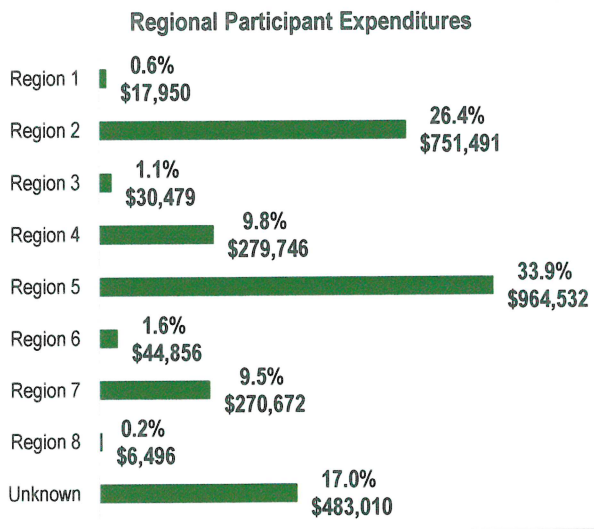
	2015-2017	2017-2019	2019-2021
Total Budget	$575,000	$4,917,087	$7,997,294
Amount Expended	$252,293.85	$8,288,293.05	$10,060,494.86 (as of March 3, 2021)

36

6 Month Snapshot: Regional Participation and Expenditures

Applicants approved from February 2020 to August 2020





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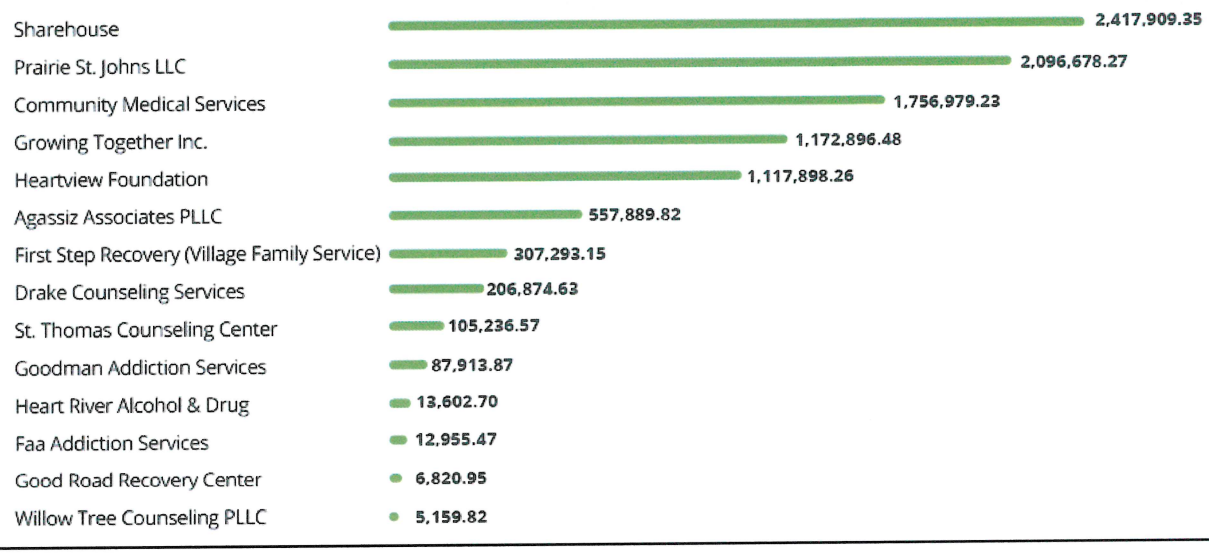
Total Voucher Reimbursements by Provider

The data below describes provider reimbursements from July 1, 2019 through December 11, 2020 ($9,866,108.57). Cumulative refunds received during this time totaled $219,292.81 for a net expenditure of $9,646,815.76.



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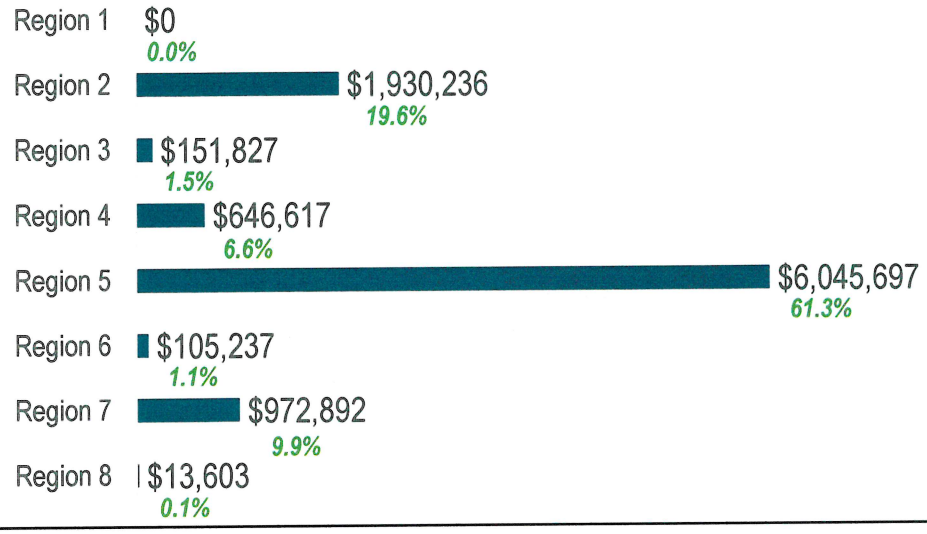
Regional Provider Reimbursements

July 1, 2019 – December 11, 2020



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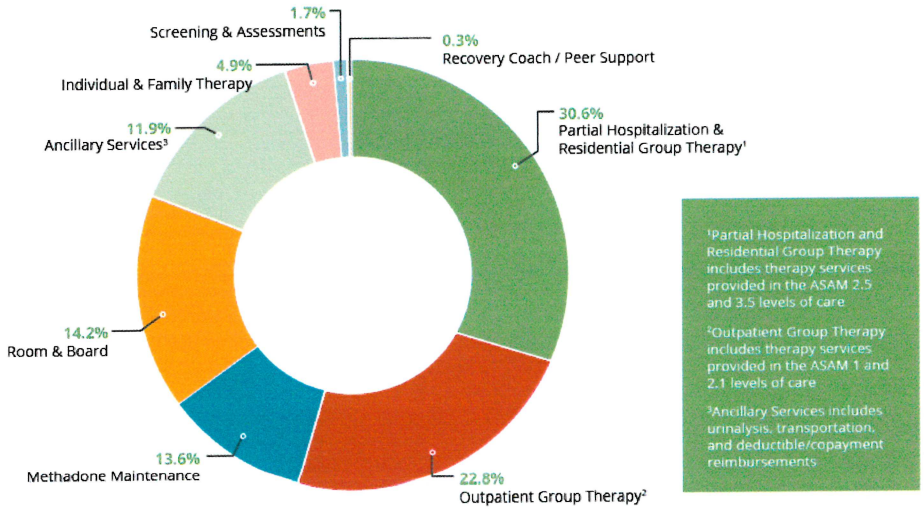
Expenditures by Service Type

Percentage of expenditures by service type from February 6, 2020 through December 11, 2020.



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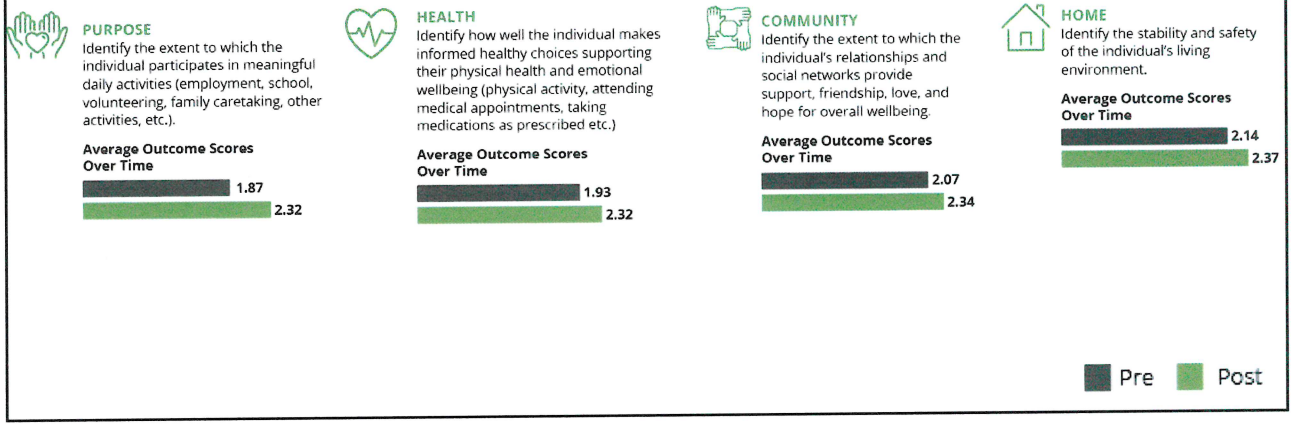
Since inception, all outcomes increased following services reimbursed through the SUD Voucher program.



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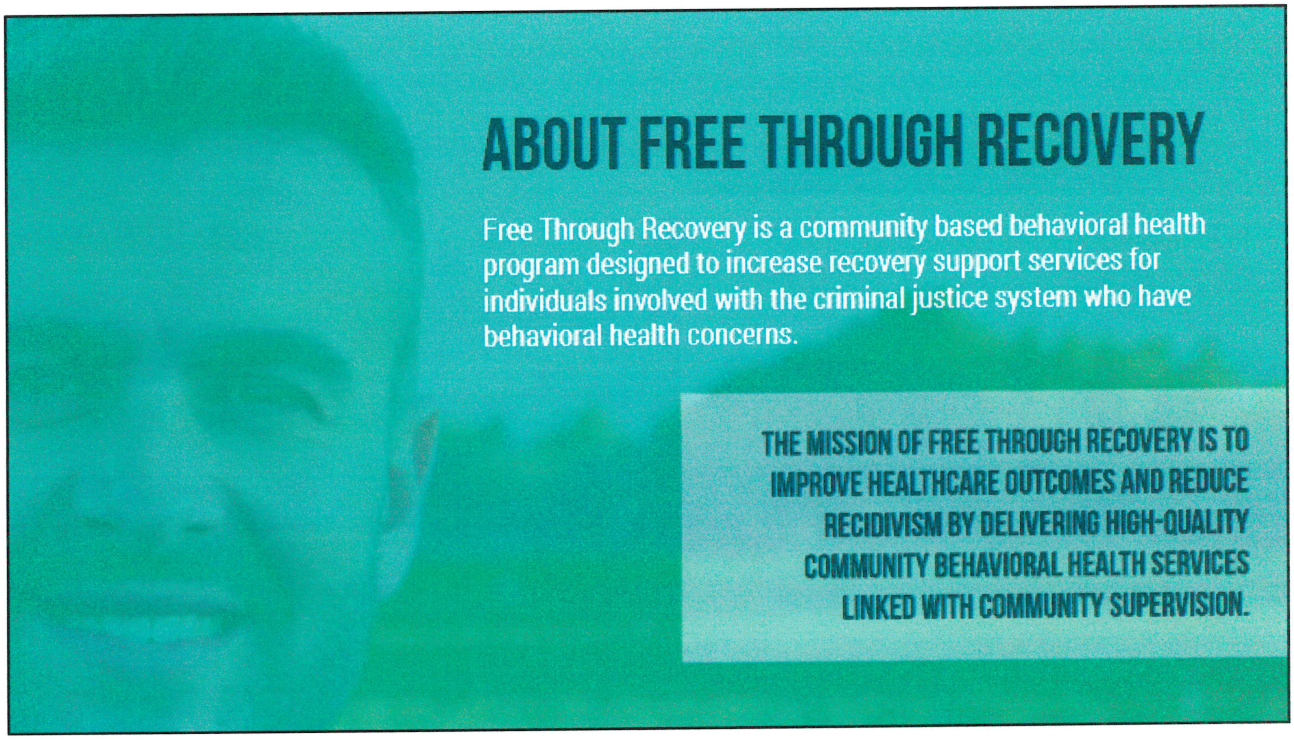

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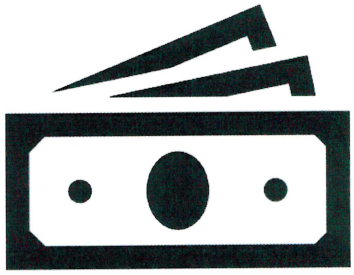
Pay for Performance Model

- Providers are paid a monthly base rate for each participant with the opportunity to receive performance pay if the participant meets at least 3 out of 4 monthly outcomes.



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Outcome Monitoring

Stable Housing

Is the person living in a residence that is supportive of their recovery?

Stable Employment

Is the person actively seeking or participating in employment?

Recovery

Is the participant demonstrating effort to reduce their substance use or the harm associated with their use and/or improve their mental health functioning.

Criminal Justice

Did the participant avoid law enforcement involvement resulting in arrest, criminal charge, or probation violation resulting in initiation of revocation?

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FREE THROUGH Recovery

Overall, from March 2018 through March 2, 2021, providers earned performance pay for 68.5% of their participants.

- 3,026 Individuals have Participated
- 995 Current Active Participants
- 35 Current Providers

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Community-Based Behavioral Health Program



In October 2020, the North Dakota Emergency Commission and Budget Section approved the Department of Human Services' Behavioral Health Division request for $1.7 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funding for the development of a Community-Based Behavioral Health Program.

Program Goal: reduce need for treatment in congregate settings, such as residential treatment facilities, inpatient hospitalizations and emergency medical interventions.

	Number of PROVIDERS	Number of INDIVIDUALS
Substance Use Disorder Treatment Services	11	98
Care Coordination Services	35	178

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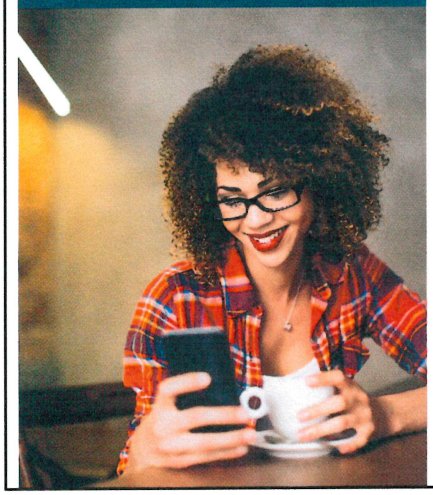
Peer Support Certification



The ND 66th Legislative Assembly passed Senate Bill 2012 giving the Behavioral Health Division authority to develop and implement a program for the certification of peer support specialists.

Administrative Rules 75-03-43 were promulgated and outlines the requirements and process for two levels of Peer Support Specialist certification:

- Certified Peer Support Specialist I (CPSS I)
  - **43 CPSS I (as of March 2, 2021)**
- Certified Peer Support Specialist II (CPSS II)
  - **12 CPSS II (as of March 2, 2021)**

Since 2018 the Behavioral Health Division hosted 21 ***trainings*** *and trained over* ***506 individuals.***

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Behavioral Health and Education

Prevention and Early Intervention Pilot	Behavioral Health School Grant Program	Behavioral Health Resource Support (B-HERO)
The ND 66th Legislative Assembly passed Senate Bill 2012 appropriating $300,000 to the Department of Human Services for the purpose of establishing a children's prevention and early intervention behavioral health services pilot project in the school system; including services to children suffering from the effects of behavioral health issues.	*The ND 66th Legislative Assembly passed Senate Bill 2012 appropriating $1,500,000 to the Department of Human Services for the purpose of providing behavioral health services and support grants to school districts to address student behavioral health needs.*	*The ND 66th Legislative Assembly passed Senate Bill 2149 which established the requirement for each school within a district to designate an individual as a behavioral health resource coordinator and Senate Bill 2313 which established the requirement for DHS to provide resources to behavioral health resource coordinators.*
October 2018 - Pilot project to Simle Middle School in Bismarck. October 2020 – Pilot project expansion awarded to Dunseith Public School (tribal) and Barnes County North Public School (rural).	25 schools utilized ND State Medicaid reimbursement during the previous school year and are eligible for funding. **12 grant applications have been received and awarded from 7 schools** (3/5/2021)	The Central Regional Education Association (CREA) was awarded the contract (through a Request for Proposal) to provide resources, information, and support to school behavioral health resource coordinators at each school in North Dakota, collaborating with the Behavioral Health Division.

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CommunityConnect
My Recovery. My Story.

July 2019 – June 2020
Program Development

Fall 2020
Hiring & Branding

January 2021
MOAs to Providers & Provider Training

February 2021
Program Soft Launch

MISSION: provide quality, community-based behavioral health services that promote collaboration and partnership to meet the individual needs of every person served.

To be **eligible** for the program individuals must be 18 years of age or older, reside in North Dakota, and have a mental health or substance use disorder diagnosis that is impacting their functionality in domains including housing, employment/financial, physical health, and community connections.

Priority will be given to the following populations: Parents and caregivers, parents and caregivers with child protection services involvement, pregnant women, Individuals that utilize emergency and detox centers, individuals who are homeless or at risk of homelessness, individuals who use drugs intravenously

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COVID-19 Behavioral Health Supports

Crisis Counseling, Assistance and Training Program (CCP Grant)

- Project Renew

Emergency COVID-19 Grant

- Support for Healthcare providers (Sanford Health, "Reach for Resilience")
- Addiction treatment (Sharehouse and Heartview)
- Mental health treatment (Agassiz Associates)
- Crisis support (Field Services)

Help is here

Resources: www.behavioralhealth.nd.gov/helpishere

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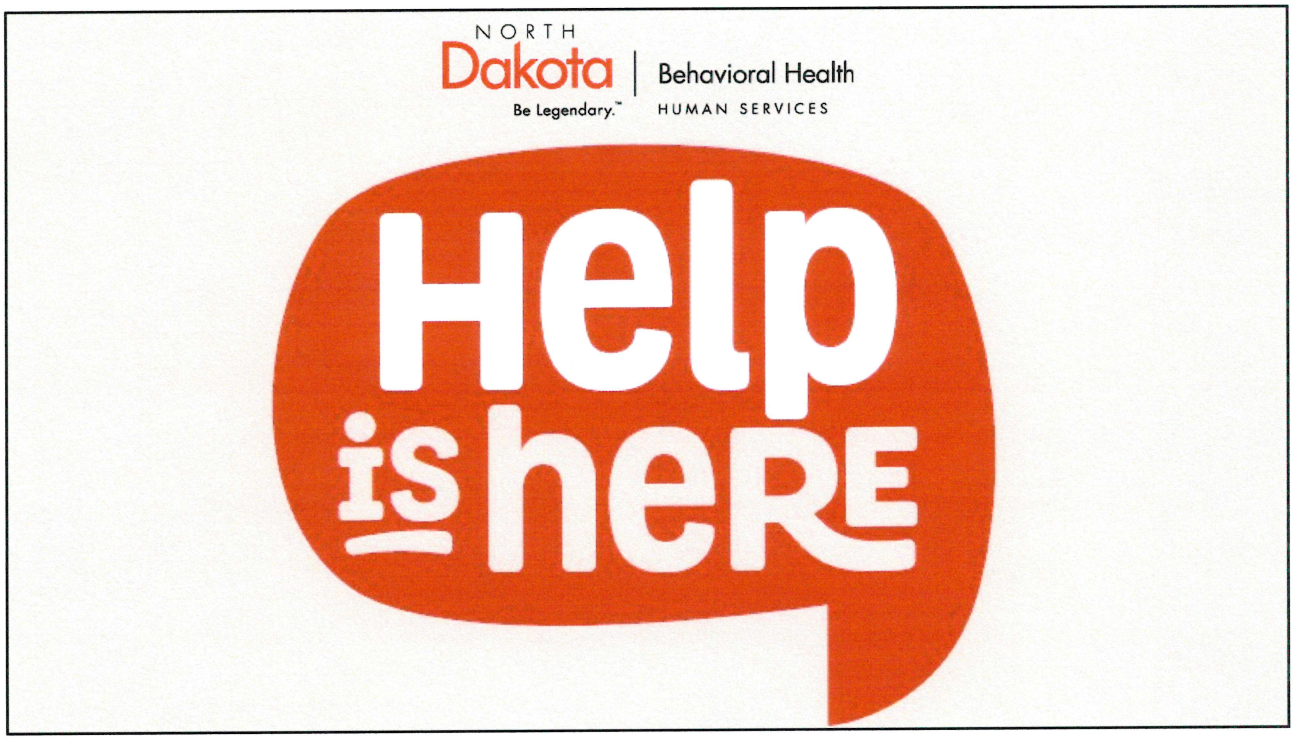
NORTH
Dakota
Be Legendary.
Behavioral Health
HUMAN SERVICES
Help
is here

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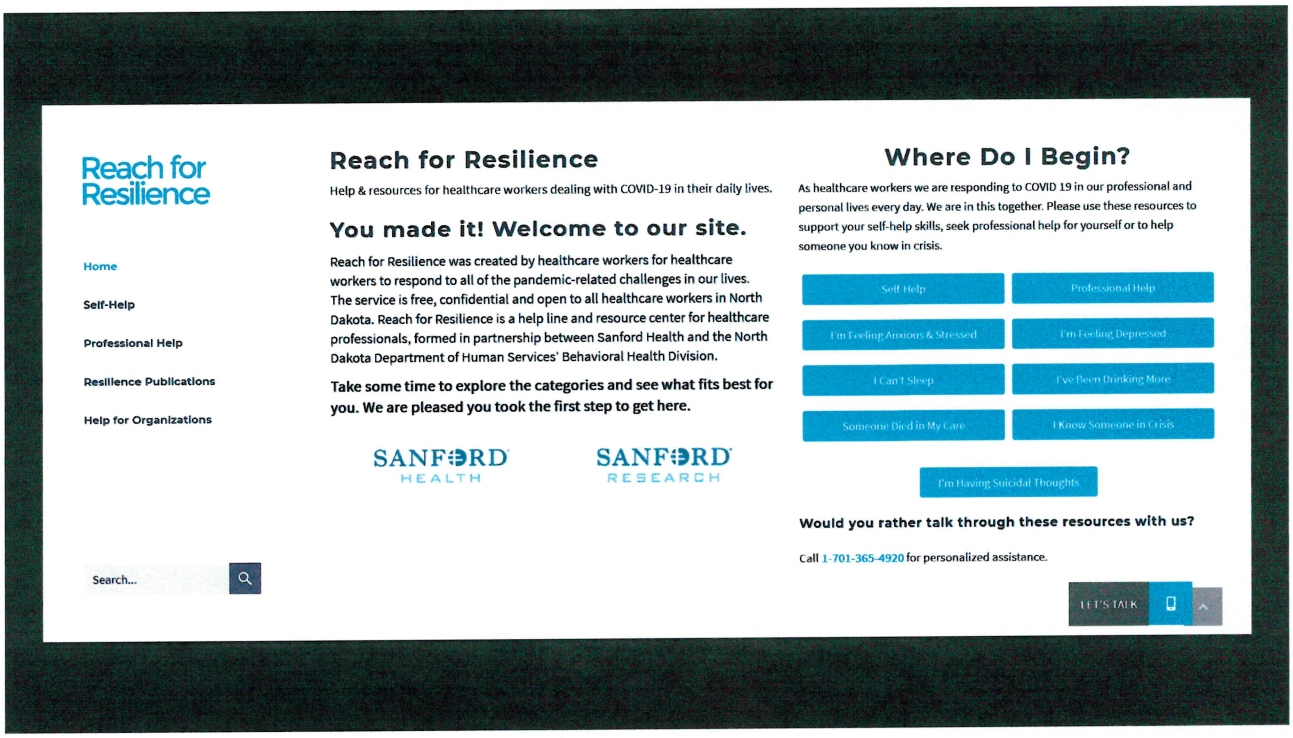
Reach for Resilience
Home
Self-Help
Professional Help
Resilience Publications
Help for Organizations
Search...
Reach for Resilience
Help & resources for healthcare workers dealing with COVID-19 in their daily lives.
You made it! Welcome to our site.
Reach for Resilience was created by healthcare workers for healthcare workers to respond to all of the pandemic-related challenges in our lives. The service is free, confidential and open to all healthcare workers in North Dakota. Reach for Resilience is a help line and resource center for healthcare professionals, formed in partnership between Sanford Health and the North Dakota Department of Human Services' Behavioral Health Division.
Take some time to explore the categories and see what fits best for you. We are pleased you took the first step to get here.
SANFORD HEALTH
SANFORD RESEARCH
Where Do I Begin?
As healthcare workers we are responding to COVID 19 in our professional and personal lives every day. We are in this together. Please use these resources to support your self-help skills, seek professional help for yourself or to help someone you know in crisis.
Self Help
Professional Help
I'm Feeling Anxious & Stressed
I'm Feeling Depressed
I Can't Sleep
I've Been Drinking More
Someone Died in My Care
I Know Someone in Crisis
I'm Having Suicidal Thoughts
Would you rather talk through these resources with us?
Call 1-701-365-4920 for personalized assistance.
LET'S TALK

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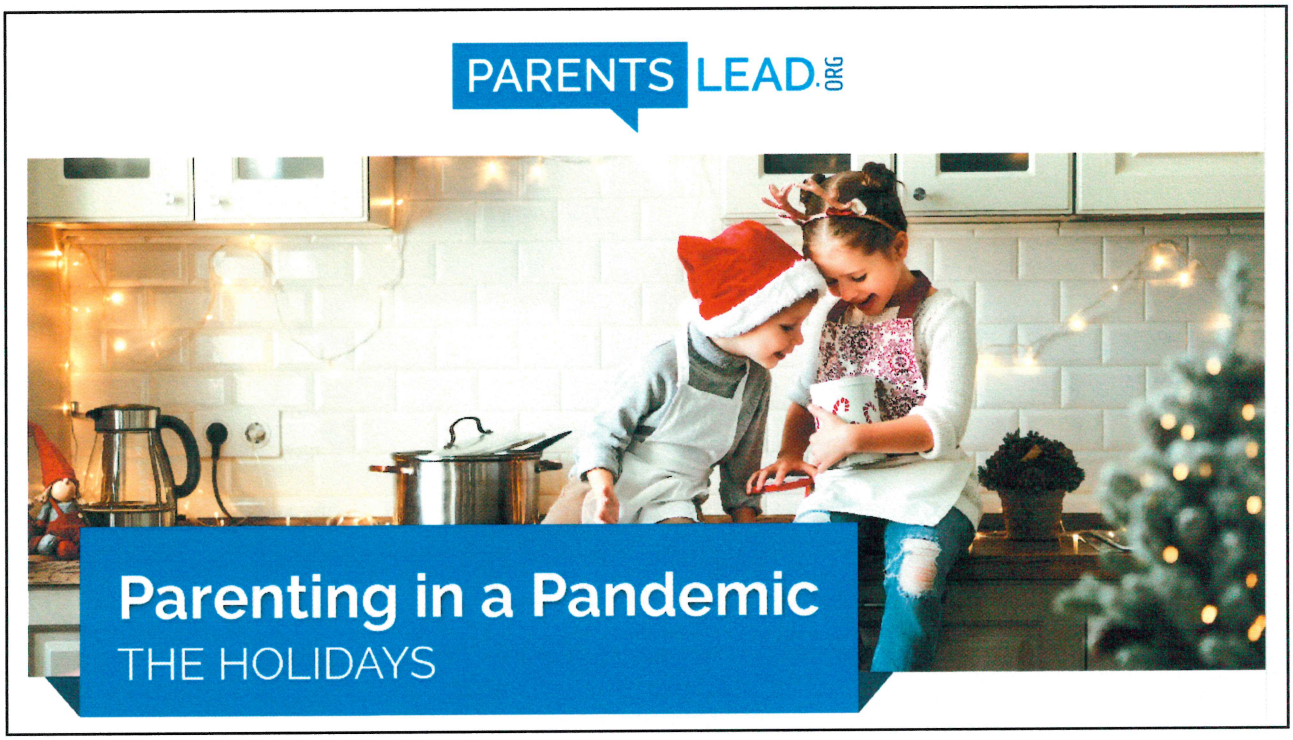

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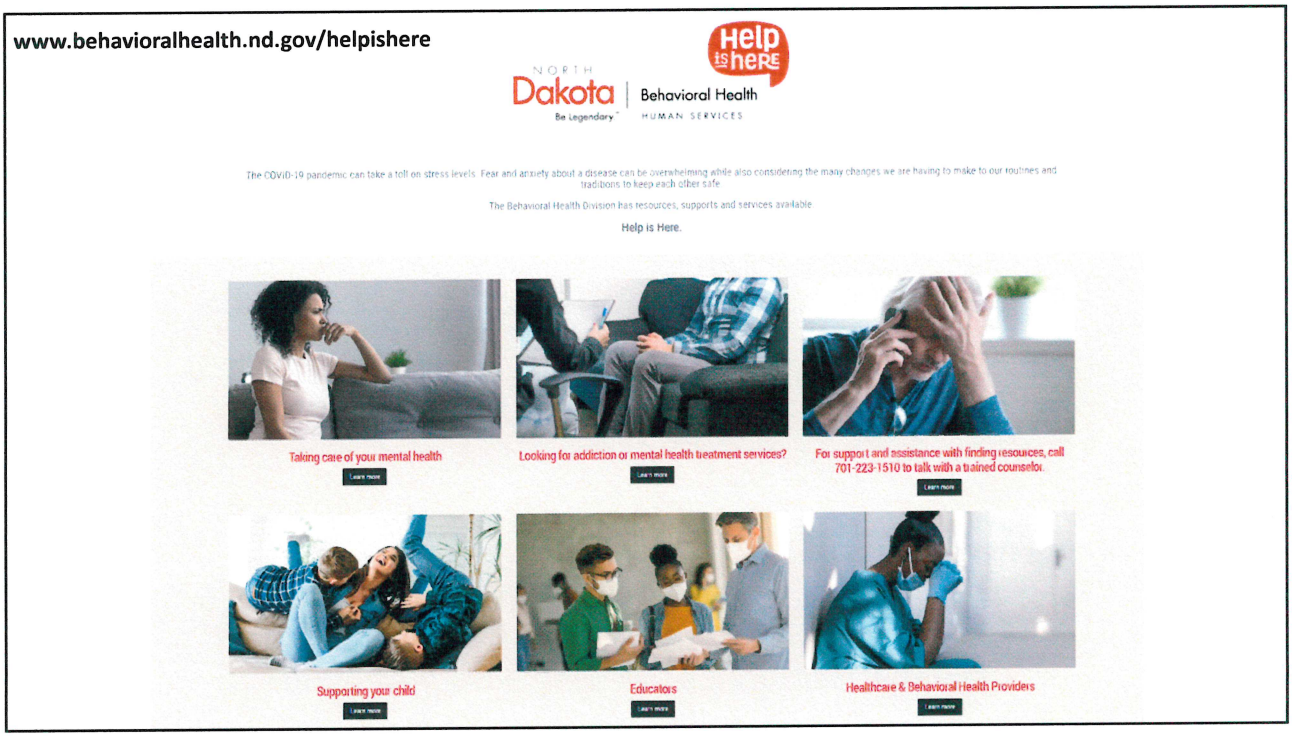
www.behavioralhealth.nd.gov/helpishere



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NORTH Dakota | Human Services
Be Legendary.

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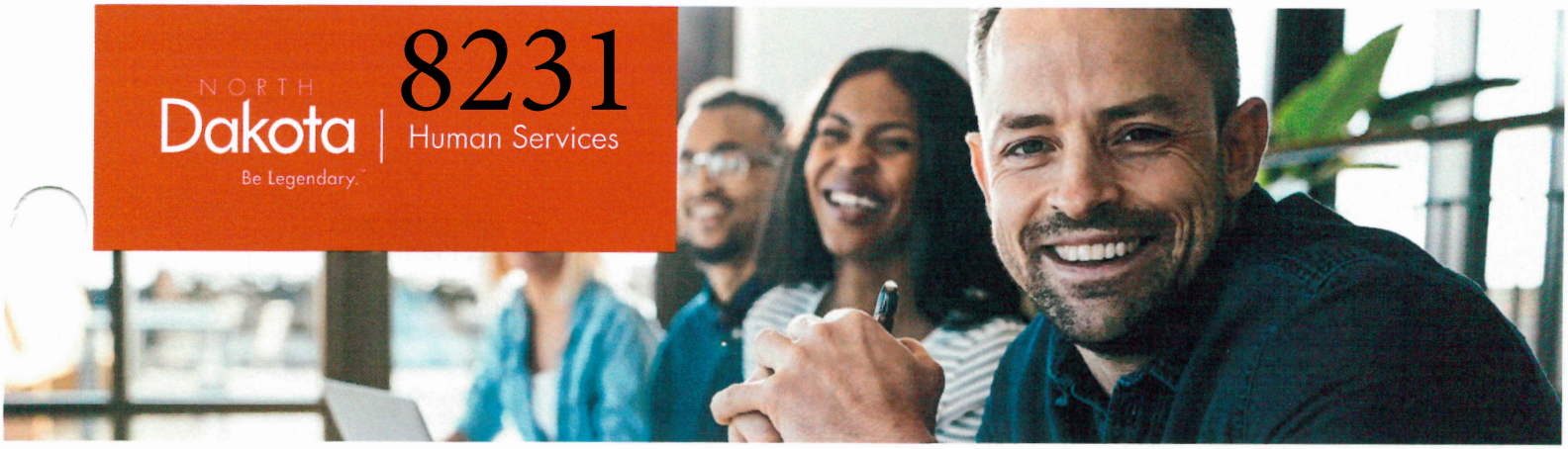

North Dakota Prevalence of Behavioral Health Conditions

	Adults
Addiction	8.9%
Mental Illness	19.1%
Brain Injury	2%

The 1915(i) will serve a subset of this population, based Medicaid eligibility and functional impairment

Medicaid 1915(i) State Plan Amendment

During the 2019 legislative session, North Dakota lawmakers authorized the Department of Human Services to create a Medicaid 1915(i) State Plan Amendment. The amendment allows North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions.

Based on the 2018 North Dakota Behavioral Health System Study, three keys to reforming North Dakota's behavioral Health system were identified:

- **Support the full Continuum of Care**
- **Increase Community-Based ServicesPrevent**
- **Criminal Justice Involvement for Individuals with a Behavioral Health Conditions**

The implementation of the Medicaid 1915(i) State Plan Amendment supports these keys and also aligns with the 2018 North Dakota Behavioral Health System Study recommendation 12.2: Pursue 1915(i) Medicaid state plan amendments.

BENEFITS OF 1915(i)

Consumers
Services available closer to home and are specifically targeted to need

Behavioral Health Professionals
Opportunities to expand workforce through non-traditional behavioral health professionals and improve access in rural areas expands workforce

Private Providers
Opportunities to bill for new services, expanding services and increasing revenue

TIMELINE

SEPTEMBER 2019
OCTOBER 2019

Pubic Input Meetings
Review of Public Input

NOVEMBER 2019
MARCH 2020

Development of Application Draft
Public Comment of Application Draft
1915(i) Application Draft Webinar

APRIL 2020

Review of Public Comments
Submit Application to CMS

FEBRUARY 2020
JULY 2020

Development of Provider Enrollment Process

AUGUST 2020

Provider Enrollment Orientation

SEPTEMBER 2020
OCTOBER 2020

1915(i) Services Orientation

JANUARY 2021
FEBRUARY 2021

CMS approval (January 20)
Go-live date (February 16)

For individuals to be eligible to receive services reimbursed through the Medicaid 1915(i) State Plan Amendment, individuals must meet the following criteria:

- Age 0+; and
- Currently enrolled in ND Medicaid or Medicaid Expansion; and
- Meet Federal Poverty Level of 150% or below; and
- Receive a WHODAS score of 50 or above; and
- Reside in and will receive services in a setting meeting the federal home and community-based setting requirements, and
- Have a diagnosis of substance use disorder, mental illness or brain injury.

The following services are approved through the 1915(i):

- Care Coordination
- Training and Supports for Caregivers
- Community Transitional Services
- Benefits Planning
- Non-Medical Transportation
- Respite
- Prevocational Training
- Supported Education
- Supported Employment
- Housing Support Services
- Peer Support
- Family Peer Support

What is the process for receiving services under the 1915(i)?

1. Individual is approved for Medicaid or Expansion
2. Individual is approved for 1915i
   - Diagnosis, Community Setting, Functional Impairment
3. Care Coordination Agency develops a Person-Centered Care Plan
4. Individual receives services identified in their individualized care plan
5. Quarterly meetings with the Care Coordinator to assess implementation of the plan and ongoing needs
6. Annual eligibility renewal

Visit **behavioralhealth.nd.gov/1915i** for more information.

8211



House Bill 1012
Medical Services Budget- Traditional

Senate Appropriations

Caprice Knapp, PhD Medical Services Director

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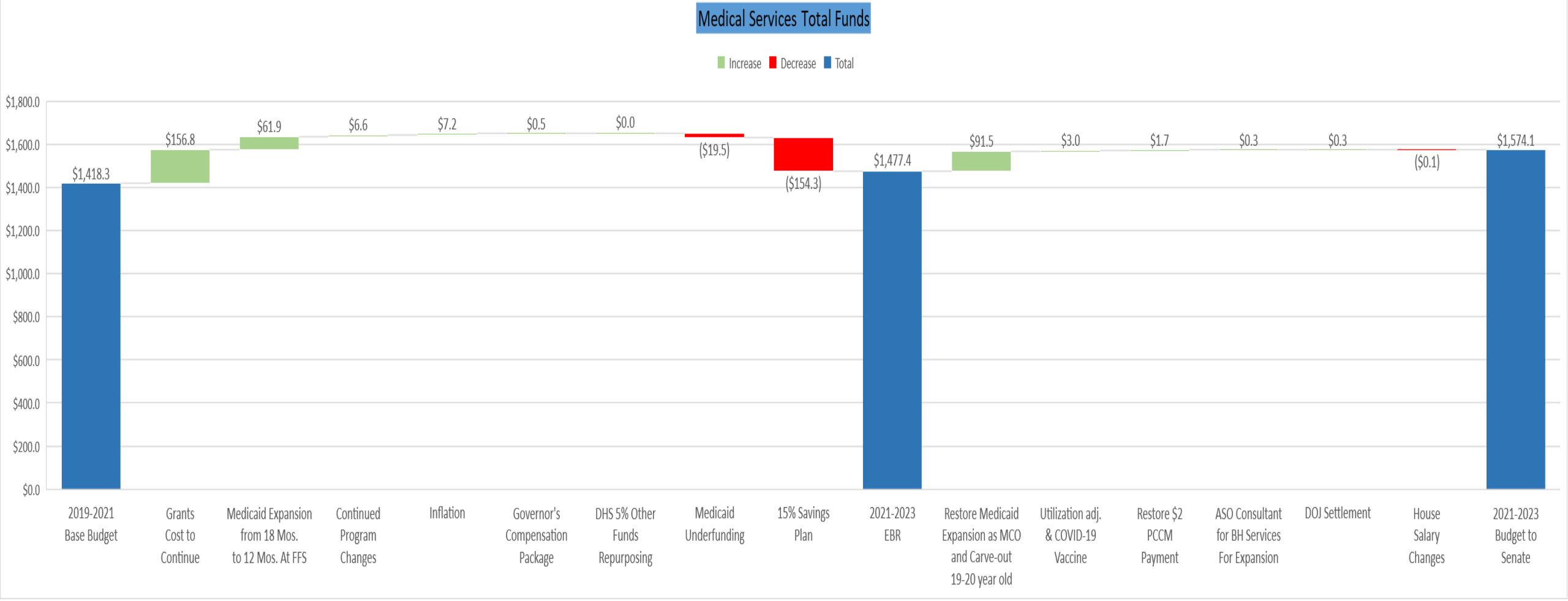
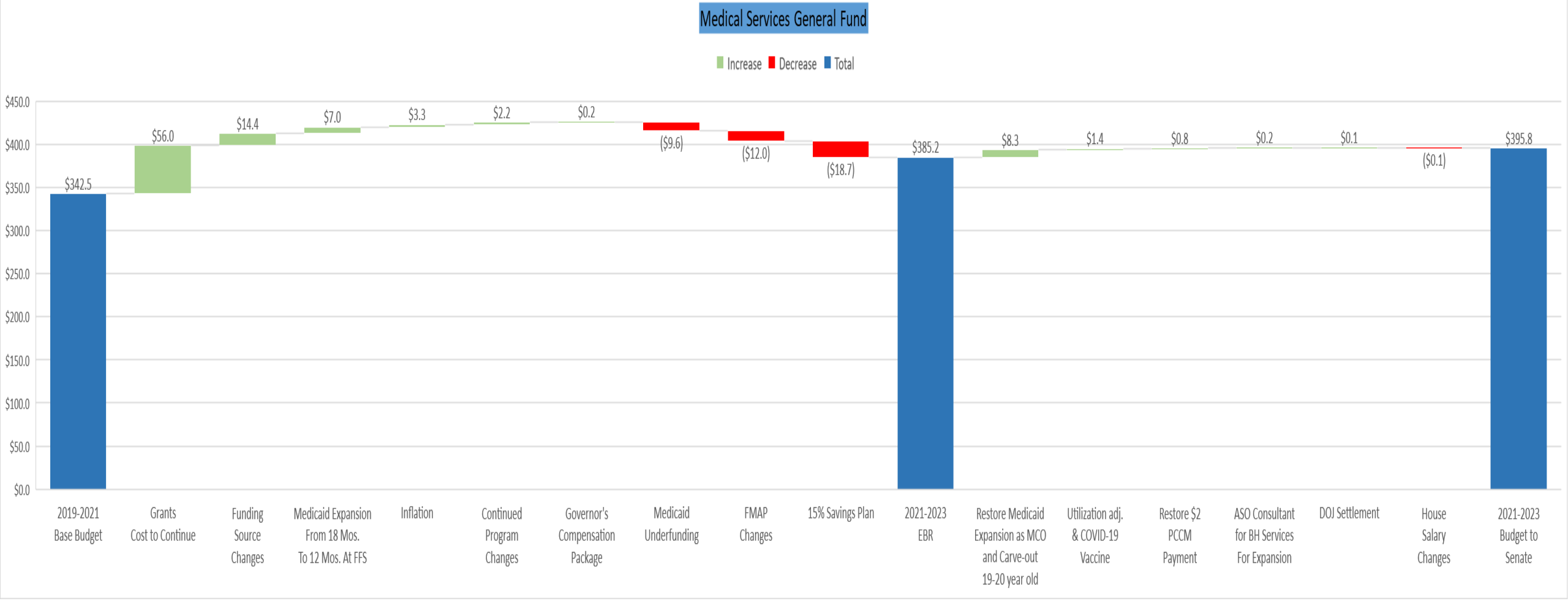
OVERVIEW OF BUDGET

Description	2019-2021 Appropriation	Increase/ (Decrease)	2021-2023 Executive Budget	House Changes Increase/ (Decrease)	2021 – 2023 Budget to Senate
Salary and Wages	17,623,821	839,862	18,471,683	(1,460,576)	17,011,107
Operating	48,290,789	8,712,126	57,002,915	234,155	57,237,070
Medical Grants	1,352,417,879	49,551,425	1,401,969,304	97,842,635	1,499,811,939
Total	1,418,332,489	59,111,413	1,477,443,902	96,616,214	1,574,060,116
General Fund	342,465,788	42,758,835	385,224,623	10,618,395	395,843,018
Federal Funds	977,292,683	30,619,126	1,007,911,809	85,997,819	1,093,909,811
Other Funds	98,574,018	(14,266,548)	84,307,470	0	84,307,470
Total	1,418,332,489	59,111,413	1,477,443,902	96,616,214	1,574,060,116
Full Time Equivalent (FTE)	86.50	12.00	98.50	(11.50)	87.00

OVERVIEW OF BUDGET CHANGES TOTAL FUNDS (IN MILLIONS)

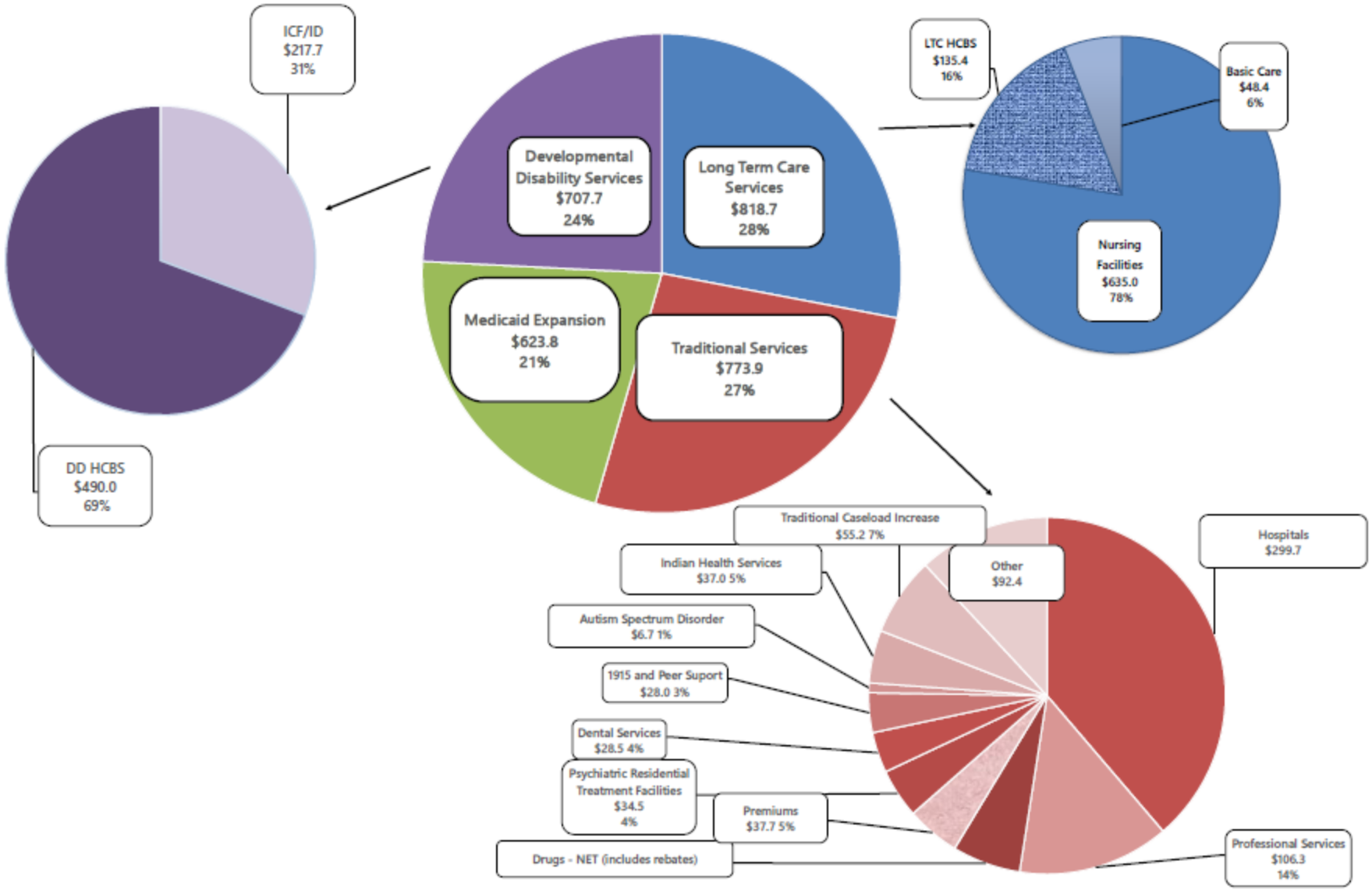


OVERVIEW OF BUDGET CHANGES GENERAL FUND (IN MILLIONS)



Human Services
2021-2023 Executive Budget
Medical Assistance Grants $2,924.2M

(expressed in millions)



2021-23 EXECUTIVE FUNDING REQUEST

- $35,000,000 Budget **(90% Medicaid Match)**
  - Target 2 Modules
- Establish Large IT Oversite – May 2021
- Release RFP in 2021
  - Systems Integrator
  - Independent Verification and Validation (IV&V) Services
  - Module 1
- Release RFP in 2022 – Module 2

MMIS Modernization			
	Total	**Federal**	**State**
MMIS	$ 35,000,000	$ 30,673,314	$ 4,326,686

PCCM $2 PMPM ELIMINATION



Estimated Total Potential Savings **$1,652,240**

Elimination of PCCM PMPM Payments			
	Total	**Federal**	**State**
Primary Care Case Management	$ (1,652,240)	$ (882,371)	$ (769,869)

DENTAL ACCESS PROJECT



Estimated Total Potential Savings **$40,000**

Elimination of Dental Access Project (loan repayment for dentists who serve a high proportion of Medicaid members)			
	Total	**Federal**	**State**
Dental Access Project	$ (40,000)		$ (40,000)

REMEDIAL EYE PROGRAM, PRTF

Estimated Total Potential Savings **$1,401,399**

Elimination of Remedial Eye, PRTF Payments			
	Total	**Federal**	**State**
Remedial Eye Program	$ (5,000)	$ (0)	$ (5,000)
PRTF Utilization	$ (1,396,398)	$ (745,834)	$ (650,565)

VALUE BASED PURCHASING FOR HOSPITALS



Estimated Total Potential Savings **$6,250,000**

Value Based Purchasing for Hospitals			
	Total	**Federal**	**State**
Value-Based Purchasing	$ (6,250,000)	$ (4,687,500)	$ (1,562,500)

Thank you!

North Dakota Medicaid



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Long-Term Care Budget- House Bill 1012

Senate Appropriations

Caprice Knapp, PhD Medical Services Director
Nancy Nikolas-Maier Aging Services Director

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Funding Requests

Nursing Home Payment Reform

- Reform of both care and property rate methodology
- Interim report submitted October 1, 2020
- Policy testimony will be presented in **Human Services Committee**
- DHS sponsored bill- House Bill 1090
- $7.2 million ($3.3m General; $3.8m Federal)

Nursing Home Bed Buy Back

- Request to purchase beds out of the current nursing home system and layaway
- State plans to pay between $12,000-$15,000 per bed
- Taking beds out of the system reduces future State liability
- $3.3m in General Funds



Services Closer to Home

Create pathways that help people access the right service at the right time

Engage proactively with providers to expand access to services



High-Performing Organization

Develop an adaptable, capable and mission driven workforce

Balance resources to achieve strategic goals

SAVINGS PACE RATES & ENROLLMENT



Estimated Total Potential Savings **$1,914,734**

Reduce PACE Rates & Enrollment

	Total	Federal	State
PACE Capitated Rate Reduction	$ (1,385,545)	$ (740,194)	$ (645,351)
PACE Enrollment Reduction	$ (529,189)	$ (282,709)	$ (246,480)
TOTAL POTENTIAL SAVINGS	**$ (1,914,734)**	**$ (1,022,903)**	**$ (891,831)**

BASIC CARE SAVINGS



Estimated Total Potential Savings **$7,300,000**

Basic Care Reduction			
	Total	**Federal**	**State**
Basic Care	$ (7,300,000)	$ (0)	$ (7,300,000)

SUMMARY OF AUTISM CHANGES

Estimated Total Potential General Fund Savings **$623,000**

- **Autism Voucher** = **$1.358 million** general fund savings by eliminating
- **Autism Waiver** = **$830,000 increase** in general funds for **increase of 54 slots** and state plan services
- **Autism Training funds** = **$93,000** in general fund savings by eliminating

ELIMINATION OF TECHNOLOGY DEPENDENT WAIVER

Estimated Total Potential Savings **$596,112**

Elimination of TECH DEPENDENT WAIVER

	Total	Federal	State
Tech Dependent Waiver	**$ (596,112)**	$ (318,560)	$ (277,552)

OVERVIEW OF LONG-TERM CARE BUDGET CHANGES

Description	Budget 2019-2021	Increase/ (Decrease)	Executive Budget 2021-2023	Increase/ (Decrease)	2021 – 2023 Budget to Senate
Grants	853,200	(330,000)	523,200	0	523,200
Medical Grants	736,510,531	85,531,242	822,041,773	(10,168,079)	811,873,694
Total	**737,363,731**	**85,201,242**	**822,564,973**	**(10,168,079)**	**812,396,894**
General Fund	377,567,931	26,612,730	404,180,661	(5,198,006)	398,982,656
Federal Funds	356,199,438	61,872,874	418,072,312	(5,970,073)	412,102,238
Other Funds	3,596,362	(3,284,362)	312,000	1,000,000	1,312,000
Total	**737,363,731**	**85,201,242**	**822,564,973**	**(10,168,080)**	**812,396,894**
Full Time Equivalent (FTE)	0.00	0.00	0.00	0.00	0.00

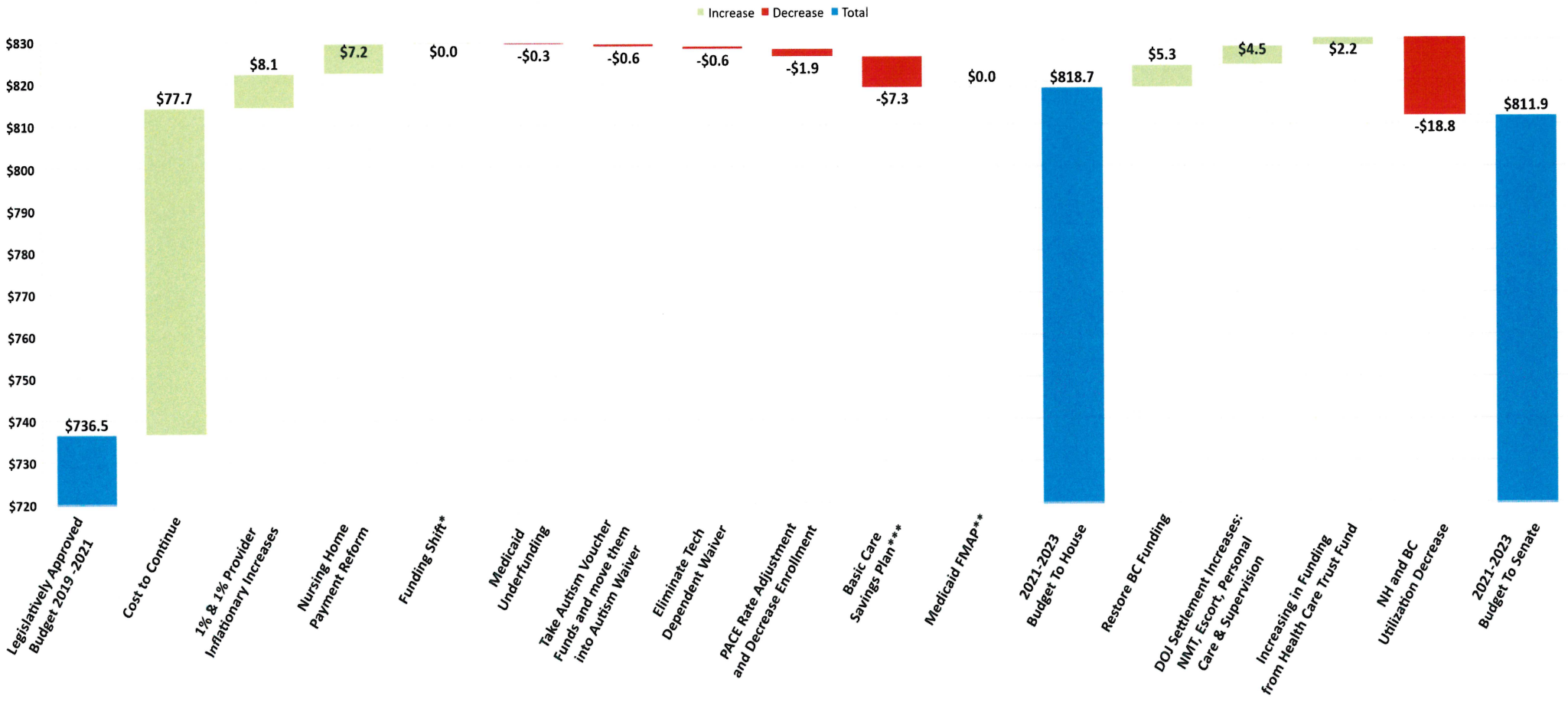
LONG-TERM CARE WALKTHROUGH

Service Description	Legislatively Approved Budget 2019 - 2021	Funding Shift	Cost to Continue	Medicaid FMAP	Take Autism Voucher Funds and move them into Autism Waiver	Basic Care Savings Plan	Eliminate Tech Dependent Waiver	PACE Rate Adjustment and Decrease Enrollment	Total Changes	2021-2023 Budget To OMB	1% & 1% Provider Inflationary Increases	Nursing Home Payment Reform	Medicaid Underfunding	Total Governor Changes	2021-2023 Budget To House
Nursing Facilities	582,849,867		39,676,637						39,676,637	622,526,504	5,646,947	7,200,000		12,846,947	635,373,451
Underfunding	(20,000,000)		20,000,000						20,000,000	0			(330,000)	(330,000)	(330,000
Total Nursing Facilities	**562,849,867**	**0**	**59,676,637**	**0**	**0**	**0**	**0**	**0**	**59,676,637**	**622,526,504**	**5,646,947**	**7,200,000**	**(330,000)**	**12,516,947**	**635,043,451**
Basic Care	49,555,981		5,717,765			(7,300,000)			(1,582,235)	47,973,746	439,126			439,126	48,412,872
Home & Community Based Services	**124,104,683**	**0**	**12,304,310**	**0**	**(645,673)**	**0**	**(596,112)**	**(1,914,734)**	**9,147,791**	**133,252,474**	**2,032,976**	**0**	**0**	**2,032,976**	**135,285,450**
SPED	17,799,841		2,020,479			0			2,020,479	19,820,320	298,683			298,683	20,119,003
Ex-SPED	1,844,963		(10,073)			0			(10,073)	1,834,890	27,782			27,782	1,862,672
Personal Care Services	34,483,377		(3,206,937)			0			(3,206,937)	31,276,440	470,710			470,710	31,747,150
Targeted Case Management	1,917,742		(1,763,206)			0			(1,763,206)	154,536	2,326			2,326	156,862
Home & Comm Based Service Waiver	30,104,751		14,492,777			0			14,492,777	44,597,528	683,636			683,636	45,281,164
Children's Medically Fragile Waiver	544,416		(154,680)			0			(154,680)	389,736	5,866			5,866	395,602
Technology Dependent Waiver	591,288		4,824			0	(596,112)		(591,288)	0	0			0	0
PACE	32,866,676		1,946,562			0		(1,914,734)	31,828	32,898,504	509,262			509,262	33,407,766
Children's Hospice Waiver	61,848		10,224			0			10,224	72,072	1,085			1,085	73,157
Autism Waiver	2,564,772		(1,068,804)		712,480				(356,324)	2,208,448	33,626			33,626	2,242,074
Autism Voucher	1,325,009		33,144		(1,358,153)				(1,325,009)	0				0	0
	0		0												
Excess Federal Authority	0		0						0	0				0	0.00
Total	**736,510,531**	**0**	**77,698,712**	**0**	**(645,673)**	**(7,300,000)**	**(596,112)**	**(1,914,734)**	**67,242,193**	**803,752,724**	**8,119,049**	**7,200,000**	**(330,000)**	**14,989,049**	**818,741,773**
General Fund	**376,714,731**	**1,000,000**	**40,219,973**	**(17,377,698)**	**(1,026,852)**	**(5,015,638)**	**(277,552)**	**(891,831)**	**16,630,402**	**393,345,133**	**3,994,328**	**3,348,000**	**(330,000)**	**7,012,328**	**400,357,461**

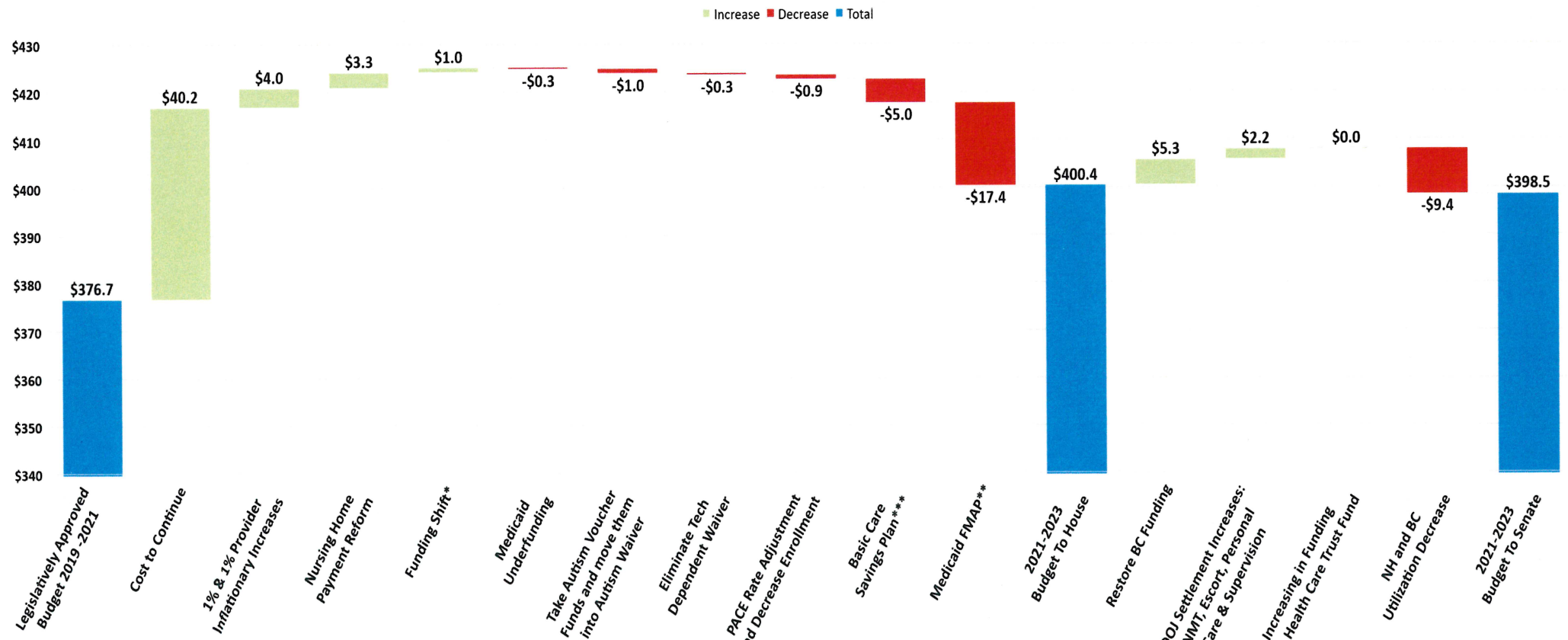
LONG-TERM CARE WALKTHROUGH

Service Description	**2021-2023 Budget To House**	NH and BC Utilization Decrease	Restore BC Funding	Increasing in Funding from Health Care Trust Fund	DOJ Settlement Increases: NMT, Escort, Personal Care & Supervision	Total House Changes	**2021-2023 Budget To Senate**
Nursing Facilities	635,373,451	(15,831,421)	0	2,150,538	0	(13,680,883)	621,692,568
Underfunding	(330,000)	0	0	0	0	0	(330,000)
Total Nursing Facilities	**635,043,451**	**(15,831,421)**	**0**	**2,150,538**	**0**	**(13,680,883)**	**621,362,568**
Basic Care	48,412,872	(2,993,944)	5,300,000	0	0	2,306,056	50,718,928
Home & Community Based Services	**135,285,450**	**0**	**0**	**0**	**4,506,748**	**4,506,748**	**139,792,198**
SPED	20,119,003	0	0	0	155,131	155,131	20,274,134
Ex-SPED	1,862,672	0	0	0	84,896	84,896	1,947,568
Personal Care Services	31,747,150	0	0	0	2,996,036	2,996,036	34,743,186
Targeted Case Management	156,862	0	0	0	0	0	156,862
Home & Comm Based Service Waiver	45,281,164	0	0	0	1,270,685	1,270,685	46,551,849
Children's Medically Fragile Waiver	395,602	0	0	0	0	0	395,602
Technology Dependent Waiver	0	0	0	0	0	0	0
PACE	33,407,766	0	0	0	0	0	33,407,766
Children's Hospice Waiver	73,157	0	0	0	0	0	73,157
Autism Waiver	2,242,074	0	0	0	0	0	2,242,074
Autism Voucher	0	0	0	0	0	0	0
Excess Federal Authority	0	0	0	0	0	0	0
Total	**818,741,773**	**(18,825,365)**	**5,300,000**	**2,150,538**	**4,506,748**	**(6,868,079)**	**811,873,694**
General Fund	**400,357,461**	**(9,395,558)**	**5,300,000**	**0**	**2,197,552**	**(1,898,006)**	**398,459,455**

LONG-TERM CARE TOTAL FUND CHANGE (IN MILLIONS)



LONG-TERM CARE GENERAL FUND CHANGE (IN MILLIONS)



Thank You!

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Medical Services Budget- House Bill 1012 Expansion

Senate Appropriations

Caprice Knapp, PhD Medical Services Director

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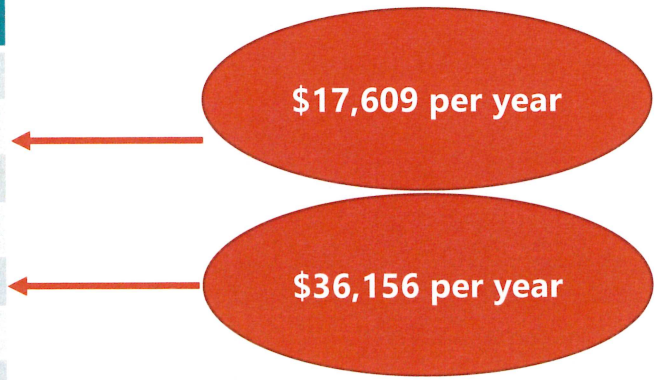
Medicaid Expansion Eligibility for Adults

Family Size	Medicaid Expansion 138% of PL
	Monthly
1	$ 1,468
2	$ 1,983
3	$ 2,498
4	$ 3,013
5	$ 3,529
6	$ 4,044
7	$ 4,559
8	$ 5,074
9	$ 5,589
10	$ 6,105
+1	$ 516



$14,000 per capita in health care benefits



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

Medicaid Expansion Comparison: under 100K People Delivery of Care Model

Medicaid Expansion Population

No MCOs

- Maine 19,812
- Alaska 51,144
- Vermont 55,431
- Montana 98,741

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

- New Hampshire 70,000 **3 MCOs serve ~213K*
- Delaware 62,534 **2 MCOs serve traditional and expansion ~199K*
- Rhode Island 66,641 **2 MCOs serve traditional and expansion ~250K*

Source: Medicaid Enrollment Report Updated 2/2020
https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html
https://www.kff.org/medicaid/stateindicator/totalmedicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

Month	Expansion SHP Members	Expansion SHP Members Non-Expansion Eligibility	Expansion SHP Members Any Medicaid Eligibility	Percent Remaining in Expansion SHP	Percent Remaining with Any Medicaid Eligibility
Jan 2019	20,719		20,719	100.0%	100.0%
Feb 2019	19,441	270	19,711	93.8%	95.1%
Mar 2019	18,399	436	18,835	88.8%	90.9%
Apr 2019	17,515	624	18,139	84.5%	87.5%
May 2019	16,594	812	17,406	80.1%	84.0%
Jun 2019	15,551	1,002	16,553	75.1%	79.9%
Jul 2019	14,672	1,155	15,827	70.8%	76.4%
Aug 2019	13,873	1,295	15,168	67.0%	73.2%
Sep 2019	13,117	1,372	14,489	63.3%	69.9%
Oct 2019	12,523	1,463	13,986	60.4%	67.5%
Nov 2019	11,937	1,532	13,469	57.6%	65.0%
Dec 2019	11,491	1,579	13,070	55.5%	63.1%

Medicaid Expansion Reimbursement Comparison Per Capita Costs Per State

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Medicaid Expansion Reimbursement Comparison Provider Reimbursement % of Medicaid

Actual % of Medicaid*

Type of Service	CY17	CY18	CY19
Inpatient	158.7%	165.8%	151.7%
Outpatient	209.8%	208.0%	204.2%
Professional	168.2%	168.2%	165.4%
Total	**175.0%**	**177.8%**	**170.3%**

***Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures**

Medicaid Expansion Reimbursement Comparison

Medicaid FFS Physician Index

FFS MEDICAID PHYSICIAN INDEX		
ALL MD SERVICES	PRIMARY CARE	OTHER SERVICES
1. Alaska (2.28)	1. Alaska (2.55)	1. Alaska (1.94)
2. Montana (1.56)	2. Montana (1.65)	2. Nebraska (1.45)
3. Delaware (1.40)	3. Delaware (1.55)	3. Arkansas (1.44)
4. Wyoming (1.38)	***4. North Dakota (1.52)***	4. Montana (1.36)
5. Nevada (1.37)	5. Maryland (1.51)	5. South Dakota (1.34)
6. Maryland (1.35)	6. Nevada (1.50)	6. Delaware (1.28)
6. North Dakota (1.35)	7. Idaho (1.45)	7. Wyoming (1.27)
8. Washington, DC (1.27)	8. Wyoming (1.44)	8. New Mexico (1.25)
9. Idaho (1.25)	9. Washington, DC (1.39)	9. Iowa (1.22)
10. New Mexico (1.19)	10. Colorado (1.31)	10. Nevada (1.21)
10. Utah (1.19)	11. Utah (1.30)	11. Wisconsin (1.17)
12. Mississippi (1.17)	12. Mississippi (1.29)	***12. North Dakota (1.15)***

Source: Kaiser Family Foundation State Health Facts, based on Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees After the ACA Primary Care Fee Bump," Urban Institute, March 2017.
Note: Other services excludes ob/gyn.



Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration



Comparison Medicaid Expansion Financial Arrangement

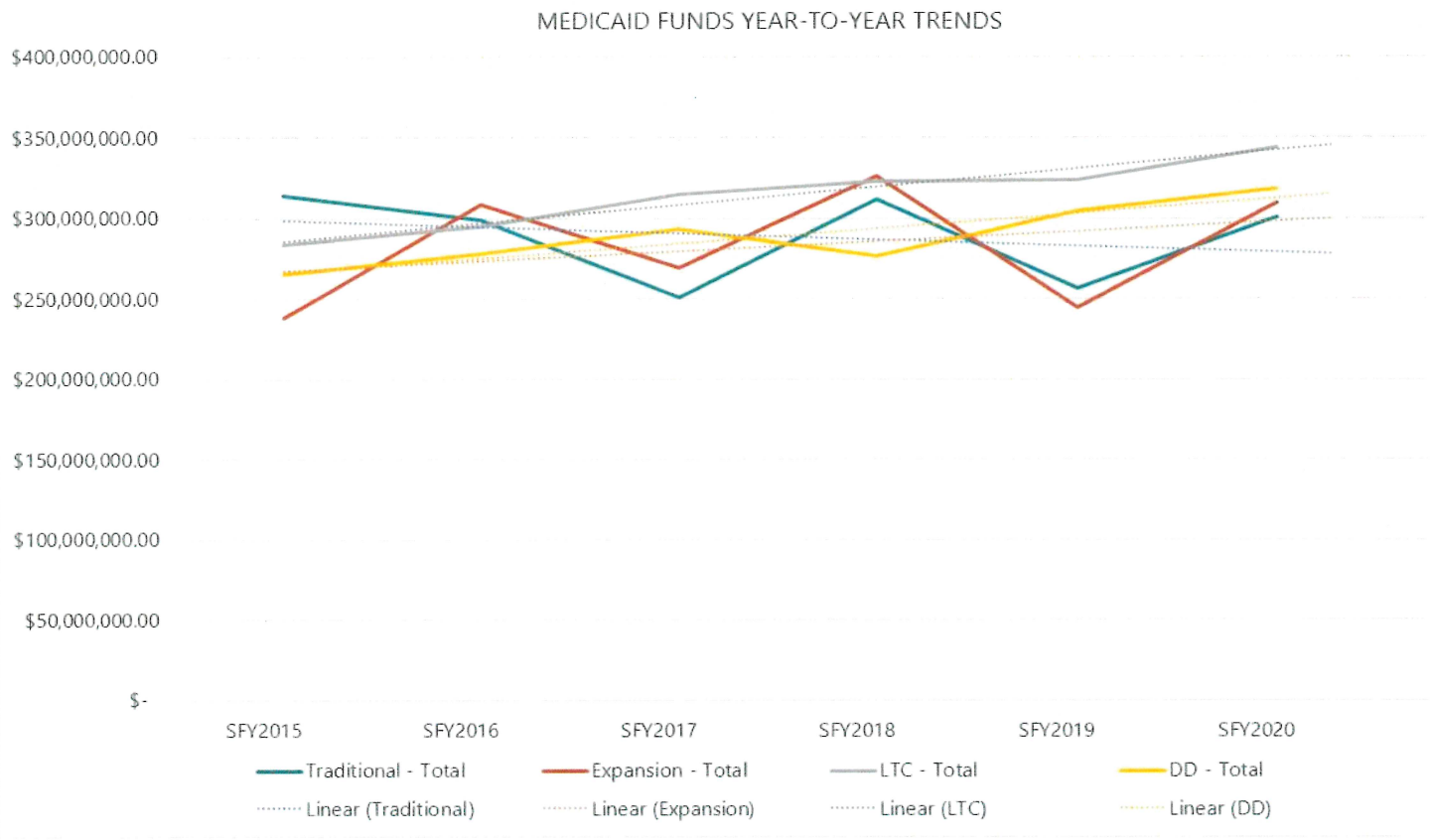
Why do State Medicaid Programs use MCOs?

1. Managed Care Organization Takes on the Risk versus the State
2. Budget Predictability
3. Budget Savings
4. Improved Outcomes

Risk & Predictability

- As in any risk-based model the more people in the risk pool the more likely the managed care organization can spread the risk across healthy and less healthy individuals
- The larger the risk pool, the more predictable and stable premiums will be.
- Premiums also rely on the average health care costs of the enrollees
- Adverse selection occurs when the insurer attracts individuals when they have greater health care needs
- In **North Dakota**, the
  - **risk pool** is the **smallest** in the **entire country** using managed care
  - **premiums** have **not** been **predictable** or **stable**
  - **churn rate** indicates that **adverse selection** is probably occurring

Comparing Has Medicaid Expansion Saved Money in North Dakota?



MEDICAL SERVICES
Medicaid Expansion Transition

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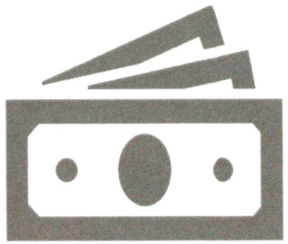
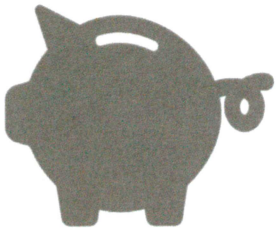
From MCO Administration to DHS In-House Administration

SAVINGS



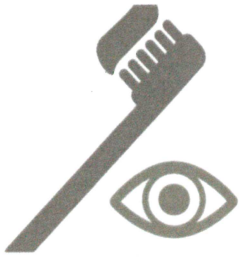
Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)



MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00



DHS Administrative Expenses

Staff Costs	$568,234.00
Contracts	$ 79,520.00
Other (Notices)	$ 23,332.00

$(10,749,572)





Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues from Public Testimony

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

- Alabama (Medical Homes to ACO)
- South Dakota (Health Homes Model)
- Connecticut (ASO model) in early 2020

South Dakota avoided $7.3 million in costs using Health Homes in 5 years

Feedback from North Dakota Medicaid Stakeholders

- Noted that **Health Homes** was the preferred model
- Subsequent meeting with outpatient stakeholders

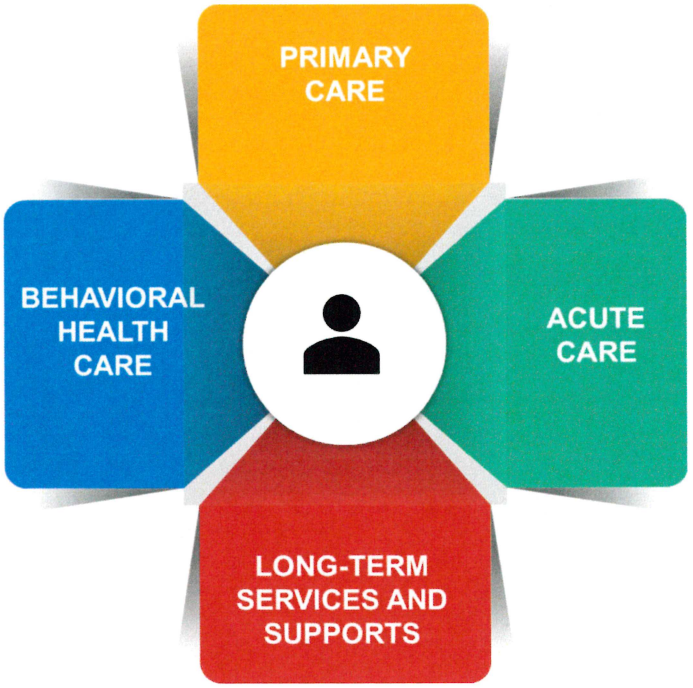
2021-2023 Executive Request

- Authorizes DHS to plan for **Health Homes** and seek CMS approval
- Enhanced payment will offset some of the reduction in rates.

Proposed Solution Health Homes

Medicaid Health Homes

- Builds on the PCMH model
- Fosters a **"whole-person"** orientation to care for individuals with **chronic conditions** through the integration and coordination of:
  - Primary Care
  - Acute Care
  - Behavioral Health Care
  - Long-Term Services & Support



Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals.
Handout shows the Medicaid percentage of payer mix for all hospitals. Average Medicaid is 8% of payer mix across all hospitals. According to enrollment data, about 20% of that is expansion enrollees.

Average estimated expansion payer mix for CAHs is 1.58% and 1.3% for PPS

HOSPITAL NAME	TOWN	HOSPITAL TYPE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ST ALEXIUS MEDICAL CENTER	BISMARCK	SHORT TERM		4%	4%	5%	4%	3%	1%	7%	7%	6%
TRINITY HOSPITALS/ST JOES	MINOT	SHORT TERM		0%	0%	0%	3%	4%	11%	11%	13%	13%
SANFORD MEDICAL CENTER - FARGO	FARGO	SHORT TERM		6%	4%	3%	4%	7%	9%	8%	8%	8%
SANFORD BISMARCK	BISMARCK	SHORT TERM		7%	7%	7%	5%	8%	7%	7%	8%	6%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	GRAND FORKS	SHORT TERM		10%	10%	10%	12%	8%	9%	9%	8%	
INNOVIS HEALTH	FARGO	SHORT TERM		5%	5%	5%	6%	7%	7%	8%	6%	6%
TIOGA MEDICAL CENTER	TIOGA	CRITICAL ACCESS HOSPITALS		0%	0%	0%	1%	1%	1%	1%	1%	1%
MOUNTRAIL COUNTY MEDICAL CENTER	STANLEY	CRITICAL ACCESS HOSPITALS		0%	0%	1%	2%	2%	2%	3%	3%	2%
MCKENZIE COUNTY HEALTHCARE SYSTEM	WATFORD CITY	CRITICAL ACCESS HOSPITALS		1%	1%	1%	3%	4%	6%	5%	4%	4%
GARRISON MEMORIAL HOSPITAL	GARRISON	CRITICAL ACCESS HOSPITALS		19%	20%	17%	26%	25%	25%	23%	22%	24%
TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	CRITICAL ACCESS HOSPITALS		9%	23%	25%	28%	30%	34%	30%	11%	26%
KENMARE COMMUNITY HOSPITAL	KENMARE	CRITICAL ACCESS HOSPITALS		0%	0%	0%	25%	33%	26%	25%	19%	17%
COOPERSTOWN MEDICAL CENTER	COOPERSTOWN	CRITICAL ACCESS HOSPITALS		1%	1%	3%	9%	0%	4%	3%	6%	6%
ST ANDREWS HEALTH CENTER	BOTTINEAU	CRITICAL ACCESS HOSPITALS		12%	13%	14%	18%	16%	14%	14%	17%	13%
NELSON COUNTY HEALTH SYSTEMS-HO	MCVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	1%	0%	1%	1%	3%
SANFORD MAYVILLE	MAYVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	3%	1%	2%	3%	3%	3%	3%
DAKAKAWEA MEDICAL CENTER	HAZEN	CRITICAL ACCESS HOSPITALS		5%	2%	2%	4%	3%	1%	5%	6%	5%
LISBON AREA HEALTH SERVICES	LISBON	CRITICAL ACCESS HOSPITALS		6%	8%	11%	9%	11%	10%	4%	7%	8%
NORTHWOOD DEACONESS HEALTH CENTER	NOTHWOOD	CRITICAL ACCESS HOSPITALS		1%	1%	1%	2%	4%	3%	4%	5%	5%
SOUTHWEST HEALTHCARE SERVICES	BOWMAN	CRITICAL ACCESS HOSPITALS		1%	1%	2%	2%	3%	2%	2%	1%	1%
JACOBSON MEMORIAL HOSPTAL	ELGIN	CRITICAL ACCESS HOSPITALS		1%	2%	23%	20%	19%	21%	20%	19%	19%
OAKES COMMUNITY HOSPITAL	OAKES	CRITICAL ACCESS HOSPITALS		4%	2%	2%	3%	7%	6%	2%	8%	9%
PRESENTATION MEDICAL CENTER	ROLLA	CRITICAL ACCESS HOSPITALS		0%	13%	12%	19%	24%	21%	28%	17%	20%
CARRINTON HEALTH CENTER	CARRINGTON	CRITICAL ACCESS HOSPITALS		1%	4%	4%	3%	5%	5%	2%	2%	6%
PEMBINA COUNTY MEMORIAL HOSPITAL	CAVALIER	CRITICAL ACCESS HOSPITALS		2%	1%	1%	4%	4%	2%	14%	2%	1%
UNITY MEDICAL CENTER	GRAFTON	CRITICAL ACCESS HOSPITALS		4%	4%	3%	3%	3%	6%	5%	4%	5%
WISHEK COMMUNITY HOSPITAL	WISHEK	CRITICAL ACCESS HOSPITALS		3%	3%	2%	1%	1%	2%	2%	2%	2%
ASHLEY MEDICAL CENTER	ASHLEY	CRITICAL ACCESS HOSPITALS		33%	11%	11%	1%	1%	1%	2%	2%	2%
CAVALIER COUNTY MEMORIAL HOSPITAL	LANGDON	CRITICAL ACCESS HOSPITALS		1%	8%	2%	3%	3%	1%	8%	1%	4%
MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	CRITICAL ACCESS HOSPITALS		2%	4%	3%	4%	6%	7%	4%	1%	9%
ST LUKES HOSPITAL	CROSBY	CRITICAL ACCESS HOSPITALS		5%	1%	1%	1%	0%	2%	1%	4%	3%
FIRST CARE HEALTH CENTER	PARK RIVER	CRITICAL ACCESS HOSPITALS		3%	3%	2%	2%	4%	3%	3%	3%	3%
ST ALOISIUS MEDICAL CENTER	PARVEY	CRITICAL ACCESS HOSPITALS		0%	0%	0%	4%	3%	5%	5%	4%	4%
LINTON HOSPITAL	LINTON	CRITICAL ACCESS HOSPITALS		0%	2%	1%	1%	3%	2%	3%	4%	2%
SANFORD HILLSBORO	HILLBORO	CRITICAL ACCESS HOSPITALS		28%	27%	31%	43%	3%	2%	2%	3%	4%
WEST RIVER REGIONAL MEDICAL CENTER	HETTINGER	CRITICAL ACCESS HOSPITALS		28%	1%	2%	1%	3%	1%	3%	3%	
TOWNER COUNTY MEDICAL CENTER	CANDO	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	2%	3%	3%	3%	2%
HEART OF AMERICA MEDICAL CENTER	RUGBY	CRITICAL ACCESS HOSPITALS		1%	21%	26%	21%	2%	25%	30%	3%	14%
MERCY HOSPITAL OF VALLEY CITY	DEVILS LAKE	CRITICAL ACCESS HOSPITALS		12%	16%	15%	20%	23%	26%	10%	14%	34%
MERCY MEDICAL CENTER	WILLISTON	CRITICAL ACCESS HOSPITALS		4%	3%	4%	5%	4%	6%	6%	16	6%
JAMESTOWN REGIONAL MEDICAL CENTER	JAMESTOWN	CRITICAL ACCESS HOSPITALS		9%	9%	8%	9%	10%	13%	13%	7%	10%
ST JOSEPHS HOSPITAL AND HEATLH CENTER	DICKINSON	CRITICAL ACCESS HOSPITALS		5%	6%	5%	5%	8%	8%	7%	2%	8%

Prior Testimony Critical Access Hospital Impact

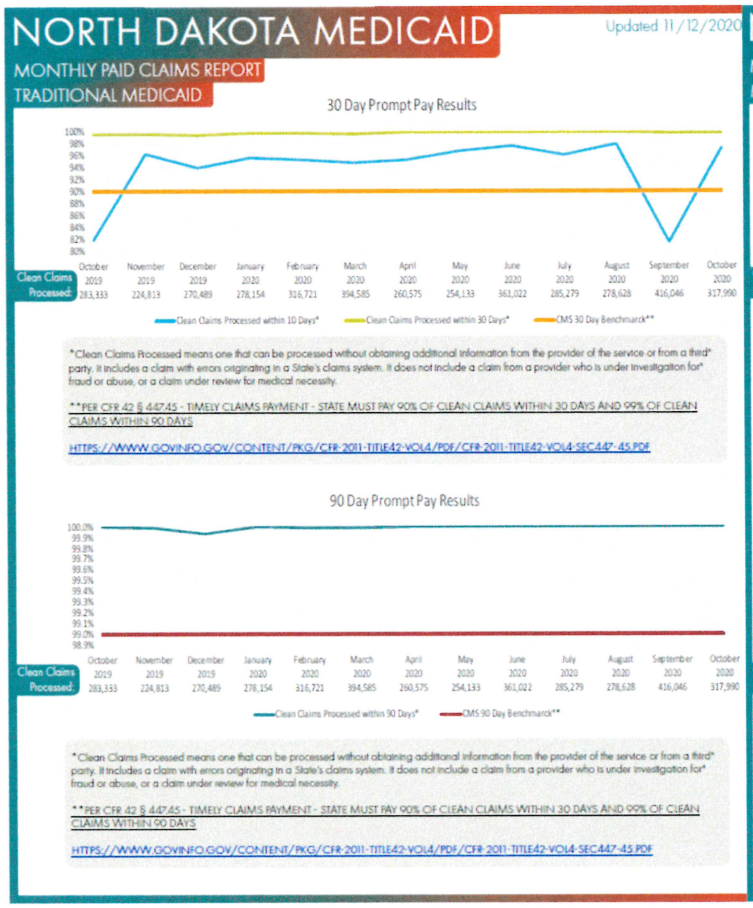
Prior testimony implied that critical access hospitals would close

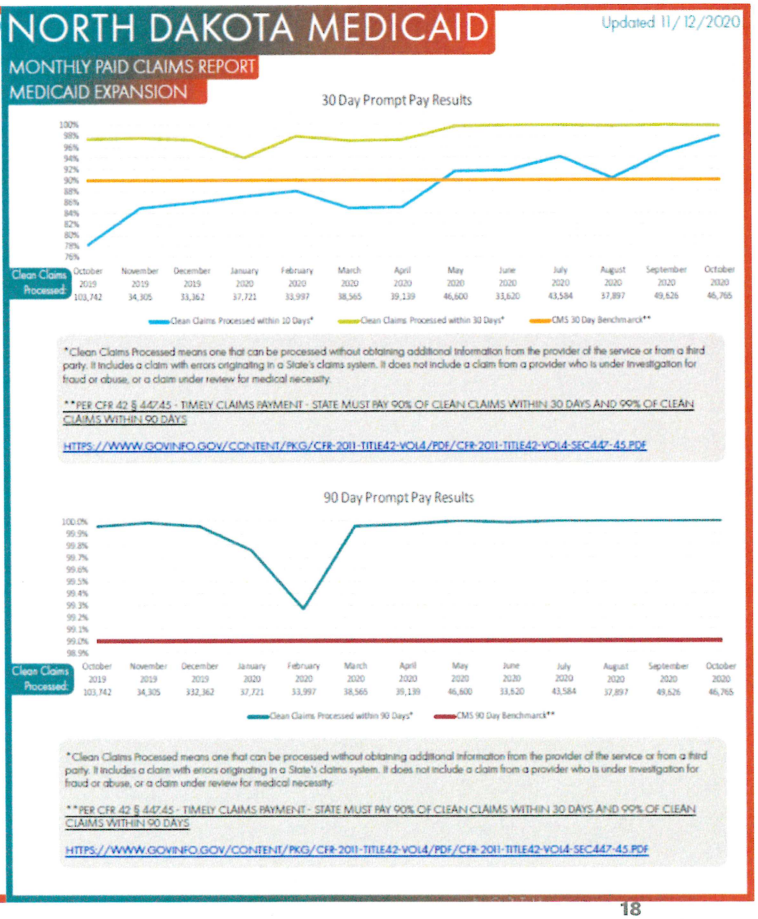
- **DOH record on hospital closures-**
  - **Dakota Heartland Health System**, Fargo closed in 2002 (PPS)
  - **Richardton Memorial Hospital and Health Center**, Richardton closed in 2009 (CAH)
  - **Red River Behavior Health Systems**, Grand Forks closed in Sept 2020 (Psych)
  - **Altru Rehabilitation Center**, Grand Forks terminated their state hospital license in 2019 (Rehab) *(Altru still remains certified as a hospital and has 2 licensed locations)*

2 Hospitals Closed Before Expansion &
2 Closed Since Expansion was Implemented

Prior Testimony
Claims Payment Turn Around

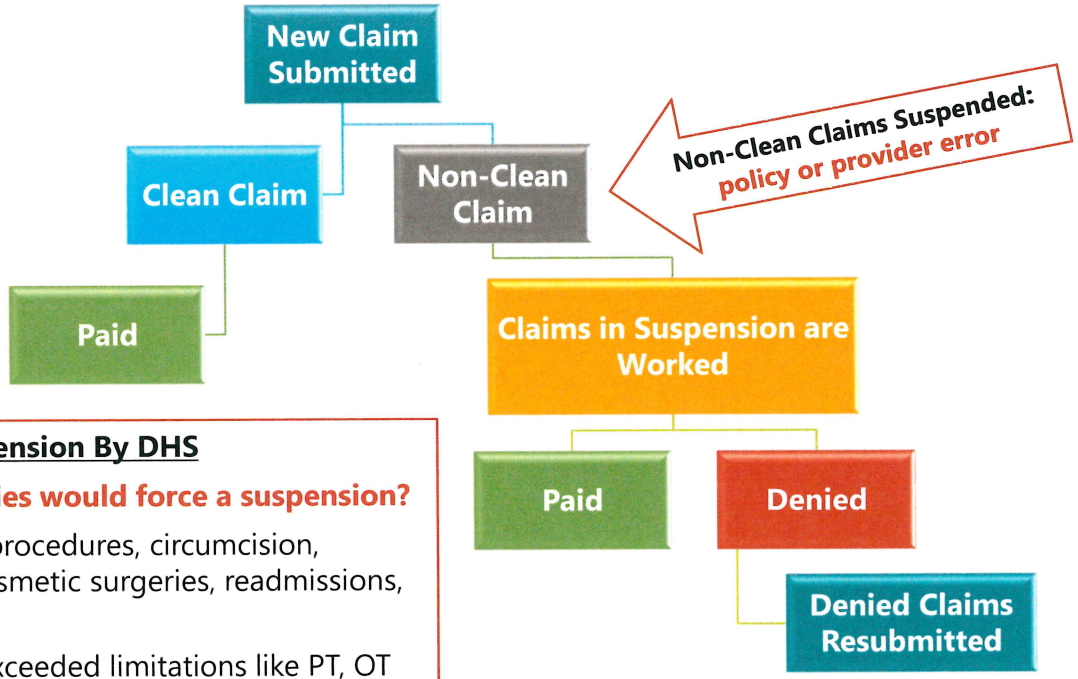
Clean Claim payment turnaround times between ND Traditional FFS Medicaid and MCO Medicaid Expansion





Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

What Medicaid policies would force a suspension?

- Review of certain procedures, circumcision, appendectomy, cosmetic surgeries, readmissions, etc.
- If a member has exceeded limitations like PT, OT
- Third party liability (TPL) as Medicaid is the payer of last resort
- DRGs not appropriate

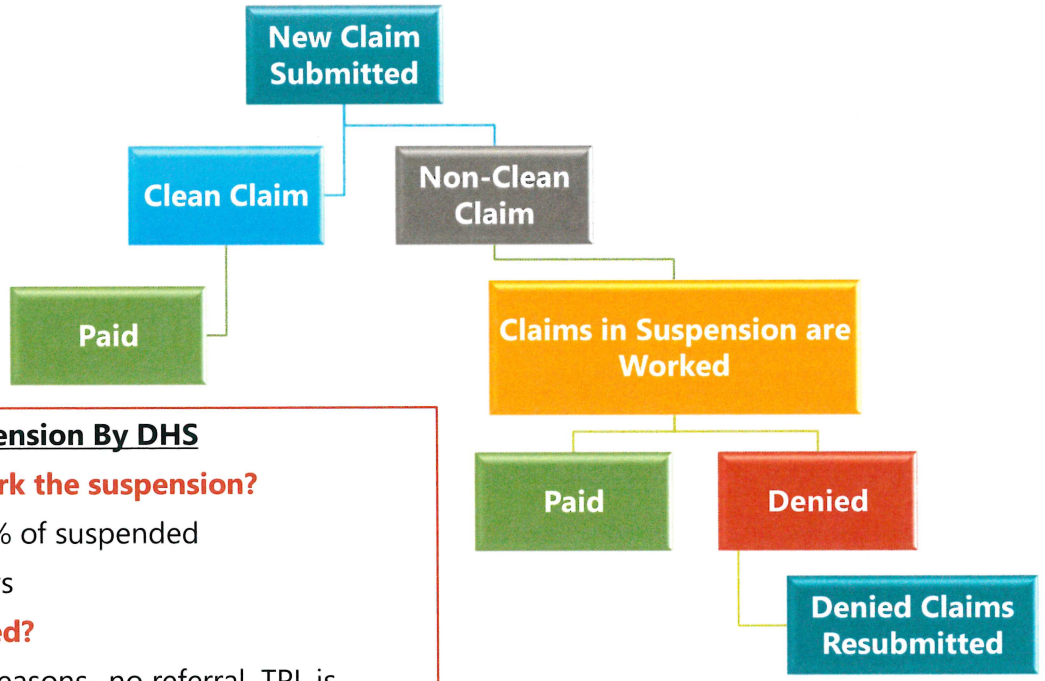
Prior Testimony Claims Payment Turn Around

MEDICAID ANNUAL PROFILE REPORT
Provider Review Results
Peer Group 1
Reviews: 7/1/2017 - 6/30/2018

Provider	# of Cases	# Cases Denied	Billing Denial	Technical Denial	Medical Necessity Denial	Denied %	Billing Denial %	Technical Denial %	Medical Necessity %	# DRGs Changed	% of Cases with DRG Changes
Sanford Medica Fargo	608	2	0	1	1	0.3%	0.0%	0.2%	0.2%	7	1.2%
Sanford Medica Bismarck	582	3	0	2	1	0.5%	0.0%	0.3%	0.2%	4	0.7%
Altru Hospital Grand Forks	437	10	0	0	10	2.3%	0.0%	0.0%	2.3%	21	4.8%
Trinity Hospital Minot	374	2	0	0	2	0.5%	0.0%	0.0%	0.5%	5	1.3%
St. Alexius Med Bismarck	275	9	1	0	8	3.3%	0.4%	0.0%	2.9%	9	3.3%
Essentia Health Fargo	187	4	0	2	2	2.1%	0.0%	1.1%	1.1%	6	3.2%
Peer 1	**2463**	**30**	**1**	**5**	**24**	**1.2%**	**0.0%**	**0.2%**	**1.0%**	**52**	**2.1%**

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

How long to take work the suspension?

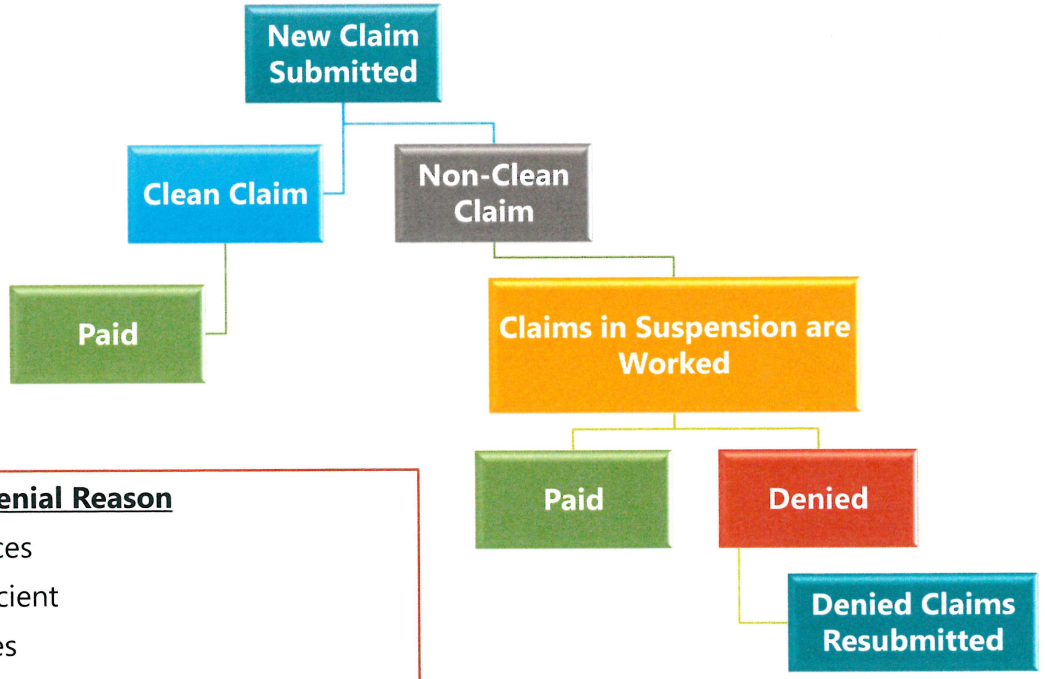
- Within 10 days 54% of suspended
- 84% within 30 days

Why are claims denied?

- These are provider reasons- no referral, TPL is insufficient, attending provider license expired, billing provider license expired, missing invoice
- These are state reasons to deny- diagnosis requires review, TPL issues, claim type on review, trauma/accident (looking for accident file like State Farm invoice)

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Top Denial Reason

- Altru- Missing invoices
- Essentia- TPL insufficient
- CHI- Missing invoices
- Trinity- Billing provider license expired
- Sanford Fargo- Billing provider license expired
- Sanford Bismarck- Billing provider license expired

Prior Testimony
ND Medicaid Savings

RX Carve Out Savings

	Realized Savings	Expected Total Savings
Claims	$ 1,509,000	$ 3,018,000
IHS	$ 3,600,000	$ 7,200,000
Premiums	$ 2,200,000	$ 3,400,000
Administration	$ 2, 641,000	$ 3,441,000
Total	**$ 9,950,000**	**$ 17,059,000**

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- IHS = $7.2 million **(*New savings)**
- Premiums = $3.4 million **(*New savings)**
- Admin = $3.441 million (< $3.991 million projected in 2019 session due to HIPF going away in 2021)

Total = $17.059 million (> $6.091 projected in 2019 session)

Prior Testimony
ND Medicaid Savings

CHIP Savings (1Q20-3Q20)

Expected CHIP cost	**$6,706,332**
▪ *Average 2,378 kids per month x Average $313.38 premium per month*	
Actual CHIP cost	**$1,932,582**
Actual Provider Payments	**$2,872,734**
Drug rebates	**($940,152)**
Savings	**$4,773,750**
% reduction	**71.18%**

Prior Testimony Commercial Premiums

Prior testimony implied that there would be an increase to commercial premiums if Medicaid expansion rates are set at traditional fee schedule.

Manatt Health Strategies consulted to see if there was any evidence of cost shifting due to decrease in government health payments for health care.

The answer was NO

Literature cited:

- Colorado Department of Health Care Policy and Financing, Colorado Hospital Cost Shift Analysis, January 2020
  - *"Despite significant reductions in uncompensated care and significant increases in Medicaid and Medicare rates, hospitals are persistently increasing the price of care."*
  - *"Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance. The increased funding generated by public, taxpayer funded programs— which are intended to reduce private insurance premiums and out-of-pocket costs — are not being passed along to health care consumers and employers."*
- Kaiser Health News, Medicaid Expansion Boosts Hospital Bottom Lines — And Prices, March 2019
- Colorado Health Institute: The Cost Shift Myth

Historical studies and articles:

- JAMA Forum, Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers, January 2017
- Journal of Health Economics, Shock, But No Shift: Hospitals' Responses to Changes in Patient Insurance Mix, September 2016 (full article)
- New York Times, Hospitals Are Wrong About Shifting Costs to Private Insurers, March 2016
- Milbank Quarterly, How Much Do Hospitals Cost Shift? A Review of the Evidence, March 2011 (Pre-ACA)

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

Medicaid expansion is still 90%/10% match regardless of if it is under a managed care company or DHS.

Even though the State match is only 10%, it is more difficult to find that State match each session. 10% of **a larger number** is harder to find than 10% of a smaller number. Suppose the Legislature does not support this policy proposal the total appropriation (at current rates**) $708 million of which $80 million is General Fund. This is an increase of $73 million from 19-21 ($14 million in General Fund)**

This point implies that taxpayers only are concerned with the 10% State match. American taxpayers are responsible for the **entire amount** as it comes from federal taxes and some from State taxes.

The federal government continues to investigate Medicaid expansion spending. GAO reports typically are the first steps before legislative action, and several have already been commissioned:

- from 2017 https://www.gao.gov/products/GAO-17-145 and
- from 2020 https://www.gao.gov/products/GAO-20-260
- from 2020 https://www.gao.gov/products/GAO-20-157
- from 2020 https://www.gao.gov/assets/720/710680.pdf.

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would ***"leave federal dollars on the table".***

During revenue downturns, 100% state-funded programs and **traditional Medicaid providers are disproportionately targeted for savings** versus expansion providers due to the funding split. Again, this creates a **non-equitable** Medicaid system.

100% General Fund or 50%/50%	90%/10%
Autism Voucher, Basic Care, AARP, Valley Senior Services, Alzheimer's Association, Independence Inc., Poppy's Promise, Red River Human Services Foundation, Enable Inc., Family Voices of ND, Mental Health America ND, Dacotah Foundation, Beyond Shelter, Cooper House, Edwin House, LaGrave on First, ShareHouse, Prairie St. John's, Northland PACE, ND Brain Injury Network, ND Brain Injury Advisory Council, ARC of ND, Nexus-PATH, Prairie Harvest Mental Health, Grand Forks Growth and Support, Development Homes, Poppy's Promise, Vocational Training Center, Designer Genes, Catholic Charities, Protection and Advocacy, ARC of North Dakota, HCBS, Nursing Homes, Dental, Vision, Pediatrics	Expansion

Developmental Disability providers and **Nursing Homes** have put in the hard work to have **more equitable reimbursement**, reducing the financial burden on the State

ND Medicaid
The Future

- Medical Services Division's aim is to restructure its Medicaid programs to promote better care and **quality** for members, **reduced burden** on providers, and be **trusted stewards** of taxpayer dollars.
- Medical Services aims to have **equity for all ND Medicaid members**, regardless of one's category of eligibility, allowing for continuity of care across the continuum to ensure high quality care and outcomes.
- Medical Services aims to **align benefits** across the entire Medicaid program. Legislators have inquired previously about providing dental benefits, vision benefits and long-term care and support services for expansion members.
- Medical Services strives for a comprehensive utilization management approach through **health homes** to ensure patient centered care across the continuum.
- Medical Services seeks to create a **realistic risk pool** that can ultimately be used to spread risk, lower cost, and drive value through the entire program.
- Medical Services aims to give providers **consistent processes** in relation to service authorization, appeals, claims submission, and provider enrollment.

Thank you!

North Dakota Medicaid



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Division Director

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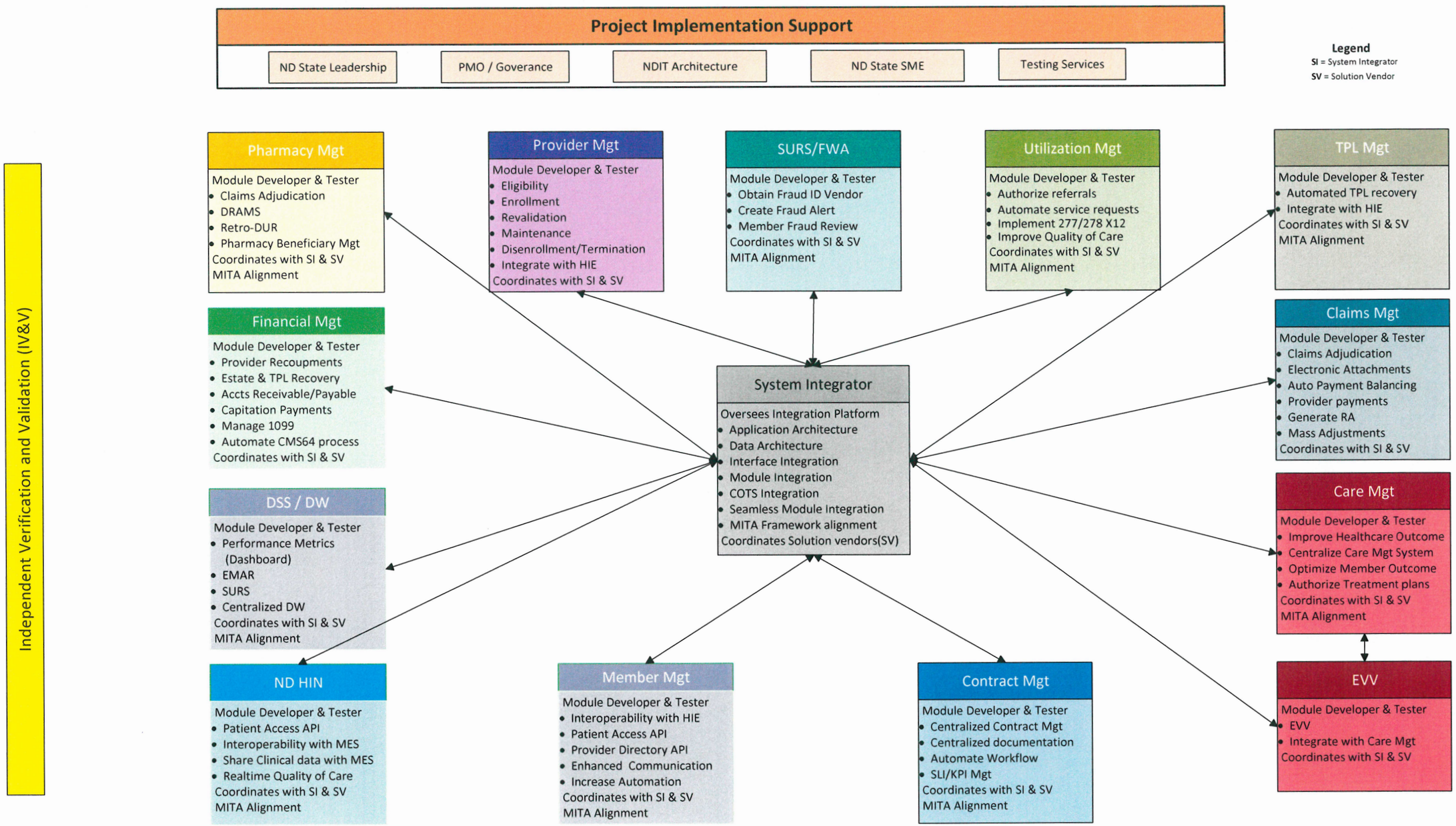
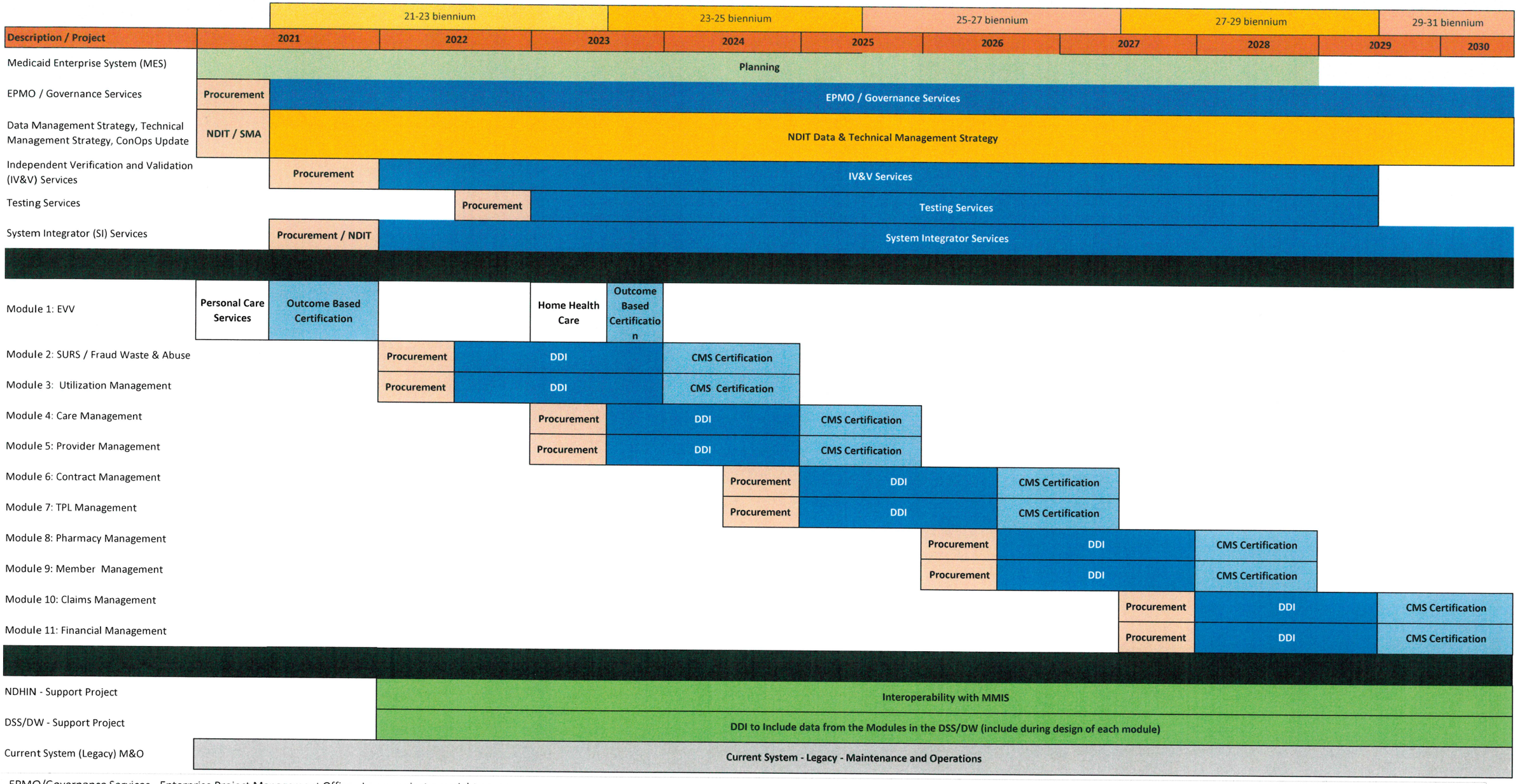
E-Mail: cknapp@nd.gov

NORTH Dakota | Human Services
Be Legendary.™

North Dakota Medicaid Enterprise System Modularity Project





EPMO/Governance Services - Enterprise Project Management Office: Large project oversight governance
IV&V - Independent Verification and Validation Services: Independent process that evaluates the correctness and quality of the project's business product to ensure that it is being developed in accordance with customer requirements.
Testing Services: Recommended to bring in a vendor to augment staff to assist with system testing
System Integrator: CMS recommends States utilize a SI to provide oversight and integration of technology services to support the MES.
The SI focuses on ensuring integration services and make sure all solutions work together to provide complete business functionality.
The SI is responsible for the integration of the systems into a seamless functional system. The SI will establish standards and ensure all modules work together with overall security and privacy remain intact when modules and components are integrated.

8029

Medicaid Expansion in North Dakota

Medicaid Expansion saves lives and rural hospitals

Backed by a broad coalition of healthcare, community service and business leaders, North Dakota legislators approved Medicaid Expansion in 2013. The program fills historic gaps in Medicaid eligibility for low-income adults ages 19-64 and covers approximately 22,000 North Dakota lives. Most Medicaid Expansion enrollees are childless adults working one or more jobs, but unable to afford health insurance. The program provides much-needed access to chronic disease management, mental health services and addiction treatment programs.

Since its implementation, North Dakota has leveraged Medicaid Expansion's cost-share model (federal match rates are 90% in 2020 and beyond), changing the face of North Dakota healthcare by reducing North Dakota providers' uncompensated care totals and stabilizing rural facilities.

AARP North Dakota
Altru Health System, Grand Forks
Alzheimer's Association MN-ND Chapter
American Cancer Society-Cancer Action Network
America's Health Insurance Plans
American Heart Association
American Lung Association
American Physical Therapy Association - ND
The Arc of ND
Ashley Medical Center, Ashley
Augusta Place - a Prospera Community, Bismarck
Blue Cross Blue Shield North Dakota
Bismarck Cancer Center
Bismarck Mandan Chamber EDC
The Bone & Joint Center
Cavalier County Memorial Hospital, Langdon
CHI Lisbon Health, Lisbon
CHI Mercy Health, Valley City
CHI Mercy Hospital, Devils Lake
CHI Oakes Hospital, Oakes
CHI St. Alexius Health Carrington Medical Center
CHI St. Alexius Health Dickinson Medical Center
CHI St. Alexius Health Garrison Memorial Hospital
CHI St. Alexius Health Turtle Lake
CHI St. Alexius Health Williston Medical Center
CHI St. Alexius Health, Bismarck
Coal Country Community Health Center
Community Action Partnership of North Dakota
Community HealthCare Association of the Dakotas
Cooperstown Medical Center, Cooperstown
Essentia Health, Fargo
Family HealthCare
Family Voices of ND
Farmers Union Insurance
First Care Health Center, Park River
FMWF Chamber
Good Samaritan Society
Good Samaritan Society Bottineau
Good Samaritan Society Lakota
Good Samaritan Society Larimore
Good Samaritan Society Mohall
Good Samaritan Society Mott
Good Samaritan Society Oakes
Good Samaritan Society Park River
Greater ND Chamber
Great Plains Food Bank
Healthcare Policy Consortium
Heart of America Medical Center, Rugby
Heartview Foundation
Jacobson Memorial Hospital, Elgin
Jamestown Regional Medical Center, Jamestown
The Leukemia & Lymphoma Society
Linton Hospital, Linton
McKenzie County Healthcare Systems, Watford City

Mental Health America of ND

Mid Dakota Clinic

Miller Pointe - a Prospera Community, Mandan

Minot Area Chamber EDC

Mountrail County Medical Center, Stanley

National Multiple Sclerosis Society

NATIVE, Inc.

NDACo

ND Academy of Physician Assistants

ND Addiction Counselors Association

ND Addiction Treatment Providers Coalition

ND AFL-CIO

ND Behavioral Health Planning Council

ND Catholic Conference

ND Center for Persons with Disabilities

ND Disability Advocacy Consortium

ND Federation of Families for Children's Mental Health

ND Hospital Association

ND League of Cities

ND Medical Association

ND Nurses Association

ND Nurse Practitioners Association

ND Occupational Therapy Association

ND Optometric Association

ND Psychological Association

ND Public Health Association

ND State Association of City and County Health Officials

ND United

ND Women's Network

Nelson County Health System, McVille

North Dakota Academy of Nutrition and Dietetics (NDAND)

North Dakota Farmers Union

Northwood Deaconess Health Center, Northwood

NexusPATH

Pembina County Memorial Hospital, Cavalier

Planned Parenthood North Central States

Prairie St. John's, Fargo

Presentation Medical Center, Rolla

Protection & Advocacy

Quentin Burdick Memorial Healthcare Facility, Belcourt

Sacred Pipe Resource Center

Sakakawea Medical Center, Hazen

Sanford Health Plan

Sanford Hillsboro Medical Center, Hillsboro

Sanford Mayville Medical Center, Mayville

Sanford Medical Center, Bismarck

Sanford Medical Center, Fargo

ShareHouse

Southwest Healthcare Services, Bowman

Spectra Health

St. Aloisius Medical Center, Harvey

St. Andrew's Health Center, Bottineau

St. Luke's Medical Center, Crosby

St. Vincent's - a Prospera Community, Bismarck

Souris Valley Care Center, Velva

Sunset Drive - a Prospera Community, Mandan

The Village/First Step Recovery Program

Tioga Medical Center, Tioga

Towner County Medical Center, Cando

Trinity Kenmare Community Hospital, Kenmare

Trinity Medical Center, Minot

Unity Medical Center, Grafton

Vibra Hospital Central Dakota, Mandan

Vibra Hospital, Fargo

West River Regional Medical Center, Hettinger

Wishek Community Hospital, Wishek

House Appropriations Committee
IN SUPPORT – HB 1012 – DHS Budget – Economic Assistance
March 11, 2021
Janelle Moos, Associate State Director- Advocacy
jmoos@aarp.org
(701) 355-3641

Chairman Holmberg and members of the Senate Appropriations Committee, I am Janelle Moos, Associate State Director of Advocacy at AARP North Dakota.

AARP is a non-profit, non-partisan membership organization with more than 84,000 members in North Dakota. Our mission is to empower people to choose how they live as they age.

We wanted to take a moment to weigh in on a couple of important economic assistance issues.

First, SNAP is an important program that ensures older adults and families get the nutrition needed. We have closely monitored the food crisis more Americans and North Dakotans faced during the pandemic. SNAP benefits are an important tool that addresses this crucial problem. It is an especially important program for Americans over 50 because many face challenges to employment, live on fixed incomes, live alone, and have limited financial resources to pay for necessities like food, housing, and essential medicine. To people struggling to put food on the table, hunger is not a political issue, it is a daily reality. SNAP is a vital lifeline that feeds 23, 840 North Dakota households. 35% of those recipients are either elderly or disabled. Also remember, participants generally spend their SNAP dollars locally, soon after receiving them, boosting local economies. An important benefit in this time.

Also, LIHEAP has served as a lifeline for low-income families. As you may know, AARP believe utility issues and rates are a key pocketbook issue. We have intervened in various cases in front of the North Dakota Public Service Commission on behalf of older adults and consumers and know the struggle of families to afford their utility payments. Having a safety net for families especially in our climate is not only the right thing it is the moral thing to do.

We encourage you to continue to support these programs to ensure no North Dakotan goes hungry or without heating or cooling assistance when they need it.

Again, we appreciate the time to raise issues important to North Dakotans 50+ and would be happy to answer any questions. Thank you.

Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Fraser, Ltd.
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Individual Consumers & Families

8296

Senate Appropriations Committee
Sixty-seventh Legislative Assembly of North Dakota
House Bill 1012
March 9, 2021
Senator Holmberg, Chair

Good afternoon Chairman Holmberg and Members of the Senate Appropriations Committee. I am Carlotta McCleary, Executive Director of Mental Health America North Dakota and Executive Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer /family driven mental health system of care that provides an array of service choices that are timely, responsive and effective.

MHAN has provided testimony since the 64th interim human service committee meetings (2015-2016) regarding our priorities for mental health services. We argue that peer to peer and parent to parent support, consumer choice, diversion from corrections, a core services zero-reject model, and conflict free grievance and appeals processes, and the access to a full and functional continuum of care serve as the backbone to correcting the crisis in North Dakota's behavioral health system.

MHAN is speaking in support of HB 1012. During the Sixty sixth legislative session, MHAN stressed that North Dakota needed to put the HSRI Report of 2018 into action. That report, much like the Schulte Report of 2014 said that North Dakota needed to drastically reduce its reliance on institutionalization and make sure that it had a fully functional community-based mental health system for children, their families, and adults that is as near their home as possible. Among the accomplishments of the last legislative session were the commitment to apply for the 1915(i) State Plan Amendment, peer support certification and training, prevention and early intervention pilot program in schools, the behavioral health pilot program, and the behavioral health resource coordinator in our schools.

MHAN's vision for this current legislative session was to ensure that the HSRI report would continue to be an active "road map" to ending the decade-long behavioral health crisis. MHAN commends the Department of Human Services for its continued emphasis on improving behavioral health services. The Department of Human Services' efforts in diverting people from corrections with Free Through Recovery and Community Connect should be applauded. MHAN also supports the building of a new State Hospital at Jamestown with reduced number of beds, along with development of six to ten beds in the western part of the state.

However, MHAN is deeply concerned about the current state of North Dakota's mental health system of care and what may come to pass with this budget. Let us start with the children's mental health system of care. Of the 180,171 children that live in North Dakota, about 29,728 of them have some form of a mental health disorder. Roughly 10% of all children in North Dakota have a serious emotional disorder (SED). As of 2019, this translates to roughly 19,098 children. We are currently serving only 1 out of every 19 children who have a serious emotional disturbance. As a result of not having access to care, many children are being sent into the juvenile justice system. From 2011 to 2017, the number of children in juvenile corrections who had a serious emotional disturbance rose from 49% to 79%. Although there have been improvements, children with serious emotional disturbance still represent the majority of children in the corrections system despite only accounting for 10% of all children in North Dakota. The *Olmstead* decision of 1999 and subsequent litigation made clear that people with disabilities (including mental illness) must be given access to community-based services before requiring that they seek only institutional care. Let me be clear: *Olmstead* applies to children too.

It comes as no surprise that the COVID-19 pandemic has led to an increase in behavioral health challenges and has forced our society to rethink how it conducts business and serves the community. Our national Mental Health America released a report this year finding that there was a 93% increase from 2019 in the number of people who took their anxiety screen, and a 62% increase in the number of people who took their depression screen. They found that children and youth ages 11-17 had been "more likely than any other age group to score for moderate to severe symptoms of anxiety and depression." In addition, they found that "since the end of May 2020, nearly every racial/ethnic group has

been experiencing consistently higher rates of suicidal ideation than the 2019 average." The Centers for Disease Control found that the COVID-19 pandemic has considerably increased the symptoms of anxiety disorder and depressive disorder compared to 2019. In their study, 40.9% of American adults reported at least one adverse mental or behavioral health condition, with 10.7% of respondents reporting to have seriously considered suicide in the previous 30 days. Suicidal ideation was especially pronounced among racial and ethnic minorities, young adults, unpaid caregivers for adults, and essential workers.

As the Executive Director of the North Dakota Federation of Families for Children's Mental Health I can attest that we have seen an increase in our children and youth who have displayed more significant mental health symptoms and suicidal ideation. In addition, COVID-19 has made it more difficult for children, families, and young adults to get access to the services and supports that they need and it has become much more difficult for teams to coordinate care. Families in the Bismarck area are reporting a concern for dealing with children's mental health crisis. Families have reported that when calling crisis response, the service is done over the phone instead of in-person. In order to deescalate someone, you really need to have an in-person, human connection to develop rapport with the individual. Once they are deescalated, in-person debriefing is essential to prevent future crises. In addition to crisis response, families in the Bismarck area are also without safe beds as an option for children's mental health crisis. Safe beds are a safe place for a child to deescalate as an alternative to costly hospitalization. As a result, the only options many families have are: a) do nothing, b) hospitalize their child, c) call law enforcement.

MHAN has other concerns with the Governor's proposed budget regarding reductions in children's mental health. The Governor's proposed budget cuts the voluntary treatment program from its previous budget of $533,440 to a proposed 2021-2023 budget of $453,424. Prior to this program, many parents were forced to relinquish custody of their children in order to receive mental health services (and those services were in a residential treatment facility). With the creation of the voluntary treatment program, those parents were no longer required to relinquish custody of their children in order to receive treatment that would be provided in that residential treatment facility. During the last

legislative session, the voluntary treatment program was given the flexibility to provide services to children in order to prevent an out-of-home placement. The voluntary treatment program is essential in families being able to maintain custody of their children and provide linkages to community-based services. Cuts to this program would be detrimental.

MHAN supports parent peer support and the organizations that provide this valuable service. Family Voices of North Dakota, who provides support to children with special healthcare needs and their families, and North Dakota Federation of Families for Children's Mental Health, who provides support to children with mental health needs and their families, are both facing reductions as proposed in the Governor's budget. Family peer support organizations provide support, provide education for families, assist families in system navigation, give education for providers, and advocate with families so that they receive the services and supports that their child needs. MHAN is also concerned with the elimination of the Experienced Parent Program for early intervention. MHAN supports fully funding family peer support organizations.

MHAN also has concerns about the current state of the mental health system for adults with serious mental illness. Of the 581,891 adults living in North Dakota, 119,870 have any mental illness (AMI). Roughly 30,258 adults in North Dakota have a serious mental illness (SMI). Much like the Developmental Disability system, individuals with serious mental illness rely on supported employment services and supported housing services so that they can maintain employment and can maintain living in the community. The proposed budget made significant cuts to both of those program areas, with some initial requests to eliminate entire programs. While some has been discussed to be restored to allow providers time to become Medicaid providers, it does not account for the fact that some of those individuals with serious mental illness will not meet the eligibility requirements of the 1915(i). Providers have serious concerns regarding whether or not their clientele will even qualify due to the requirement to have a WHODAS score of 50 or above. Another concern we have with the trajectory of supported employment services is with maintaining connection to services as a client's wages increase. For instance, once the client is being supported in a job and they get paid, they may no longer meet the financial eligibility for Medicaid. Will there be a process in place to maintain 1915(i)

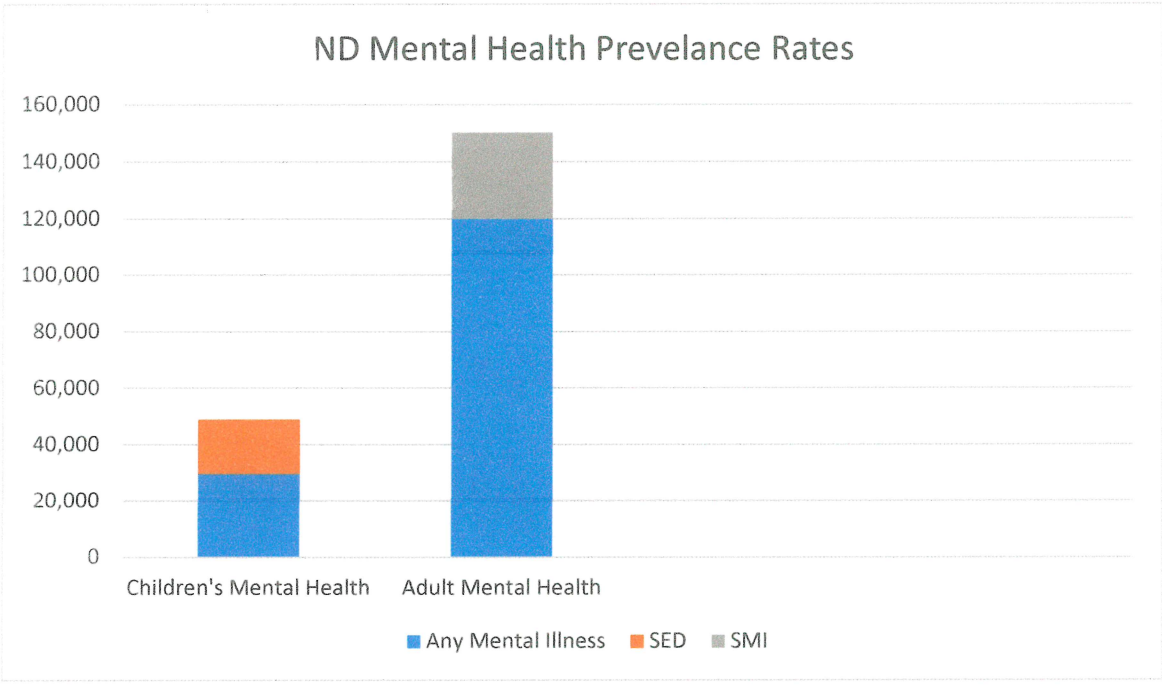
while transitioning the adult SMI population who are no longer base Medicaid eligible, into Medicaid Expansion, or will they be cut off from services entirely?
This brings us to the 1915(i). Mental Health Advocacy Network advocated that all individuals meeting the definition of serious mental illness and serious emotional disturbance be eligible for the 1915(i) if they had access to Medicaid. Unlike "any mental illness," in adults, a serious mental illness is defined as "someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities." Unlike any mental illness in children, a "serious emotional disturbance" refers to a "diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities." These definitions also mean that an individual diagnosed with a serious mental health disorder are at significant risk of institutional level of care or meet the criteria for needing institutional level of care. When North Dakota submitted its application to the Centers for Medicare and Medicaid Services (CMS), it anticipated that it would be serving 11,150 individuals, divided between those with substance use disorder (SUD), serious mental illness (SMI), serious emotional disturbance (SED), and traumatic brain injury (TBI). If we only consider serious mental health disorders among children and adults, North Dakota has a legal obligation to serve those 49,356 people. These *are* the individuals with the most significant mental health needs.

MHAN urges the restoration to the cuts that have been made to the "1915(i) savings" to allow time and potential changes and adjustments to the 1915(i) to ensure that people are not going without services.

As you can see there is still a lot of work left to do in mental health. Now is not the time to reduce our efforts to improve the mental health system of care for children, adults, and their families.

Thank you for your time and I would be happy to answer any questions you may have.

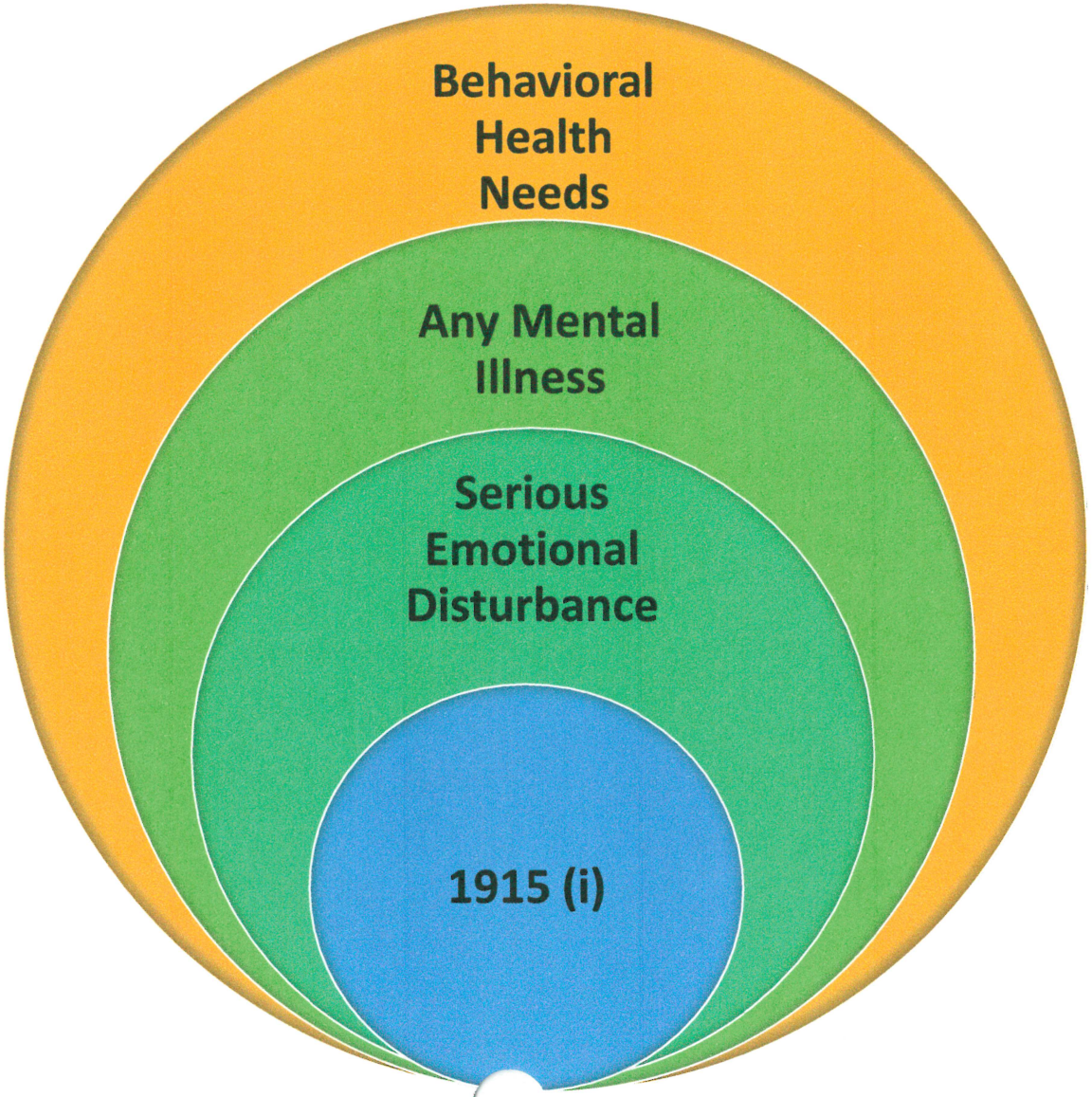
Carlotta McCleary
Mental Health Advocacy Network (MHAN), Spokesperson
Email: cmccleary@mhand.org
Phone: (701) 255-3692



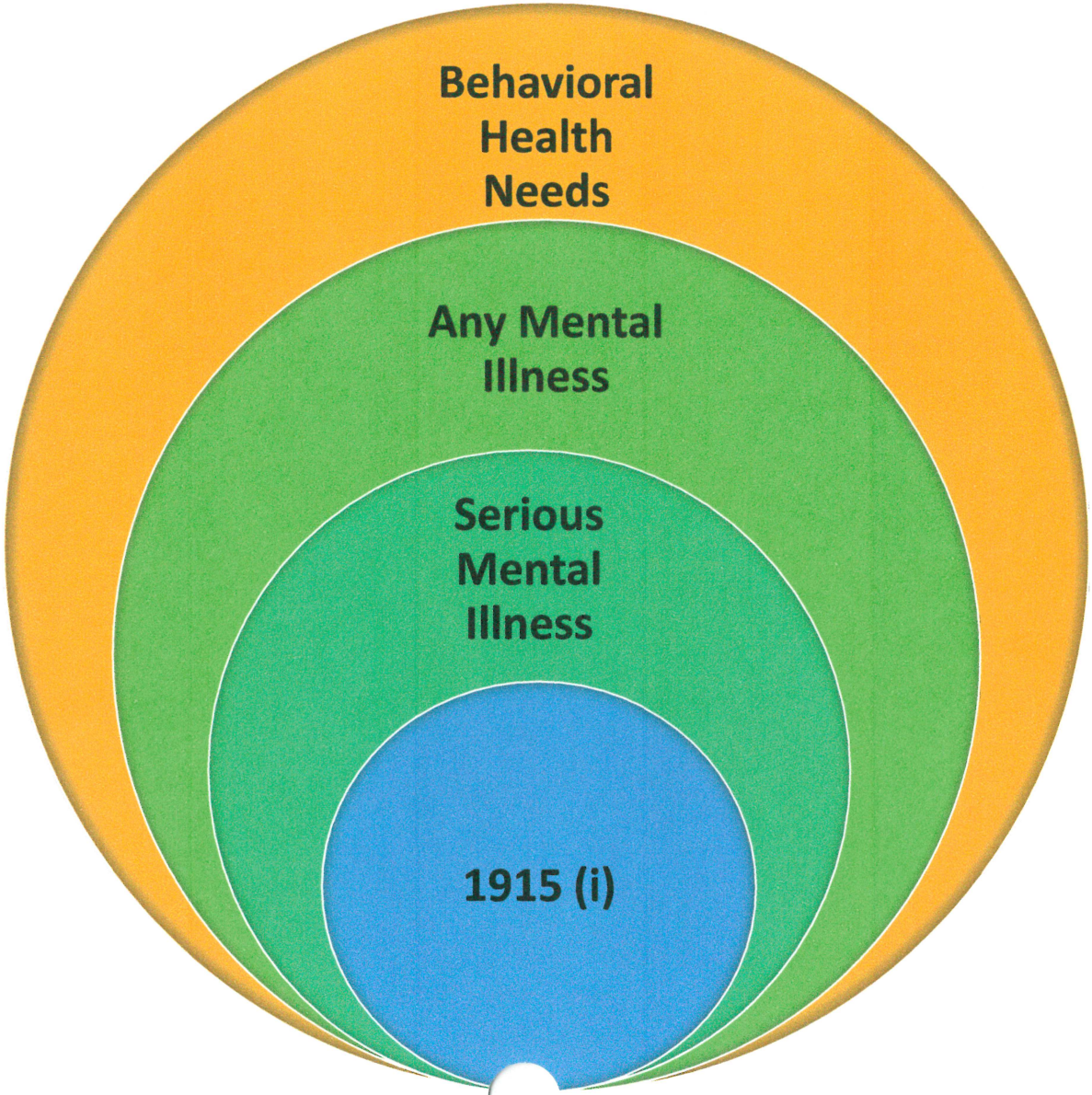
Serious Emotional Disturbance (SED): for people under the age of 18, SED is a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

Children with Mental Health Needs



Adults with Mental Health Needs



Any Mental Illness (Adults 18+), United States (2019): 20.6% (51.5 million)[1]

North Dakota Adult Population: 581,891[2]

North Dakota AMI (Adult) Translation: 119,869.5

Serious Mental Illness (Adults 18+), United States (2019): 5.2% (13.1 million)[3]

North Dakota Adult Population: 581,891[4]

North Dakota SMI (Adult) Translation: 30,258

Any Mental Illness (Children), United States: 16.5%[5]

North Dakota Children Population (2019): 180,171[6]

North Dakota AMI (Children) Translation: 29,728.2

Serious Emotional Disturbance (Children), United States: 10.6%[7]:

North Dakota Children Population (2019): 180,171[8]

North Dakota SED (Children) Translation: 19,098.1

Children Health Insurance, North Dakota (2019):

-Medicaid Enrollment (Kids Count), Aged 0-20: 56,371 (26.6%)[9]

-Medicaid children (Kaiser FF): 1/5 children in ND: 36,034.2[10]

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[1] National Institute of Mental Health, "Statistics: Mental Illness," https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (accessed March 5, 2021).

[2] The Annie E. Casey Foundation: Kids Count Data Center, "Total Population by Child and Adult Populations in North Dakota," https://datacenter.kidscount.org/data/tables/99-total-population-by-child-and-adult-populations?loc=36&loct=2#detailed/2/36/false/1729,37,871,870,573,869,36,868,867,133/39,40,41/416,417 (accessed March 5, 2021).

[3] National Institute of Mental Health, "Statistics: Mental Illness."

[4] The Annie E. Casey Foundation: Kids Count Data Center, "Total Population by Child and Adult Populations in North Dakota."

[5] Daniel G. Whitney, Mark D. Peterson, "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children," *JAMA Pediatrics* 173, no. 4 (2019): 389-391. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377 (accessed March 5, 2021).

[6] The Annie E. Casey Foundation: Kids Count Data Center, "Total Population by Child and Adult Populations in North Dakota."

[7] Nathaniel J. Williams, Lysandra Scott, Gregory A. Aarons, "Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis," *Psychiatric Services* 69, no. 1 (January 1, 2018): 32-40. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700145 (accessed March 5, 2021).

[8] The Annie E. Casey Foundation: Kids Count Data Center, "Total Population by Child and Adult Populations in North Dakota."

[9] The Annie E. Casey Foundation: Kids Count Data Center, "Medicaid Recipients Ages 0 to 20 in North Dakota," https://datacenter.kidscount.org/data/tables/10817-medicaid-recipients-ages-0-to-20?loc=36&loct=2#detailed/2/any/false/1729,37,871,870,573,869,36,868,867,133/any/21043,21044 (accessed March 5, 2021).

[10] Henry J. Kaiser Family Foundation, "Medicaid in North Dakota" (October 2019) http://files.kff.org/attachment/fact-sheet-medicaid-state-ND (accessed March 5, 2021).

-Children who have health insurance, by type:[11]

-Employer-based only: 116,000 (62%)

-Direct-purchase only: 12,000 (6%)

-Other private: 6,000 (3%)

-Public only: 30,000 (16%)

-Both public & private: 8,000 (4%)

-Uninsured: 15,000 (8%)

-ND Children ages 0 to 18 enrolled in Healthy Steps (CHIP) in 2019: 3,002 (1.6%)[12]

-Medicaid in ND Adults, aged 19-64: 1/13 (7.69%), or 44,747.4[13]

ND Medicaid 1915(i) State Plan Amendment

-Anticipated number served: 11,150

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[11] The Annie E. Casey Foundation: Kids Count Data Center "Children who have health insurance by health insurance type in North Dakota" https://datacenter.kidscount.org/data/tables/10183-children-who-have-health-insurance-by-health-insurance-type?loc=36&loct=2#detailed/2/36/false/1729,37,871/4847,4848,4849,4153,2807,2811/19706,19707 (accessed March 5, 2021).

[12] The Annie E. Casey Foundation: Kids Count Data Center "Children ages 0 to 18 enrolled in Healthy Steps (CHIP) in North Dakota," https://datacenter.kidscount.org/data/tables/10818-children-ages-0-to-18-enrolled-in-healthy-steps-chip?loc=36&loct=2#detailed/2/any/false/1729,37/any/21045,21046 (accessed March 5, 2021).

[13] Henry J. Kaiser Family Foundation, "Medicaid in North Dakota" (October 2019) http://files.kff.org/attachment/fact-sheet-medicaid-state-ND (accessed March 5, 2021).

7976

Testimony HB 1012

Senate Appropriations Committee

March 9-10, 2021

Good afternoon Chairman Holmberg and members of the Committee. My name is Trina Gress, I am Vice President of Community Options. I stand before you today to represent Community Options and the clients we serve.

My testimony is in opposition HB 1012 as it was submitted to the Senate. HB1012 proposes to cut four Community Options services with the intent that the clients will be served in the 1915i Medicaid State Plan Amendment (1915i) after 12/30/2021.

My first request is that you extend this date through the entire biennium until 6/30/2023. While I fully understand and support the implementation of the 1915i, December 30, 2021 is an realistic target date. Providers and clients need time to gather the proper documentation and determine if clients are even eligible to review services in the 1915i.

In addition, there are major issues with the eligibility process and flow of services involving the 1915i. Below are the three biggest barriers to getting clients enrolled to receive services from the 1915i.

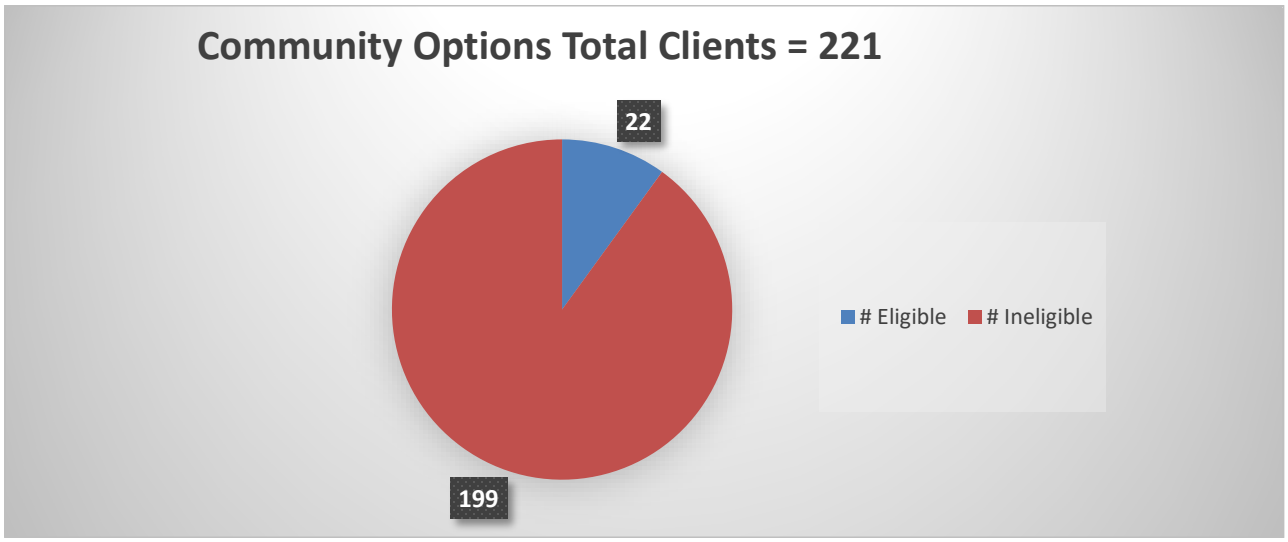
1. Eligibility hoops a client must jump through in order to receive 1915i services.
    - Must be Medicaid/Medicaid Expansion eligible.
    - Must get a score on the World Health Organization Disability Assessment Schedule (WHODAS) of 50 or higher. (See handout) The WHODAS must be completed by an independent, trained professional or the County Zone Worker. The WHODAS may also be done by the client's legal guardian. The assessment must identify employment/housing/peer supports/etc as a need on the WHODAS.
    - Must have an approved diagnosis according to ICD-10 Diagnosis Codes. (See Handout) There are clients who may need to get a psychological or neuropsychological evaluation to attain the diagnosis. This could take months to attain. NOTE – Not all Brain Injuries are included in the 1915i, only Traumatic Brain Injury is included, Acquired Brain Injury is not.

2. Need to secure Care Coordinators to meet the requirements of 1915i. Community Options is unable to provide care coordination and employment supports so a 3rd party will have to be secured to do Care Coordination. Currently, there is a lack of providers to cover the state to provide these services.

3. When a client secures employment, their earnings must be reported to the Zone. Financial Eligibility for the 1915i must not exceed 150% of Federal Poverty Line (FPL). For a single person household in FY 2020= $1,595 per month or 40 hours per week $9.20 per hour. If the client reaches the 150% FPL all 1915i services are discontinued immediately.

According to our data, there is only a small percentage of the clientele who will be deemed eligible for 1915i services. Reasons why include: the client's WHODAS score was not high enough or the client is currently working and does not meet the 150% FPL.

There are 221 clients working with Community Options Brain Injury Pre-Vocational and Return to Work programs and the Supported Employment programs. Of this number only 22 clients would be eligible to receive services from the 1915i.



As a result of so many clients not meeting eligibility criteria for 1915i services, Community Options is requesting this committee consider keeping the Pre-Vocational and Return to Work Brain Injury programs as well as the Supported Employment Programs.

In conclusion, there will always be a need of services for those people not meeting the 1915i eligibility guidelines. Community Options is requesting this committee fully fund these programs and extend the date to 6/30/2023 to ensure there is no gap in services for the currently served clients. If funds are not replenished in the DHS budget there will be almost 200 clients affected by this decision and will go without services as of 1/1/2022.

I appreciate your time and consideration in these matters listed above. Thank you, do you have any questions?

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CPAs & BUSINESS ADVISORS

SENATE APPROPRIATIONS COMMITTEE

House Bill 1012, Fair Rental Value

HISTORICAL PROPERTY RATE SETTING

- Current property rates are set based on accounting standards reporting of depreciation on allowable capital assets and interest on related debt financing
- Building and fixed equipment capital assets are subject to a per bed maximum allowable cost which limits what a facility can invest
- Depreciation on capital assets is calculated based on a straight-line method over an estimated useful life set based on AHA guidelines
- Interest expense is based on the payment terms of the allowable debt and includes the amortization of debt financing costs
- The allowable depreciation and interest are divided by actual cost report year resident days or 90% occupancy days, whichever is higher, to get to the rate per day
- ($500,000 of depreciation + $400,000 of interest expense) divided by 25,000 days = $36 rate per day

HISTORICAL PROPERTY RATE SETTING

- Current system provides for high rates in the earlier years after a major project, and decreasing rates as it ages due to short lives of some assets
- Current system only repays facilities for cost of capital projects over future years which discourages renovations as it will always require debt
- Current system does not provide funding to build reserves for future projects which leads to large projects having to be funded with debt which increases overall cost

PROPOSED FAIR RENTAL VALUE (FRV)

- Property rate would be based on a % return of the fair value of all allowable capital assets to determine the Fair Rent
- Capital asset Fair Value will still be subject to a per bed limit that is based on RS Means cost per square foot multiplied by an allowable square footage per bed license (entire facility space)
- Equipment is limited to $15,000 per bed license and land and land improvements are limited to 10% of the building limits
- FRV is adjusted annually for depreciation, changes in the effective age and an inflation factor
- Effective age increases annually, but can be decreased by capital renovations made which encourages ongoing maintenance
- The Fair Rent is then divided by actual cost report year days or 90% occupancy days, whichever is higher, to get to the rate per day

PROPOSED FAIR RENTAL VALUE (FRV)

- FRV will provide a more stable property rate
  - Early year rates will not be as high as current system, estimated cap is $62.14 vs $86 currently the high rate
  - Rate will remain stable over time as long as the facility maintains the buildings
- FRV will provide revenue streams that will help facilities reserve for future projects and encourages renovations over time without having to utilize debt to fund the entire project
- See Attachment 3 for calculation examples of new projects

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FRV FOUR YEAR PHASE IN

- 71 facilities are estimated to see an increase in their property rates due to the transition from historical property rate setting to FRV
- These 71 facilities will see an average estimated impact of $7 per day increase in total on their rates that will increase the estimated Medicaid spending by $8,619,000
- FRV proposed rate setting will phase this increase in over 4 years at an estimated cost of $2,155,000 in each of the fiscal years 2023-2026
- Information is included as Attachment 1

FRV HOLD HARMLESS

- 8 existing facilities are estimated to have property rates as set under the current property rate rules that will exceed the 1/1/23 FRV rates based on 2020 rate data
- The Medicaid cost for these facilities is already included in the current DHS budget, there is no new money needed to keep them under the current property rate system
- If these 8 facilities were forced to move their rates down to FRV on 1/1/23, it would reduce revenues to them by an estimated $1,500,000 based on the estimated FRV vs current 2021 property rates, this could lead to debt obligation issues
- Of these 8, 3 are estimate to transition to FRV in year 1 with all but 1 transitioning by year 8
- Missouri Slope will be new in 2021 and is not expected to transition to FRV as the interest rate on the debt is too high
- See information provided in Attachment 2 and 3

QUESTIONS?

Thank you for the opportunity to share this information with you.

Bradley W DeJong, CPA
Partner, Director of Senior Living Services
Eide Bailly LLP
Fargo, ND

Attachement 1

Facility Name	2019 Licensed Beds Per Survey or Ortherwise 2018 Beds per State	2020 Census	Lower Of Actual or Maximum Sq Feet Per Bed	FRV/PPD adjusted for 90% occupancy (fair rent/patient days)	Current Property Rate per Day	Difference per Day		Increase Rate change Medicaid Impact	Property Rate Increases Capped at 25%	Annual Impact
Aneta Parkview Health Center	39	12,604	600.00	$ 30.59	$ 25.88	$ 4.71		$ 51,739	$ 1.18	$ 12,935
Ashley Medical Center	40	10,884	421.13	$ 16.58	$ 10.44	$ 6.14		$ 45,558	$ 1.54	$ 11,390
Augusta Place - a Prospera Commur	48	17,332	848.19	$ 48.05	$ 44.95	$ 3.10		$ 31,714	$ 0.78	$ 7,929
Ave Maria Village	100	35,494	588.85	$ 27.83	$ 22.68	$ 5.15		$ 100,360	$ 1.29	$ 25,090
Baptist Health Care Center	140	50,517	950.00	$ 50.51	$ 38.88	$ 11.63		$ 324,039	$ 2.91	$ 81,010
Benedictine Living Center of Garriso	52	18,262	388.65	$ 16.91	$ 16.34	$ 0.57		$ 5,246	$ 0.14	$ 1,311
Bethany on 42nd	116	42,053	950.00	$ 55.89	$ 46.52	$ 9.37		$ 209,355	$ 2.34	$ 52,339
Bethany on University	172	60,599	891.84	$ 51.62	$ 41.32	$ 10.30		$ 238,460	$ 2.58	$ 59,615
Bethel Lutheran Nursing & Rehabilit	150	42,625	600.00	$ 22.85	$ 10.58	$ 12.27		$ 281,841	$ 3.07	$ 70,460
Dunseith Community Nursing Home	30	9,218	730.53	$ 22.79	$ 8.46	$ 14.33		$ 126,587	$ 3.58	$ 31,647
Elim Care Center	136	40,873	600.00	$ 22.85	$ 11.07	$ 11.78		$ 201,302	$ 2.94	$ 50,325
Elm Crest Manor	68	24,543	950.00	$ 43.47	$ 21.09	$ 22.38		$ 296,482	$ 5.60	$ 74,121
Eventide Heartland	82	28,561	600.00	$ 33.25	$ 29.67	$ 3.58		$ 62,096	$ 0.90	$ 15,524
Eventide Jamestown	115	35,832	600.00	$ 30.59	$ 22.41	$ 8.18		$ 177,334	$ 2.04	$ 44,334
Fargo Nursing and Rehab Center, LL	110	23,989	700.00	$ 34.46	$ 33.59	$ 0.87		$ 12,147	$ 0.22	$ 3,037
Four Seasons Health Care Center	37	12,421	690.51	$ 29.77	$ 19.77	$ 10.00		$ 62,830	$ 2.50	$ 15,707
Garrison Memorial Hospital Nursing	28	8,064	291.96	$ 12.06	$ 10.86	$ 1.20		$ 5,953	$ 0.30	$ 1,488
Golden Acres Manor	64	21,959	502.25	$ 15.44	$ 8.17	$ 7.27		$ 88,342	$ 1.82	$ 22,086
Good Samaritan Society Bottineau	52	15,037	826.69	$ 30.79	$ 13.43	$ 17.36		$ 136,549	$ 4.34	$ 34,137
Eventide Devils Lake Care Center	48	16,573	600.00	$ 14.38	$ 6.64	$ 7.74		$ 88,146	$ 1.93	$ 22,037
Good Samaritan Society Lakota	38	11,959	812.32	$ 30.29	$ 14.73	$ 15.56		$ 123,747	$ 3.89	$ 30,937
Good Samaritan Society Larimore	42	13,310	667.07	$ 29.46	$ 17.24	$ 12.22		$ 67,782	$ 3.05	$ 16,946
Good Samaritan Society Mohall	57	16,703	597.12	$ 26.60	$ 17.14	$ 9.46		$ 88,009	$ 2.37	$ 22,002
Good Samaritan Society Mott	42	13,543	654.50	$ 24.76	$ 14.26	$ 10.50		$ 78,455	$ 2.62	$ 19,614
Good Samaritan Society Oakes	59	19,173	716.51	$ 26.93	$ 12.52	$ 14.41		$ 151,489	$ 3.60	$ 37,872
Good Samaritan Society Park River	54	17,272	522.91	$ 20.15	$ 14.77	$ 5.38		$ 45,066	$ 1.34	$ 11,266
Griggs County Care Center	44	13,390	600.00	$ 30.59	$ 26.22	$ 4.37		$ 35,150	$ 1.09	$ 8,787
Heart of America Care Center	55	16,943	600.00	$ 26.72	$ 19.71	$ 7.01		$ 67,297	$ 1.75	$ 16,824
Hill Top Home of Comfort	58	20,474	559.91	$ 23.34	$ 19.09	$ 4.25		$ 48,724	$ 1.06	$ 12,181
Knife River Care Center	86	30,888	702.29	$ 32.35	$ 29.68	$ 2.67		$ 52,549	$ 0.67	$ 13,137
Luther Memorial Home	99	30,694	600.00	$ 18.98	$ 7.85	$ 11.13		$ 153,425	$ 2.78	$ 38,356
Lutheran Home of the Good Shephe	75	20,152	533.33	$ 27.47	$ 25.19	$ 2.28		$ 22,090	$ 0.57	$ 5,523
Lutheran Sunset Home	91	31,344	614.45	$ 22.27	$ 11.25	$ 11.02		$ 178,033	$ 2.76	$ 44,508

Maple Manor Care Center	63	16,102	800.00	$	44.16	$ 41.53	$ 2.63	$	20,028	$	0.66	$ 5,007
Marian Manor Healthcare Center	72	23,307	822.83	$	25.49	$ 9.59	$ 15.90	$	205,823	$	3.97	$ 51,456
Maryhill Manor	48	15,672	676.29	$	34.15	$ 23.41	$ 10.74	$	109,634	$	2.69	$ 27,408
Missouri Slope Lutheran Care Cente	250	84,253	675.94	$	33.27	$ 20.98	$ 12.29	$	585,208	$	3.07	$ 146,302
Mountrail Bethel Home	48	10,681	600.00	$	30.59	$ 22.36	$ 8.23	$	29,527	$	2.06	$ 7,382
Napoleon Care Center	36	11,249	641.72	$	32.54	$ 29.04	$ 3.50	$	20,019	$	0.87	$ 5,005
Nelson County Health System Care (	39	13,388	513.21	$	15.74	$ 8.36	$ 7.38	$	60,399	$	1.84	$ 15,100
North Dakota Veterans Home	52	17,540	700.00	$	33.56	$ 31.64	$ 1.92	$	14,495	$	0.48	$ 3,624
Northwood Deaconess Health Cente	45	13,566	600.00	$	30.59	$ 22.55	$ 8.04	$	62,110	$	2.01	$ 15,527
Parkside Lutheran Home	38	12,742	881.34	$	42.84	$ 21.24	$ 21.60	$	148,747	$	5.40	$ 37,187
Prince of Peace Care Center	53	12,910	457.36	$	11.78	$ 6.50	$ 5.28	$	44,613	$	1.32	$ 11,153
Rolette Community Care Center	40	14,092	800.00	$	46.63	$ 43.39	$ 3.24	$	39,843	$	0.81	$ 9,961
Rosewood on Broadway	125	43,152	786.24	$	42.10	$ 37.88	$ 4.22	$	92,978	$	1.06	$ 23,245
Sanford Hillsboro	30	10,915	691.47	$	39.43	$ 39.00	$ 0.43	$	3,258	$	0.11	$ 814
Sheyenne Care Center	170	48,628	807.52	$	40.28	$ 27.76	$ 12.52	$	400,220	$	3.13	$ 100,055
Sheyenne Crossings Care Center/TC	64	22,510	700.00	$	37.09	$ 36.47	$ 0.62	$	4,355	$	0.16	$ 1,089
Souris Valley Care Center	50	14,377	417.28	$	16.45	$ 10.41	$ 6.04	$	47,818	$	1.51	$ 11,955
Southwest Healthcare Services	40	12,962	600.00	$	30.59	$ 20.34	$ 10.25	$	72,651	$	2.56	$ 18,163
St Vincent's - a Prospera Communit	101	36,141	762.68	$	30.63	$ 16.89	$ 13.74	$	287,690	$	3.44	$ 71,923
St. Aloisius Medical Center	80	25,038	786.11	$	44.24	$ 38.94	$ 5.30	$	85,351	$	1.32	$ 21,338
St. Benedict's Health Center	124	40,005	529.27	$	20.37	$ 10.49	$ 9.88	$	209,721	$	2.47	$ 52,430
St. Catherine's Living Center	52	16,565	766.77	$	38.38	$ 20.43	$ 17.95	$	161,477	$	4.49	$ 40,369
St. Gerard's Nursing Home	35	11,172	950.00	$	36.86	$ 10.43	$ 26.43	$	139,888	$	6.61	$ 34,972
St. Luke's Home	88	30,805	950.00	$	57.88	$ 47.29	$ 10.59	$	162,301	$	2.65	$ 40,575
St. Luke's Sunrise Care Center	40	11,435	600.00	$	26.72	$ 15.06	$ 11.66	$	50,526	$	2.91	$ 12,631
St. Rose Care Center	44	13,758	410.84	$	10.69	$ 6.43	$ 4.26	$	28,337	$	1.07	$ 7,084
Strasburg Nursing Home	55	17,924	754.00	$	23.48	$ 7.37	$ 16.11	$	191,537	$	4.03	$ 47,884
Sunset Drive - a Prospera Communit	128	44,785	633.05	$	30.17	$ 25.20	$ 4.97	$	144,758	$	1.24	$ 36,189
Tioga Medical Center LTC	30	9,380	417.03	$	22.04	$ 22.03	$ 0.01	$	132	$	0.00	$ 33
Towner County LivingCenter	30	9,837	600.00	$	30.59	$ 24.35	$ 6.24	$	21,848	$	1.56	$ 5,462
Tri-County Reitrement and Nursing	39	12,991	950.00	$	48.07	$ 21.05	$ 27.02	$	184,594	$	6.76	$ 46,148
Trinity Homes	230	69,416	811.07	$	30.24	$ 12.23	$ 18.01	$	300,091	$	4.50	$ 200,023
Villa Maria Health Care	120	43,701	632.32	$	25.62	$ 15.92	$ 9.70	$	228,689	$	2.43	$ 57,172
Wedgewood Manor	50	13,619	600.00	$	22.85	$ 12.31	$ 10.54	$	70,421	$	2.63	$ 17,605
Western Horizons Care Center	45	14,732	592.38	$	22.58	$ 10.45	$ 12.13	$	112,389	$	3.03	$ 28,097
Wishek Living Center	60	18,784	600.00	$	18.98	$ 7.72	$ 11.26	$	99,019	$	2.81	$ 24,755
Woodside Village	138	48,887	674.29	$	35.57	$ 34.61	$ 0.96	$	21,549	$	0.24	$ 5,387
	5,891	**1,897,153**		**$**	**33.08**	**$ 25.64**	**$ 7.44**	**$**	**8,619,942**			**$ 2,154,985**

Attachment 2

Facility Name	2019 Licensed Beds Per Survey or Ortherwise 2018 Beds per State	2020 Census	Lower Of Actual or Maximum Sq Feet Per Bed	FRV/PPD adjusted for 90% occupancy (fair rent/patient days)	Current Property Rate per Day	Difference per Day		Annual Hold Harmless Medicaid Impact (difference/day times medicaid days)
Eventide Fargo	98	34,282	950.00	$ 61.42	$ 67.60	$ (6.18)		$ (90,775)
McKenzie County Healthcare Systen	47	13,887	782.55	$ 51.95	$ 80.00	$ (28.05)		$ (169,360)
Miller Pointe - a Prospera Communi	120	42,592	841.49	$ 48.52	$ 54.25	$ (5.73)		$ (159,141)
Minot Health and Rehab LLC	114	21,904	377.72	$ 20.20	$ 27.09	$ (6.89)		$ (69,891)
Pembilier Nursing Center	37	12,996	600.97	$ 32.27	$ 37.97	$ (5.70)		$ (30,087)
Richardton Health Center Inc	28	9,590	584.46	$ 38.06	$ 65.54	$ (27.48)		$ (182,092)
St. Gabriel's Community	72	25,544	800.00	$ 46.30	$ 49.05	$ (2.75)		$ (34,972)
Valley Eldercare Center	196	66,052	661.89	$ 36.76	$ 38.33	$ (1.57)		$ (62,870)
	5,891	1,897,153						**$ (799,188)**

Attachment 3
NDLTCA
HB 1090
Fair Rental Value Calculations
- Hold Harmless Impacts

Estimated New Project with Full Replacement of a 100 Bed Facility

2.5% Project Loan at 100% of Cost

Year	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	[illegible]	[illegible]
2	53.71	62.20
3	53.20	62.23
4	52.05	62.24
5	51.51	62.23
6	48.32	62.19
7	47.76	62.13
8	47.18	62.03
9	46.58	61.91
10	45.97	61.76
11	39.47	61.58
12	38.83	61.36
13	38.17	61.12
14	37.50	60.84
15	36.81	60.52

5% Project Loan at 100% of Cost

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 75.94	$ 62.14
75.29	62.20
74.59	62.23
73.24	62.24
72.48	62.23
69.04	62.19
68.20	62.13
67.31	62.03
66.37	61.91
65.39	61.76
[illegible]	[illegible]
57.41	61.36
56.27	61.12
55.07	60.84
53.81	60.52

6.5% Project Loan at 100% of Cost

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 89.03	$ 62.14
88.38	62.20
87.68	62.23
86.31	62.24
85.52	62.23
82.04	62.19
81.14	62.13
80.17	62.03
79.15	61.91
78.05	61.76
71.01	61.58
69.76	61.36
68.43	61.12
67.01	60.84
[illegible]	[illegible]

2.5% Project Loan at 95% of Cost

Year	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	[illegible]	[illegible]
2	52.66	62.20
3	52.17	62.23
4	51.05	62.24
5	50.53	62.23
6	47.38	62.19
7	46.84	62.13
8	46.29	62.03
9	45.72	61.91
10	45.14	61.76
11	38.67	61.58
12	38.06	61.36
13	37.44	61.12
14	36.80	60.84
15	36.14	60.52

5% Project Loan at 95% of Cost

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 73.78	$ 62.14
73.15	62.20
72.50	62.23
71.18	62.24
70.45	62.23
67.06	62.19
66.25	62.13
65.41	62.03
64.52	61.91
63.59	61.76
[illegible]	[illegible]
55.71	61.36
54.63	61.12
53.49	60.84
52.29	60.52

6.5% Project Loan at 95% of Cost

Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
$ 86.21	$ 62.14
85.59	62.20
84.93	62.23
83.60	62.24
82.84	62.23
79.41	62.19
78.55	62.13
77.63	62.03
76.66	61.91
75.62	61.76
68.63	61.58
67.45	61.36
66.18	61.12
64.83	60.84
[illegible]	[illegible]

Specific Facility Holdharmless Estimates

- assumes zero new capital expenditure for both sides of the calculation

Year	Missouri Slope, 6.625% Int Rate		Richardton, 3.5% Int Rate		Miller Point, 3.0% Int Rate	
	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 109.42	$ 62.43	$ 61.71	$ 36.04	[illegible]	[illegible]
2	109.28	62.49	60.77	36.00	40.76	50.48
3	108.67	62.54	60.04	35.95	39.51	50.41
4	107.12	62.55	59.29	35.88	39.01	50.32
5	106.43	62.54	58.17	35.79	38.40	50.20
6	101.93	62.51	37.93	35.69	37.71	50.06
7	101.14	62.45	37.09	35.57	33.86	49.89
8	100.30	62.37	[illegible]	[illegible]	33.07	49.69
9	99.40	62.25	34.53	35.26	32.55	49.47
10	98.43	62.11	33.79	35.08	32.07	49.22
11	89.72	61.93	29.83	34.88	25.23	48.94
12	88.62	61.73	29.07	34.65	24.16	48.63
13	87.45	61.49	28.26	34.40	23.66	48.28
14	86.20	61.21	27.44	34.13	23.15	47.90
15	[illegible]	[illegible]	26.60	33.83	22.62	47.49

Year	St Gabriel's,		Eventide		McKenzie County	
	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	$ 47.26	$ 40.36	[illegible]	[illegible]	$ 86.10	47.60
2	46.13	40.24	54.16	56.57	85.59	47.57
3	44.53	40.11	52.98	56.49	79.56	47.53
4	42.62	39.95	50.95	56.38	79.02	47.46
5	41.42	39.77	46.01	56.25	78.41	47.37
6	[illegible]	[illegible]	44.75	56.09	76.12	47.26
7	37.23	39.34	43.27	55.91	75.55	47.12
8	31.29	39.09	42.05	55.69	62.59	46.96
9	29.75	38.81	39.90	55.44	61.99	46.78
10	27.49	38.50	35.06	55.16	59.35	46.57
11	25.68	38.17	33.72	54.85	58.72	46.33
12	24.21	37.81	32.28	54.50	58.08	46.07
13	22.66	37.42	30.78	54.11	49.48	45.77
14	21.04	37.00	29.11	53.69	48.81	45.45
15	19.33	36.54	26.90	53.23	[illegible]	[illegible]

Year	Valley Senior	
	Historical Rate Calculation Estimate	Fair Rental Value Rate Calculation Estimate
1	[illegible]	[illegible]
2	29.70	39.49
3	24.02	39.42
4	21.44	39.32
5	19.36	39.21
6	16.81	39.07
7	15.47	38.92
8	13.96	38.74
9	12.48	38.55
10	9.89	38.32
11	8.37	38.08
12	7.68	37.80
13	6.56	37.51
14	4.98	37.18
15	3.36	36.83

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/9/2021 PM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 2:12 PM

Senators present: **Holmberg, Krebsbach, Wanzek, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern. Senator Bekkedahl and Senator Heckaman** were absent.

Discussion Topics:

- Services Cuts
- Rural Hospitals
- Medicaid Expansion

Tim Blasl, President, North Dakota Hospital Association, testified in favor and submitted testimony #8104.

Dave Molmen, CEO, Altru Health System, testified in favor and submitted testimony #8293

Mike Delfs, CEO, Jamestown Regional Medical Center, testified in favor and submitted **testimony** #8234

Jane Jerzak, NDHA Advocate, testified in favor and submitted testimony #8232

Kurt Snyder, Executive Director, Heartview Foundation, testified in favor and submitted testimony #8298.

Ty Hegland, Volunteer Chair, NDATPC, testified in favor and submitted testimony #8164.

Brenda Owen, testified in favor and submitted testimony #8500.

Holly Johnson, North Dakota Autism Spectrum Disorder Task Force, testified in opposition and submitted testimony #8202, #8206, #8205, #8204, #8203.

Senator Fors, District 19, submitted an amendment LC 21.0271.02002; testimony #7755.

Shelly Peterson, President, ND Long Term Care Association, testified in favor and submitted testimony #8380.

Denise Harvey, Director of Program Services, ND Protection & Advocacy, testified in favor and submitted testimony #8383.

Arik Spencer, President and CEO, Greater North Dakota Chamber, testified in favor and submitted testimony # 7700.

Debra Johnson, CEO, Prairie Harvest Mental Health, testified in opposition and submitted testimony #7507.

Nancy McKenzie, Executive Director, Nexus-PATH Family Healing, testified in opposition and submitted testimony #8052.

Heather Simonich, Operations Director, Nexus-PATH Family Healing, testified neutrally and submitted testimony #8041.

Additional written testimony: #7915, #8093, #8103, #8105, #8182, #8207, #8271, #8291. #8319

Senator Holmberg closed the hearing at 4:49 p.m.

Skyler Strand, Committee Clerk

2021 HB 1012
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 9, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to testify in support of House Bill 1012 (as introduced). I ask that you give this bill a **Do Pass** recommendation.

Medicaid (Traditional)

Medicaid payments play an important role in hospitals' finances, which can affect beneficiaries' access to care. Like other public payers, Medicaid payments do not cover the cost to the hospital of providing the care, resulting in payment shortfalls. Adequate provider payment rates help to ensure improved outcomes and access to necessary medical services for the people who rely on Medicaid to get their health care.

Medicaid Expansion

Medicaid Expansion was designed to significantly reduce the number of uninsured and improve their health by providing access to routine health care and preventive screenings. Covering about 24,000 North Dakotans, Medicaid Expansion has been very good not only for patients, but North Dakota communities and health care providers as well. The federal government pays 90% of the cost. This requires the state to pay only 10% – considerably less than the 50% the state pays for traditional Medicaid enrollees. Before the program was authorized, North Dakota hospitals' bad debt and charity care rose from $102 million in 2008 to $274 million in 2014—a nearly threefold increase. Thanks to Medicaid Expansion, hospital bad debt has dropped by nearly 50 percent. This significant decrease in uncompensated care has contributed to positive operating margins for a number of our hospitals.

We support reauthorization of Medicaid Expansion at the rates that were appropriated last session. We are not asking for an increase. We are simply asking that current rates – rates that have been in place with no increase since 2014 – be maintained. The cut being proposed by the Department of Human Services (Department) represents a reduction of $100 million annually to hospitals (acute care hospitals). It makes little fiscal sense to cut $10 million in general funds and lose the corresponding $90 million in federal funds which amounts to an approximately 45 percent cut in hospital reimbursement.

The federal share for Medicaid Expansion is a nine to one return on investment. It provides dollars that flow directly into local communities, supporting wages, employment, consumer spending, and state tax revenue. It is critical to covering operating costs at our hospitals and clinics, the loss of which will result in staff cuts and closed facilities.

It has also been proposed to move administration of the Medicaid expansion program away from a private carrier and to the Department. We feel the administration of the Medicaid expansion program by a private carrier has worked well and our members would like to see that continue. We are also concerned with the FTEs that the Department is requesting to add in order to administer Medicaid Expansion and that they will not be sufficient to provide the strong managed care being provided by the current private carrier.

Medicaid – Value-Based Purchasing

NDHA supports a collaboration between the State and hospitals to design a Value-Based Purchasing model that will create incentives that encourage enrollees to take personal responsibility for their health, provide program cost certainty, and support practice innovations that further the objectives of efficient, patient-centered care delivery.

Conclusion

In summary, hospitals treat and care for the citizens of North Dakota in a variety of settings and at a number of locations. Services must be provided 24 hours a day, seven days a week, 365 days a year, and the competition for employees has been raised to a new level. I ask that you support reauthorizing Medicaid Expansion at current reimbursement rates, maintain administration by a private carrier, and providing for a partnership model between the State and provider organizations to implement a Value- Based Purchasing model.

For these reasons, we support HB 1012 and ask that you give it a Do Pass recommendation. Thank you. I would be happy to address any questions you may have.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Chairman Holmberg and members of the committee, thank you for the opportunity to appear before you today. For the record, my name is Dave Molmen and it is my privilege to serve as CEO of Altru Health System. I am here to offer comments in support of HB 1012.

I want to begin by thanking you, legislators, for your longstanding support for and focus on healthcare needs in our state. Your work has had an incredibly positive impact for our people.

This afternoon you will hear testimony on various aspects of Medicaid Expansion, and in my comments, I would like to focus on the historical underpinnings of our program in North Dakota.

This committee has heard prior testimony asserting that payments under this program are higher than other states, and as such, should be reduced to be more "in line" with those other states. While on the surface, that argument may have some appeal, it doesn't hold up when we look at the facts.

I would like to briefly walk you through an understanding of how North Dakota came to expand Medicaid to explain why we feel the issue has been wrongly framed, and why it would not be advisable to implement reductions.

When the Affordable Care Act was signed into law in 2010, it created the Medicaid Expansion program wherein, if states determined to extend Medicaid eligibility to those with incomes of up to 138% of federal poverty level, the federal government would provide 100% of the funding to do so in 2014, phasing down to 90% in 2020 and beyond.

The question of Medicaid Expansion was debated vigorously in the North Dakota legislature in 2013. Although the program held the promise of making care available to low-income families with a large federal match, legislators were concerned, both about the long-term sustainability of the program and whether the federal share of funding would remain true to the initial representations.

Ultimately, the Legislature recognized the high benefit of this program to over 20,000 North Dakota citizens and moved ahead with plans to implement. It was the right thing to do for the health and well-being of North Dakotans, and in the succeeding years Legislators' wisdom would be borne out.

It's important to recognize that, after authorization, a parallel debate was taking place among our state's health care providers. Hospitals in the US had $160 billion cut from their Medicare payments to pay for Medicaid Expansion and other components of the Affordable Care Act. On one hand, participation in this program was a way to get some of that money back, but on the other, providers had severe concerns about the stability and funding of the program and for taking on a new category of care that may pose new risks, especially the risk of cost shifting. For a time, it appeared as though we might not be able to get enough contracts with providers to cover the state for care.

Now here's the important part, and I'm going to call this the North Dakota way.

I'm sure you're all aware of many situations in which North Dakota gets treated unfairly under Federal programs in comparison to many more populous, more urban states. Medicaid Expansion, by contrast, is an example where North Dakota used skill in negotiating our unique position to achieve something very good for our state.

The Obama administration had, to the time of our negotiation with them in 2013, not been successful in getting Expansion authorized and implemented in any "red state". It was highly motivated to do so, and willing to do what was needed to get it going in North Dakota. The bottom line is that in these negotiations, they agreed to terms that would provide a rate of payment for services in North Dakota that would not have to be cross subsidized by other patients, as they do in other states. This was a major victory and it leveraged our position as a small rural state to get terms that worked our state. As I said, we can find plenty of examples where it hasn't worked that way for North Dakota, but this is something that over the years has delivered huge benefits to our people. Nearly a decade into the program, the federal government continues to pay 90% of the cost.

Mr. Chairman and members, should the state reverse this position, health care will be put at great risk. That move would result in only a small relative benefit (10%) to our state coffers, while turning away well over $100 million from our economy every year. $100 million dollars *every year.* I think of what we do in North Dakota to bring any enterprise into the state that brings with it $100 million in revenues annually. Think what a loss it would be to send $100 million out of the state every year.

It's important to remember that over half of that $100 million goes to directly pay nurses, doctors, and other workers, who provide the care to our people, pay taxes, build houses, and buy groceries. That's nearly 1,000 jobs across our state. Jobs in Hettinger, and Harvey, Bismarck and Grand Forks, Mayville and Jamestown; those are jobs of people caring for their neighbors in every community, my community and yours.

I want to emphasize that this is an issue that impacts all providers of care and does so in equal proportion in every community in our state, those in our rural areas and larger cities alike. I'm confident that if asked, health care leaders in any community, small or large, they would tell us the loss of this reimbursement would be a devastating blow. For many of our institutions, the reduction would be larger than their entire bottom line.

Study after study after study has shown that in other states *the payment for services under their Medicaid programs are less than the cost providers' incur to deliver them*. This means that in those states the burden must be shifted to commercial payors or other sources. The tab has to be picked up by their Blue Cross Blue Shield plans, other payment sources, or somehow cut out of services delivered.

Emulating other states' model does not strike me as a formula for success.

Although I do not have access to the figures for the whole state, I would speculate that, in our state, implementation of the reimbursement reductions advocated by the DHS would cut payments by 40% or in some cases, nearly in half. Given historically low margins of hospitals in our State, it doesn't take any complex actuarial formula to conclude that if you reduce the payment for any

type of service by 40-50%, that service would then have to now have to be subsidized by other services or payments from other sources. And I would say that for any form of payment, whether it was Medicaid, commercial insurance, or any other form of payment.

My question is, why would we do that? Why would we want to severely cut the payments to support the program only to send the money that could pay for it out of the State of North Dakota to Washington DC? Why would we purposely underpay services and then turn away $9 to at best save 1?

The North Dakota Legislature was wise to expand our Medicaid program. It's done immeasurable good for our citizens and our state. We negotiated well and effectively to ensure the program's sustainability. Mr. Chairman and members of the committee, I ask that in your wisdom you act to protect our success and see that it not be undone. I would further encourage you to remove the "sunset" provision in the bill as unnecessary. This is an important component of our state's budget and would receive the needed scrutiny without sunsetting the entire authorization every biennium.

Chairman Holmberg, I'll close where I started. I thank the members of this committee for their selfless efforts on behalf of our citizens. As we move into the future, we're eager to discuss how we might continue to build toward a healthier and more productive State.

Senate Appropriations Testimony

Medicaid Expansion

March 9th, 2021

INTRODUCTION:

Name: Mike Delfs

Position: President/Chief Executive Officer

Organization: Jamestown Regional Medical Center

Chairman Holmberg and Members of the Appropriations Committee,

I appreciate the challenging and important work all of you are doing for North Dakota and I'm thankful for your willingness to serve. The legislature and the ND Hospital Association have accomplished some amazing things to positively impact the health of North Dakotans and provide coverage for at-risk individuals, particularly those who fall within the confines of the Medicaid Expansion program.

Thank you for the time to today to present information on what Medicaid Expansion means to Healthcare across the state, to the communities we serve and most importantly, to the people whose healthcare needs we serve.

As stated previously, but certainly worth repeating; there are few programs that can boast a 10% state contribution to access an additional 90% from the federal government. While some have asserted the payment rate is too high, I would remind everyone that the rate was set high by design. To mitigate cost shifting to other programs and payers, the healthcare providers and state worked together to establish a rate that could stand on its own and not produce the unintended consequence of cost shifting. In fact, one need only look at our neighbor to the south to see the effects of a state that did not enroll in Medicaid Expansion (essentially take only Medicaid rates). South Dakota's commercial rates are higher around 190% of Medicare fee schedule rates for professional fees and 260% of Medicare fee schedule rates for Facility Fees while in ND we are at 170% and 175% respectively according to a 2020 Rand study.

It is important to keep in perspective that the funding used for Medicaid Expansion by the Federal Government (the 90%) is originated through the taxes paid by North Dakotans and decreasing the amount the state takes through the federal match is essentially taking North Dakotan's tax dollars and consciously sending this funding elsewhere in the U.S. The portion of all of our taxes that goes to pay for the program will not decrease simply because the state decreases payment to healthcare providers.

The positive impact of the Medicaid Expansion dollars can't be overstated. Aside from the obvious positive influence of decreased bad debt, more patients qualifying for coverage and therefore seeking out care, the secondary but equally important economic impact for our communities is vital across the state. Economically, these dollars flow through to communities and end up as money spend at the local hardware store, grocery story, car dealership, or spent on a new home and countless other ways. What would the state do to attract $125 million to the economy of North Dakota and to our communities around the state?

Primarily, the Medicaid Expansion program has improved health of our citizens who receive care on a regular, consistent basis, with properly managed chronic conditions (such as hypertension and diabetes), and now receive much needed screenings that mitigate potential life threatening conditions and expensive treatment.

While providing medical care to an at-risk population, the Medicaid Expansion reimbursement has also provided a safety net to North Dakota's hospitals by reducing the amount of uncompensated care, commonly known as bad debt. For decades, segments of our population without medical coverage or with poor coverage, have used the emergency room as their healthcare option when their conditions became so bad they had no choice but to seek emergency assistance. As you may know, emergency room fees can run as much as ten times the fees of a primary care visit which further exacerbates the problem.

Consider the primary impact to hospitals and healthcare providers of losing these dollars. The patients who fall within the Medicaid Expansion rates do not simply "go away" if the reimbursement is reduced down to traditional Medicaid Rates. They continue to need services while the costs associated with providing care for them i.e. salaries of nurses, doctors, technicians, people to keep the facility germ free etc. do not change and in fact most often go up year-over-year to meet the increased cost of living. Similarly, the cost of medical (and nonmedical) supplies, drugs, equipment etc. continue to increase every year. Unfortunately, the fact remains; there are very few services that break even at traditional Medicaid rates and in fact, most services are reimbursed at a significant loss at traditional Medicaid rates. These

losses range from 30% up to 50% or more on every dollar spent. This is true at all hospitals and healthcare providers across the U.S.

What could this mean for your local hospital? For example, at Jamestown Regional Medical Center, decreasing payment down to traditional Medicaid rates would result in a loss between $900,000 and $1 million dollars per year. Hospitals across the state, including Jamestown Regional Medical Center, and the communities we serve, will be faced with some extremely hard choices. Are there services that the community needs but we can no longer provide? Will patients have to drive hundreds of miles to get the same services they are receiving locally today? Will your rural hospital be there in the future if they are no longer paid at the current rate for these patients? This is not an overly dramatic question to ask.

New information has just came out in January of 2021 from CHPQR (Center for Healthcare Quality and Payment Reform) a national association dedicated to improving quality and exploring payment reform. They have assessed how many rural hospitals in each state are at immediate and high risk for closing. In ND, 9 rural hospitals are at immediate risk for closing with another 7 at high risk for closing. While some of this is due to the COVID-19 crisis, it illustrates that hospitals in ND do not have exorbitant bottom lines or that Medicaid Expansion dollars are reimbursement revenue that is the proverbial cherry on top. This reimbursement is vital for all hospitals to continue providing services locally be it a rural or urban setting.

I asking, on behalf of hospitals across the state that you continue reimbursement for the Medicaid Expansion program at the current levels. It helps patients, helps healthcare in maintaining the ability to serve our communities and it is good for the communities we serve both economically and from a healthcare perspective. In short, it is good for North Dakota.

Thank you.



8232

House Bill 1012

Medicaid Expansion Testimony

March 2021

WIPFLI

House Bill 1012 – Medicaid expansion

Information presented in this document is intended to address the value of:

- Reauthorizing the program
- Continuing with current reimbursement rates

Wipfli LLP is a national accounting & consulting firm focusing on the health care industry including hospitals, health systems, physician clinics and other providers:

- Strategic financial & capital planning
- Reimbursement
- Revenue cycle
- Audit and accounting

House Bill 1012 – Medicaid expansion

Our comments address the following:

- Why the current Medicaid expansion program is important to support the stability of healthcare in North Dakota
- What type of return on investment the Medicaid expansion program provides for the state
- How the data used to conclude on the program cost is in question

House Bill 1012 – Medicaid expansion

Medicaid expansion supports the stability of healthcare in North Dakota

House Bill 1012 – Medicaid expansion

Why the current Medicaid expansion program and current funding level is important to support the stability of healthcare in North Dakota

- North Dakota reports health concerns and access challenges.
- Healthcare workforce challenges impede access to care and care continuity.
- Care transformation is essential to ensure the right care is provided at the right time at the right place. Stable healthcare provider funding is required to support this significant initiative.
- A strong healthcare ecosystem supports economic stability of the State
- Medicaid Expansion has reduced hospital bad debt expense, which as benefited not only hospitals, but the State as well with a reduction in spending.

House Bill 1012 – Medicaid expansion

Need stable funding for care transformation

Goal: Healthy North Dakota

The hospitals in North Dakota acknowledge these workforce and demographic challenges and recognize the need to transform care to better address care access and care coordination with community health and social resources. However, the transformation process requires:

- Investment in technologies
- Well trained and stable healthcare workforce
- Access to health facilities and telemedicine capabilities

These initiatives are long term investments that hospitals and health systems around the state have been making. These investments require adequate and stable funding including Medicaid Expansion reimbursement rates that cover costs.

Source: The Robert Graham Center

House Bill 1012 – Medicaid expansion

Need stable healthcare for a stable economy

Business and industry focuses on the availability of high-quality healthcare and education systems for its employees.

"Hospitals are economic anchors in their communities"

North Dakota hospital facts (2016 Health Care Economic Impact Study NDHA):

- Employ 19,942 full time equivalents directly, 33,502 considering indirect jobs.
- According to Job Service North Dakota, the healthcare and social assistance industry represents the State's largest non-governmental employers. This industry employs one out of every seven (14.2%) of all workers in North Dakota.
- $5.7B - Effect of hospital expenditures on total state economic output.
- Each hospital job supports about two additional jobs, and every dollar spent by a hospital supports roughly $2.30 of additional business activity. (American Hospital Association)

House Bill 1012 – Medicaid expansion

Need Stable Healthcare for a Stable Economy

Business and industry focuses on the availability of high-quality healthcare and education systems for its employees.

- A stable source of hospital reimbursement through the Medicaid Expansion program is essential to provide for the economic stability of the hospital industry in the state, which benefits the entire state.
- **North Dakota cannot afford to lose any of its 47 hospitals including 36 critical access hospitals, providing essential healthcare to rural areas of the state.**

Source: American Hospital Association

House Bill 1012 – Medicaid expansion

Medicaid expansion – Learnings to date

- Medicaid expansion enrollment in most states is higher than initial estimates with a correlating reduction in uninsured rates
- Significantly improved healthcare access to low-income individuals
- Evidence of reduced psychological stress due to challenges paying healthcare bills
- Evidence of pent-up demand for care to date – creating higher costs:
  - Significant increase in prescription drug use (diabetes drugs, contraceptives and cardiovascular drugs)
  - Higher use of emergency department services
- Reduced risk of hospital closures especially in rural areas

Source: Kaiser Health News

House Bill 1012 – Medicaid Expansion

Medicaid expansion program provides an excellent return on investment for North Dakota

House Bill 1012 – Medicaid expansion

The Return on Investment

North Dakota Medicaid Expansion Estimates (Annual)		
Premium per member	14,107	
Number of members	21,100	
Total reported annual premium payments	297,650,200	
Funded with Federal $	267,885,180	90%
Funded with State $	29,765,020	10%

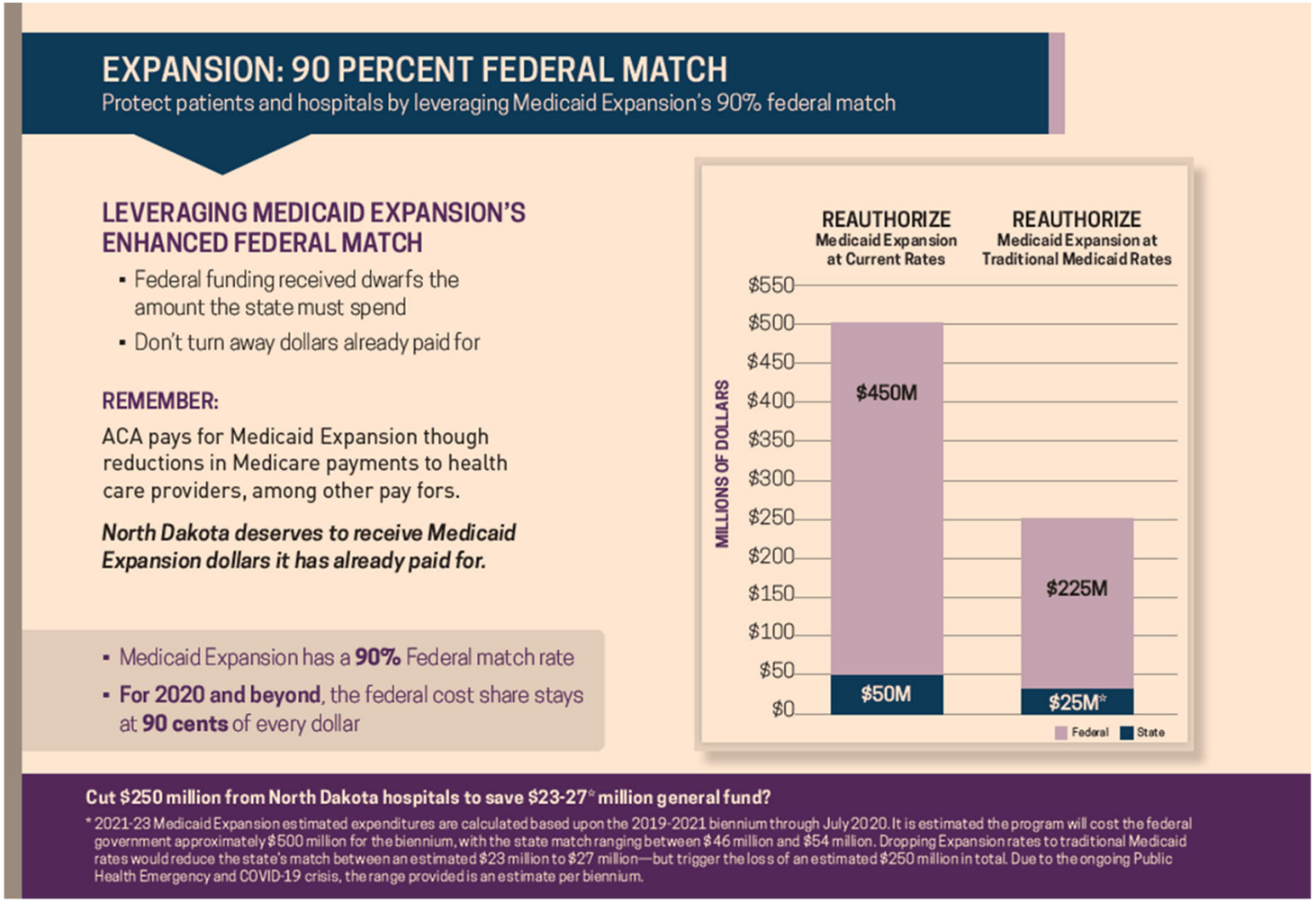
Source: North Dakota Human Services Report on House Bill 1012

North Dakota Medicaid Expansion Estimates (Annual)	
Funded with State $	29,765,020
Savings on State funding uncompensated care	(5,000,000)
Total State expenditure	24,765,020
Total General Fund budget (annual)	2,420,000,000
% of total General Budget	1.0%

Plus possible savings on:
- Behavioral Health
- Prisoner Health

- Medicaid Expansion is 90% funded with Federal Dollars.
- The State's investment is offset by other savings including savings on uncompensated care funded by the State.
- In total, Medicaid Expansion with offsets represents only 1% of the General Fund Budget.

House Bill 1012 – Medicaid expansion



Source: North Dakota Hospital Association

Medicaid expansion funding

- Reauthorization would cost the state $50M per biennium or $25M per year.
- Reducing Medicaid expansion to traditional Medicaid rates would cost the state $25M per biennium or $12.5M per year.
- This difference represents approximately 0.5% of North Dakota's general fund budget.

House Bill 1012 – Medicaid expansion

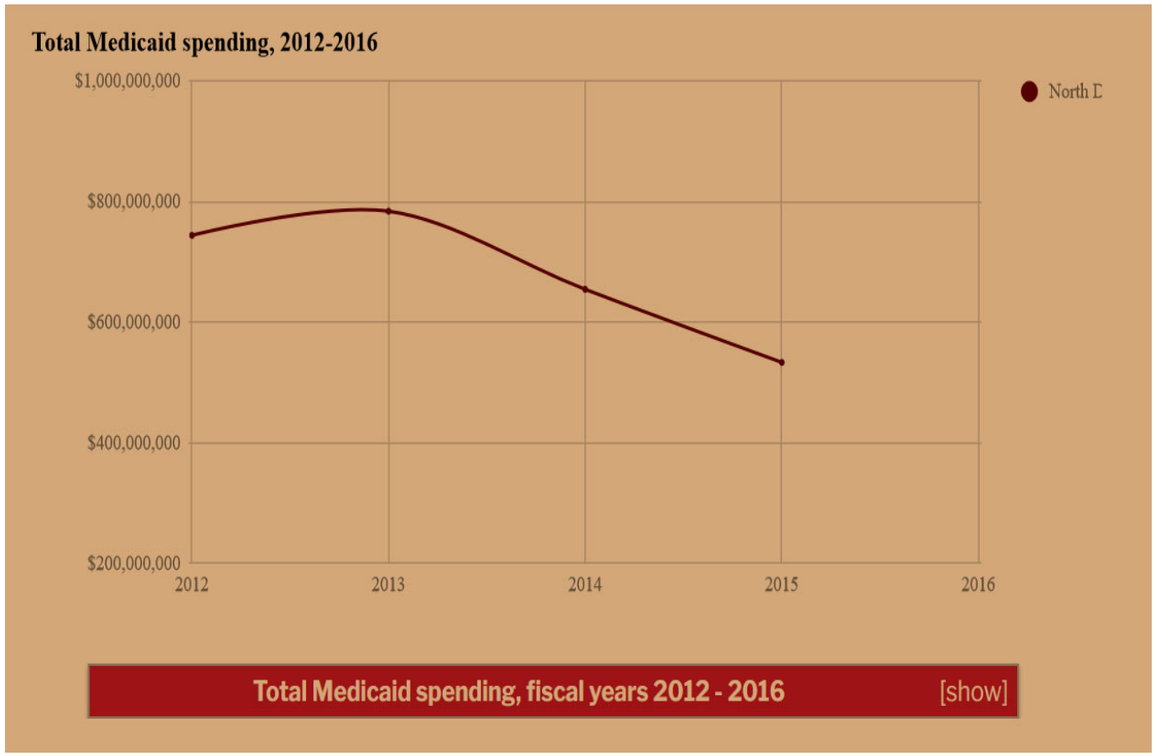
North Dakota Medicaid Expansion Budget - State Impact on Spending					
Difference in funding - current state and proposed funding	State Medicaid Expansion Obligation - Current	State Medicaid Expansion Obligation - Proposed at Medicaid Rates	Difference in State Funding Level current vs. proposed rates	Total General Fund Budget	Impact on General Fund Budget
Biennial	50,000,000	25,000,000	(25,000,000)	4,840,000,000	-0.52%
Annual	25,000,000	12,500,000	(12,500,000)	2,420,000,000	-0.52%

Source: North Dakota Hospital Association

Medicaid expansion funding at current levels

- Significant impact to healthcare providers to address current healthcare gaps in both medical and mental healthcare.
- Very small impact to the State's General Fund budget.
- Stable funding model is needed to work together on the State's future goals:
  - to create pathways that help people access the right service at the right time
  - to engage proactively with providers to expand access to services.

House Bill 1012 – Medicaid expansion



Source: Ballotpedia

Medicaid in total

- Medicaid spending on North Dakota's Medicaid program **declined** by about 28.3 percent between fiscal years 2012 and 2015.
- This is supported with recently published Commonwealth Fund research paper entitled *The Impact of Medicaid Expansion on States' Budgets* which noted that During 2014–17, Medicaid expansion was associated with a 4.4 percent to 4.7 percent reduction in state spending on traditional Medicaid.

House Bill 1012 – Medicaid expansion

The Possible Alternative Scenario

- Should the Medicaid Expansion funding level decrease to traditional Medicaid rates, hospitals in North Dakota will be providing care even further below cost. Currently, the blend of Medicaid and Medicaid expansion service reimbursement combined is already less than full cost. This considers the facilities, workforce and other investments required to maintain and improve care for the residents of North Dakota.
- The likely scenario would be to shift these unfunded costs to other payors in the State – Commercial Payors that are funded by businesses and residents in the State.
- Rather than supporting 10% of costs for Medicaid Expansion beneficiaries, these State stakeholders would be essentially funding 100% of the unfunded Medicaid costs.

House Bill 1012 – Medicaid expansion

The return on investment – In summary

- After initially fully funded by the federal government, the Medicaid Expansion Program is now 90% federally funded & 10% state funded.
- The cost to the State remains relatively low, compared to the high impact of maintaining a stable healthcare ecosystem with the responsibility of hospitals in the state to shape the future of healthcare in North Dakota as discussed in the previous section of this document.
- There is much to be done to improve access to healthcare for North Dakotans. Given the challenges related to COVID19 and the destabilization this has had on the healthcare industry in North Dakota, this is not the time to change a program that is functioning well, and that has helped to stabilize the health care industry in the state.

House Bill 1012 – Medicaid Expansion

The data used to conclude on the Medicaid program cost is in question

House Bill 1012 – Medicaid expansion

How the data used to conclude on the program cost is in question

- The Medicaid program creates reports on spending on average per beneficiary. The most recent information publicly available is from 2018.
- The Medicaid program classified North Dakota as a "low data quality state" with respect to Medicaid cost and beneficiary information, meaning that some data elements were missing in reporting to enable the data to have a high level of confidence in the data.
- A summary of "low quality data state information" is presented on the following page. *Please note that some states without reported information in Medicaid Expansion have been hidden from this chart.*

House Bill 1012 – Medicaid expansion

2018 Information by State for "low level of data usability states"

Table 3. Per Capita expenditure estimates for states with a low level of data usability (2018)

State	Total	Children	Adult: non-expansion, non-disabled,	Aged	People with disabilities	Adult: ACA Medicaid expansion
Illinois	$6,562	$2,532	$5,586	$17,879	$18,274	$4,027
Indiana	$8,605	$4,096	$7,268	$12,344	$12,321	$12,679
Kentucky	$6,813	$3,637	$6,597	$10,383	$11,986	$6,629
Maine	$10,673	$4,505	$4,520	$14,031	$21,439	$5,038
Michigan	$6,922	$2,787	$4,909	$19,257	$15,912	$5,797
Montana	$7,175	$4,380	$5,661	$19,223	$15,672	$6,341
New Jersey	$9,420	$3,196	$8,028	$24,595	$31,284	$6,103
North Dakota	$14,387	$6,847	$6,931	**$64,964**	**$54,325**	$828
Oregon	$10,920	$6,604	$11,921	$25,176	$23,040	$11,581
Pennsylvania	$11,654	$3,356	$5,774	$37,702	$25,852	$3,757
Rhode Island	$7,928	$3,482	$5,254	$18,272	$15,406	$6,711
Virgin Islands	$3,848	$3,000	$3,849	$3,019	$7,476	$3,823
Washington	$6,934	$2,724	$6,876	$19,748	$20,076	$5,928
Min	$3,848	$1,914	$2,110	$3,019	$7,476	$828
Median	$8,126	$3,482	$5,661	$18,272	$18,274	$5,928
Max	$14,387	$6,847	$11,921	$64,964	$54,325	$12,679

- Note: this table excludes states that did not report dollars for Medicaid expansion.

House Bill 1012 – Medicaid expansion

Let's look at "high quality data states"

Table 3. Per Capita expenditure estimates for states with a high level of data usability (2018)

State	Total	Children	Adult: non-expansion, non-disabled,	Aged	People with disabilities	Adult: ACA Medicaid expansion	Expansion compared to Non Expansion
Alaska	$10,019	$6,066	$7,119	$23,047	$32,615	$8,787	123%
Arizona	$6,258	$3,171	$4,227	$9,590	$20,939	$6,165	146%
California	$6,449	$2,789	$2,812	$14,548	$23,462	$5,545	197%
Connecticut	$8,890	$3,715	$5,446	$18,012	$30,321	$6,917	127%
Delaware	$9,315	$4,603	$8,645	$21,703	$22,799	$7,476	86%
Georgia	$5,356	$2,807	$4,905	$10,333	$10,772	-	
Hawaii	$6,436	$2,997	$4,558	$13,383	$22,397	$5,630	124%
Idaho	$7,349	$2,743	$6,771	$14,468	$19,424	-	
Louisiana	$6,523	$3,531	$6,187	$10,869	$12,086	$6,326	102%
Maryland	$9,132	$3,699	$7,404	$19,733	$24,653	$8,434	114%
Mississippi	$7,556	$4,053	$5,212	$13,486	$12,859	-	
Nevada	$5,854	$2,882	$5,718	$8,472	$14,277	$6,673	117%
New Hampshire	$9,905	$4,007	$6,183	$24,451	$21,609	$9,355	151%
New Mexico	$6,381	$3,757	$3,693	$10,706	$22,184	$5,637	153%
Ohio	$8,248	$3,510	$6,025	$21,536	$16,909	$7,422	123%
South Dakota	$8,286	$3,256	$6,228	$18,188	$20,464	-	
West Virginia	$7,232	$2,869	$4,698	$23,013	$13,983	$5,080	108%
Min	$5,356	$2,743	$2,812	$8,472	$10,772	$5,080	181%
Median	$7,349	$3,510	$5,718	$14,548	$20,939	$6,673	117%
Max	$10,019	$6,066	$8,645	$24,451	$32,615	$9,355	108%

- Almost all states in the high-quality states reported Medicaid Expansion expenditures per beneficiary higher than Non-Expansion expenditures.

House Bill 1012 – Medicaid Expansion

State Medicaid comparison – a deeper dive
Alaska vs. North Dakota

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

- Information provided by the North Dakota Department of Human Services indicated that the cost per beneficiary for the Medicaid expansion program was significantly lower than that reported by North Dakota.

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Source: North Dakota Human Services Report on House Bill 1012

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

- **Source and validation of data** - It is unclear is the values in the chart reflected on the previous page is consistently reporting payments made to providers, payments made to Managed Care Organizations for premiums, or other information for comparability purposes.
- **Demographics are key in comparisons** - Information regarding demographics of the Medicaid population would be essential for understanding and comparing level of expenditures including % of the population that are children vs. adults, % of population that have chronic conditions etc.
- **Expense by category information** - It would also be important to understand "spend" by category such as drugs, behavioral health, medical care etc. for a truly meaningful comparison.

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

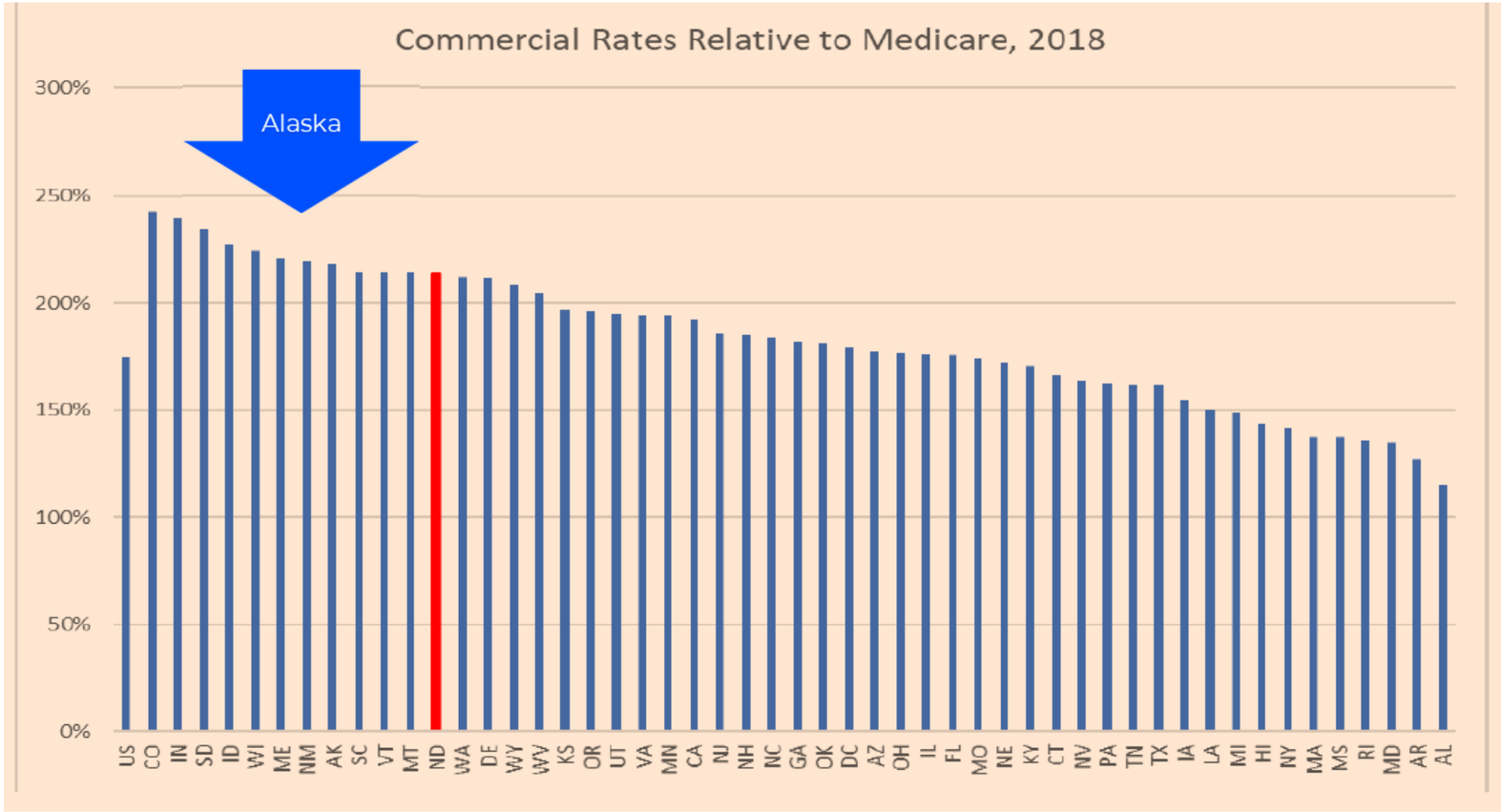
FFS MEDICAID PHYSICIAN INDEX		
ALL MD SERVICES	PRIMARY CARE	OTHER SERVICES
1. Alaska (2.28)	1. Alaska (2.55)	1. Alaska (1.94)
2. Montana (1.56)	2. Montana (1.65)	2. Nebraska (1.45)
3. Delaware (1.40)	3. Delaware (1.55)	3. Arkansas (1.44)
4. Wyoming (1.38)	***4. North Dakota (1.52)***	4. Montana (1.36)
5. Nevada (1.37)	5. Maryland (1.51)	5. South Dakota (1.34)
6. Maryland (1.35)	6. Nevada (1.50)	6. Delaware (1.28)
6. North Dakota (1.35)	7. Idaho (1.45)	7. Wyoming (1.27)
8. Washington, DC (1.27)	8. Wyoming (1.44)	8. New Mexico (1.25)
9. Idaho (1.25)	9. Washington, DC (1.39)	9. Iowa (1.22)
10. New Mexico (1.19)	10. Colorado (1.31)	10. Nevada (1.21)
10. Utah (1.19)	11. Utah (1.30)	11. Wisconsin (1.17)
12. Mississippi (1.17)	12. Mississippi (1.29)	***12. North Dakota (1.15)***

Source: North Dakota Human Services Report on House 1012

- Question on the data: This table indicates Medicaid physician reimbursement for physician services (all categories)in Alaska is **significantly higher** than North Dakota.

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data



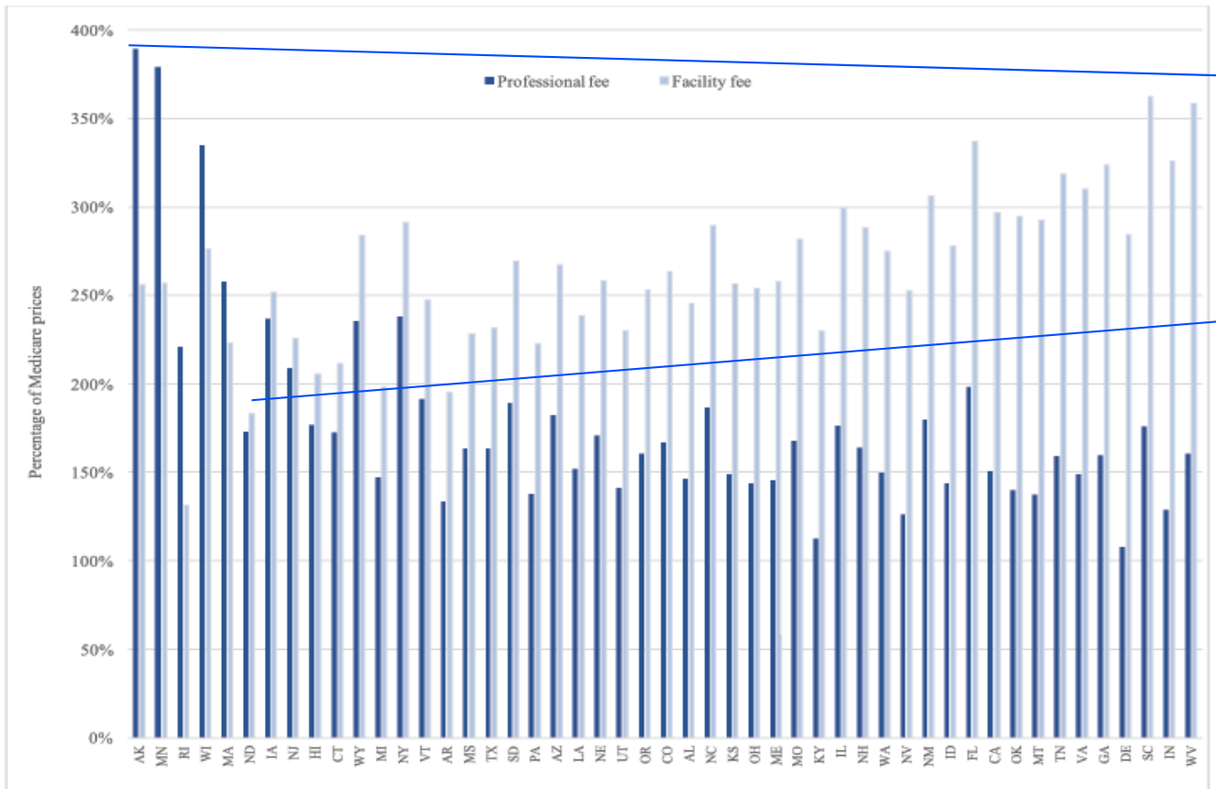
Source: North Dakota Human Services Report on House Bill 1012

- This table indicates that Alaska's commercial rates for hospital services are also higher than rates in North Dakota, better supporting the healthcare delivery system in general.

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota commercial reimbursement data

Figure 4.5. Relative Facility and Professional Prices, by State, 2016–2018



Alaska

North Dakota

NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. For each state, this figure denotes relative prices for facility and professional payments. States are sorted by the percentage-point difference between facility and professional relative prices.

Source: Rand Corporation

- The Rand Corporation study indicated that Alaska's commercial rates were significantly higher than North Dakota's for hospital and physician services.
- Alaska's hospitals would likely have a better chance of "cost shifting" Medicaid losses than hospitals in North Dakota.

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

- The demographics of Alaska Medicaid beneficiaries are significantly different than North Dakota, with children representing 57% of beneficiaries compared to 40% in North Dakota.

Medicaid Enrollees 2014		
	North Dakota	Alaska
Aged	8%	7%
Disabled	12%	13%
Adult	39%	23%
Children	40%	57%
Total	100%	100%

Source: Kaiser Health News

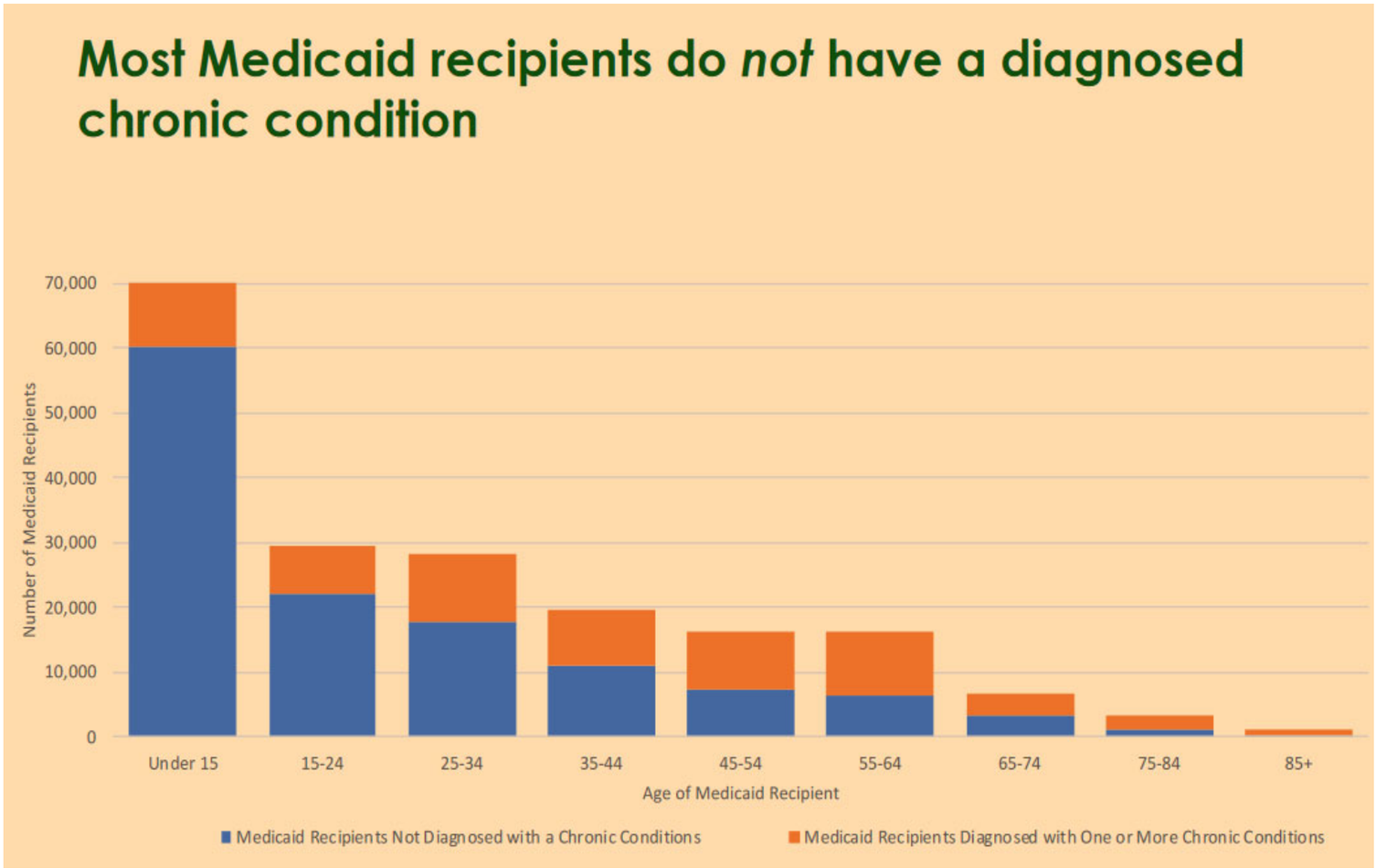
- Per the Congressional Budget Office information, Medicaid spending on children is approximately 52% of the cost related to adult beneficiaries:

Average Federal spending per Medicaid enrollee in 2020 (federal portion only):		
Adult	4740	
Children	2480	52% of adult cost

Source: Congressional Budget Office Report

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data



- To compare cost per beneficiary between North Dakota and Alaska, it would be important to understand the number of chronic conditions in the Medicaid beneficiary pool.
- In Alaska as noted in the accompanying chart, Most Medicaid recipients in Alaska do not have a diagnosed chronic condition.

Source: Evergreen Economics

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

Chronic Conditions Drive Spending, FY2018

a.	b.	c.	d.	e.
	Average Spending Per Medicaid Recipient			
Age of Recipient	All Recipients	Without a Diagnoses for a Chronic Condition	One or More Chronic Condition Diagnoses	Incremental Cost of Chronic Condition (d – c)
Under 5	$7,656	$5,510	$26,000	$20,490
05-09	$5,065	$2,765	$17,932	$15,167
10-14	$6,939	$2,688	$25,311	$22,623
15-19	$10,023	$3,247	$30,550	$27,302
20-24	$9,178	$4,310	$22,907	$18,597
25-34	$11,284	$4,395	$23,256	$18,861
35-44	$12,281	$3,604	$23,226	$19,622
45-54	$15,403	$3,525	$25,191	$21,666
55-64	$17,677	$3,590	$26,778	$23,188
65-74	$14,915	$3,101	$25,376	$22,275
75-84	$26,357	$7,828	$37,759	$29,931
85+	$48,105	$20,100	$60,632	$40,532
All Recipients	**$10,951**	**$3,891**	**$25,699**	**$21,635**

- Alaska's Medicaid population is significantly younger than North Dakota's plus…
- The uncertainty of beneficiaries with chronic conditions in Alaska vs. North Dakota could impact the per beneficiary expenditure data between states.

Source: Evergreen Economics Medicaid Spending & Enrollment in Alaska

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data – in summary

- The Alaska Department of Health Services Annual Medicaid Reform Report from 2020 noted a significant amount of effort at the state level focused on managing the Medicaid program efficiency and effectiveness. Several key initiatives have provided Medicaid program "savings" for Alaska according to this report including:
  - Care management programs and care coordination
  - Coordinated telemedicine programs
  - Pharmacy system reform
  - Behavioral health system reform
  - Enhancement in the Federal Tribal Referral System
- Alaska is focusing on strategies to enhance the effectiveness of the Medicaid program and better coordinate care in a value-based system.

House Bill 1012 – Medicaid expansion

Alaska compared to North Dakota Medicaid data

- In conclusion, without a deeper dive into the data behind the analysis, it is difficult to conclude on the relative overall impact to the State on Medicaid Expansion initiatives by distilling the information into one average cost per beneficiary number.
- We did identify however, active initiatives in Alaska to enhance the effectiveness of the Medicaid Program through several reform measures to better manage the population of the State, taking a longer-term multi-faceted view to improve the health of the population in the State.

Educational & research document

“The Medicaid expansion research project is supported by funding from the North Dakota Medicare Rural Hospital Flexibility Program, administered by the Center for Rural Health at the UND School of Medicine and Health Sciences. Funding is provided through the Federal Office of Rural Health Policy by the U.S. Department of Health and Human Services.”

Contact us



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Chairman Holmberg and members of the Senate Appropriations:

My name is Kurt Snyder, and I am the Executive Director of the Heartview Foundation. Heartview is a drug and alcohol treatment program established in 1964. We have one hundred twenty-five employees including an Opioid Treatment Program, outpatient programming, mental health services, and a 16-bed residential program in both Bismarck and Cando, ND. Heartview is currently offering Medication Assisted Treatment (MAT) to 291 individuals including some at North Dakota State Penitentiary in Bismarck and Dakota Women's Correctional in New England. At any given time, we have over 400 individuals in our care. We employ a psychiatrist, medical providers, psychologists, nurses, addiction counselors, mental health counselors, social workers, peer support specialists, case managers, and residential technicians. Last year we served individuals from 38 of the 53 counties of ND. Of our patient population, 67% are Medicaid or Medicaid Expansion. (20% Medicaid and 47% ME).

I am here today to voice our support for the re-authorization of Medicaid Expansion and The SUD Voucher. More specifically we support the following:

SUD Voucher

The SUD Voucher has been invaluable to providing access and care to so many citizens of North Dakota. And today, the need for substance use services is greater than ever as the opioid epidemic and COVID-19 devastate our communities. Therefore, we request that you fund the SUD Voucher at the level of the Governor's request. We are grateful for this program and we understand that the voucher needs to be the funding of last support. I have added some options for considerable cost savings and strategies to reduce reliance on the SUD Voucher.

- **Presumptive Eligibility** - The patients we serve at Heartview that are eligible for ND Medicaid or Medicaid Expansion currently experience a 3 to 4 month wait time for enrollment through Burleigh County. We estimate that if all Medicaid/ME eligible patients at Heartview were enrolled immediately upon entering services, we would reduce our utilization of the SUD Voucher by $650,000 per year. In addition, those patients would also have benefit coverage for other medical needs. All of which would be federally matched dollars instead of the general fund dollars of the SUD Voucher. Community Medical Services, the opioid treatment program in Minot and Fargo conservatively estimates they would reduce utilization of the SUD Voucher by $720,000 per year. The solution for immediate enrollment of these individuals is by identifying the Opioid Treatment Providers as "qualified entities" for the process of "presumed eligibility". Centers for Medicare & Medicaid Services give states broad discretion to identify "qualified entities". These "qualified entities" are then capable of making presumptive eligibility determinations based on an individual's household income and other requirements. Presumptive eligibility serves a dual purpose of providing immediate access to needed health care services while putting people on a path to ongoing coverage. This system already is utilized by the hospitals in ND. Please consider that Heartview's patient population is 20% ND Medicaid and 47% Medicaid Expansion.

- **One-Million-Dollar Grants** – Heartview Foundation supports the (3) one-million-dollar grant opportunities proposed by the House in HB1012. Heartview sees this as a viable path to develop much needed services in under-served regions of the state. Heartview Foundation-Cando, a 16-

bed residential facility, just celebrated 5 years and is a shining example of meeting the behavioral health needs in a rural community. This effort was made possible by an opportunity much like the proposed one-million-dollar grants. Heartview Cando and Towner County Medical Center have forged a successful partnership in Cando, ND that has resulted in Medication Assisted Treatment Services (Towner County Medical Center is serving over 70 individuals for opioid use disorders), mental health services, outpatient and residential addictions services to a community of 1,100 people in a very rural region of ND. Towner County Medical Center and the community of Cando invited the Heartview Foundation with funding support from Dakota Medical Foundation to purchase and renovate a building for a 16-bed residential unit. This building was formerly a 24-bed residential facility owned and operated by Center for Solutions. Heartview deliberately downsized the bed capacity in order to remain in compliance with the IMD restrictions in order to leverage the coverage of ND Medicaid and Medicaid Expansion. The one-million-dollar grants would allow the SUD providers to expand into underserved areas of the state with a one-time investment but would not substantially increase the reliance on the SUD Voucher.

Removing the Sunset Clause

- I have a number for you, **47**. 47% of our patient population is Medicaid Expansion. Almost ½ of our patient population is covered for only 2 years at a time. How can treatment providers plan expansion efforts into rural or underserved communities with such a vulnerable funding base? How can we be expected to meet the needs and demands of the opioid epidemic without confidence in our funding streams? The one-million-dollar grant opportunities require a 5-year commitment to provide services in that region for the grant to be forgiven. I would remind you that 47% of the Heartview Foundation patient population is only covered 2 years at a time. Any expansion efforts by our agency is complicated by the sunset clause. If the sunset clause is removed from Medicaid Expansion, we have no objection to the 5-year commitment. Please remove the sunset clause!

Retain Medicaid Expansion with a Private Insurance Carrier

We strongly oppose moving Medicaid Expansion under Medicaid for these main reasons:

- **Claims Processing** – If Medicaid Expansion is moved under the ND Medicaid umbrella 67% of our patient population would be subject to ND Medicaid's claims processing. This terrifies me! ND Medicaid has testified on many occasions that clean claims are paid in a timely manner, which we agree upon. The problem, however, is that ND Medicaid denies 33% of Heartview claims, while other commercial payers average under 9%. Furthermore, reprocessing denied claims is extremely difficult with ND Medicaid. We often experience wait times of weeks, and sometimes months to even get a response from Medicaid on a single claim. The reprocessing effort of ND Medicaid is insufficient and continuously results in a backlog of unprocessed claims. In January 2019 ND Medicaid gave us a $450,000 cash advance because we were having cash flow issues due to overwhelming outstanding Medicaid claims.

- **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)** - MHPAEA was meant to prevent health insurance plans from imposing less favorable benefit limitations on mental

health or substance use disorder benefits than on medical surgical benefits. Medicaid Expansion fully complies with MHPAEA. ND Medicaid does not. MHPAEA specifically restricts the use of annual limits. ND Medicaid has annual restrictions on Intensive Outpatient, Partial Hospitalization and High Intensity Residential. Parity also insures that "Medical Necessity" be the standard for authorizing services. Again, ND Medicaid does not follow parity in this respect. ND Medicaid does not utilize accepted clinical standards for authorizations but instead providers must request additional days of coverage that sometimes takes months for approval. If Expansion is moved under ND Medicaid over 67% of our patients would not have the important protections of this federal parity law. The law that prevents discrimination and stigma.

We Support an increase of rates for SUD Providers

- Last session there was an amendment that was intended to provide consistent reimbursement rates across providers. However, it turned out that reimbursement rates within substance use providers were not established equitably. ASAM Level 2.5, (which makes up over 50% of our revenue) was given a higher reimbursement rate to hospital-based programs with a lower rate for community-based programs. To give you an idea of the inequity of the amendment from last session, we were initially notified that we would be receiving a 59% increase effective July 1, 2019 (this provided conformity across all SUD providers). The hospital providers complained, and DHS capitulated to carve out a special rate for the hospital SUD providers for ASAM level 2.5. We were subsequently informed that we would not receive the 59% we were promised but rather only a 13% increase. I would argue that the quality of our care exceeds hospital-based programs because we offer all 3 FDA approved medications for opioid use disorder. I would also point out that even within the ND Medicaid Fee structure, there is no difference between hospital-based programs and community-based PHP programs, (Attached). **I would ask that community-based providers of ASAM level 2.5 receive the same current rate as the hospital-based ASAM level 2.5 within the Medicaid Expansion product.** Most Medicaid Expansion enrollees are childless adults working one or more jobs and in much-needed access to chronic disease management, mental health services and addiction treatment programs. As a result of the needs of this population they are overrepresented in our services (47% Medicaid Expansion). **Substance use providers need enhanced rates in order to continue to grow and meet the demands of our state.** The spend for substance use and mental health services when compared to the overall spend is minimal. However, the behavioral health needs of this population are overwhelming.

This concludes my testimony, and I would stand for any questions.

Kurt Snyder, MMGT, LSW, LAC
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ND Medicaid
Substance Use Disorder Treament Services Fee Schedule
as of 10/1/2020

Inclusion or exclusion of a procedure code, supply, product, or service does not imply Medicaid coverage, reimbursement, or lack thereof.

Revenue Code	Code	Description	Medicaid Fee
--	--	ASAM Level 1	Professional Fee Schedule
--	H2035	ASAM Level 1 (group)	$15.16
0906	H0015	ASAM Level 2.1	$188.19
0913	S9475	ASAM Level 2.5	$365.93
1003	H2034	ASAM Level 3.1*	$33.46
1003	H0012	ASAM Level 3.2	$177.12
1002	H2036	ASAM Level 3.5	$564.57
1002	H0011	ASAM Level 3.7	$705.71

* ASAM 3.1 will only be reimbursed if the member is concurrently receiving ASAM 2.1 or 2.5.

8164



SUD VOUCHER

SUPPORT THE

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Please Support the SUD Voucher

Chairman Holmberg and Members of the Committee,

The past year has been a challenging one for the Substance Use Disorder (SUD) providers of North Dakota. With the ongoing COVID-19 Pandemic and suspension of acceptance of new patients into the SUD Voucher Program, providers have had to balance an increase in demand for services with a sudden lack of resources.

North Dakota's SUD providers represent one of the most important parts of the overall healthcare and behavioral health systems in North Dakota. With a high prevalence of alcoholism and binge drinking in our state, combined with an Opioid Crisis and Methamphetamine resurgence, these providers work tirelessly to serve those in need. Despite being underfunded and in high demand, these providers save lives while simultaneously saving millions in healthcare, social service, legal, and correctional costs.

The North Dakota SUD Voucher is one of the most important tools in serving North Dakotans who have a Substance Use Disorder. The voucher provides not only the ability of patients to obtain critical services in a timely manner, but it provides provider choice so patients can stay close to home and their families. Additionally, the voucher serves as a tool to keep patients out of emergency rooms, hospital beds, jails, courts, and morgues.

With the suspension of accepting new patients into the program on July 1, 2020, many providers were left with no options for their patients. With countless patients in the process of accessing services, the pipeline to serve those in need was cut off with a twelve hour notice. Though some may look at this as an unfortunate outcome of an expended appropriation, providers have often asked our association what they should tell those patients. Additionally some have wondered if those patients will survive long-term? When we ask providers to take a year off from serving patients, we run the risk of significant damage to patients, communities, and our state.

Continued On Back...

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With an ongoing pandemic, high alcoholism rates, Opioid Crisis, and Methaphetamine resurgence, we respectfully ask you support the original $17 million dollar request for the voucher by Governor Burgum with no restrictive amendments. The residential cap would disqualify thousands of patients from proper services, harm the patients with the greatest need, and not meet parity standards. Additionally the $3,000,000 in grants will only create underfunded facilities away from population centers where there are staff and patients to support them.

Though some may see the original request as a significant budget increase, those of us who serve patients know this represents increased savings to our communities and state, as well as the ability to save more lives.

Sincerely,



Ty Hegland
Chair, North Dakota Addiction Treatment Providers Coalition

Main Points:

- 98% of Licensed Addiction Counselors in North Dakota believe the SUD Voucher saves lives.

- SUD patients are not revenue neutral. Supporting the SUD Voucher saves millions in countless areas. According to the National Institute of Health, one dollar spent in SUD services saves $6.00 in correctional costs and/or $13.00 in primary healthcare costs.

- There should be no cap of residential services. The SUD Voucher should support all levels care across the state of North Dakota and ASAM CUA assessments and treatment plans by licensed clinicians should always lead determinations of level of care. A full continuum of care is vital to our state.

- There are nearly 100 entities and thousands of individuals working to provide SUD services in North Dakota. 70% of providers believe their patients and practices were negatively affected when we stopped accepting new patients into the voucher program on July 1, 2020.

- Patients need a fully funded two year voucher. Passing the $17 million dollar request by Governor Burgum will help the industry get back on track and stop the underfunding of these critical services.

- Due to limited funding, the SUD Voucher should not be extended to providers operating outside the borders of North Dakota unless they reside in an underserved area and complete a Certificate of Need style process.

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SUD Voucher - No Residential Limits

Chairman Holmberg and Members of the Committee,

On the behalf of Substance Use Disorder patients, families, and providers, we are respectfully requesting you do not put any residential limitations on the SUD Voucher. As a group of providers representing the thousands of SUD patients and families across the state, we fear the unintended consequences of such a move may kill patients and cause millions of dollars in unnecessary costs.

Residential SUD providers care for some of the sickest patients in our state. Rather than have these patients fill up emergency rooms and jails, providers across our state provide exceptional care for their addiction, physical, and case management needs. Without residential services, we will only compound the costs of the Department of Human Services budget by spending more money in Medicaid through hospital stays, as well as increase the correctional costs across this state in county jails and state prisons.

Legislators across North Dakota need to understand that residential services are not an option. Patients are placed into residential care as a result of licensed clinicians conducting unbiased chemical use assessments based on American Society of Addiction Medicine criteria. Providers do not have the ability to pick and choose levels of care. No matter how much you may want to force a patient into doing outpatient care, thousands of patients across our state will fail in outpatient settings due to the extent of their addiction. Once again, this will only compound the costs of the Department of Human Services.

Finally, without residential level of care at an equal playing level, I fear the state may be in violation of The Mental Health Parity and Addiction Equity Act (MHPAEA). Once again, this may only compound the costs of the Department of Human Services. As a result, we respectfully as the original request of $17,000,000 be reinstated and no restrictive amendments be put on providers/patients so we can properly serve those in need.

Ty Hegland, NDATPC Board Chair

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The Key Components of Supporting North Dakota SUD Patients & Providers

* The citizens and patients of North Dakota need a fully-funded SUD Voucher for the full two years of a biennium.

* Patients need the support of a full continuum of care. Due to the severity of illness and additional factors clinical assessments, commitments, jail diversion programs, etc., we cannot eliminate support for any levels of care, as it will cause serious harm to thousands of patients across North Dakota. This includes Residential, Outpatient, Medication Assisted Therapy, and Community Based Supports.

* SUD Providers across the state support the efforts of the ND Dept. of Human Services with community based services and social supports. However it is imperative that due to the severity of illness and ASAM clinical standards, Residential and Outpatient Clinical Services continue to be prioritized and supported due to being the core services of SUD treatment for patients.

* The costs of not treating SUD patients is not revenue neutral. NDATPC encourages the state to continue pursuing Medicaid Waivers to offset general funding costs, including pursuit of an IMD Waiver. The 1915i Waiver is a great start in this process, however we cannot continue to deny Residential/High Intensity Care for low-income individuals in North Dakota, as it causes more harm to patients, families, and communities. As a result of not having an IMD waiver, hospitals, jails, and many additional entities experience higher operating costs and patients receive services that are not effective in dealing with Behavioral Health/SUD disorders.

* According to the National Institute of Health, for every dollar spend on SUD services, $6.00 are saved in correctional costs and $13.00 are saved in primary healthcare costs.

* Due to recent budget issues, North Dakota should not enroll providers who are not licensed in the State of North Dakota, unless it is an underserved area and they complete a Certificate of Need process. Given the volume of providers within five miles of the border, the depletion of a SUD Voucher fund will only accelerate if this occurs and we will run into the same issue of the 2020-2021 biennium.

* The State of North Dakota should be in be in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) at all times. This includes sufficient access for patients and payments to providers.

* ASAM Assessments carried out by licensed clinicians need to determine levels of care for patients. Other entities should not be involved in influencing service provision and levels of care through policy, as it causes patients to be cared for in inappropriate clinical settings and compounds the Behavioral Health/SUD disorders of a patient.

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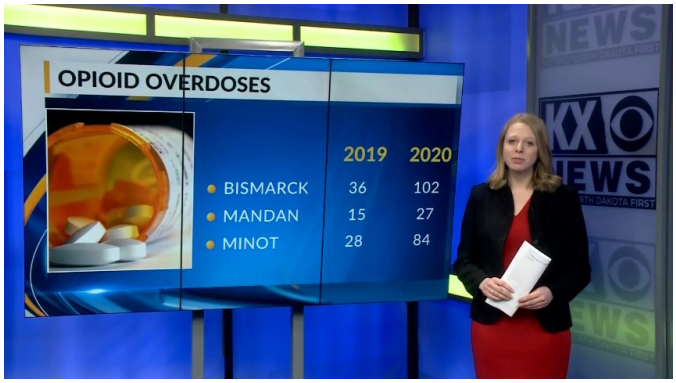

Opioid Epidemic Worsening in North Dakota

By Maddie Bierftempel
February 23, 2021

Before COVID-19 plunged the world into a global health crisis, an epidemic of a different kind was ravaging communities across America. But the opioid epidemic hasn't disappeared — in fact, it's only gotten worse. "Been doing this, law enforcement, for 28 years. I've never seen anything like what we're seeing now," Bismarck Police Deputy Chief Randy Ziegler said.

In 2020, opioid overdoses were at their highest ever in the country, according to the **CDC**, and in some of North Dakota's biggest cities. "This is a new trend," Minot Police Chief John Klug said. "This is something that, we went from three overdose deaths in 2019 to 18 in 2020, and before that, we didn't have any." That's a sixfold increase in deaths caused by drug overdoses in Minot. Into 2021, the problem continues. "We've already had several this year, it doesn't seem to be slowing," Mandan Police Lt. Patrick Haug said.

In Bismarck, opioid overdoses went from 36 in 2019 to 102 in 2020. Fatalities went up from four to 10. In Mandan, overdoses jumped from 15 to 27. And in Minot, the suspected fentanyl overdose calls went from 28 to 84. Those numbers have kept the Heartview Foundation in Bismarck busy. It's one of just three opioid treatment centers in the entire state. "We oftentimes are operating on waitlists, because people are calling in for services and we have more people calling in than we have the capacity to serve," Heartview's Chief Operating Officer Jessica Brewster said, referring mostly to their residential services.

Jessica Brewster oversees the nonprofit's methadone clinic, which is a medical treatment for people struggling with opioids. She says their services draw patients from all over the state, including rural areas lacking resources. "We absolutely do have people that are driving to us from Beulah, Hazen, Dickinson," Brewster said. The nonprofit's telehealth options have expanded since COVID, but the efficacy of that is less certain. "They're better than nothing," Brewster said.

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A program helping provide opioids misuse prevention education in rural areas recently received $800,00 in grant money. Strengthening the Heartland is a collaboration between both North Dakota and South Dakota State Universities to address shortages in services. “One of the big things is that 90 percent of the counties have a mental health care shortage, so getting this knowledge and resources out the counties was this project,” Meagan Scott said. Scott helps lead the project and says it’s a struggle for many to simply ask for help. “In small communities, there’s also a stigma. You don’t always want to admit that you might need help, so that’s also a problem too, that everybody might find out about it,” Scott said.

While it’s well documented the pandemic is correlated with increases in addiction, alcoholism and mental health backslides for many — police say it’s hard to attribute current overdose surges to COVID. “I don’t think there’s any way for anybody to have any indication that it would,” Klug said. But all three did point to a common culprit predating COVID: fentanyl, a synthetic opioid that can be fatal even in tiny amounts. “Now, they’ve introduced these fentanyl pills, which back in the day you’d never seen on the street,” Ziegler said.

Ziegler said pills laced with fentanyl are coming in from out of state, namely Detroit, Michigan. “The street names are 30s or blues. People think they’re getting oxys but they’re actually getting pills that are laced with fentanyl, or they’re straight fentanyl,” Ziegler said. Often, the pills purport to be something else, but pack fatal amounts of the synthetic opioid. “They’re sold as cocaine, but there’s fentanyl in it. They’re sold as a pill, but there’s fentanyl in it,” Klug said.

The deadly drug adds another layer to policing when a user dies from an overdose. If dealers do get tracked down, whether they can be charged for the death is still murky in the law. “It’s very hard to get any sentence that holds somebody responsible for the death because in a typical case you have to prove intent. Well, my intent was to deliver, not to kill you,” Klug said. There’s currently a bill in the legislature aiming to address that by having an enhanced penalty for anyone who “sells, distributes, delivers, or conspires to deliver” drugs that result in death. It passed the State House 77-19 and is awaiting a vote in the Senate. While changes in law might be coming, changes in policing have already taken place at the departments. “Now we combine our investigators at the PD with investigators from the drug task force so they can use their knowledge,” Klug said. “We combine those two teams, it gives us extra support from staffing standpoint.”

All three departments say their officers carry Narcan with them, a non-prescription nasal spray that can reverse overdoses. It’s available at CVS, and with that kind of widespread availability, you might expect to see fewer deaths, but the opposite is happening. “Narcan is probably kind of one of those wonder drugs, but it also has a backside to it, because yes, it’s helping us prevent death in these heroin and fentanyl overdoses. But it’s also giving these people understanding that if I do overdose, there’s Narcan. It can save me,” Haug said.

Though North Dakota’s overdose situation already is bleak, it’s still just a small glimpse of the problem because of underreporting. Still, police gave a reminder of the state’s Good Samaritan law, which says if you call for help and cooperate with law enforcement, you won’t be punished. “If you were there, and there’s drugs there being used and somebody overdoses and you make the call, nothing is going to happen,” Klug said.

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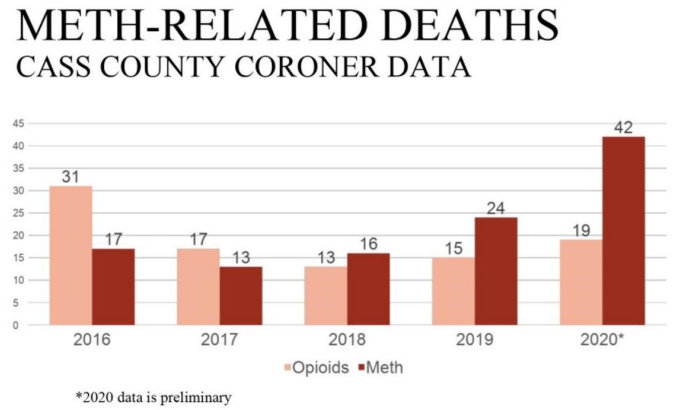

Meth Outpaces Opioids as Leading Cause of Overdose Deaths in Fargo Area

By David Olson
February 21, 2021

Fargo - Drug overdose deaths in Cass County have been on the rise since 2018 and the total number of fatal meth overdoses in 2020 eclipsed the total number of fatal opioid overdoses in 2016, a year notorious for the number of lives lost to opioid addiction.

Comparing the 42 fatal meth overdoses in 2020 to the 31 fatal opioid overdoses in 2016, Robyn Litke Sall, substance abuse prevention coordinator for Fargo Cass Public Health, said she believes the community is "on the cusp" of an even greater fatal drug problem for which there are very few solutions.

She said that is because, unlike opioids, there is no chemical antidote people can use to reverse a meth overdose. Sall made her comments during a meeting of the Fargo City Commission Monday evening, Feb. 8. She said exacerbating the drug overdose problem is the fact that the area is "in the midst of another big surge in trafficking."

While fatal opioid overdoses fell in 2017 and 2018 after the overdose reversal drug Narcan became more widely available to the public through a FCPH program, Sall noted, the number of those types of overdoses crept back up, reaching 19 overdose deaths in 2020. She added, that about 155 opioid overdose reversals using Narcan were reported to Fargo Cass Public Health in the last half of 2020, compared to 200 similar incidents in all of 2019.

According to Sall, FCPH handed out a record 564 doses of Narcan to individuals in January of this year. Commissioner Tony Gehrig questioned why opioid overdose deaths have been rising in number even as the number of Narcan doses being distributed to the community has gone up.

Sall said the number of opioid-related deaths would probably be higher without the Narcan distribution, and she noted that after years of seeing rising numbers of new hepatitis C cases, FCPH saw fewer new cases in 2019 after the Narcan distribution program was put in place. "We're hopeful those hepatitis C numbers have trended downward as a result of this program," she said.

When it comes to fatal drug overdoses, Sall said numbers nationwide show "what's happening here is happening virtually all over the country." And despite the toll taken by drugs like meth and opioids, Sall said the drug responsible for causing the most number of deaths, eclipsing all other drugs combined, continues to be alcohol, via things like alcohol poisoning and injuries linked to alcohol.

Support the SUD Voucher

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CASS COUNTY GOVERNMENT
www.casscountynd.gov

Office of the Sheriff
Jesse Jahner, Sheriff

January 13, 2021

North Dakota House Appropriations Committee
ND State Capitol Building
Via electronic submission

I am writing today to express support for the ND SUD Voucher program, and to urge approval of the requested increase in funding for the 2021-2022 biennium.

As the administrator of one of the largest jails in North Dakota, in the county with the greatest population and highest per capita need for services, I can attest to the fact that the SUD program has been one of the most beneficial programs we have ever participated in, and has contributed more significantly to improved outcomes for recipients than any other single program for which I have been a stakeholder.

You may not be aware that persons who are incarcerated are ineligible for Medicaid reimbursements. If a person is enrolled in Medicaid at the time they are arrested, their coverage lapses during the period that they are physically incarcerated. If they have never enrolled, they must wait until after they are released to start the process, as there is no existing support for enrollment navigators, no access to internet, and often persons in jail do not have access to the necessary information needed to enroll for coverage even though they may be eligible.

The SUD Voucher has filled the gaps in our needs continuum in multiple ways. It was instrumental in allowing us to connect defendants afflicted with addiction to immediate treatment for opioids, providing necessary funding to bridge the gap until Medicaid enrollments could be completed by the clinic. The SUD Voucher was also a critical resource for helping to ensure a seamless transition from inmate to patient for dozens of people who entered residential treatment programs. It was devastating to us when the funding ran out, resulting in the elimination of a primary route for immediate access to needed care.

The funding for this program is needed now more than ever, and we all recognize that the amount allocated last time significantly underestimated the actual need. This is a program that pays real dividends for those it serves, and I wholeheartedly support the proposed budget request. The various government units are going to spend this money either way – I believe we should spend it in support of treatment rather than in response to the medical and behavioral consequences of ongoing and un-addressed addiction.

Sincerely,

Capt. Andrew Frobig
Jail Administrator
Cass County Sheriff's Office

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Funds Run Dry for North Dakota Addiction Treatment Program — Counselors Say Lives are at Stake

Written By: Patrick Springer | Aug 29th 2020

Dale Lein couldn't shake the hold alcohol had on him. His addiction started in high school and followed him like a shadow throughout life. He found it difficult to hold down a job. He occasionally got into car accidents while driving drunk. He became estranged from his family. Finally, last year, a health crisis forced Lein to reckon with the fact that alcohol was destroying his life. A brain tumor, shoulder surgery and complications from decades of hard drinking put him in the hospital for four weeks. Alcohol, his doctors said, was killing him.

Lein desperately wanted to get sober. But he faced what seemed like an insurmountable problem. He was disabled and couldn't afford treatment. Then Lein got a break. He qualified for a state program that pays for addiction treatment for those who lack health insurance or other means to pay. After failed efforts in the past, Lein has achieved sobriety, thanks to help from counselors at Heartview Foundation and the state payment program.
"I've been sober now a year and five months," Lein said. "That's the longest I've ever been sober." Before getting treatment, "That's all I did my whole adult life was drink and drink and drink."

The payment program, called the substance use disorder voucher program, has provided treatment for 4,200 people struggling to recover from addictions since it started in September 2016. But money for the program is unexpectedly running out, so the North Dakota Department of Human Services was forced to freeze the program, barring new clients from enrolling — cutting off access to a program that addiction treatment advocates say is a lifeline for people who otherwise end up, untreated, cycling through hospital emergency rooms and jails, at much greater cost.

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“They’re going to end up in our jails and emergency rooms — or they’re going to die,” Tonya Sorenson, a licensed addiction counselor and clinical supervisor at First Step Recovery in Fargo said of those who will lack treatment because the program is closed to new clients. “That’s the reality of what we’re dealing with. We see our clients in the paper, in the obituaries.”

Pamela Sagness, director of behavioral health for the state Department of Human Services, said officials have worked to maintain services for those currently in the voucher program. “The continuity of services is just vital,” she said, noting the risk of relapse for anyone battling addiction. Officials have struggled to budget for a new program and, for the current budget, had to make their best estimates of demand for services in December 2018.
“We’re really for the first time getting our arms around the scale of the need,” she said. The program currently is paying to help 1,348 clients.

The state's regional human service centers are aware of the suspension of new voucher clients and can once again serve as the “safety net for addiction service needs” and have expanded access to 24/7 crisis services in all regions, Sagness said. “No services were discontinued or stopped,” she said. “The notification was specific to stopping growth of the program.” Heartview Foundation, First Step Recovery and 20 other addiction treatment centers around the state were abruptly told on June 30 that money was running out, giving them just hours to prepare and try to finish pending applications.

Before the voucher program, those who couldn’t afford addiction treatment from private counselors had to seek treatment at eight regional human service centers around the state, where they often faced long waiting times, addiction treatment advocates said. “They were required to stand in long lines in human service centers around the state,” said Kurt Snyder, executive director of Heartview Foundation. “The beauty of the voucher system is it allows the private providers to open their doors to all comers. It made a real difference for a lot of people.”

Lein started his treatment with an 18-day regimen, with three days of residential service followed by 15 days of outpatient counseling and therapy. He continues to meet with his counselor once weekly, has weekly group therapy and regularly attends Alcoholics Anonymous meetings. “It does wonders,” he said. “It does absolute wonders for people who are in a crisis right now.” Under the voucher program, clients whose treatment is deemed medically necessary can qualify for evidence-based treatment from approved addiction treatment centers located close to home. The funding freeze on new clients — which addiction treatment advocates say could deny services to thousands of people struggling with addictions around the state — comes despite Gov. Doug Burgum’s outspoken support for addiction recovery, which he has made a priority issue since taking office in December 2016.

Yet addiction counseling center executives, including those at Prairie St. John's, ShareHouse and First Step Recovery, said they are unaware of efforts by Burgum to try to come up with money to provide services to new clients. “Under Gov. Burgum’s leadership, DHS is working diligently to pursue federal funding and identify possible rollup dollars in its existing budget to provide additional funding for the SUD voucher program, after attempts to find other sources including CARES Act funding were exhausted,” Burgum spokesman Mike Nowatzki said in a statement.

Human services officials have “consistently asked to increase funding to meet demand” for the voucher program, increases that were incorporated in Burgum’s budget requests last session, and approved by lawmakers, he said. Funding for the program, which enjoys strong bipartisan support in the Legislature, has risen dramatically since the program’s start four years ago.
“Behavioral health and recovery remains a priority of this administration, and to suggest otherwise because of a funding situation related to further expanding a program that has already been significantly expanded under this administration is disingenuous,” Nowatzki said.
'A race against the clock'

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Spending in 2015, the voucher progam's first year, totaled $252,294, which mushroomed to almost $8.3 million during the 2017-19 budget. During the current budget for 2019-21, vouchers are budgeted for $7.9 million — but more than $7.1 million had been spent by early August, with almost a year remaining in the biennium. Spending for 2017-19 exceeded the current biennium because the current two-year budget was planned before all of the receipts from the last biennium were in hand, Sagness said. "We want to get services to people in need," she said. "That's our mission. But there are limits to the funding."

To serve clients caught by the voucher funding squeeze, Prairie St. John's and ShareHouse are absorbing some of the costs. "It became a race against the clock to help people," said Ty Hegland, executive director of ShareHouse, adding that the vouchers are a "gap filler for patients who have no other means." ShareHouse will spend $50,000 to $60,000 per month to help fill the void, while Prairie St. John's bad debt and charity care spiked by $100,000 this month, said Jeff Herman, Prairie St. John's chief executive. "It's deplorable," Herman said, referring to the emergency created by the state's abrupt cutoff. "That's embarrassing for the state."

Extending charity care is difficult because treatment centers operate on thin margins, so it can't be sustained indefinitely, Hegland said. Meanwhile, costs elsewhere will spike as people with untreated addictions end up in jails and emergency rooms, he said. "This isn't just going to go away," Hegland said. "It's not going to be revenue neutral, and it's going to be very expensive."

A family member of a client who couldn't be accepted for treatment because voucher funding has been exhausted scolded staff at Summit Counseling Services, which serves western North Dakota, where treatment is scarce. "How can you sleep at night?" an angry family member asked staff, Executive Director Brenda Owen recalled. "It's heartbreaking."

Despite the freeze on adding new voucher clients, funding will be available for new patients receiving methadone treatments for opioid addictions, because federal money can pay for that, Sagness said. But the state general fund is the sole funder of the voucher program.
The rise in funding has been possible because of strong legislative support for the voucher program, said Sen. Judy Lee, R-West Fargo, chairwoman of the Senate Human Services Committee. "This was a legislative-established program," she said, which she views as an investment rather than an expense. "It's been remarkable," she said, adding that budgeting for the new program was an "absolute dartboard deal trying to figure out."

When the Legislature convenes in January, replenishing funds for the substance use disorder voucher program will be a priority, Lee said. But the state's economy has been hammered by the pandemic, which has caused oil revenues to plunge. "We know it's going to be a really challenging budget year," she said. She agrees with addiction counseling advocates that it's better to help people before their lives spiral into crisis. Legislators are convinced that the program pays dividends by helping people lead productive lives.

"Catch people before they fall to the bottom again and get them on track again," she said. Recovering from addiction is a constant struggle, Lein said. He feels grateful that his voucher approval recently was extended. "I'm still fighting alcohol," he said. "There's no doubt about it. I can't imagine what I'd do if I didn't get in. I don't know where I'd be. I don't even know if I'd be alive." As for the lack of funds to accept new clients, he added, "I'm hoping and praying that this will change."

https://www.inforum.com/news/4107496-north-dakota-launches-state-funded-voucher-program-addiction-treatment

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Drug Overdoses On the Increase

Overdose deaths have quadrupled in the Minot area since last year

By Andrea Johnson
September 30, 2020

Overdose deaths in the Minot area have increased dramatically over the past year but police say it is not clear whether the stress of the ongoing coronavirus pandemic is one of the reasons why. "The pandemic's effect on the opioid use is unclear," said Minot Police Department Capt. Dale Plessas, investigations and records commander, in an email interview. "We saw an increase in overdoses prior to the pandemic."

According to the Minot Police Department, police had responded to 67 overdose incidents between Jan. 1 and Sept. 15, with 11 of those incidents resulting in overdose deaths. In all, there have been 13 overdose deaths in Minot through Sept. 15. In 2019 police responded to 31 overdose incidents in Minot, with three official overdose deaths.

Even those numbers may be out of date. On Monday Minot police said they were investigating the apparent overdose deaths of two 24-year-old men and sought help from the public in identifying what type of drugs the men might have taken and from where they might have gotten those drugs. Police said they fear that more people might overdose and die. During an unrelated court hearing on Tuesday, Ward County Deputy State's Attorney Todd Schwarz remarked to Judge Gary Lee that, by Schwarz's count, the area is now up to 14 fentanyl overdose deaths this year and Ward County now has more fentanyl overdose deaths than it does due to COVID-19. He said two more were lost over the weekend.

A woman who has been charged with dealing drugs wrote a letter to Lee this week from the jail and begged to be released to go to a drug treatment program. She told the judge that someone she loved died in her arms of a drug overdose last week. The woman, sober now after spending a few days in jail, wrote that she realizes that she has been battling drug addiction for years, knows that she is very ill, and wants to take the opportunity to get better. The woman is one of many people in the community who has lost a family member or a friend to the tragedy of a drug overdose or have found themselves facing criminal charges that are connected to their own addiction battle.

"Many overdoses and deaths that have occurred in the Minot area are linked directly to fentanyl," wrote Plessas in the emailed interview. "Often, opiate users purchase the drugs under the false pretense that they are receiving heroin or Oxycodone. The only way for drug users to protect themselves is to stop using." Police have said that fentanyl is particularly dangerous, not only to users but also to police officers and other first responders who might be exposed at the scene of an overdose.
"Fentanyl is reportedly up to 50 times more potent than heroin," said Plessas in the email. "As a result, we are concerned about the potential danger to first responders. Our officers are supplied with personal protective equipment to include gloves, N95 masks, and Tyvek ensembles. To date, our officers have not reported any exposures to fentanyl that required treatment."

Continued On Back…..

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Officers have also saved the lives of some of the people who have overdosed. “Our officers are equipped with Narcan to protect them from accidental exposure and to administer to victims of opioid overdoses,” said Plessas. Narcan, which is also known as naloxone, is a medication that can temporarily reverse the results of an opioid overdose and restore normal breathing, according to the National Institute on Drug Abuse. It usually works in two to five minutes, but the effects wear off and the person will still always require medical attention after the overdose. Naloxone can be administered via auto injection or nasal spray. Friends, family or others who administer naloxone to reverse an opioid overdose are protected from civil liability under state law.

Plessas said that officers have seen various drugs in overdose cases, but fentanyl is commonly part of the equation.

Plessas said officers want people to know that help is available.

https://www.minotdailynews.com/news/local-news/2020/09/drug-overdoses-on-the-increase/

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Drug Overdoses, Fatalities on the Rise in Fargo

By Bailey Hurley
January 22, 2021

FARGO, N.D. (Valley News Live)

Drug overdoses are on the rise in Fargo, up over 300 percent compared to this time last year.

Fargo Police say just within the first few weeks of 2021 the department has responded to nine overdoses, two of which were fatal. By this time last year, FPD had responded to two overdoses, one of which was fatal. “And those are just calls that we got sent out to! There’s a lot of people that overdosed and by virtue of Narcan or family members or friends, they’re being revived and the police would never know about that,” Fargo Police Chief David Zibolski said.

Our goal and our mission as a narcotics unit is to identify the people that are supplying the drugs that lead to overdoses. Basically, they’re taking advantage of people suffering from addiction and we’re holding those people accountable,” Narcotics Sergeant Matt Christensen said.

Christensen says most overdose cases in the metro involve mixtures of fentanyl, heroin and meth. He says some of the cases the department is currently investigating have ties to California. Christensen also says more often than not, the ones supplying the deadly drugs in the metro are not local.

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https://www.valleynewslive.com/2021/01/23/drug-overdoses-fatalities-on-the-rise-in-fargo/

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Presentation to Senate Committee: 3.9.2021

Brenda Owen
7795 St. Gertrude Ave
Raleigh, ND 58564
701-659-0490

Chairman: Committee members

Here in support of SUD Voucher portion of Bill 1012
Representing:

Summit Counseling Services: Outpatient Behavioral Health Agency, located in Williston, Dickinson and Bismarck since 2015

Summit Prairie Recovery Center – Residential Treatment Center, Raleigh ND, south of Flasher

I have worked in Behavioral Health for 20 years plus, in the State system for more than 15 years. Prison System 3 Human Service Centers (Jamestown, Devils Lake, Williston)

1 in 8 people with Substance Use Disorder, new state released by SAMSHA
1 out of 5 people utilize Medicaid/Sanford Expansion type of insurance services.

(Forgiveness, passionate about what I do, non- politically correct, going to say some things that disagree with what has been presented to the legislature)

Grieved and Angered.
Testimony conflicts with (Masters Research paper prepared by me in 2012) utilized by the state in their presentations to justify their positions.

1 Initially to justify their spending thousands on their IDDT Program (Dual Diagnosis with University of Ohio) (2010)

2. Manipulated stats to justify their change to Open Access to justify not spending money on Addiction and individual services. (2014-2015)

3. Utilized to justify the 1915 (I) program. (2020)

4. Now manipulated to indicate too much money is being spent on (Long term) term care (This session)
*Stats are specific to those with developmental disabilities/severe substance use that will not get better due to inability to not get better. Included case management, those that can't drive or totally care for themselves, such as nursing home care, those in subsidized housing, vocational rehab individuals that

need support, not those in short term placement such as treatment that were high functioning and are able to return to high functioning.

*Manipulated statistics –

Rosalie (Director of State Hospital) Presented that the recommendations for "residential" treatment are out of fear and are "overstated" because people are afraid.

Absolutely: People are afraid, who would not be fearful of seeing your family member overdose
Group: Month ago, 12 clients, 9 overdosed in 30 days prior to treatment, 1 of them three times

Narcan, Ambulances Services, First Responders, Air Ambulances
*All of them had attempted outpatient services and could not stop their use.
*All the opioid users – had abused the MAT program medications, purchased them on the street and abused them along with fentanyl.

*It's not FEAR – it's NEED.

Treatment recommendations are not made by the families or the patient, they are made by Bachelor's and Master's Level, Licensed Addiction Counselors using the criteria established and recommended nationally by the American Society of Addiction Medicine. These criteria are based on 6 Dimensions. The score of these dimensions determine placement.

It is being said that MAT treatment is "cost effective".
True it is less costly and can be very effective is done in an evidence-based manner.

However, it is a tool and is being abused. It is to be prescribed and the clients are to participate in treatment programming. One cannot just substitute and not deal with the psychological aspects of addiction. (Again, ever person abusing opioids in treatment at SPRC have abused these medications)
*Many do not want the MAT medications – they want to be totally clean.
*Many cannot afford the MAT medications even if they wanted them.
*Many do not have transportation to continue MAT medications.
*Have already abused the MAT medications.
*Feel forced to take the MAT medications because there are not other services to assist with withdrawal and they cannot get into residential or outpatient services.
*MAT medications are harder to wean off then regular opioids.
*Cash cow to some of the providers prescribing as it's easier to dose than do treatment.

*Many MAT providers in state are unregulated and unsupervised, selling prescriptions in the Walmart parking lot in Dickinson, not requiring treatment, over prescribing to the point clients are in a zombie state and no follow up given, only by telehealth and no supervision.

* Peer Support – helpful but again, only a tool. Is only helpful in early stages of addiction with motivated clients and in the maintenance stage after formal treatment is completed.

Some officials are suggesting that "peer support" will take the place of Licensed Addiction Professionals. This is not helpful and untrue. They have limited training, and typically the clients are not invested, the reimbursement is not enough to sustain the positions. Agencies are having to supplement these positions from other areas. Huge liability risks!

*Clients need a full continuum of care. From prevention, outpatient, residential and aftercare services.
*It is suggested that more funding be put in prevention (absolutely) but what do we do with the client on the deep end until that shows effectiveness? We need to continue to treatment those with full blown addiction issues and offer them the opportunities to get well. We do not abandon people medically, why with behavioral health issues?

North Dakota continues to count beds, however there is no process to count needs of those unserved.

SPRC receives 5 to 12 calls a day of clients that are Sanford Expansion, Medicaid, Uninsured or with high deductibles that cannot find services anywhere in the state.

*Last Friday by noon we received 10 calls from people with these issues we could not serve.
*50 calls a week of unserved individuals, 200 a month, just from our agency and people do not even realize we are available.
*People are terrified.

*Typical addicted client.
*May Lack Transportation
*Is couch surfing.
*Cannot afford day care.
* Deep end clients typically cannot hold a job.
*Are not able to access Human Service Center's due to the style of intake (early morning, have to wait – denied and must return – they give up or are unable to secure transportation) Often forced into groups they don't want to be in that are not addiction related (engagement group – 5 or 6 weeks) prior to addiction group, they quit due to the lack of access, success and belief that someone cares, often turned away and referred to other agencies that will not serve them due to the level of care needed and low reimbursement from Medicaid/Sanford Expansion (frustrating and clients will not follow through – too hard)
*Recommendations are to low and not effective, no place to get help.
*struggle maintaining motivation to jump over the barriers.

Typical wait for residential if needed 4 to 6 weeks for people with regular insurance, 6 to 8 weeks for those with Medicaid/Sanford Expansion (if at all) only so many of these beds available due to IMD restriction. Regular insurance people are finding treatment out of state due to lack of services in state,

Arizona, Vegas, California, Florida are their favorites. North Dakota insurance monies are going out of state with no return. Due to not being able to connect with their families and having no after care plan they quickly relapse.

*Yesterday in group, 13 clients, 7 of them said if they weren't safe, they would have relapsed and left treatment because they were so uncomfortable (vomiting, diarrhea, muscle cramps, stomach upset, unable to sleep, tremors, temperature) All were on prescribed medications for withdrawal. What happens to those that do not have the safe environment to recover in? All have tried outpatient and MAT medication in past with no success or limited success.

Covid:
*Federal stats show 30% increase in use of fentanyl since shut down.
*Relapses in those sober/clean 10 and 20 years due to loss of employment, business shut down and not able to care for families.
*Many people were without insurance 60 days after shutting down and unable to secure Medicaid or Sanford Expansion of it they did there was a significant wait time.
*Voucher Disappeared
*Increases in overdose, suicides, other mental health concerns for individuals and families.

Unfortunate time to run out of monies when the need was the highest ever in the history of the United States and North Dakota

*Opioids quickly addictive – so very dangerous sometimes just days. Experimentation is so different with this drug than with alcohol and marijuana.

The poor who suffer, most are never able to receive services, particularly residential.
Even if people can take Medicaid and are within the 16-bed limit, they only reserve a few if any beds for Medicaid due to low reimbursement, delayed reimbursement or having to appeal the reimbursement decisions due to the handling of the claims at the state level.

Calls coming from ER Doctors, Nurses, Families, Ambulance personal but mostly: From the Human Service Centers – it is interesting that it is this agency that is indicating there is no need when they are desperate for placements and services for their clients.

Solutions/Suggestions:
Fund the voucher at is full proposal: Even this amount is not enough.
Propose an IMD Waiver: Cap the limit if you are concerned about too many beds or too much growth for any one agency.
Monitor/Require appropriate documentation to utilize the voucher (Initially when the voucher was proposed the state was not prepared and did little to monitor the financial need of those requesting services, thus some agencies were quick to capitalize with little accountability)

*Restructure Medicaid for that claims are processes and paid in a timely manner. Medicaid reimburses about ½ of other insurance payors. With this problem, no one wants to take these clients. Make it inviting to take Medicaid. When we call you cannot talk to a person, you are forced to email and then often there is no return message, people are rude and often times they do not know the rules, different people tell you different things. It is not uncommon that their website tells you the clients are eligible on a certain day and the services are provided and the checks for services issues only to be recalled because their website is no accurate. Thus, the agencies are not able to obtain payment for those services. Most private providers are not willing to do this or take the risks of serving these clients.

Optional/Available Services

- **Respite Care** to provide primary caregiver(s) with temporary relief from the stress and intensity of caring for a child with special needs
- **Assistive Technology** such as video modeling, DVDs, equipment, language generating devices, etc.
- **Memberships** to community organizations directly related to voucher-funded services
- **Registration** to workshops or training for independent living skills
- **Adaptive sports and activities** related to voucher-funded activities

Optional/Available Services *(continued)*

- **Transportation**
- **Specialized camps**
- **Parent training**
- **Educational materials**
- **Tutoring**
- **Sensory equipment**
- **Safety equipment**
- **Self-care equipment**

NOTE: House Bill 1038, approved during the 2013 North Dakota Legislative Session, created the autism voucher program and specified that vouchers cannot cover behavioral therapies.

NORTH Dakota | Human Services
Be Legendary.™

Home and Community-Based Services Unit
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Toll-free: 1-800-755-2604
Fax: 701-328-1544
Email: dhsautism@nd.gov
600 E. Boulevard Ave., Dept. 325
Bismarck, ND 58505

DN 345 (8-2019)

8202

Autism Services **Voucher Program**

Who?
What?
Why?
How?

NORTH Dakota | Human Services
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Who qualifies for the voucher program?

Families of children ages 3 through 17 *diagnosed with an Autism Spectrum Disorder* that have a gross family income up to 200% of the Federal Poverty level, and are not receiving services through a Medicaid waiver, may qualify for the **Autism Services Voucher Program**. See details at www.nd.gov/dhs/autism.

Why apply?

The goal of the **Autism Services Voucher Program** is to address gaps in non-therapy related services and to provide education and support to families who may not qualify for other help.

What does the program do?

The voucher program helps pay for assistive technology, training, and other approved support services that enhance the quality of life of children with Autism Spectrum Disorders and help meet the unique needs of their families.

The program provides vouchers totaling up to $12,500 per year, per qualifying child, to help eligible families with the cost of supporting a child with autism.

IMPORTANT: Early intervention and therapy services are not covered by the voucher program.



How do families apply?

To apply for voucher services, a family must complete an application, which is online at www.nd.gov/eforms/Doc/sfn60611.pdf or available from the North Dakota Department of Human Services, 600 E. Boulevard Ave., Bismarck, ND 58505.

Families must provide proof of income, proof of ND residency of at least six-months, and a copy of a confirmed diagnosis of Autism Spectrum Disorder.

In addition, professional recommendations are required for approval of all voucher purchases. The application and income chart, as well as other information about autism-related services, are online at www.nd.gov/dhs/autism.

21.8072.02001

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2089

Introduced by

Human Services Committee

(At the request of the Department of Human Services)

A BILL for an Act to create and enact a new subsection to section 50-06-32 of the North Dakota Century Code, relating to the autism spectrum disorder task force; to amend and reenact subsection 17 of section 50-06-05.1 and section 50-06-32.1 of the North Dakota Century Code, relating to financing of welfare programs and housing stabilization supports and rental assistance and the autism spectrum disorder voucher program; to repeal sections 1-02-35 and 50-06-14 of the North Dakota Century Code, relating to obsolete effective date language and financing of welfare programs; to provide a statement of legislative intent; to provide for a legislative management study; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 17 of section 50-06-05.1 of the North Dakota Century Code is amended and reenacted as follows:

17. To administer, allocate, and distribute any funds made available for the making of direct cash assistance payments, housing ~~assistance payments~~stabilization supports, and rental ~~subsidies under any rental~~ assistance ~~programs initiated by the federal government not otherwise by law made the responsibility of another state agency possessing statewide jurisdiction~~and to promote cooperation and working agreements with public agencies and including the housing finance agency and department of commerce, and private human services agencies.

SECTION 2. A new subsection to section 50-06-32 of the North Dakota Century Code is created and enacted as follows:

The department shall contract with a private, nonprofit entity that does not provide autism spectrum disorder services to facilitate and provide support services to the autism spectrum disorder task force.

SECTION 3. AMENDMENT. Section 50-06-32.1 of the North Dakota Century Code is amended and reenacted as follows:

50-06-32.1. Autism spectrum disorder voucher program ~~pilot project~~ - ~~Legislative management report~~Report to autism spectrum disorder task force - Appeal.

1. The department of human services shall establish a voucher program ~~pilot project beginning July 1, 2014,~~ to assist individuals and the family of such individuals in funding equipment, services, care and ~~general educational needs related to~~social activities or other needs to compensate for a deficit created by an autism spectrum disorder for individuals below two hundred percent of the federal poverty level from age three to under age ~~eighteen~~twenty-five who have been diagnosed with autism spectrum disorder. The program must include funding for in-home supports not to exceed forty hours per month, community activities, and transportation of the individual diagnosed with autism spectrum disorder to and from voucher-funded activities or services. The program may include funding for assistive technology; video modeling videos or equipment; language-generating devices; training and educational material for parents; parenting education; sensory equipment; tutors; safety equipment; travel tools; self-care equipment; timers; visual representation systems; respite care; specialized day care; language comprehension equipment; and registration and related expenses for workshops and training to improve independent living skills, employment opportunities, and other executive or social skills.
2. The department shall adopt rules addressing management of this voucher program ~~pilot project~~ and establishing the eligibility requirements and exclusions for this voucher program ~~pilot project~~. The program may not provide a voucher for early intensive behavioral intervention, including applied behavioral analysis, intensive early interventional behavioral therapy, intensive behavioral intervention, the Lovaas method, the Denver model, LEAP (learning experiences - an alternative program for preschoolers and parents), TEACCH (treatment and education of autistic and related communication handicapped children), pivotal response training, or discrete trial training.
3. The department shall allocate funding for family care navigator services that will assist the autism spectrum disorder voucher-approved individual and family in navigating

systems related to obtaining and coordinating services, equipment, care, and other eligible needs.

4. The department shall conduct ongoing outreach efforts to increase awareness of the voucher program funding available to eligible individuals with autism spectrum disorder and the families of these individuals. Quarterly, the department shall report to the autism spectrum disorder task force.

5. A decision on a voucher application which is issued by the department under this section may be appealed as provided under chapter 28-32.

~~4. The department of human services shall report to the legislative management regarding the autism spectrum disorder program pilot project.~~

SECTION 4. REPEAL. Sections 1-02-35 and 50-06-14 of the North Dakota Century Code are repealed.

SECTION 5. LEGISLATIVE INTENT - AUTISM SPECTRUM DISORDER VOUCHER PROGRAM. The department of human services shall ~~adopt~~draft proposed rules to seek additional flexibility for the administration of the autism spectrum disorder voucher program to ensure families can be served within available appropriations. ~~The administrative code changes should consider changes that include reducing the amount of approved voucher funds available to each household and the amount of time during which a household may use approved voucher funds.~~Before being adopted by the department of human services, the draft rules first must be approved by the autism spectrum disorder task force. The department of human services shall request the legislative assembly to fund the autism spectrum disorder voucher program with one million three hundred and eighty-five thousand dollars.

SECTION 6. LEGISLATIVE MANAGEMENT STUDY - AUTISM SPECTRUM DISORDER WAIVER AND VOUCHER PROGRAMS ~~AND TASK FORCE~~. During the 2021-22 interim, the legislative management shall consider studying the autism spectrum disorder waiver and voucher programs and other programs designed to provide services to children who are impacted by autism spectrum disorder ~~and the elimination of the autism spectrum disorder task force~~. The study may include consideration of the structure of the programs and whether there are any gaps and unmet needs. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 7. EMERGENCY. This Act is declared to be an emergency measure.

21.8072.02001
Title.

Prepared by the Legislative Council staff for
Senator Heckaman
March 2, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2089

Page 1, line 1, after "to" insert "create and enact a new subsection to section 50-06-32 of the North Dakota Century Code, relating to the autism spectrum disorder task force; to"

Page 1, line 1, after "50-06-05.1" insert "and section 50-06-32.1"

Page 1, line 3, after "assistance" insert "and the autism spectrum disorder voucher program"

Page 1, after line 16, insert:

"**SECTION 2.** A new subsection to section 50-06-32 of the North Dakota Century Code is created and enacted as follows:

The department shall contract with a private, nonprofit entity that does not provide autism spectrum disorder services to facilitate and provide support services to the autism spectrum disorder task force.

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2. The department shall adopt rules addressing management of this voucher program ~~pilot project~~ and establishing the eligibility requirements and exclusions for this voucher program ~~pilot project~~. The program may not provide a voucher for early intensive behavioral intervention, including applied behavioral analysis, intensive early interventional behavioral therapy, intensive behavioral intervention, the Lovaas method, the Denver

model, LEAP (learning experiences - an alternative program for preschoolers and parents), TEACCH (treatment and education of autistic and related communication handicapped children), pivotal response training, or discrete trial training.

3. The department shall allocate funding for family care navigator services that will assist the autism spectrum disorder voucher-approved individual and family in navigating systems related to obtaining and coordinating services, equipment, care, and other eligible needs.

4. The department shall conduct ongoing outreach efforts to increase awareness of the voucher program funding available to eligible individuals with autism spectrum disorder and the families of these individuals. Quarterly, the department shall report to the autism spectrum disorder task force.

5. A decision on a voucher application which is issued by the department under this section may be appealed as provided under chapter 28-32.

~~4. The department of human services shall report to the legislative management regarding the autism spectrum disorder program pilot project.~~"

Page 1, line 20, replace "adopt" with "draft proposed"

Page 1, line 22, remove "The administrative code changes should consider"

Page 1, replace lines 23 and 24 with "Before being adopted by the department of human services, the draft rules first must be approved by the autism spectrum disorder task force."

Page 2, line 2, after "with" insert "one million"

Page 2, line 2, after "hundred" insert "and eighty-five"

Page 2, line 4, remove "**AND TASK FORCE**"

Page 2, line 7, remove "and the elimination of the autism spectrum disorder task"

Page 2, line 8, remove "force"

Renumber accordingly

Testimony
House Bill 1012 – Department of Human Services Budget
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 9, 2021

Chairman Holmberg and Members of the Senate Appropriations Committee:

I am Holly Johnson, a Licensed Board Certified Behavior Analyst, and the appointed Behavioral Specialist member of the Governor's Autism Spectrum Disorder Task Force (ASDTF). I live in Minot, and I've been working with children and families in the Autistic community in a variety of capacities over the past 15 years. I am here today on representing the ASDTF to advocate continuation of funding for the Autism Spectrum Disorder (ASD) Voucher.

This program was created 'to address the gaps in non-therapy related services and to provide education and support to families who may not qualify for other help', as disseminated in the DHS program brochure (attached). However, screening eligible for the Voucher indicates that the person is not eligible for the Waiver. Reducing funding for the ASD Voucher now will mean these families will have to compete for slots on the ASD Waiver, which has had a waitlist of 50+ children since its inception.

DHS, through SB 2089, sought to eliminate the ASD Voucher in it's entirety, taking the position that it was "repurposing" the General Fund money from the ASD Voucher to the ASD Waiver, which is matched with Medicaid dollars. This was done with no notice to, or discussion with, the ASDTF. While DHS is tasked with cutting 15% of its General Funds by the Governor, this should not mean a 100% cut of the ASD Voucher, and an overall 50% reduction of the ASD-related service funding. DHS is not only "repurposing" the full amount it stripped from the ASD Voucher into the ASD Waiver, it is also reducing the amount allocated to the ASD Waiver from the 2019-2021 biennium.

As an Autism Task Force, we want to know where that money goes. This should inarguably be reevaluated after the legislative management study, as is currently engrossed in SB 2089. We urge this Committee to put the full prior appropriation amount back ($1.325M). Then, through the study during the 21-23 biennium, determine if the ASD Voucher program's budget needs to be reduced. This "repurposing" will end up excluding children in need from services.

There are issues with the Department's assumption that ASD Voucher-eligible individuals can be served by the ASD Waiver.

- The child must be screened at an ICF/institutional level of care for the ASD Waiver. Many children on the ASD Voucher will not be eligible for the ASD Waiver, leaving them with no services. There is no guarantee they will qualify. Testimony to the Senate Human Services Committee indicated, "people who are eligible for the Voucher are not eligible for Medicaid or a Medicaid waiver," and, "a good portion of them (kids on the Autism Voucher) would (lose services)."
- Diverted ASD Voucher children who actually qualify for ASD Waiver services may lose four years of eligibility for services. Children must be under the age of 13 to qualify for ASD Waiver services, with the hope it will be increased by 2 years this legislative session, in SB 2085. If over this age, they will not qualify for the ASD Waiver. Additionally, there is up to a two year waitlist to access the ASD Waiver, so those being serviced by the ASD Voucher, who manage to meet heightened ASD Waiver eligibility requirements, may be left waiting for services. There is no other safety net.

ASD Waiver/Voucher during the first half of the legislative session:

- The original text of SB 2089, introduced by DHS, repealed the ASD Voucher.
- HB 1012 begins hearing testimony on DHS Budget.
- On 2/8/2021, through amendments to SB 2089, Senate Human Services restored the ASD Voucher along with $300,000 for the 2021-2023 biennium, and included a study of the Autism Voucher, Autism Waiver, and Autism Task Force.
- On 2/12/2021, SB 2089 passed in the Senate.

- On 2/22/2021, DHS' budget (HB 1012) passed the House with the removal of the ASD Voucher. Opposition testimony was provided on 1/25/2021 by the ND Autism Advocacy Coalition during public commentary to House Appropriations – Human Resources Division, and explicitly identified the DHS budget line item regarding the ASD Voucher.
- During amendment discussions between House Appropriations and DHS in mid-February, the budget math was not fully explained. The testimony to House Appropriations was that the Department is not eliminating services for children with autism, they are eliminating a program, but increasing ASD Waiver slots to pick up the people in the ASD Voucher.
- However, in the savings plan document, the word "voucher" is not even identified. It specifically states, 'Eliminate and shift dollars into existing waiver and state plan services for ASD to draw down a match,' is described as 'Programmatic Efficiency Savings,' which is misleading.
    - Total Savings = $425,617
    - General Fund Savings = ($528,706)
    - Federal Fund Savings = $954,323
- In reality, DHS is cutting the ASD Voucher entirely AND reducing the budget for the ASD Waiver by ($356,324). A summary of this diversion can be referenced in the 'Budget & Spending Breakdown' document (attached).

Moving into the second half of legislative session, here's what is happening:

- On 3/3/2021, the ASDTF presented proposed amendments drawn up by Legislative Council (attached) to the House Human Service Committee. The goal with the amendments is to make the ASD Voucher more usable and impactful for children with autism and their families; so the funding is actually spent on services, which include in-home and community-based supports. In order for this to be a reality, the ASD Voucher would have to retain its funding. In this hearing, DHS continued to support the repeal of the ASD Voucher.

Today, the ASDTF wants to educate Senate Appropriations on what “repurposing” means in the DHS savings plan for the ASD Voucher, and that full funding for the ASD Voucher ($1,325,000) should continue along with the Autism Task Force’s proposed amendments provided to House Human Services to improve the program.

- The ASDTF is advocating for the 52 children approved for ASD Voucher funds in 2017-2018, 39 children in 2018-2019, 48 children in 2019-2020, and 42 children in 2020-2021 who would be losing services (~90 children each biennium). Even with the addition this legislative session of 54 slots to the current 96 slots in the ASD Waiver (150 total slots), we will not be able to serve the total number of children currently on the Waiver waitlist (reported at 70 during February 2021 ASDTF meeting). Potentially, we are adding 90 more children each biennium to the ASD Waiver waitlist, that is, if the ASD Voucher recipients are critical enough to qualify for the ASD Wavier based on institutional level of care.
- The budget for the ASD Waiver for the next biennium is less than this biennium, so “repurposing” these General Fund dollars is a surreptitious concept. It is not “budget neutral” as described in other testimony from DHS when discussing adding the 54 slots to the ASD Waiver.
- For the past 4 biennia, DHS has requested full funding or the ASD Waiver and ASD Voucher, with the expectation that because of program limitations, the funding would not be fully expended, and the leftover could be redistributed to other DHS programs. Now, the Department seeks to divert funding for individuals with autism to other budeget areas. The ASDTF urges this committee to not rob Peter to pay Paul.
- ASD Waiver and ASD Voucher funding is necessary for the future vision proposed by DHS, as over 50% of those institutionalized at LSTC (youth and adults) have a diagnosis of autism. DHS is going to realize its program goal of reducing the LSTC census – where each individual costs the state over $400,000 per year – means there must be an alternative set of services established in the community, except they are slashing those in-home and community-based services.

In summary, the ND Autism Spectrum Disorder Task Force, strongly opposes the attempt to repeal and entirely defund the Autism Spectrum Disorder (ASD) Voucher program. The ASD Voucher program should have the intent to reach as many families as possible, filling any gaps left by other ASD programs and services. We are asking for transparency, as we have not been given any chance to discuss this. Timing has not been in our favor, but now that we have the necessary information to work this through in the remainder of this legislative session, we ask the Senate Appropriations Committee to consider this budget item carefully and synchronize both sides. This is our opportunity to improve the ASD Voucher through the proposed amendments, and we appreciate the opportunity to ensure this program stays funded for the next biennium.

This concludes my testimony. This testimony has been provided on my personal time and in no way represents DHS or LSTC. Thank you for your time and consideration. If I can be of assistance during this time of deliberation, please contact me at holly.johnson.bcba@outlook.com. I am happy to answer any questions.

Sincerely,

Holly Johnson, MS, BCBA, LBA
Board Certified Behavior Analyst #1-14-15198
ND Licensed Behavior Analyst #L15

8203

Autism Spectrum Disorder Voucher & Waiver Budget & Spending Breakdown

2019-21 ASD Voucher Auth

$1,325,009

2019-21 ASD Waiver Auth

$2,564,772

96 slots

ASD Voucher 2019-21 Expenditures

$160,628

ASD Waiver 2019-21 Expenditures

$395,577 96 slots

2021-23 DHS ASD Voucher Budget Figure

$1,358,153 (+$33,144)

2021-23 DHS ASD Waiver Budget Reduction

$1,495,968 (-$1,068,804)

Diverted

$645,673 to HCBS Waiver

$712,480 to ASD Waiver

Adding 54 slots

2021-23 DHS Reallocated ASD Waiver Budget (including inflation) 150 slots

$2,242,074 (-$356,324)*

***2021-23 Budget allocation for 150 ASD Waiver slots is less than 2019-21 budget for 96 ASD Waiver slots which has traditionally had a 50+ person waiting list**

21.0271.02002
Title.

Prepared by the Legislative Council staff for
Senator Fors

March 3, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 11, after line 13, insert:

"**SECTION 20. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Renumber accordingly

Testimony on HB 1012
Senate Appropriations Committee
March 9, 2021

Good afternoon Chairman Holmberg and members of the Senate Appropriations Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 211 assisted living, basic care, and skilled nursing facilities in North Dakota. I am here in support of HB 1012 and ask for your support of basic care and nursing facility funding.

HB 1012

First, just a quick recap of the number of beds and facilities – see the attachments for assisted living, basic care, and nursing facilities.

Second, I want to address basic care funding. Originally the DHS budget proposed a decrease in basic care funding of $7.3 million.

This would have been catastrophic for the facilities caring for residents in basic care. I am happy to say the House restored $5.3 million to the basic care budget.

Before the pandemic hit basic care utilization was growing, more people needing basic care assistance were seeking this living arrangement with services. However, as you can see, basic care occupancy has dropped because of COVID-19, so the money for the increase in caseload/utilization is probably not necessary, and thus the $5.3 million restored by the House may be sufficient except for our request of another $439,126 to increase their annual inflator to 2% rather than the current 1%.

What is basic care and why is it important? Basic care is a congregated residential setting with private and semi-private rooms, providing 24 hour staffing. Basic care provides an all-inclusive rate providing room, meals, personal care services, supervision, activities, transportation, medication administration, nursing assessment and interventions and care planning. Residents range in age from late 30's to over 100 years old, with the average age in the mid 80's. Almost two-thirds of residents living in basic care need assistance to pay for their care. The average basic care assistance rate on July 1, 2020 was $129.69, what a bargain! Twenty-four hour care, all-inclusive rate that covers all of your needs. An independent study commissioned by DHS in 2014 stated in their report, (Myers & Stauffer), "It is therefore in the state's best interest to proactively invest additional resources to further develop it's non-institutional resources, (HCBS, basic care and assisted living) that promote the ability of the elderly and disabled to "Age in place" and be served for as long as possible in their own home or another community residential setting.". Please take a look at Attachment B labeled Basic Care Rates Effective July 1,2020, the average rate is $129.69. North Dakota has a real gem, called basic care and I ask that you support the House restoration of funding.

The next budget item I would like to address is Adult Residential Care. These are licensed basic care providers specializing in head injury services, (two) and in dementia care, (thirteen). These facilities are funded under the Medicaid waiver and the clients they serve screen in need of skilled nursing care. Adult Residential Care is a more independent integrated setting with 24 hour access of staff to support their independence.

Below is the list of the 15 Adult Residential Care facilities and their daily Medicaid rate, their licensed bed capacity and their occupancy as shared on the 1-14-21 HC Standard report.

FACILITY NAME	CITY	DAILY RATE	LICENSED BEDS	OCCUPIED
Maple View	Bismarck	$112.08	36	31
Edgewood Senior Living	Fargo	$108.93	35	33
Maple View Memory Care	Minot	$103.22	43	32

Edgewood Senior Living	Mandan	$107.08	73	48
Maple View Fargo	Fargo	$108.26	36	30
Ecumen – Evergreens	Fargo	$114.72	54	32
Edgewood Senior Living	Minot	$123.77	22	18
Edgewood Senior Living	Minot	$126.38	133	97
Roseadele	Jamestown	$127.47	20	20
Edgewood Senior Living	Bismarck	$133.13	44	36
Maple View	Grand Forks	$125.62	36	25
Edgewood Senior Living	Jamestown	$127.35	61	39
Lakewood Landing	Mandan	$154.94	38	32
Open Door Center	Valley City	$173.00	10	10
Dakota Pointe – HIT INC	Mandan	$198.24	10	10

Besides the daily rate above, a room and board rate of $758.00 per month is allowed. These providers are also in need of at least a two percent rate adjustment per year. The Governor's Budget allows only a one percent adjustment.

The next budget item is nursing facilities. This budget provides an enhancement of $7.2 million for reforming the Nursing Facility Payment System. We support the changes to the Nursing Facility Payment System and ask that you do also.

The study of the payment system was a long grueling process and it challenged us to think differently. The study was mandated in the 2019 legislative session and you directed a revised payment methodology be developed. Not a tweaking of the old system but the creation of a new methodology. That took us awhile to grasp. I believe for the first few meetings, someone in the group would ask, "Are you sure this is necessary? Wouldn't it be better to change our current system and improve it to incentivize efficiency?" Then we would go back, read the legislative language you approved and said no, we need to change the entire payment methodology and thus we did! Many times, during our months of meetings I did not think we would arrive at consensus, but we stuck with the process and in the end at our September 2020 membership meeting, approved the new payment system by a vote of 99-1. At the end we did not get everything we advocated for and neither did the state,

but we believe this system can achieve better efficiency of state resources and a quality service that delivers on our promise of assuring the elderly get quality care at the end of their life.

We could never had completed this study without the knowledge and expertise of two payment experts. Joe Lubarsky, President of Eljay, LLC and Brad DeJong, Senior Partner with Eide Bailly. Brad is an expert in North Dakota's nursing facility payment system and Joe is a national expert in the development and modification of nursing facility payment systems. He has assisted in the design of payment systems in 30 states. Without their expert knowledge this project would have never been successful. Brad DeJong is with us today and he will testify on the details for the new proposed fair rental system.

As you are aware, HB 1090 contains all the policy language to implement the new payment system and HB 1012 contains the money. It is impossible to just talk about the money without talking about the new policy behind it. All policies are based upon a long and sometimes challenging negotiation process. Each detail impacts one another. They are all related and entwined to the overall success of the new payment system. We know you have final approval the as legislature determines policy and the budget. I am hoping you see the value and can support all changes we are bringing to you. To trust the state and national experts who know complex payment systems. There are key components that are vital to the implementation and success of the new system.

Key Features of the New Pricing Model

1. Moves to a hybrid pricing model verses our current cost-based system with limits.

2. Set price levels as a percentage of median, with direct care and other direct care at 120% of median and indirect at 110% of median.
3. The indirect price will be established separately for small nursing facilities, 55 beds and under, and large facilities, greater than 55 beds. Small nursing facilities will have a higher price of approximately $4 dollars in the indirect cost category.

4. The margin cap in all cost centers will be 3.46% of the price. Please do not confuse this with an operating margin under our current system. In our current system, everyone gets an operating margin, that will not be true in our new system. Every facility will have the opportunity to receive a margin, but it will be based on where they are operating relative to the Price Point.

- Facilities that are 3.46% or more under the Price Point will receive the facility specific allowed cost plus the margin.
- Facilities that are within 3.46% of the Price Point will receive the Price.
- Facilities that are at or over the Price Point will only receive the Price, no margin.

5. The new pricing model, (not the property component), would implement on 1-1-22 and the 6-30-21 cost report will be used to set the initial prices.

6. We are proposing a hold harmless provision for two years on the operating side. For the initial year starting 1-1-22 nursing facilities

will be able to select to operate under the existing cost based methodology or the new pricing model. All nursing facilities will receive two sets of rates and they will decide and select the one they want. This two year hold harmless is very important and will help those who may experience rate decreases under the new pricing model to transition more slowly into the new payment model. The House took further action to assist the high cost/high staffed facilities in transition. For the rate years 2022 and 2023 they directed $2.1 million to enhance the operating margin before they transition into the hybrid pricing model.

7. In the second year of implementation, 2023, the hold harmless provision continues. A nursing facility can continue to stay under the existing cost based system or convert to the new payment system. In year three, all must convert to the new pricing model.

8. Rebasing will occur every two years for the first four years and will be examined after that period.

9. The Medicare Skilled Nursing Facility Market Basket will be utilized to increase rates in the non-rebasing years. Item 8 & 9 are really important because we are losing a key component on the payment system. That is called annual rebasing. Under annual rebasing today, if your costs are <u>under</u> the cost limit and your costs increase substantially, you get that full increase in your rate up to the limit. This feature has saved many facilities and has been vital. But we are giving it up. In giving this "annual rebasing up", it is important to get the annual Skilled Market Basket and rebasing of the price every two years.

10. A process has been developed to address atypical cost increases in a non-rebasing year. (i.e., pandemic – national minimum wage) and that will be outlined through the rule promulgation process.

11. Equalization of Rates continues.

12. When the two year transitional hold harmless ends, we would like to see the development of a new quality incentives payment. This is not part of the legislation before you today but something I would like to bring back in 2023 for implementation in 2024.

    Based upon a statistical analysis of costs there is <u>one</u> driver of why it costs more in some North Dakota nursing facilities and that is the number of staff they have. Lower cost facilities have less staff, high cost facilities have more. Under this new system some high staff facilities may need to reduce staffing to be successful under this model. An analysis of cost and quality data in North Dakota shows those with higher costs, (higher staffing), have better overall quality outcomes. We would like to see a system that rewards quality and allows all nursing facilities to earn back dollars in the form of a quality payment to help support the cost of their higher staffing. Today we need the two year hold harmless transition payment, but in the future, we would love to see this as a quality payment. (See two charts on quality)

13. Implement a Fair Rental Value System as the property component on 1-1-23. Implementing this component of the new system is going to take time because to establish your Fair Rental Value the state will need to collect square footage and cost of additions and renovations made on all nursing facilities over their lifetime. This also needs a

hold harmless provision, and this provision will be needed until everyone crosses over into the fair rental system. The hold harmless provision is to help those that have recently undertaken a major construction project or to help those that are planning a major construction project if the financing of the project was in place by 12-31-21. The majority of the new money here are for those nursing facilities that have a low property rate to transition to a higher property value.

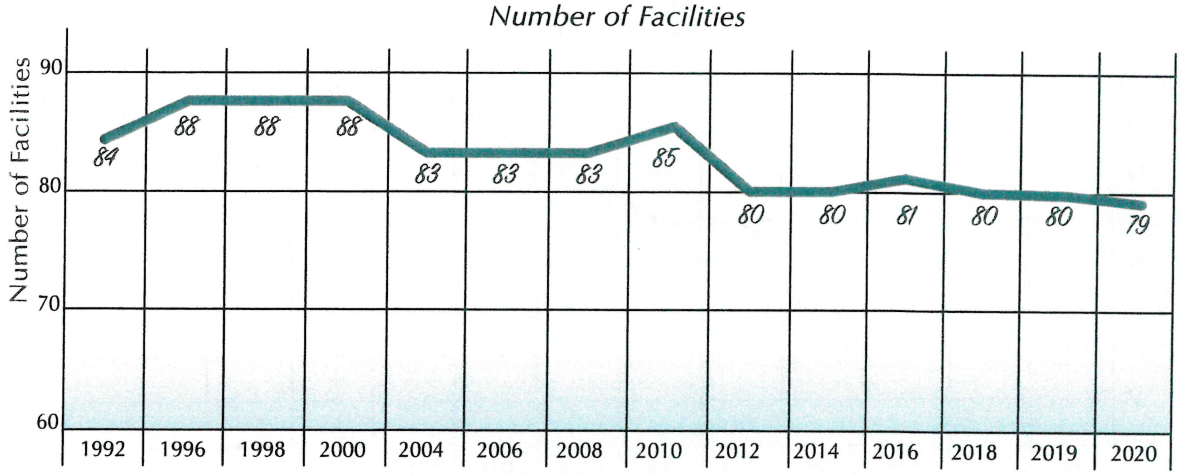
Brad DeJong is going to address in detail the fair rental system so I would like to defer any question on that topic to him.

This concludes my testimony and I welcome your questions

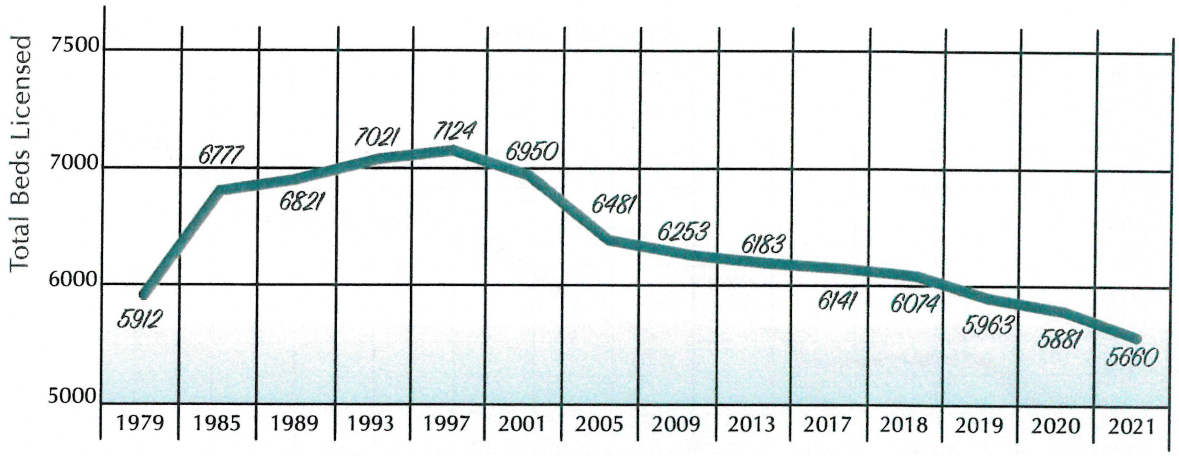
Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

Nursing Facilities

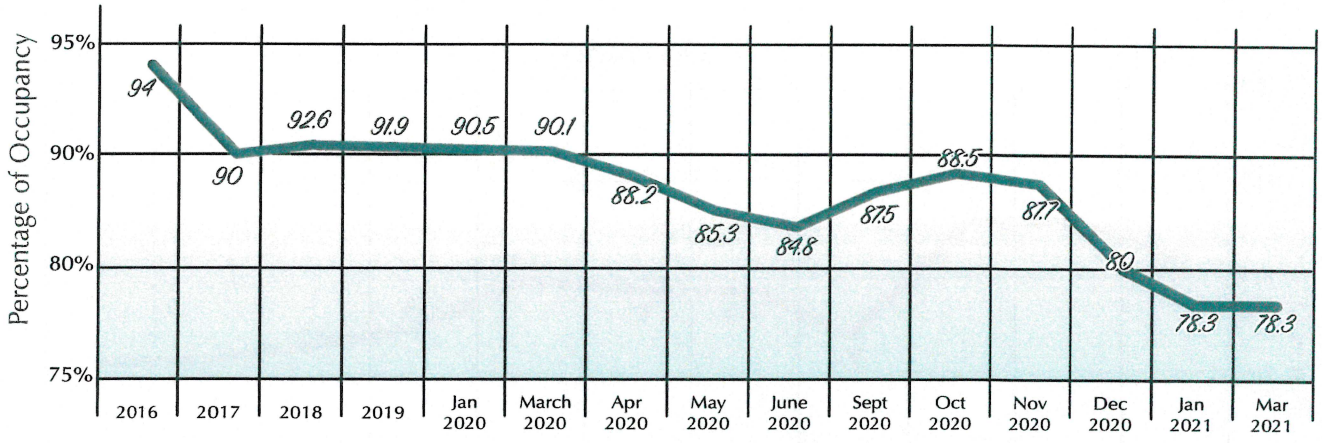
Number of Facilities



Licensed Beds



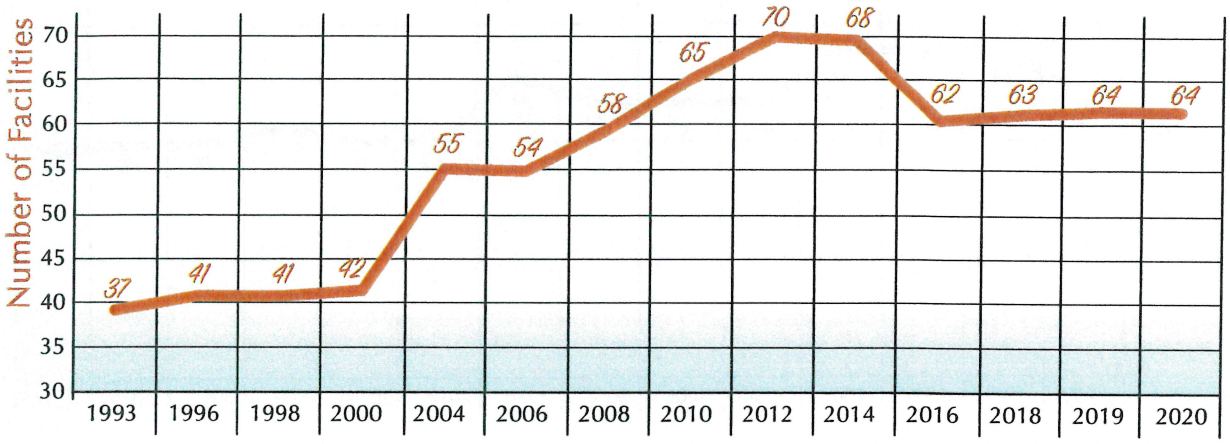
Occupancy



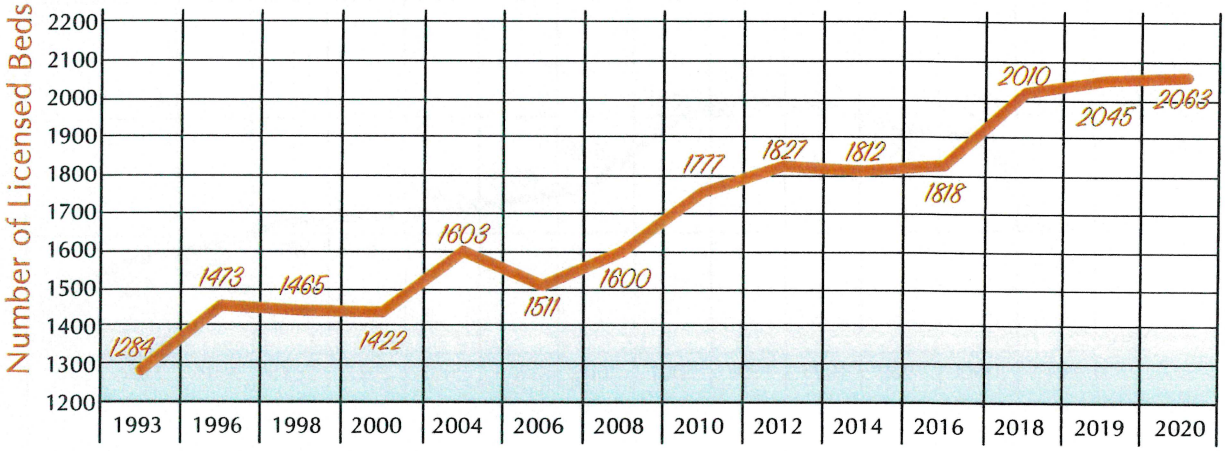
September 2020 Based on HC Standard Report on September 10, 2020
October 2020 Based on HC Standard Report on October 2, 2020
November 2020 Based on HC Standard Report on November 2, 2020
December 2020 Based on HC Standard Report on November 30, 2020
January 2021 Based on HC Standard Report on January 11, 2021
March 2021 Based on HC Standard Report on March 4, 2021

Basic Care

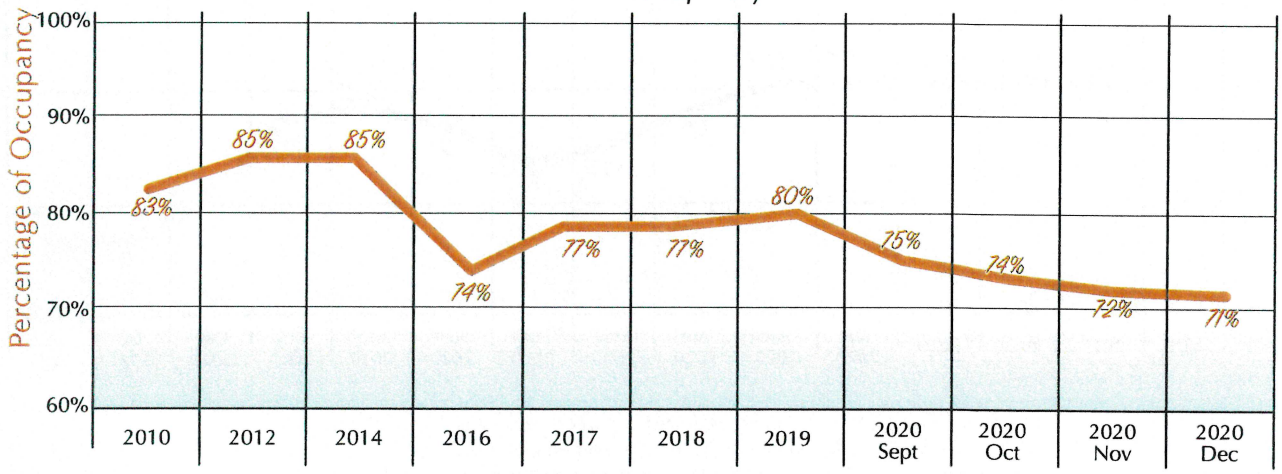
Number of Facilities



Licensed Beds



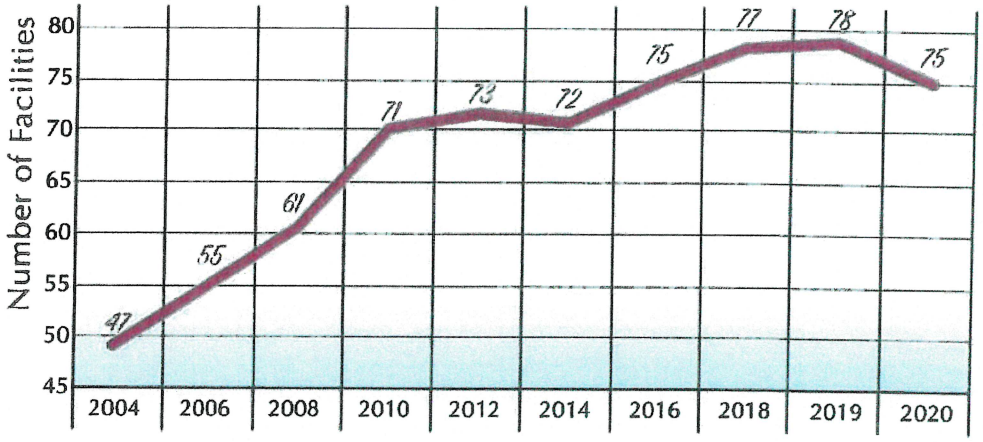
Occupancy



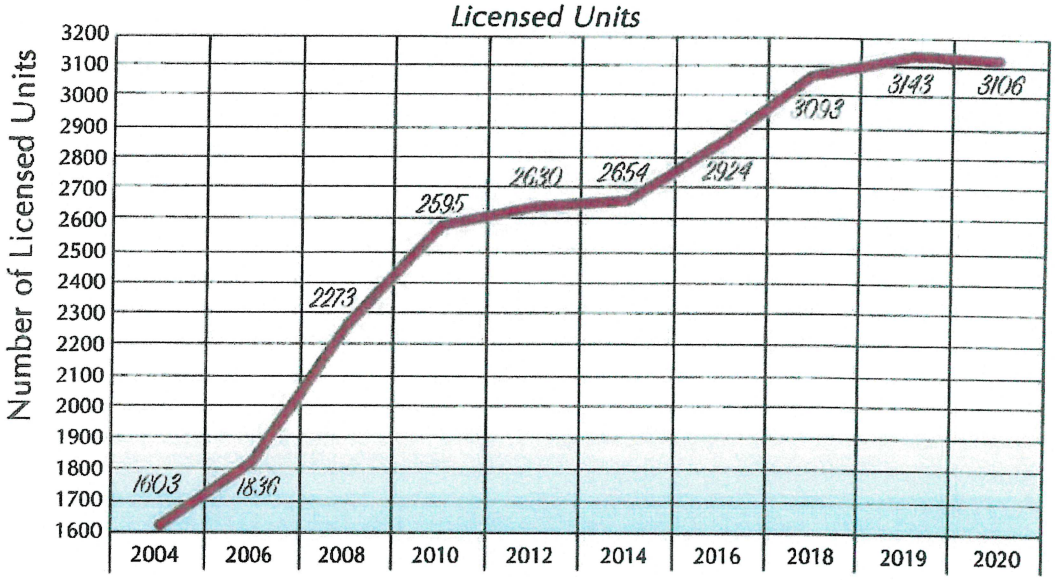
The occupancy for 2020 is based upon the 9-10-20, 10-2-20, 11-2-20 and 11-30-20 data submitted by basic care facilities (n=61) and HC Standard/Covid Reporting

Assisted Living

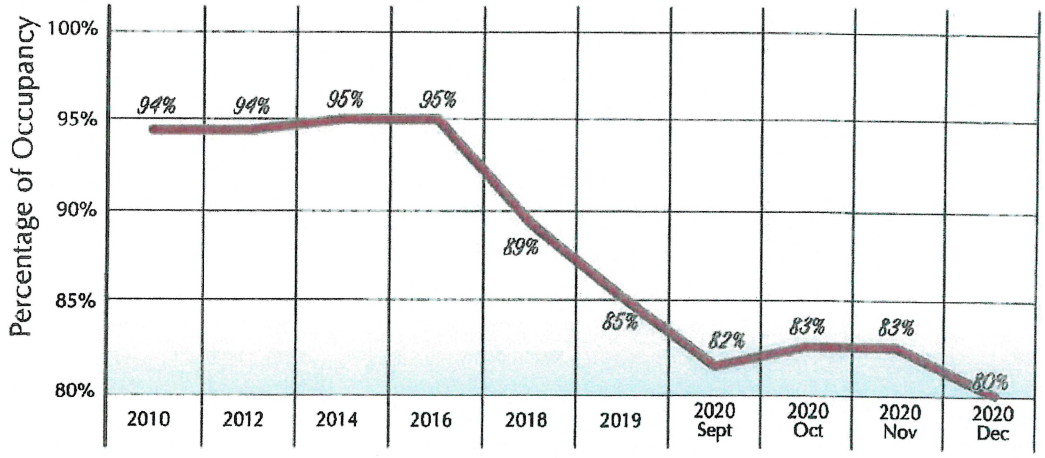
Number of Facilities



Licensed Units



Occupancy



The occupancy for 2020 is based upon the 9-10-20, 10-2-20, 11-2-20, and 11-30-20 data submitted by assisted living facilities (n=69) and HC Standard/Covid Reporting

NORTH Dakota | Human Services
Be Legendary.

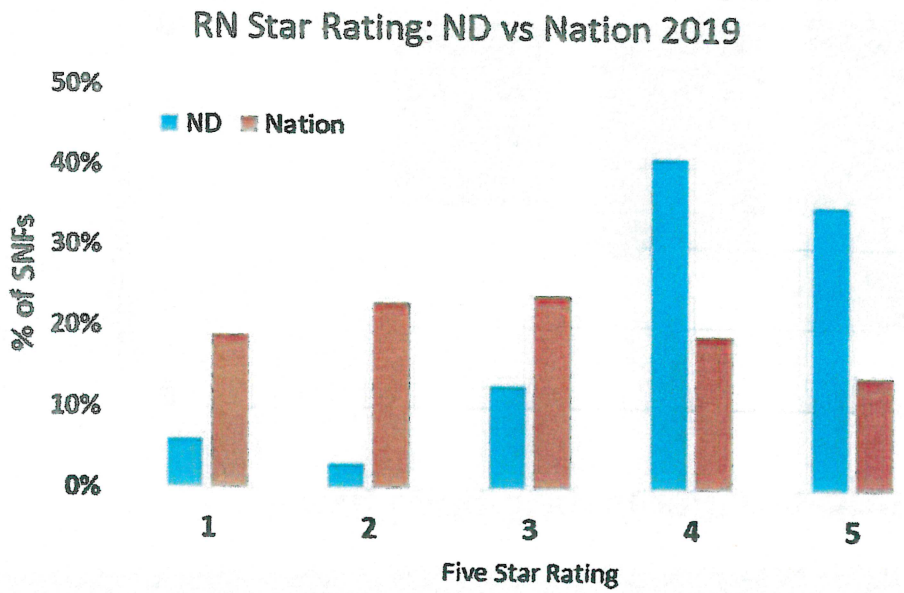
Basic Care Rates Effective July 1, 2020

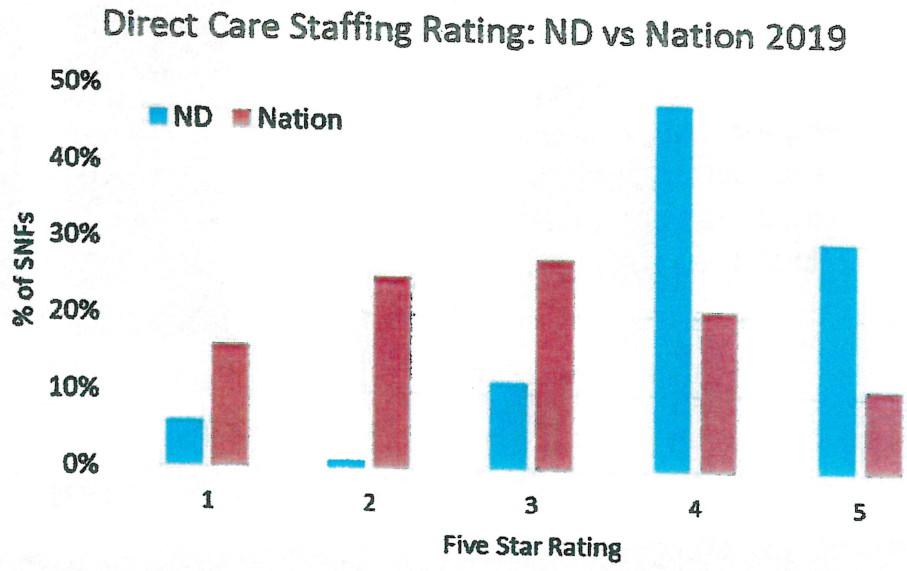
Faciltiy	City	Personal Care Rate	Room & Board Rate	Total Rate
Prairie Villa	Arthur	$77.99	$68.99	$146.98
Augusta Place	Bismarck	$53.56	$84.42	$137.98
Edgewood Bismarck Senior Living	Bismarck	$64.87	$40.81	$105.68
Edgewood Vista at Edgewood Village	Bismarck	$63.64	$63.51	$127.15
Prairie Pointe	Bismarck	$99.88	$80.57	$180.45
St. Gabriel's Community	Bismarck	$73.77	$112.91	$186.68
The Terrace	Bismarck	$72.37	$57.95	$130.32
St. Francis Residence	Cando	$48.98	$84.91	$133.89
St. Luke's Sunrise Care Center	Crosby	$59.64	$96.81	$156.45
Eventide - Lake Country Manor	Devils Lake	$45.69	$71.01	$116.70
Odd Fellows Home	Devils Lake	$50.65	$59.44	$110.09
Evergreen Dickinson	Dickinson	$45.85	$68.70	$114.55
Manor St. Joseph	Edgeley	$65.06	$43.80	$108.86
Edmore Rest Home	Edmore	$93.49	$39.92	$133.41
Dakota Hill Housing	Elgin	$60.29	$39.85	$100.14
Evergreen Place	Ellendale	$59.58	$64.81	$124.39
Bethany Towers	Fargo	$68.63	$59.88	$128.51
Edgewood Fargo Senior Living	Fargo	$64.94	$61.17	$126.11
Evergreens of Fargo - 1401	Fargo	$77.00	$59.53	$136.53
Evergreens of Fargo - 1411	Fargo	$77.47	$59.34	$136.81
Good Samaritan Society - Fargo	Fargo	$49.39	$59.44	$108.83
Gackle Care Center	Gackle	$71.27	$58.46	$129.73
Edgewood Parkwood Place	Grand Forks	$50.59	$43.16	$93.75
St. Anne's Guest Home	Grand Forks	$59.27	$67.71	$126.98
Tufte Manor	Grand Forks	$55.08	$65.41	$120.49
Senior Suites at Sakakawea	Hazen	$85.82	$65.25	$151.07
Edgewood Jamestown	Jamestown	$74.17	$77.79	$151.96
Rock of Ages Home, Inc.	Jamestown	$62.71	$46.29	$109.00
Hill Top Home of Comfort	Killdeer	$77.53	$88.38	$165.91
Good Samaritan Society - Lakota	Lakota	$78.54	$90.80	$169.34
Good Samaritan Society - Larimore	Larimore	$44.43	$97.07	$141.50
Parkside Lutheran Home	Lisbon	$79.16	$87.02	$166.18
Maddock Memorial Home	Maddock	$61.00	$65.90	$126.90

Basic Care Rates Effective July 1, 2020

Faciltiy	City	Personal Care Rate	Room & Board Rate	Total Rate
Edgewood Mandan	Mandan	$51.26	$58.11	$109.37
Lakewood Landing	Mandan	$46.48	$67.13	$113.61
Sheridan Memorial Home	McClusky	$52.22	$42.38	$94.60
Edgewood Minot Senior Living	Minot	$42.18	$36.45	$78.63
Borg Pioneer Memorial Home	Mountain	$57.26	$46.34	$103.60
Napoleon Care Center	Napoleon	$60.15	$61.65	$121.80
Lutheran Home of the Good Shepherd	New Rockford	$58.18	$94.73	$152.91
Osnabrock Community Basic Care	Osnabrock	$57.19	$42.81	$100.00
Good Samaritan Society - Park River	Park River	$36.38	$68.76	$105.14
Harold S. Haaland Home	Rugby	$67.29	$66.96	$134.25
Golden Manor	Steele	$63.47	$63.34	$126.81
Siena Court	Wahpeton	$79.62	$82.21	$161.83
The Leach Home	Wahpeton	$54.77	$77.23	$132.00
Bethel Lutheran Home	Williston	$62.95	$79.96	$142.91
Redwood Village	Wilton	$79.19	$65.09	$144.28

ND vs Nation: Staffing Star Rating 2019





Improving Lives *by* Delivering Solutions *for* Quality Care

AHCA
AMERICAN HEALTH CARE ASSOCIATION
NCAL
NATIONAL CENTER FOR ASSISTED LIVING

Staffing Association with Quality ND Facilities 2019



FINDING: As staffing Star Rating increases so does the average Quality Measure Star Rating

Note: 1 star facilities (n=5) were assigned 1 star by CMS due to staffing data errors; not because of low staffing levels; and were excluded

AHCA
NCAL

Senate Appropriations Committee
House Bill 1012
March 9, 2021
Senator Holmberg, Chair

Chairman Holmberg and Members of the Senate Appropriations Committee. I am Denise Harvey, Director of Program Services with the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency that protects people with disabilities from abuse, neglect, and exploitation, and advocates for the civil and legal rights of people with disabilities.

P&A supports the building of a new State Hospital with reduced beds, in conjunction with the establishment of 6 to 10 beds in the western part of the state. While this is not the first request for the building of a new State Hospital, it is time. The institutionalized setting provided through the large older buildings is not conducive to modern treatment and requires additional staffing due to its size. A new facility would be much more efficient, both in cost and serving individuals. Funds that would be spent for costly renovations would be better spent providing services in the western part of the state. There is a tremendous need for beds in the western part of the state, to both serve individuals who require more intensive services and to prevent family members from being separated in times of need. It is expected for persons with medical needs to receive services near their homes, and it is also expected for persons with mental illness to receive services near their homes.

P&A supports the 1915(i) state plan amendment, and the tremendous efforts made to put this into place. P&A appreciates the extensive work done by DHS to expand behavioral health services to meet the needs of people with the right service, at the right time, nearest their home. While there are many positive steps taking place, there are questions about the number of agencies that are ready to provide services through the 1915(i) at this time, and proposed budget reductions related to this. P&A expresses concern about reductions in funding for family support programs to include Family Voices and the Federation of Families. It is our understanding that these programs are marked for significant cuts for the next biennium. The support provided for families through these programs is invaluable. P&A expresses concern about the elimination of the Experienced Parent Program for early intervention. In addition, the large reduction proposed for the Voluntary Treatment Program is concerning. Prior to the establishment of this program, parents were put in situations where they were required to relinquish custody of their child to access needed mental health services, including the use of residential treatment facilities. Reductions in funding for these programs would be very detrimental to families with the highest level of needs.

P&A supports peer support, along with certification and professional supervision for this program. We look forward to hearing of the positive results from consumers using this program. This has been a top priority for the consumers of mental health services for years, and we are very grateful for the support provided for this program and encourage on-going full financial support for this program.

P&A supports full funding for the North Dakota Brain Injury Network. The proposed significant cut in this program, which already has a limited staff of 3 persons, would drastically reduce services provided across the state of North Dakota. Services provided through the North Dakota Brain Injury Network that involve outreach, education and collaboration are not individual specific services and would not be reimbursable through the 1915(i). While the efforts to increase services for individuals with brain injury through the 1915(i) are greatly appreciated, there remains much work to be done beyond this. The knowledge base and services provided by the North Dakota Brain Injury Network are essential for individuals with brain injuries and family members throughout our state. In addition, P&A supports full funding for the facilitation of the ND Brain Injury Advisory Council by the Consensus Council. The work of the Advisory Council is vast and complex. The particularly skilled facilitation provided for meetings with members across the state, along with sub-committees, has been important in assisting the Council to meet targeted goals to best serve individuals with brain injuries and family members.

I am glad to answer any questions.

Denise Harvey, Director of Program Services
Protection & Advocacy
701-328-2950

7700

Greater North Dakota Chamber
HB 1012
Senate Appropriations Committee
March 9th, 2021

Mr. Chairman and members of the Senate Appropriations Committee, my name is Arik Spencer, President and CEO of the Greater North Dakota Chamber (GNDC). GNDC is North Dakota's largest statewide business advocacy organization. We stand in support of House Bill 1012, first for continued funding of Medicaid Expansion and second, continued funding at current rates.

The ongoing and steep rise of health insurance costs is of paramount concern to North Dakota's business community. Without continued funding of Medicaid expansion at current rates, Healthcare providers may be forced to shift the cost of care to others, which will have the net effect of increasing health insurance costs, because those with health insurance, in effect, pay for the financial loss hospitals incur when they provide services at a loss and to those without insurance.

Additionally, Medicaid Expansion provides workers, who otherwise would have no health insurance, options which are critical to maintaining a strong and healthy workforce in many industries.

Finally, as North Dakota employers seek to recruit and retain workers increased health insurance costs will only serve to put North Dakota employers at a disadvantage relative to other states.

In conclusion I ask that HB 1012 receive a do pass recommendation with continued funding for Medicaid Expansion at current rates and I will stand for any questions the committee has.

PRAIRIE HARVEST
MENTAL HEALTH
930 N. 3rd St., Grand Forks, ND 58203-2408

March 3, 2021

To: Chairman Ray Holmberg and Members of the Senate Appropriations Committee

HB: 1012 – In Opposition

Good day:

I am Debra Johnson, CEO of Prairie Harvest Mental Health in Grand Forks. Thank you for your work and support of programs that affect our most vulnerable adults – those with serious mental illness. Today I will provide testimony that indicates why Prairie Harvest Mental Health is in opposition to HB1012 which if approved as it stands now will put the safety and wellbeing of consumers who are at risk of losing vital housing and services that support them on their mental health recovery journey.

Prairie Harvest Mental Health provides Therapeutic Services as well as Supported Residential Services under a contract with Northeast Human Service Center.

Since our inception in 1991 Prairie Harvest Mental Health has worked in a unique and successful partnership with Northeast Human Service Center. This structure has allowed us to focus on our respective strengths. Northeast Human Service Center provides the treatment services and along with Prairie Harvest Mental Health in a team approach with the consumer Therapeutic Services as well as Supported Residential Services are delivered in a recovery based, consumer focused manner.

Over the years Prairie Harvest Mental Health has raised over $4 million in grants to build 42 units of permanent supportive housing all at varying levels of support (see attached Exhibit A). These properties were grant funded and currently have zero debt. Development was accomplished by working with Northeast Human Service Center to provide long-term supportive services so that consumers who need long-term support are able to live in an environment that suits their sometimes complex needs. In addition to the bricks and mortar raised to build the Prairie Harvest Mental Health Permanent Supportive Housing revenues are generated in the form of rents (paid by vouchers) to pay the utilities and maintenance as well as funds to replace needed capital expenses (roof, furnace, etc.). There are no remaining funds for programming needs.

The State Contract has historically contracted for the therapeutic needs by establishing a daily rate (Exhibit A).

Our partnership with Northeast Human Service Center has allowed consumers to remain in the community which is, of course healthier as well as cost effective. Our data indicates for example that one young man prior to receiving Prairie Harvest services experienced 193 days in institutional care. He lived in Prairie Harvest Housing beginning in 2004. The Prairie Harvest permanent supportive housing enabled him to work on his recovery, resulting in his hospitalization days decreasing to 46 in 2009, two in 2010 and he has not been in the hospital since. He currently lives and works in the community with minimal staff contact (just brief medication monitoring assistance).

In addition to the Therapeutic Services and Supported Residential Services, Prairie Harvest Mental Health provides:

- Representative Payee (63 consumers) (No State funds)
- Life Skills/Job Development (40 consumers) (No State funds)

Also included in Exhibit A are the costs associated with institutional care, transitional housing and crisis care, as well as the Supportive Services and Therapeutic Services provided by Prairie Harvest Mental Health.

Working with consumers on a daily basis has given us insight of their on-going needs.

During the COVID pandemic Prairie Harvest Mental Health has worked tirelessly to keep the consumers safe and healthy. We implemented policies related to PPE and other precautions immediately. Mask mandates and limited visits from others was required. As a result, we only had two positive individuals with no symptoms and one who was hospitalized and later recovered. Our staff implemented programs and services over Zoom to help keep consumers busy and connected as they work on their recovery journey. Staff helped keep them connected to family and friends using Zoom and Facetime and established telehealth procedures. As this document is being written Prairie Harvest Mental Health consumers and staff have received vaccines. Prairie Harvest Mental Health services are vital to continued success in living in a least restrictive yet supportive environment.

The following is a summary of the recommendation of the Department of Human Services Behavioral Health Department as well as the House Appropriations Human Resource Committee.

In the chart prepared by the Behavioral Health Department and approved by the Human Resources Legislative Appropriations Committee you will note that the Prairie Harvest Mental Health budget reduction is $1,061,100 and an ending contract available for the provider of $1,644, 260. This reduction was made in response to the approval of the 1915(i) Amendment to the State Medicaid Plan. Note that the 1915(i) does not support Therapeutic Services.

Department of Human Services
1915I Contracts reduced in the Executive Budget Request
2021-2023 Biennium

Division	Description	Executive Budget Request Savings	Notes	Remaining Contract Total for Provider	Actual House Restoration	Total Reduction by contract with House Changes
Behavioral Health	Reduce Parent to Parent - 1915i Realignment	(11,250)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	69,375	5,625	(5,625)
Behavioral Health	Reduce Brain Injury - Resource Facilitation (NDBIN) - 1915i realignment	(279,247)	Not direct services - 15% reduction of total contract for efficiencies	474,719	195,472	(83,775)
Behavioral Health	Reduce Brain Injury - Pre-voc program (Skillsmart) - 1915i realignment	(168,750)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	253,125	84,375	(84,375)
Behavioral Health	Reduce Brain Injury - Return to work (Workstart) - 1915i realignment	(174,277)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	261,416	87,139	(87,138)
Behavioral Health	Reduce peer support certification	(13,590)	no change	0		(13,590)
Behavioral Health	Reduce Peer support pilot	(15,000)	no change	0		(15,000)
Subtotal Behavioral Health		**(662,113)**		**1,058,634**	**372,611**	**(289,502)**
Children and Family Services	**Reduce Family Peer Support (Family Health Info & Ed Ctr) - 1915i re-alignment**	**(100,000)**	**Not direct services - 15% reduction of total contract for efficiencies**	**148,750**	**73,750**	**(26,250)**
[illegible]	Reduce LaGrave contract - 1915i re-[illegible]	[illegible]	All tenants pay rent; NEHSC gives services; remaining $ support [illegible]	[illegible]	[illegible]	[illegible]
Human Service Center	Reduce Prairie Harvest Mental Health contract - 1915i re-alignment	(1,414,800)	All tenants pay rent; NEHSC gives services; remaining $ support until 1915i efficient	1,644,260	353,700	(1,061,100)
Human Service Center	Reduce Cooper House contract - 1915i re-alignment	(283,464)	services; remaining $ support until 1915i efficient	425,196	141,732	(141,732)
Human Service Center	Reduce Supportive Employment contract - 1915i re-alignment	(583,226)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	291,613	291,613	(291,613)
Human Service Center	Eliminate Gerridee's Place contract for long-term residential - 1915i re-alignment	(901,008)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021). All clients quality under 1915i and contract	450,504	450,504	(450,504)
Human Service Center	Reduce Supportive Employment contract - 1915i re-alignment	(62,000)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	31,000	31,000	(31,000)
Subtotal Human Service Centers		**(3,431,998)**		**3,123,823**	**1,362,299**	**(2,069,699)**
Total DHS Savings Plan		**(4,856,224)**		**5,389,841**	**2,181,271**	**(2,674,953)**

Following the actions taken in the House further analysis allowed Prairie Harvest Mental Health Management to conclude the following:

(1) In the 2019/2021 budget our services are categorized as

a. $1,357,200 Supported Residential

and

b. $1,395,336 Therapeutic Services

$2,752,536 Total Provider Contract

When the Behavioral Health Department calculated the Prairie Harvest Mental Health budget reduction, they used the full $2,752,536.

To properly calculate that budget reduction, they should have used the Supported Residential Services portion amount of $1,357,200. Therapeutic Services of $1,395,336 are not funded by 1915(i).

In this case the budget reduction to Prairie Harvest Mental Health contracted services would be $339,250 (if using 50%) and the total available in the provider contract would be $2,413,286 for 2021/2023.

(2) When the 1915(i) Amendments were considered Prairie Harvest Mental Health was grouped in with Housing First Providers (LaGrave, Cooper House, etc.).

The Prairie Harvest Mental Health services greatly differ in that we operate under the SAMHSA Permanent Supportive Housing Model as well as our array of services available under the Supported Residential Program.

Because we believe our forecasted contract was calculated using incorrect data, I am requesting that if providers are not fully restored that the Prairie Harvest Mental Health calculation is re-visited and corrected.

Prairie Harvest Mental Health is committed to developing the systems necessary to implement 1915(i) and are currently in the application stage as well as attending the on-line trainings as they become available. We are also utilizing technical assistance from the 1915(i) team at the State.

Prairie Harvest Mental Health has a stable supportive Board of Directors and staff. We advocate for individuals living in the least restrictive housing of their choice.

Following are letters of support from family members, consumers, and professionals.

In closing, I am not only the Chief Executive Officer of Prairie Harvest Mental Health, I am also a daughter, sister and mom to people with behavioral health concerns. My late Mom struggled her entire life with schizoaffective disorder and chronic anxiety. Because services such as those provided by Prairie Harvest Mental Health were not available to help, my Mom lived in a nursing home for 12 years beginning when she was 69 years old. I am asking you to help us remain a source of support for those who have long been underserved or overlooked. My true calling is advocacy. The end goal for this advocacy effort is that those we currently serve continue to learn, grow, and recover and that the services are uninterrupted.

Exhibit A

PRAIRIE HARVEST
MENTAL HEALTH
930 North Third Street * Grand Forks, ND 58203-2408
Phone: 701-795-9143 * Fax: 701-772-5560 * E-Mail: info@prairieharvest.net * www.prairieharvest.net

Prairie Harvest Mental Health Permanent Supportive Housing

Harvest Homes 12 apartments 24-hour support		Prairie Lodge 6 bedrooms Peer support	
Harvest Lodge 6 bedrooms Peer support		Single Family Residence Limited staff support	
Siewert Plains 8 bedrooms 24-hour support		Stern Place 9 apartments Limited staff support	

Total asset value: $4,031,607
Debt: $0

Operating Funding

	2019-2021 Biennium	2021-2023 Biennium
Northeast Human Service Center	$2,752,536	$1,337,736

Other Funding Used to Augment State Funded Services

Rents	$ 464,400 (covers fixed costs)
Grants (includes PPP grants)	$ 302,000
Work Contracts	$ 14,000
Donations/Fundraising	$ 96,000
Thrift Store Sales	$ 240,000
Client Service Fees	$ 68,600
Federal	$ 187,200
	$1,372,200

Mental Health Daily Rates Comparison

Local Hospital Psychiatric Ward	$2,126
State Hospital	$ 535
Basic Care Nursing Home	$ 147
Transitional Housing – State Run	$ 82
Local Jail	$ 75
Crisis Beds	$ 74
Prairie Harvest Mental Health	
24 Hour Group Living	$ 82
24 Hour Apartment Complex	$ 82
Peer Lodge	$ 38
4 Hour Supported 9 Plex	$ 28

Revised 1/15/2021

United Way
A Participating Agency

Exhibit B

January 22, 20221

To whom it may concern,

I would like to express my support for Prairie Harvest Mental Health and the work that they perform in the city of Grand Forks. There is no doubt that the commitment Prairie Harvest Mental Health has shown to our community has improved the lives of many of our citizens suffering from mental illness. The support and services provided by Prairie Harvest Mental Health to the persons they serve is an integral part of the Grand Forks network of support service entities. Furthermore, their services have likely reduced expenses to other entities, such as the shelters, jails, and hospitals.

I have recently learned that Prairie Harvest Mental Health is facing a potential State budget cut of $1,414,800 in the 2021/2023 biennium. It is my understanding that the Department of Human Services believes these cuts could be re-couped through the yet to be finalized Medicaid 1915(i) amendment. Aside from the uncertainty of the 1915(i) amendment, reimbursement under this proposal would require Prairie Harvest Mental Health staff to set up an insurance billing procedure, receive training, and begin the Medicaid billing process. These endeavors take time to accomplish and a temporary loss in funding could vastly impact the services provided by Prairie Harvest Mental Health.

Due to the potential temporary loss in funding and the necessary services provided by Prairie Harvest Mental Health, I would respectfully request restoration of the full $1,414,800 to the 2021/2023 biennium budget to be allocated for their continued efforts. Your continued support, will ensure that the citizens of Grand Forks can continue to depend on them as an important resource and partner. I have no doubt that they have positively impacted the lives of community members and enriched the community as a whole through their efforts.

Sincerely,

J. Moe #301

Jeremy Moe

Prairie Harvest Board Member

January 22, 2021

Debra Johnson
Prairie Harvest Mental Health
930 N 3RD ST
Grand Forks, ND 58203

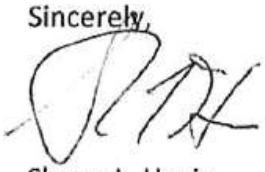
Dear Ms. Johnson,

It has been brought to my attention that Prairie Harvest Mental Health is facing a potential State budget cut of $1,414,800 in the 2021/2023 biennium. The Department of Human Services believes that the organization can re-coup this amount from Medicaid under the newly approved 1915(i) amendment.

Prairie Harvest has been providing permanent supportive housing and recovery-based services in Grand Forks since 1992 in a successful public/private partnership with Northeast Human Services. I am very concerned that if these funds are cut many individuals with mental illness will not receive adequate services that enable them to live in permanent supportive housing and/or receive services that allow them to work on their mental health wellness and recovery. This would create a situation where the consumers you serve end up in a more restrictive setting such as in jail, shelters, long term care, etc..

I would like you to ask on my behalf, that the State consider restoring the $1,414,800 back into the budget for 2021/2023.

Sincerely,



Shaun L. Havis

CITY OF GRAND FORKS
255 N 4TH STREET - P.O. BOX 5200 - GRAND FORKS, ND - 58206-5200

OFFICE OF THE MAYOR
BRANDON BOCHENSKI
(701) 746-2607
BBOCHENSKI@GRANDFORKSGOV.COM

January 26, 2021

Debra Johnson, CEO
Prairie Harvest Mental Health
930 North 3rd Street
Grand Forks, ND 58203

Dear Ms. Johnson:

The City of Grand Forks is home to many agencies that provide innumerable vital services to our community and its residents. Prairie Harvest Mental Health is one of these agencies and, as is the case throughout the state, the work of these agencies has a daily positive impact on the health and wellbeing of our citizens.

At their meeting on January 25, 2021, Grand Forks' City Council expressed their opposition to DHS budget cuts that would endanger your agency and clients. The proposed cuts to the Department of Health and Human Services budget for the 2021/23 biennium have the potential to do serious damage to your agency and the clients you serve. While the 1915(a) amendment is *expected* to provide a welcome source of additional Medicaid funding, there are still many unknowns associated with rolling this out.

Given the recent loss of Lutheran Social Services and the ongoing impacts of Covid-19, now is not the time to put to North Dakota's network of service providers at further risk. While we understand the budgetary challenges that are present to the State of North Dakota at this time, the Grand Forks City Council feels that eliminating DHS funding at this time would be premature.

We are proud of the long and successful partnership that has grown between the City of Grand Forks and Prairie Harvest. Permanent supportive housing providers are a key component of our continuum of care and an essential element of our community. The work that you and similar agencies do is invaluable. Please accept this letter on behalf of the Grand Forks City Council as support for you and your work.

Respectfully,

Brandon Bochenski
Mayor of Grand Forks

High Plains
Fair Housing Center



January 25, 2021

To whom it may concern,

It is my understanding that Prairie Harvest Mental Health is facing a potential State budget cut of $1,414,800 in the 2021/2023 biennium. At this time of public health crisis when social distancing and health protocols are exacerbating people's mental illnesses - this budget cut will negatively impact Grand Forks and likely result in many people with mental illness losing their homes.

In 2016, an estimated 17% of adults aged 18 and older in North Dakota (about 99,199 people) met the criteria for any mental illness. A total of 4.0% of North Dakota adults aged 18 or over (about 23,454 people) in 2016 had a serious mental illness (SMI) in the past year (ND Behavioral Health Systems Study, 2018 pg. 15).

Recently, High Plains began to notice an increase in calls from people who were in the process of being evicted or were evicted as a direct result of behaviors related to their disabilities, in particular mental illness. Many of these clients became homeless. In response to these concerns, High Plains completed a series of housing discrimination testing based on mental disabilities, in particular mental illness. The results of the study showed 25% instances of discrimination based on mental illness. Furthermore, a statewide survey of mental health practitioners revealed that 57% of their clients experienced housing discrimination.

Prairie Harvest Mental Health has absolutely improved the quality of life of the Grand Forks by providing housing, counseling and support services to persons with mental illness. Especially during this pandemic, we need Prairie Harvest's services in our community to remain fully funded or we may end up with a new public health crisis.

Sincerely,

Michelle Rydz

Michelle Rydz
Executive Director

www.highplainsfhc.org
High Plains Fair Housing Center | info@highplainsfhc.org
PO Box 5222 | Grand Forks, ND 58206 | 701-203-1077
Nothing in this letter is legal advice, for legal advice please see an attorney.

Protection & Advocacy Project
400 East Broadway, Suite 409
Bismarck, ND 58501-4071
Phone: (701) 328-2950 Fax: (701) 328-3934

January 22, 2021

Debra Johnson, CEO
Prairie Harvest Mental Health
930 North Third Street
Grand Forks, ND 58203-2408

Dear Deb:

As I understand it, the proposed DHS budget for the 21-23 biennium includes a cut of $1,414,800 to your contract. While it is suggested that this amount can be recouped from Medicaid through the 1915(i), this is really an unknown as the 1915(i) is not yet being implemented in ND. I'm further concerned that this means it is expected that individuals you serve must be on Medicaid and additionally eligible for services through the 1915(i); that individuals not on Medicaid and otherwise eligible for the 1915(i) will not be able to access services through you without another funding source.

Your organization is essential to the types of Home and Community-Based Services (HCBS) needed in ND, including the provision of permanent supportive housing and recovery-based services. Without these services, individuals will be at a greater risk for institutionalization.

Please consider this is a letter of support for Prairie Harvest Mental Health. State funding for Prairie Harvest Mental Health should not be cut. ND is trying to expand HCBS to try to meet the needs of individuals with behavioral health issues... not cut them.

Sincerely,

Teresa Larsen
Executive Director

www.ndpanda.org
Relay ND: 711
Toll Free: 1-800-472-2670
24 hour emergency service: 1-800-642-6694

The independent, federally mandated protection and advocacy system for the State of North Dakota

January 12, 2021

To Whom It May Concern,

I am writing to express my support for Prairie Harvest Mental Health and the positive impact it has on my brother and my family. My brother has been a client and resident of PHMH for 4 1/2 years and in this time has he greatly improved his mental and physical health.

For 43 years he had lived with our mother in Minot, ND. With age and illness, she became unable to care for him. I took guardianship of him and moved him to Grand Forks in 2016. He moved into Siewert Plains, a group home operated by PHMH that has 24-hour staff. As with the majority of people with mental health illnesses, counseling and the adjustment of medication is an ongoing process. The staff at SP are able to monitor and address any changes that they see in his behavior before it becomes a larger issue. It is a great feeling knowing that he is under such great care in a positive, healthy environment and that he has someone there for him at all times.

PHMH has also provided a social outlet for my brother that he never had before. He enjoys his groups and social activities, such as cooking, games, exercise, and other activities. He has developed social interaction skills that he has never had. All of this has had an amazing impact on the mental health of my brother.

Prairie Harvest has been the perfect fit for my brother and I can't imagine what we would do without the support and care that they provide. My brother is as mentally healthy as he has ever been and has grown so much from the support that PHMH provides.

Sincerely,



Les Moore
3649 15th Ave South
Grand Forks, ND 58201
Mobile 701-330-3547
les@iconarchitects.com

To:

From: The Guardians of Gene Pelton, Dawn Pelton Malene, guardian and Sister and Ray Pelton, Father and Guardian

Re: Support for Harvest Home in Grand Forks, North Dakota

Date: January 13, 2021

Our family offers our heartfelt support for and thanks to the staff and administrators of Harvest Home in Grand Forks North Dakota where Gene Pelton , our brother and son, has been a client/resident for 15+ years. Without the safety and compassion shown to him, Gene would have been a street person many years ago and may not have survived.

Gene, diagnosed as having paranoid schizophrenia ,relies on medication to stabilize his medical condition; and the staff has monitored his medication which Gene proved not be able to do on his own. This truly has saved his life.

We are impressed that Gene has been taught to take responsibility for his own apartment keeping it clean and orderly. The staff provides support for off-campus needs such as transporting him to medical appointments, grocery shopping and occasional recreational activities.

This safe environment offers companionship when it is desired while providing the privacy dictated by his illness. Gene loves living at Harvest Homes and says often, " This is my home." He enjoys visit with us but is always ready to "get back to my home" .

Our family is so grateful that the state of North Dakota has developed and funded this forward thinking place for adults with mental illness. The caring staff provides a perfect balance of providing support and encouraging appropriate independence. Please continue the fund this life saving concept, safe and facility.

Respectively submitted,

Guardians: Dawn Pelton Malene
Ray Pelton

1-13-21

Sara Vogel's' story:

Hi, my name is Sara Vogel and I live at Siewert Plains. I have been here for over 5 years. Prairie Harvest has helped me to reach my goals and become a better person. I have more confidence in myself then I did before I came here. My mental illness was horrible. Before I came here, I was using drugs, alcohol, hanging out with the wrong people. I was also manic. My symptoms got worse and I could not cope with the stress of my life. It got better for me when I got into Prairie Harvest and got on the right medicine, started attending groups, learned how to cope with stress and how to socialize. I have made a lot of friends through Prairie Harvest. Now that I feel better and able to cope with stress, I am looking for a job with my job coach and would like to get my own place. I would like to thank the staff and nurse at Prairie Harvest for everything that they have done for me.

1/13/21

David Hird
675 N 43RD ST #103
Grand Forks, ND 58203

To Whom it may concern:
PHMH means care for mental illness. My vital medication is given to me and for me.
PHMH means staff support and peer support. for me.
Staff are both friendly and professional. I make connections with peers.
PHMH means security for me. I live in a safe place in and environment that is far better than anywhere else I formerly lived.

PHMK means that my daily needs are taken care of. My mother always asked what I had on the meal plan and she marvels at the variety of the things I eat.

PHMH means improvement in many types of living needs. The groups contribute to many facets of my life. From hypothermia to core-values I get patient education.

Sincerely,
Shavid Hird

I like having Prairie Harvest to lead me during difficult times. I like having hellos and they always find a way to make you feel at home. I like it here at the Lodge and the support it shows me. Prairie Harvest is always involved and helpful.

Thank you,
Danny O.

Kelly – **wishes to remain anonymous**

I just got out of jail. I was in for mental health related reasons. Next, I went to the state hospital in Jamestown, ND. I was there for 8 months and was basically homeless and mentally distraught. Deeply distraught. I was afraid and homeless. My psychologist promised he would let me stay at the hospital until I was safe. The people I worked with at the hospital had never heard of PHMH in Grand Forks, and so, I was the first patient to get a tour of Prairie Harvest facilities.

There was a work sight permanent housing opportunity and programs to help with medication, help getting into school, and hundreds of other clients in my same position, mentally. I liked it. I met with Prairie Harvest staff and they invited me to be a client. I ended up in the Lodge Program, which is permanent housing for clients where we govern most of our own lifestyle without too much interference from staff.

Since I've been with Prairie Harvest, I've gone to college and worked steady for the entire time I've been here. I'm on my medication everyday and feeling much healthier. I made a ton of friends. I quit smoking, drinking, and using drugs for almost 16 years. I've been honored with being made Prairie Harvest client of the year as well as CCL Lodge Member of the Year, which is an award given to one person in the entire Lodge Program nation wide.

My family is so relieved that I'm getting the help from Prairie Harvest staff. They have a person to help me in any cat3egory of help I may need. I'll probably stay a client for the rest of my life. I pray that other with mental health problems are as lucky as I've been to find a place like this.

PRAIRIE HARVEST
MENTAL HEALTH
930 N. 3rd St., Grand Forks, ND 58203-2408

PRAIRIE HARVEST MENTAL HEALTH

930 North 3rd Street
Grand Forks, ND 58203-2408

Phone: 701-795-9143
Email: info@prairieharvest.net
Web: www.prairieharvest.net



You can make a bigger difference than you think.

Mission Statement

We promote independence and an enhanced quality of life for adults with serious mental illness.

PRAIRIE HARVEST
MENTAL HEALTH

Vision

Prairie Harvest Mental Health envisions people with serious mental illness living free from stigma and fully integrated into our community.

Values

Service: Serving people with serious mental illness is our highest value.

Dignity: We treat everyone we serve and each other with courtesy, compassion and respect.

Recovery: We focus on individuals maximizing their fullest potential.

Competence: We strive for excellence and effectiveness in all that we do.

Education: We educate ourselves and the community which decreases stigma and enhances community awareness.

Health: We believe there is no health without mental health.

Parity: We believe that health insurance plans should cover mental health at levels that are equal to any other medical benefits.

Prairie Harvest Mental Health

Who are We?

- A private non-profit organization classified as a 501 (C)(3) by the Internal Revenue Service;
- Concerned citizens serving on a volunteer board of directors;
- Community volunteers;
- Advocates, family and friends of clients;
- Clients;
- Paid Staff

What Do We Do?

Prairie Harvest Mental Health provides community and facility based services to vulnerable adults. Quality of life is greatly enhanced through improved living environment, access to services and programs and the opportunity for employment.

What Are Our Goals?

- To help improve the quality of life for clients;
- To expand housing choices;
- To increase employment opportunities;
- To incorporate peer-support in agency programming;
- To educate the public to a better understanding and acceptance of mental illness and other forms of human needs;
- To reduce stigma for individuals with serious mental illness;
- To encourage community involvement and support for community based programs;
- To develop financial resources to enhance and expand Prairie Harvest Mental Health and its activities;
- To expand delivery to rural communities.

Prairie Harvest Mental Health Programs For Adults with Serious Mental Illness

Community Based Services:

- Supported Residential Program
- Extended Services Program
- Representative Payee
- Life Skills
- Job Development

Facility Based Services:

- Harvest Homes - 12 apartment complex
- Prairie Lodge - Peer-supported 6 bedroom house
- Harvest Lodge - Peer-supported 6 bedroom house.
- Siewert Plains - 8 bedroom 24-hour support house
- Stern Place - 9 apartment complex
- Singe Family Dwelling

One out of five families is affected with mental illness.

Community Based Services

Supported Residential

Daily Living Activities

Under the guidance of Direct Care Workers, clients learn skills that lead to independent living which include:

- Housekeeping
- Laundry
- Hygiene
- Grooming
- Grocery Shopping
- Meal Planning
- Nutrition
- Budgeting

Housing and Subsidies

Direct Care Workers provide assistance to clients in locating independent housing and applying for: Supplemental Security Income, Social Security Disability Income, Medical Assistance, Food Stamps and Fuel Assistance.

In addition, clients are assisted through subsidizing their rental and security deposits until housing assistance is received. Subsidies are also available for utility deposits and grocery allotments to get them on their feet. Through our Home Place Thrift Store, clients receive basic household items to furnish their apartments.

Financial Management: Representative Payee

Upon approval from the Social Security Administration, Prairie Harvest Mental Health provides Representative Payee services to individuals who are unable to manage his or her Social Security benefits. Prairie Harvest Mental Health helps ensure benefits are first used for the basic needs of the individual, providing the beneficiary with a more stable living environment.

Supported Residential - continued

Loan Fund

Clients are eligible to obtain interest free loans to obtain items such as medications, furniture, telephones, DVD players and televisions. Clients make regular payments based on their incomes.



Medication Management

We offer two medication monitoring programs:

1. Under the self administered medication program, a Prairie Harvest Mental Health nurse is available on a weekly basis, or as needed, to review, update and educate clients about medications and medical issues or questions.
2. For those needing closer supervision, a Prairie Harvest Mental Health nurse oversees certified Medication Monitors who go into the client's home up to two times a day to observe that medications are taken correctly and in compliance.

3. Medical Guidance

Prairie Harvest Mental Health nurse assists clients with any medical concerns they have;

- Notifies the appropriate medical staff;
- Schedules appointments;
- Arranges for annual physical, dental and vision exams;
- Compiles medical histories for clients;
- Maintains emergency data forms.



Socialization Activities

Socialization is encouraged through a variety of activities designed for our clients. Coordination and transportation are provided for clients.

- Birthday Club
- Recreational Activities
- Y Family Center - reduced rates
- Peace of Mind

Extended Services

Why is Extended Services Needed?

Extended Services is based on the premise that work should be accessible to everyone, regardless of disability. It offers a vocational solution for many individuals who were, in the past, considered unemployable. Extended Services is a concept that allows all persons with disabilities to work in the community and to ensure that the employer and the employee receive the assistance and support necessary for this to happen.

How Does Extended Services Work?

Extended Services match competent workers with available jobs in the community. Services include a careful matching of worker abilities and interests with specific job requirements. Specialized training is provided to the new employee at the job site by an Employment Training Specialist and follow-up services are available for as long as the worker is employed.

Who Will Benefit From Extended Services?

Employers:

- Will gain a conscientious, punctual, competent worker, receive free screening and training of supported employment workers, receive an opportunity for tax incentives, and reach equal opportunity affirmative action goals and positive public image.

Employees:

- Will gain increased self-esteem and a sense of fulfillment, structure to their daily lives, greater financial security, and have increased involvement in the community.

Who Will Benefit From Extended Services?

Our Community:

- Will have tax dollars redirected to independence and productivity., enhance rights and roles of all people, and expand the number of people looking for entry level positions.

What Does Extended Services Involve?

Job Placement – Qualified individuals are assisted in locating available jobs in the community. Many factors are considered when an individual is matched to a position such as: job duties, job locations and work hours, transportation available to the worker, worker's skills and interests, employer expectations.

Job Training – There is no cost to the company. If needed an Employment Training Specialist provides the new employee with one-on-one training and support at the job site. This on-site assistance is reduced as the employee becomes proficient in completing the job to company standards.

Ongoing Support – The employee's work performance is monitored by the Employment Training Specialist for as long as the individual is employed. Additional training or support, if needed, will be provided at any time.

Life Skills

What is Life Skills?

Life Skills promotes a well-balanced and healthy lifestyle to clients who would be homeless without services by:

- Teaching individuals how to care for their immediate needs,
- Preparing individuals to care for themselves on a long-term basis,
- Encouraging individuals to remain active through participation in various activities and hobbies, and
- Educating individuals, as well as the community, about mental illness.

How Does The Life Skills Program Work?

Prairie Harvest Mental Health clients are referred to the Life Skills Coordinator for Life Skills. Once individuals are referred, the Coordinator determines what assessments need to take place. Based upon those assessments, the Coordinator plans a program with the help of the client. For example, the client and Coordinator might conclude that they need to work on their laundry skills as well as developing a hobby. That client's program would focus on those needs.

Life Skills

Household Chores	Meal Planning	Meal Preparation
Grocery Shopping	Hygiene	Transportation Training
Budgeting	Laundry	Emergency Preparedness
Organization	Scheduling	Social Skills
Safety Training	Health Training	Medication Training
Hobbies	Recreation	Socialization Activities

Skill Groups

Leisure Club	Health & Wellness Group	Exercise Group
Walking Group	Road to Healthy Living Group	

Wellness Club

With health and wellness the primary focus, clients participate by earning points for healthy choices. Points are redeemed at the 'Wellness Store' for merchandise.

Job Development

What is Job Development?

Job Development provides a range of services to the community and clients who, without services would become homeless. This range of service includes: service coordination, client assessment, service monitoring and employment education to clients, businesses and the general public.

The Job Developer will work on expanding job opportunities in the community as well as providing participants with skill building activities so they can return to work. The Job Developer helps work on changing society attitudes about hiring people with disabilities as well as to work with participants in changing their perceptions about working. Social benefits that go along with work are: a reason to get up in the morning, respect from co-workers, improved self-esteem, to name a few. The Job Developer helps educate the community business leaders and citizens about the potential people with mental illness have in working in competitive jobs.

The Job Developer:

1. Provides an assessment of each client in the following areas: need to work, interest in working, ability to work and type of work that the client is interested in doing.
2. Establishes relationships with community employers.
3. Provides direction and assistance to participants in obtaining jobs with livable wages and benefits.
4. Helps to identify, secure and supervise potential work contracts for work teams.
5. Works to create better paying jobs with the opportunity for advancement for participants.
6. Conducts individual and group training sessions on various work related skills such as: Job Searching Skills, Interviewing, Resume Writing, Co-worker Relationships, Appropriate Hygiene and Clothing for Work, Accepting Change in Schedules, SSI and SSDI Benefits.

Employment Groups

- Pathways to Wellness
- Lodge Job Club

Facility Based Services

Harvest Homes

This 24-hour staffed facility is an important addition to the continuum of care for individuals with mental illness. It bridges the gap between living independently in one's own apartment and group home living.

Harvest Homes consists of twelve one bedroom apartments, where one is an accessible dwelling unit.

Facility includes a common area kitchen and recreation room, where meals and socialization can be shared by residents.

Supportive services are provided through the partnership with Prairie Harvest Mental Health and Northeast Human Service Center. Referrals to the facility are through the case management system at Northeast Human Service Center. The services provided are designed to enhance and maintain the individual's level of independence, while improving their quality of life.

These services include:

- Case Management
- Crisis Management
- Nursing
- Medication Monitoring
- Daily Living Activities
- Socialization Opportunities
- Community Involvement
- Employment Groups
- Skill Groups



Opened in1997

Lodge

What is a LODGE?

A Lodge is an affordable dwelling for 6 people who share in running the home, including domestic chores and the purchase and preparation of food. The residents make their own house rules and manage their own activities. In addition, they are employed at a business run by their sponsoring agency, in this case, Prairie Harvest Mental Health. The work is part-time or full-time and organized so that one member can readily substitute for another whenever necessary.

The Lodge program at Prairie Harvest Mental Health is designed to follow the Fairweather Lodge Model. This is a national model developed by Dr. George Fairweather for adults with persistent mental illness. This model is currently implemented in 10 states, including North Dakota. The primary philosophy driving this model is that people that live together and work together can more easily recover and find stability for the long term.

What is a Prairie Harvest Mental Health Lodge like?

Prairie Harvest Mental Health supervises two Lodges in Grand Forks: Prairie Lodge and Harvest Lodge. Each Lodge has the capacity to accommodate 6 individuals in private bedrooms. The Lodge resembles a healthy family, with each member contributing to the maintenance and care of the house and of each other. Staff presences at the Lodge is very minimal. Their role is mainly to mentor, advise, mediate and help out in emergencies.



Prairie Lodge

Opened in 2000

Lodge - continued

How do I refer someone to the Prairie Harvest Mental Health Lodge Program?

Prairie Harvest Mental Health currently contracts with Northeast Human Service Center, located in Grand Forks, North Dakota. All referrals must come through Northeast Human Service Center. For more information on **Northeast Human Service Center,** call **701-795-3000.**

Groups:

- Job Club
- Exercise Group
- Other Groups as needed



Harvest Lodge

Opened In 2001

Siewert Plains

An 8-bed permanent living facility for adults with serious mental illness, Siewert Plains opened in May of 2008. In an effort to bridge the gap between transitional and permanent living, Siewert Plains offers 24-hour support along with educational groups and trainings to augment Prairie Harvest Mental Health's supportive services.

These services include:

- Case Management
- Crisis Management
- Nursing
- Medication Monitoring
- Daily Living Activities
- Socialization Opportunities
- Community Involvement
- Employment Groups
- Skill Groups



Opened in 2008

Stern Place Apartments

Stern Place has been made available through an Economic Stimulus grant through our local Grand Forks Urban Development. Stern Place augments the Grand Forks communities permanent supportive housing with the addition of 9 self-contained apartments. This complex opened March 2012

Supportive services are available on a limited basis. A nurse assures all tenants receive medications in the mornings. Additional staff work four hour shifts from 4:30—7:30 PM. Monday through Friday. Medication monitors ensure medications are taken twice daily over the weekends. Case Management is provided through Northeast Human Service Center. Limited staff support provided through Prairie Harvest Mental Health, includes Life Skills, Job Development and Case Assistance.

Stern Place is suited for independent individuals. With limited support services and staff presence, tenants need to be capable of supporting themselves. Expectations include: independence with self-care, housekeeping, cooking and laundry.



Opened in 2012

Single Family Dwelling

This residence houses one to two people, providing another choice for individuals with serious mental illness who prefer independent community living. All supportive services are available to tenants in this home.



Purchased in 1999

Work Opportunities

Prairie Harvest Mental Health believes that everyone deserves the opportunity to work in competitive employment and to be paid fair wages. Prairie Harvest Mental Health and the Home Place Corporation have various positions for people with disabilities.



Home Place Thrift Store

Clerking, sorting and custodial positions in a retail setting provide opportunities for learning the skills necessary for similar positions in the community.

Community Support

Prairie Harvest Mental Health provides one-on-one support to individuals with serious mental illness to help them succeed in the competitive employment field. Services are individualized and focus on the skills areas needed to strengthen work related activities.



Rag Contract

Prairie Harvest Mental Health cuts clothing into rags to sell to community and state agencies. State agencies can now order goods and services directly from work activity centers. The rags are cotton or cotton blend. We get out of style, stained, or overstock clothing from the Home Place Thrift Store to cut into rags. The rags are sold in 50 pound lots or as requested by customer.





Cleaning Contract

Prairie Harvest Mental Health provides cleaning services at Augustana Lutheran Church.



The Home Place Thrift Store

The Home Place Thrift Store is a division of Prairie Harvest Mental Health, a business in the Grand Forks community. The Home Place Thrift Store exists to provide customers with affordable goods and clothing and to provide resources to Prairie Harvest Mental Health.

The Home Place Thrift Store provides a great shopping experience for any member of the family.

You will find something for everyone at the "Home Place", located at **1811 S. Washington in the Town & Country Mall**. Clothing, furniture, household items and a variety of miscellaneous items make shopping fun at the Home Place. New or like new items at low prices. Affordable shopping for everyone.

Donations are always appreciated. All donations are tax deductible, stay in the community and benefit individuals in the Grand Forks community. The Home Place Thrift Store picks up donations of clothes, furniture, working appliances, computer equipment less than 3 years old, books, household items, etc. at no cost. Also accept ripped, stained or torn cotton/cotton blend clothing for the Prairie Harvest Mental Health work program.

Due to the COVID-19 pandemic, all donations are accepted during business hours. Place your boxed or bagged donations in the back of The Home Place truck parked in front of the store. Accepting furniture donations, please call 701-795-9143 to schedule time to drop off donation.

The Home Place is in need of volunteers to work in the thrift store. Volunteering provides an excellent opportunity to give back to the Grand Forks community. Any time you can give is appreciated.

Thrift Store Hours

Monday - Friday: 10:00 AM—6:00 PM

Saturday: 10:00 AM - 5:00 PM

Sunday: Closed



Board of Directors

Nicole Amsbaugh, MPAS, PA-C - Grand Forks, ND

Irene Dybwad - Grand Forks, ND - Retired - Grand Forks County Family Service Supervisor

Thomasine Heitkamp - Grand Forks, ND - UND - Chair of Department of Social Work

Kate Kenna—Grand Forks, ND - Retired - Licenser/Recruiter at PATH

Bill Lund - Grand Forks, ND - Retired RN

Kristi Magnuson-Nelson - Grand Forks, ND - Owner - Hugo's/Hugo's Wine & Spirits

Jeremy Moe—Grand Forks, ND— Grand Forks Police Department

Vicki Morrissette - Grand Forks, ND - UND Dean of Students Office - Director of Judicial Affairs & Crisis Program

Eric Scheffer - Grand Forks, ND - Bremer Bank - Assistant Vice President of Banking

Sue Shirek - Arvilla, ND - Northlands Rescue Mission - Executive Director

Dolly Stennes - Grand Forks, ND - Retired - Northeast Human Service Center

Paul Stenseth - Grand Forks, ND - Retired - Alerus Financial Senior Trust Officer

Sonia Zimmerman - Grand Forks, ND - UND - Associate Professor Occupational Therapy

Client Advisory Board

The Client Advisory Board is a client run entity with a Prairie Harvest Mental Health staff coordinator that reports directly to the Prairie Harvest Mental Health Board of Directors about the needs and wishes of the clients. It will be a way for the voice of the client to be heard as well as a way to better involve Prairie Harvest Mental Health clients in the workings and activities of Prairie Harvest Mental Health. The Client Advisory Board representatives will consist of 1 representative from Harvest Homes, 1 representative from Stern Place, 1 representative from Siewert Plains, 2 representatives from Supported Residential, 1 representative from Prairie Lodge and 1 representative from Harvest Lodge. Meetings will be held on the last Tuesday of the month.

Updated 7/1/2020

United Way

Testimony
House Bill 1012
Senate Appropriations
Senator Ray Holmberg, Chairman
March 9th, 2021

Chairman Holmberg, members of the Senate Appropriations Committee, I am Nancy McKenzie, outgoing Executive Director of Nexus-PATH. Nexus-PATH is a member of Nexus Family Healing, providing child welfare and behavioral health services in ND. I am here today to provide input on HB1012, specifically the Medical Services budget, relating to the equalization of Targeted Case Management (TCM) rates. My co-worker, Heather Simonich, is also providing testimony in this section, but specifically as it relates to school-based services.

We understand the Department's effort to equalize TCM rates within and across state plans. However, I speak to you today out of concern that the decision to equalize rates across all services and state plans, in a short time period, without a cost-based rate-setting process, has tremendous impact on delivery of care. I am referring to targeted case management within treatment foster care, which we provide statewide for youth who need more intensive services.

Treatment foster care is funded by a maintenance rate, with funding that flows through the Child & Family Services Division, and a targeted case management (TCM) rate billed to Medicaid. Roughly 15 years ago, when North Dakota worked to actively leverage more federal funding, those costs of treatment foster care that were eligible for Medicaid funding were shifted to the TCM "bucket" (about 30% of costs); other costs remained in the maintenance "bucket" (making up the remaining 70%.

The two together resulted in the established funding for treatment foster care. Since then, inflationary increases as legislatively allocated have been provided. Formal cost-based rate-setting has not been undertaken.

In mid-December of 2020, our agency received notification from DHS Medical Services Division that an equalization of rates was included in the Department's budget as submitted, and that equalizing all rates might have an impact on services we provide. A look at the proposed change showed a 46% reduction in the rate for our agency, to be implemented effective July 2021. Ours is a calendar year budget, and the impact of that reduction would be $773,000 for the last six months of this year alone, over $1.6 million in a 12-month period. The service is not sustainable with that reduction.

We have entered into discussions with Child & Family Services about starting a cost-based rate-setting process as it relates to the maintenance rate, as this has never been done; however, there are no clear timelines as to when this might be completed, given the need for CFS staff, DHS fiscal staff, and our agency staff to work together during the busy legislative session.

The concept of equalizing rates is not one we don't understand; however, it is not realistic to expect an agency to pivot and shift within a few months' time period to adjust to that large a loss. In addition, this comes at a time when the child welfare system is asking us to provide more intensive services in foster care, which isn't possible at a lower cost.

Nexus-PATH requests that your committee consider an amendment to HB1012 to delay implementation of the new lowered rate for a one-year period, to allow solid cost-based rate-setting to be completed for both the maintenance rate and the case management rate.

Thank you for consideration of this request; I'm happy to answer any questions you may have.

Testimony
House Bill 1012
Senate Appropriations
Senator Ray Holmberg, Chairman
March 9th, 2021

Chairman Holmberg, members of the Senate Appropriations Committee, I am Heather Simonich, Operations Director of Nexus-PATH. Nexus-PATH is a member of Nexus Family Healing, providing child welfare and behavioral health services in ND. I am here today to provide input on HB1012, specifically the Medical Services budget, relating to the equalization of Targeted Case Management (TCM) rates.

We understand the Department's effort to equalize TCM rates within and across state plans. However, as a provider charged with supporting our schools and communities with much needed community-based services now more than ever – we have significant concerns regarding the established targeted case management rate.

Recently, Nexus-PATH creatively partnered with six North Dakota school districts to deliver intensive case management services to students and their families. This is a formal partnership with a signed MOU that places a Nexus-PATH school case manager within the school building. This individual works as a member of the school team serving students with the highest needs as identified by school staff. This partnership offers school professionals and students access to an intensive service not available through traditional school supports.

The Nexus-PATH case manager serves as a bridge between school, home, and the community. An individualized care plan based on a comprehensive assessment of student and family needs and strengths guides service delivery. The case manager routinely visits the family home, assists with transportation, connects the family to services available in the community,

assists with student behavior at school, and works intensively with the student and family to build the skills necessary to overcome their challenges. Importantly, this service is provided throughout the summer and provides the family with access to a 24/7 on-call service staffed by a licensed social worker. Initial feedback from school professionals, students, and families has been overwhelmingly positive.

Currently, the cost of this service is funded by Medicaid Targeted Case Management or BCBSND billing, the school district, and various grants/donations. The cost of this service is not sustainable without a significant contribution by the school district and sustained grant funding. As a provider, it is an ongoing challenge to rely heavily on unstable grant and school funding from one year to the next. The challenges in our rural areas related to the behavioral health workforce shortage and serving clients across expansive geography necessitates a targeted case management rate be established based on true service costs. The service referenced here is an excellent example of the type of service required to meet our most vulnerable families where they are at, build trust, and begin healing while at the same time supporting our educators and improving academic success.

In closing I am reminded of Superintendent Baesler's testimony to the House Appropriations Human Services Division, *"We cannot do this alone".* These words weigh heavy on me as a service provider. I have provided you with an example of one innovative and successful private-public partnership to better meet the needs of our students and their families. North Dakota service providers can do this if provided adequate reimbursement for service. It will take all of us, and your full support, but I believe we can answer the call.

Thank you for the opportunity to testify before your committee today. I am happy to answer any questions you may have.

The individuals listed below provided permission to include their name, email, and school district (or agency) in support of this testimony and welcome any questions you may have regarding their partnership with Nexus-PATH to deliver School Case Management service.

Missy Eidsness
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March 8, 2021

ACS CAN Testimony in Support of North Dakota House Bill 1012
Senate Appropriations Committee

My name is Sara Mannetter and I am the Government Relations Director for American Cancer Society Cancer Action Network – North Dakota.

The American Cancer Society Cancer Action Network (ACS CAN), the nonprofit, non-partisan advocacy affiliate of the American Cancer Society advocates for public policies that reduce death and suffering from cancer including policies supporting Medicaid Expansion.

For the 4,200[i] North Dakotans who will be diagnosed with cancer in 2021, access to affordable, comprehensive care is essential to detecting, treating and surviving the disease. In North Dakota, cancer is the second leading cause of death and an estimated 1,310[ii] state residents will die from the disease this year. Preserving low-income adults and families access to affordable, comprehensive health care coverage is critical in the fight against cancer**.**

ACS CAN strongly supports continued funding for Medicaid Expansion. HB 1012, appropriates funding to the Department of Human Services, to maintain health insurance coverage for thousands of low-income North Dakotans through our state's Medicaid program.

In 2017, Governor Jack Dalrymple made the decision to extend the July 2017 sunset of the state's Medicaid Expansion Program. And Governor Doug Burgum took action that extends the program through July 2019. HB 1012 will reauthorize the program and preserve access to coverage for more than 20,000 individuals, including cancer patients, survivors and those at risk of cancer through July 31, 2023. Medicaid expansion has promoted earlier cancer detection, resulting in fewer cancer deaths and improved outcomes for patients.

- Medicaid expansion was associated with improved rates of colorectal[iii], prostate, and cervical cancer screenings.[iv]
- Individuals enrolled in Medicaid prior to their cancer diagnosis have better survival rates than those who enroll after their diagnosis.[v]
- Medicaid expansion led to an increase in both total and earlier-stage cancer diagnoses in expansion states, while the gap in diagnoses between expansion and non-expansion states widened.[vi]
- Medicaid expansion was associated with decreased cigarette and other tobacco product purchases, as well as increased access, utilization, and coverage of evidence-based smoking cessation medications.[vii]

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American Cancer Society Cancer Action Network, Inc.
fightcancer.org/northdakota

Additionally, our state's economy, our hospitals and health systems and provider networks are stronger. In states that have fully expanded Medicaid eligibility:

- Uninsured rates have decreased, which has reduced uncompensated care costs
- Hospitals are 84 percent less likely to close[viii]
- Marketplace premiums that are about 7 percent lower than non-expansion states[ix]
- Expansion has created and protected jobs, which has increased personal incomes and state revenues

The health coverage provided through our state's Medicaid program helps to improve outcomes and reduce the burden of cancer by offering access to prevention services; timely cancer screening and early detection services; as well as affordable treatment services and care. [x,xi,xii]

Maintaining access to comprehensive and affordable health care coverage through state Medicaid programs is a matter of life and survivorship for countless low-income cancer patients, survivors and North Dakotans at risk of cancer. Preventing cancer is much less expensive than treating it and ensuring that low-income individuals and families continue have access to comprehensive, affordable health insurance coverage is one of the most critical ways that we can reduce cancer incidence and mortality and continue making progress to win the fight against cancer.

The American Cancer Society Cancer Action Network urges legislators to support continued funding for Medicaid Expansion in HB 2012.

Thank you for allowing me to submit testimony.

Sara Mannetter, ACS CAN

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[i] American Cancer Society. Cancer Facts & Figures 2021. Atlanta: American Cancer Society; 2021.

[ii] Ibid.

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[iv] Mazurenko O, Balio C, Agarwal R, Carroll A, & Menachemi N. The Effects Of Medicaid Expansion Under The ACA: A Systematic Review. *Health affairs (Project Hope)*, *37*(6), 944–950. doi:10.1377/hlthaff.2017.1491.

[iv] Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* (2009); 115(6):1300-9.

[v] Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* (2009); 115(6):1300-9.

[vi] Soni A, Cawley J, Sabik L, & Simon K. Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses. *The American Journal of Public Health*, *108*(2), 216–218. doi:10.2105/AJPH.2017.304166.

[vii] Maclean JC, Pesko MF, Hill SC. Public insurance expansions and smoking cessation medications. *Economic Inquiry*. 2019; 57(4):1798-1820; Bailey SR, Marino M, Ezekiel-Herrera D, et al. Tobacco cessation in Affordable Care Act Medicaid expansion states versus non-expansion states. Nicotine & Tobacco Research. ntz087, https://doi.org/10.1093/ntr/ntz087.

[viii] "Understanding The Relationship Between Medicaid Expansions And Hospital Closures." *Health Affairs*, Jan. 2018, www.healthaffairs.org/doi/10.1377/hlthaff.2017. 0976.

[ix] "The Effect of Medicaid Expansion on Marketplace Premiums." *U.S. National Library of Medicine, National Institutes of Health*, September 2016, resource.nlm.nih.gov/101704401.

[x] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218.

[xi] Dehkordy, SF, Hall, K, West, B, et al. "Medicaid Expansion Improves Breast Cancer Screening for Low Income Women." November 30, 2015. https://www2.rsna.org/timssnet/Media/pressreleases/14_pr_target.cfm?id=1849

[xii] Ungar, Laura. "More KY Medicaid Patients Get Preventative Care." *Courier Journal*. August 7, 2015. Web www.courier-journal.com/story/life/wellness/2015/08/05/preventive-care-rises-among-kentucky-medicaid-patients/31190973

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March 9, 2021

North Dakota Senate Appropriations Committee

Chairman Holmberg and Committee Members,

My name is Jeff Herman. I serve as the CEO of Prairie St. John's of Fargo. I am also the Chairman of the Board of Directors for the ND Hospital Association and a past member of the State Mental Health Planning Council.

Prairie St. John's offers a continuum of behavioral health care including acute inpatient hospital care, residential treatment and day hospitalization. Our patients come from throughout North Dakota. We are a part of a network of private and public providers.

I am here to ask that you support the $9 million Substance Use Disorder Voucher allocation increase recommended by the Governor in HB1012.

Through my 25+ years in behavioral health, I have come to conclude that for persons who suffer from addiction and mental illness, the best outcomes are correlated with; 1. Immediate attention when there is an openness to care on the part of the patient, 2. Care is provided at the level determined by appropriately trained professionals, and 3. A reliable method of payment for services that exist so patients are not further destabilized and that providers stay viable. No person enters our facility without all these considerations being reviewed. The level of care ranges from individual assessment to acute hospital care (as an aside we provided over $5.5 million dollars of charity care last year, a $1 million increase due to capped SUDS funding).

As you know the allocation that you made last legislative session served our citizens for only about one year of the biennium. The additional $9 million will serve to give the experience for a full biennium and provide evidence as to what is needed and what tweaks we need to make to

stabilize the programs in the next biennium. To change the program now would be making changes before useable information is available.

I also understand that NDDHS needs resources of staff to implement the voucher funding. This past year we were given 2 hours notice that there was going to be a freeze on the funding. The Department sets the criteria (ASAM criteria) to be used for treatment, it sets the process for getting patients approved for funding, then Providers absolutely felt blamed for meeting the demands of the volume of patients that needed the critical service. The full two-year investment will prevent pain and suffering for many individuals and families. The SUD program is also prudent to prevent clogging up our emergency rooms, courts, and prisons systems.

Thank you. Jeffrey A. Herman, MBA, RN

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

Senate Appropriations

HB 1012

March 9, 2021

Chairman Holmberg and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

NDMA supports keeping Medicaid Expansion at current rates through a private carrier. Reducing Medicaid Expansion at this point would have a devastating effect on North Dakota's healthcare system.

As the committee knows, Medicaid Expansion is 90% funded by the federal government. Therefore, moving Medicaid Expansion in house would provide a cost savings of $10.7 million, with a loss of $85.9 million to North Dakota's healthcare systems and private providers. There is no doubt that this would have a massive impact on all providers, not just hospitals.

The 2016 allotment was particularly harsh on physicians. Physicians did not receive a 4% cut, or even a 10% cut. According to our calculations, the Department cut traditional Medicaid physician payments by 33%. With reduction of Medicaid rate and the elimination of the budgeted 3% inflationary increase, the total reduction to health care

providers was $30.5 million. The North Dakota Medical Association had serious concerns about these cuts. In short, the already small operating margins of many systems and providers were eliminated.

Medicaid expansion helped cushion the blow of these cuts. Medicaid expansion is a program that is working well for the patients and the providers. NDMA urges this committee to keep the program as it is today.

Expanding Medicaid provided the much-needed coverage to our low-income patients, improved access to care, improved the health and well-being of the newly insured, and improved the financial stability of our clinics and hospitals. Medicaid expansion is not simply a budget issue. You must also consider the real human effects of this decision, including the health and well-being of those who gain coverage under expansion. Medicaid expansion provided coverage to a population who never before had coverage – including behavioral health coverage.

Our physicians provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from the services we are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state. Our capital needs continue to grow, with aging facilities, technology and equipment. Our costs for medical

equipment, new technology and supplies continue to increase. We must pay the same rates for physicians, nurses and other health care personnel as the rest of the country.

NDMA is very concerned that going back to the trend of poor payment will not bode well for the future of health care in North Dakota. In time, the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care workforce and capital needs are not met. We need to work together on all avenues that provide resources to sustain our health care system.

Physicians in North Dakota continue to do their part in providing good access to quality medical care for Medicaid beneficiaries and showing their ongoing commitment to the long-term sustainability of the Medicaid program. We look forward to working with the Committee in addressing the future needs for Medicaid medical services. Thank you for the opportunity to address this committee. I would be happy to answer any questions.

North Dakota Practicing Physicians by Specialty

Specialty - Primary Care

Of the 1695 total physicians, 34% or 581 physicians are in primary care. For this purpose, we define primary care as family medicine, internal medicine, obstetrics, and pediatrics (first self-designated specialty only).

Specialty	Count	%	Specialty	Count	%
Allergy and Immunology	6	0.35%	Ophthalmology	40	2.36%
Anatomic or Clinical Pathology	34	2.01%	Orthopaedic Adult Reconstruction	1	0.06%
Anesthesiology	84	4.96%	Orthopedic Surgery	54	3.19%
Cardiac Electrophysiology	3	0.18%	Orthopedic Trauma	2	0.12%
Cardiothoracic Surgery	1	0.06%	Otolaryngology	22	1.30%
Cardiovascular Disease	29	1.71%	Pain Medicine	1	0.06%
Cardiovascular Surgery	7	0.41%	Pain Medicine-Anesthesiology	6	0.35%
Child Abuse Pediatrics	1	0.06%	Pain Medicine-Physical Med & Rehab	1	0.06%
Child and Adolescent Psychiatry	8	0.47%	Palliative Medicine	1	0.06%
Child Neurology	1	0.06%	Pathology	1	0.06%
Clinical Pathology	2	0.12%	Pediatric Allergy	1	0.06%
Colon and Rectal Surgery	5	0.29%	Pediatric Anesthesiology	1	0.06%
Critical Care Medicine	20	1.18%	Pediatric Cardiology	6	0.35%
Dermatology	21	1.24%	Pediatric Critical Care	5	0.29%
Dermatopathology	2	0.12%	Pediatric Gastroenterology	1	0.06%
Diagnostic Radiology	57	3.36%	Pediatric Hematology/Oncology	5	0.29%
Emergency Medicine	85	5.01%	Pediatric Infectious Disease	1	0.06%
Endocrinology, Diabetes & Metabolism	11	0.65%	Pediatric Nephrology	1	0.06%
Family Medicine	326	19.23%	Pediatric Ophthalmology	1	0.06%
Forensic Pathology	1	0.06%	Pediatric Orthopedics	1	0.06%
Gastroenterology	21	1.24%	Pediatric Pulmonology	1	0.06%
General Surgery	58	3.42%	Pediatric Radiology	1	0.06%
Geriatric Medicine (Family Medicine)	1	0.06%	Pediatric Rehabilitation Medicine	1	0.06%
Geriatrics	2	0.12%	Pediatric Rheumatology	2	0.12%
Hand Surgery	6	0.35%	Pediatric Surgery	2	0.12%
Hematology	20	1.18%	Pediatrics	91	5.37%
Hematology (Internal Medicine)	1	0.06%	Phlebology	1	0.06%
Hematopathology	1	0.06%	Physical Medicine & Rehabilitation	2	0.12%
Hospital Medicine	115	6.78%	Physical Medicine and Rehabilitation	12	0.71%
Infectious Disease	13	0.77%	Plastic Surgery	15	0.88%
Internal Medicine	93	5.49%	Psychiatry	67	3.95%
Interventional Cardiology	9	0.53%	Pulmonary Disease	13	0.77%
Interventional Radiology	11	0.65%	Radiation Oncology	13	0.77%
Maternal and Fetal Medicine	3	0.18%	Radiology	14	0.83%
Maxillofacial Surgery	11	0.65%	Reconstructive	1	0.06%
Medical Genetics	2	0.12%	Reproductive Endocrinology & Infertility	3	0.18%
Musculoskeletal Radiology	1	0.06%	Rheumatology	12	0.71%
Neonatal-Perinatal Medicine	17	1.00%	Sleep Medicine-Internal Medicine	2	0.12%
Nephrology	21	1.24%	Sleep Medicine-Psychiatry and Neurology	2	0.12%
Neurological Surgery	21	1.24%	Sport Medicine-Family Medicine	5	0.29%
Neurology	28	1.65%	Sports Medicine (Family Medicine)	2	0.12%
Neuropysiology	1	0.06%	Surgical Critical Care	4	0.24%
NeuroRadiology	2	0.12%	Surgical Oncology	2	0.12%
Nuclear Radiology	2	0.12%	Thoracic Surgery	2	0.12%
Obstetrics and Gynecology	71	4.19%	Trauma Surgery	1	0.06%
Occupational Medicine	2	0.12%	Urology	19	1.12%
Oncology	11	0.65%	Vascular Surgery	5	0.29%

North Dakota Practicing Physicians by City

City	Count	%	City	Count	%	City	Count	%
Belcourt	5	0.29%	Garrison	1	0.06%	New Town	2	0.12%
Beulah	5	0.29%	Grafton	3	0.18%	Northwood	1	0.06%
Bismarck	367	21.65%	Grand Forks	218	12.86%	Oakes	4	0.24%
Bottineau	2	0.12%	Harvey	4	0.24%	Park River	3	0.18%
Bowman	2	0.12%	Hazen	2	0.12%	Rolette	1	0.06%
Carrington	1	0.06%	Hettinger	9	0.53%	Rolla	3	0.18%
Casselton	1	0.06%	Hillsboro	2	0.12%	Rugby	5	0.29%
Cavalier	3	0.18%	Horace	1	0.06%	Stanley	2	0.12%
Crosby	1	0.06%	Jamestown	35	2.06%	Tioga	1	0.06%
Devils Lake	13	0.77%	Langdon	1	0.06%	Trenton	1	0.06%
Dickinson	35	2.06%	Linton	1	0.06%	Valley City	6	0.35%
Dunseith	2	0.12%	Lisbon	1	0.06%	Wahpeton	12	0.71%
Elgin	2	0.12%	Mandan	10	0.59%	Watford City	6	0.35%
Fargo	716	42.24%	Mayville	3	0.18%	West Fargo	16	0.94%
Fort Totten	1	0.06%	McVille	2	0.12%	Williston	38	2.24%
Fort Yates	5	0.29%	Minot	138	8.14%			
Gackle	1	0.06%	Minot AFB	1	0.06%		1695	

March 9, 2021

Senate Appropriations Committee
HB 1012

CHAIRMAN HOLMBERG AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP.

AHIP appreciates that Engrossed HB 1012 reauthorizes North Dakota's Medicaid Expansion program until 2023. As an industry, we are supportive of Medicaid Expansion Programs and Medicaid Managed Care as a mechanism to improve beneficiary outcomes while controlling costs over time. Medicaid managed care plans (MCOs) have a proven record of demonstrating value and addressing the challenges states face in caring for more complex populations.

However, we are concerned that fragmenting North Dakota's expansion population by removing 19 and 20-year-olds will be disruptive and will needlessly deprive this population of the improved beneficiary outcomes that MCOs provide.

The success of these plans has resulted in states increasingly relying on MCOs to provide care management and administrative services. Between fiscal years 2010 and 2018, Medicaid managed care plan enrollment increased by 121%. As of 2018, more than 75% of all Medicaid enrollees were enrolled in an MCO, up from about 50% in 2010.

Achieving budgetary certainty is only one aspect of Medicaid managed care. Research shows that MCOs are improving access and the overall quality of care for Medicaid enrollees. The Menges Group's recent analysis indicates that MCOs improved their performance in 26 of 30 key quality metrics between 2014 and 2018.

In addition to the overall quality improvements, MCOs have been developing innovative, cutting-edge programs that improve care delivery and benefits for enrollees.

Most significantly, regarding the 19 and 20-year-old population, managed care can be an essential tool to ensure that newly insured individuals receive the full spectrum of care they require. For example:

- Medicaid managed care plans are creating and covering telehealth programs that expand access to care and increase doctors' ability to coordinate care for patients. These solutions address rural access to care, behavioral health services, and chronic pain management.
- Medicaid managed care plans are improving the ways enrollees can access provider networks, including creating tools that allow enrollees to locate doctors more easily in their networks, view practice information, and rate their doctors.

For these reasons, we ask that you keep 19 and 20-year-olds in the Medicaid expansion population by adopting the proposed teensy-weensy amendment set out below. Thank you for your time and consideration. I would be happy to answer any questions.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO.1012

Page 10, line 22, after the word "services," delete "and coverages for individuals ages nineteen and twenty"

Renumber accordingly

Written Testimony on HB1012 relating to Substance Use Disorder Voucher 1-25-21

Chairman Holmberg and members of the Senate Appropriations Committee, for the record my name is Dave Marion and I have the great fortune of working for the Summit Prairie Recovery Center, located in rural Raleigh, North Dakota and west of the Missouri river. Summit Prairie Recovery Center is a one of kind, committed residential agency working with individuals seeking addiction and mental health services. It provides a short term, quiet, rural environment for recovery with committed staff and therapists experienced in substance use and mental health concerns.

We are in support of:

The re-instatement and full funding of the ND Substance Use Disorder Voucher Program to include acceptance of new providers and participants. The SUD Voucher Program has served as a safety net for those without health insurance or adequate resources to access addiction treatment in ND, however, funding ended in July for people seeking to enroll in the program. We receive around 10-15 calls daily from clients with Medicaid and Sanford expansion looking for intensive outpatient services and residential beds. Many of these individuals are referred to us by the physicians in the Emergency Rooms. Most of these individuals have experienced overdose and their lives are at extreme risk and are referred to us from other professionals that find lack of services for those most extreme needs. One client, who lived 60 miles from the nearest treatment professionals, reported he had no internet access due to rural location and lack of knowledge of technology and the inability to get himself sober enough to begin the learning process. How much more hostile can it get… his life was baron, no transportation or ability to obtain services, but denied by his insurance. He was alone and wanted help, unfortunately this happens so often for too many in ND. These are individuals that could be helped by the SUD Voucher system. The ND SUD Voucher is one the most important tools in serving the increasing need for North Dakotans who have a Substance use disorder. The voucher provides not only the ability of patients to obtain critical services in a timely manner, but it provides provider choice so patients can stay close to home and families. In addition, the voucher serves as a resource to keep patients out of emergency rooms, hospital beds, jails, and courts.

In recent conversations on the House side, the Dept. Of Humans services reps have used residential services as a negative thing. We have always been in support of a full continuum of care and the number of sick individuals that need this level of care and cannot access care is very large. Residential determinations are assessed by licensed clinicians and the critical need for residential care for the most critical individuals needing that level of help. My fear is that the inference of having too many residential beds will decrease even more access for individuals seeks this level of help. The amendments that came out of house human resources seem to add another layer of restrictions for all trying to seek help. It is disheartening that we would create more hurdles to get great quality services, at whatever level that is in the continuum of care. The SUD Voucher was established to address barriers to treatment and increase the ability of people to access treatment and services for substance use disorders. With one of the goals being to allow the individual to choose a provider with objectives to increase the number of providers and service options and those options communicated to individuals. Another Goal being able to improve access to quality services with objectives of SUD providers to provide evidence-based

services on an individual need, in addition to reduce financial barriers for individuals accessing needed services.

So, at the end of the day, it should always be, how we best serve individuals that need and want the help at whatever level that is. With these current amendments being considered, it does not seem that it is about serving people, rather more about restricting providers from accessing funds to help people. These amendments will be hurdles that add another layer, thus, not putting clients first.

With the ongoing pandemic that compounded, high alcoholism rates, Opioid Crisis and Meth resurgence we respectfully ask your support of reinstating the $17-million-dollar request for the voucher. Though some may see a significant budget increase, those of us who serve patients that want better and committed to changing their path know that this will save lives!

Respectfully,

Dave Marion

Testimony for HB 1012

Senate Appropriations Committee

March 10, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, I am Steven Reiser, Director of Dakota Central Human Service Zone. I am also a member of the North Dakota Human Service Zone Association. Please accept this testimony in favor of HB 1012.

The counties of McLean, Mercer, Oliver and Sheridan formed a social service district in 2006 and started operating as district on January 1, 2007. The mission of the district was to provide a better service to the county residents and when possible lower costs. In 2007 Dakota Central employed 36 staff. At the end of 2019 Dakota Central employed 31 staff. There can be cost savings and efficiencies found when counties join together but it takes time. Even though caseloads have grown from 2007 Dakota Central is able to employ fewer staff. If you look at 2020 staff numbers Dakota Central is down to 25 staff because of 4 staff transferring to state employment and reducing two more staff.

Zones have done a lot in one year and are working hard to improve services and find efficiencies but there has to be financial stability to the achieve kind of improvements we all hope for.

The amendments added to the bill by the House Appropriations were positive but fall short of what is needed for zone funding. SB 2086 is the policy bill passed regarding zones. In this bill reserve fund limits were increased to $250,000 in smaller zones. I believe the intent of raising this limit from $100,000 was to allow for more decision making at the local level for administrating human service programs. Using all of the reserve funds that zones have now to replace the dollars that the zone budget is short for the last biennium will not allow for this type of close to the client decision making. If 19 zones were allowed to keep $100,000 this would amount to $1.9 million in additional spending. It would be $4.75 million for $250,000 limits.

Thank you for allowing me to testify and I would answer any questions you might have.

8271

THE CITY OF Fargo FAR MORE

CITY OF FARGO POLICE DEPARTMENT

Chief David B. Zibolski

105 25th Street North, Fargo, North Dakota 58102
Office: 701-241-1400 Fax: 701-297-7789
www.fargopolice.com

March 3, 2021

Senate Appropriations Committee
Senator Ray Holmberg, Chair
600 E Boulevard Avenue
Bismarck, ND 58505

Re: Support of HB 1012 to fund the Cooper House in Fargo, North Dakota

Dear Chairman Holmberg and members of the Committee,

I am the Chief of Police in Fargo, North Dakota, and I am writing you today in strong support of HB 1012, which requests to provide $570,000 in funding to support continued operations of the Cooper House. As you may be aware, the Cooper House has operated in Fargo for nearly ten years, focusing as a Housing First project. In doing so, they provide housing to 42 permanent residents, as well as provide 24/7 service that includes mental health, addiction, and chronic homelessness.

The Cooper House has not only provided housing for 42 individuals who would otherwise be homeless and on the streets of Fargo, but has been an excellent public safety partner for our department to work with in addressing these issues. Their existence and service provide needed options for our department members who encounter chronically homeless individuals, and as such, create a cost savings in both time and resource spending by our department. Their professional staff assist attendants with day-to-day needs, aids them in handling conflicts, and monitors the amount of alcohol brought into the facility, with the goals of acquiring sobriety and better day-to-day functioning. The facility is a joint effort with the Dakota Foundation, the Fargo Housing Authority, the Southeast Human Service Center, Family Health, and Cass County Social Services.

I personally spoke with several of our officers who have day-to-day engagement with the Cooper House and who express the importance of this funding appropriation to ensure its continued operations. The continued support of the Cooper House not only provides necessary and needed service to our homeless community, but also reduces the cost and personnel commitment of other law enforcement interventions, which are often times less effective.

The Fargo Police Department strongly supports the $570,000 appropriation request in HB 1012 and I urge you to vote in favor of this bill. Should you have any additional questions, please feel free to contact my office.

Sincerely,

David B. Zibolski
Chief of Police

DBZ/pls

8291

North Dakota Senate Appropriations Committee

HB 1012 – Medicaid Expansion

Pass Testimony – March 9, 2021

Testimony of Pat McKone, American Lung Association

Good afternoon,

My name is Pat Mckone. I am the Senior Director for Advocacy and Public Policy for the American Lung Association. Thank you for the opportunity to provide testimony on HB 1012, which would extend North Dakota's Medicaid expansion program until 2023.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing more than 36 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 103,000 North Dakotans. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association believes everyone should have access to quality and affordable health coverage. Medicaid expansion is critical for patients with and at risk for lung disease. For patients with asthma, coverage through Medicaid expansion means access to prescription drugs and visits with their doctor, both necessary to stay healthy and avoid a costly trip to the emergency department. Medicaid expansion is associated with a reduction in preventable hospitalizations, including for asthma and COPD.[i]

Access to preventive services through Medicaid expansion also ensures that people have access to services like tobacco cessation treatment and lung cancer screening at no cost. Research shows an association between Medicaid expansion and early stage cancer diagnosis, when cancer is often more treatable,[ii] as well as decreased mortality, including for lung cancer.[iii] The five-year survival for lung cancer is nearly five times greater for cases caught before the tumor spreads.[iv]

Medicaid expansion ensures that over 20,000 North Dakotans have access to quality healthcare. Medicaid expansion is also playing an important role in addressing health disparities—one recent study found that states that expanded Medicaid under the ACA reduced racial disparities in timely treatment for cancer patients.[v] Medicaid expansion is also associated with improvements in quality measures, including for asthma management, at federally qualified health centers, which are critical healthcare providers for low-income patients.[vi] Clearly, Medicaid expansion is beneficial for patients with lung disease and other serious and chronic conditions.

The Lung Association in North Dakota supports this proposed legislation and encourages North Dakota to continue Medicaid expansion, without imposing any additional barriers to coverage. Thank you for the opportunity to provide testimony.

Sincerely,

Pat McKone, Senior Director
Public Policy and Advocacy
Pat.mckone@lung.org
218.726.4723

[1] Hefei Wen Kenton J. Johnston, Lindsay Allen, and Theresa M Waters. "Medicaid Expansion Associated with Reductions in Preventable Hospitalizations." November 2019. Health Affairs. Doi 10.1377/hlthaff.2019.00483
[1] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", American Journal of Public Health 108, no. 2 (February 1, 2018): pp. 216-218. Available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166.
[1] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772535
[1] SEER Cancer Statistics Review, 1975-2015
[1] American Society of Clinical Oncology, "Racial Disparities in Access to Timely Cancer Treatment Nearly Eliminated in States with Medicaid Expansion." American Society of Clinical Oncology Annual Meeting. June 2, 2019. Access at: https://www.asco.org/about-asco/press-center/news-releases/racial-disparities-access-timely-cancer-treatment-nearly
[1] Megan B. Cole, Omar Galárraga, Ira B. Wilson, Brad Wright, and Amal N. Triveldi. "At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality Of Care," Health Affairs 36, no. 1 (January 2017): pp. 40-48. Available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0804.

HB 1012
NDACP Testimony
Senate Appropriations Committee
Hon. Ray Holmberg , Chairman
March 9, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, greetings, and thank you for this opportunity. I am Bruce Murry, Executive Director of the North Dakota Association of Community Providers (NDACP.org). NDACP is the membership organization of 30 licensed providers of services to North Dakotans with developmental disabilities (DD). We serve about 90% of people with DD in North Dakota.

As a registered lobbyist (#330) for NDACP, I would like to introduce several board members who will give in-person, video, or written testimony from their respective areas of expertise:

Julie Erickson, CEO of Grand Forks Growth and Support Center, Grand Forks;
Scott Anderson, Program Service Director for Development Homes, Inc., Grand Forks;
Lorena Poppe, CEO of Poppy's Promise, Bismarck, NDACP Vice President;
Scott Burtsfield, CEO of Vocational Training Centers (VTC), Fargo;
Brooke Austin, CEO of Community Living Services, Fargo, who in turn will introduce at least two people currently receiving services proposed for elimination:
Jackie Krei of Fargo, and Jackie Long of Fargo;
Tom Newberger, CEO of Red River Human Services Foundation, Fargo; and
Jon Larson, CEO of Enable, Inc., Bismarck, our NDACP President.

NDACP has a relatively modest legislative platform for the 2021-2023 biennium, in recognition that uncertain times face the energy and agricultural sectors in our state.

- Maintenance of the House's restoration of approximately eleven million dollars ($11,000,000) to provider rates for residential habilitation and intermediate care facilities for people with intellectual and developmental disabilities (ICFID), but also,
  - Maintenance of the Governor's proposed two million, four hundred thousand dollar increase ($2,400,000) to day support services such as individual employment, group employment, and prevocational services, with a matching reduction to Intermediate Care Facilities for people with Intellectual Disabilities (ICFID) and residential habilitation;
- Restoration of $240,000 in funding for mandated DD provider accreditation with the Council on Quality and Leadership (CQL);
- Inflationary increases to DD providers of 3% each year of the 2022 - 2023 biennium, especially due to economic and wage pressures in various communities;

- Maintaining the House's appropriation of up to $250,000 to NDDHS to financially stabilize DD providers disproportionately affected by the COVID-19 emergency — especially In Home Support providers who suffered the greatest losses;
- Restoration of all cuts to Section 11 State General Fund services to people with DD who don't qualify for the DD Medicaid Waiver;
- Fully fund the 1915(i) Medicaid Amendment with special attention paid to ensure it remains accessible to people with DD/ID, and review of the proposed World Health Organization Disability Assessment Schedule threshold score of 50 — a very severe score;
- Fully fund reforms and behavioral health initiatives from the Life Skills and Transition Center;
- Retention of a substantial state tax credit to employers who hire North Dakotans with developmental disabilities and mental illness, in HB 1405 (2021). HB 1405 received a unanimous do-pass recommendation from Senate Finance and Taxation Committee on March 9, 2021.

Many members also support restoration of funding for recreation and leisure centers with consideration of serving additional communities; a close review of the infant development and Part C budgets to ensure timely services can be brought to bear to minimize developmental delays; and strengthening of rates in related home and community based services to North Dakotans with other kinds of disabilities — QSP services under Aging Services and for brain injury, as well as 1915(i) Medicaid Amendment behavioral health services.

NDACP is persuaded that building a new State Hospital as proposed in HB 1012 makes sense to move more mental health services to the community. It is difficult to move beyond brick and mortar legacies built by generations past, but it is probably time.

Many of you know we have welcomed Angela Dinius as Workforce Development Director for NDACP. She and I are both happy to answer any questions that may arise about NDACP, its members' services to people, and our priorities. Our contact information is below.

Thank you for your kind attention.

NDacp
Bruce Murry
Executive Director
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Cell: (701) 220-4933
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Bismarck, ND 58501
brucemurry@ndacp.org
NDACP.org
North Dakota Association of Community Providers

NDacp
Angela Dinius
Workforce
Development Director
Phone: (701) 204-4837
Cell: (701) 226-4493
1500 E Capitol Ave
Suite 205
Bismarck, ND 58501
workforce@ndacp.org
North Dakota Association of Community Providers

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/10/2021 AM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 8:28 AM covering Human Service Zones, Human Service Centers and the State Hospital.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern and Heckaman.**

Discussion Topics:

- Foster care vs QRTP (Qualified Residential Treatment Programs)
- FTE positions
- Governance of Human Service Zones & Health Insurance
- Additional Substance Abuse Residential beds
- New State Hospital Study
- Indirect Costs for Human Services
- County Control of Human Service Zones
- Salary inequities
- Spend down of Human Service Zones reserves

Sara Stolt, Chief Operating Officer, Dept. of Human Services testified in favor and submitted testimony #8458.

Rosalie Etherington, Chief Clinic Director/NDSH Superintendent testified in favor and submitted testimony #8456, #8570.

Terry Traynor, Executive Director, ND Association of Counties – testified in favor and submitted testimony #8471.

Taylor Restad, Grand Forks Housing Authority – testified and presented neutral testimony #8537.

Chad Peterson, Chairman, Cass County Commission – testified in favor and submitted testimony #8581.

Kim Jacobson – Agassiz Valley Human Service Zone – testified in favor and submitted testimony #7897.

Steve Reiser, Director, Dakota Central Human Service Zone – testified in favor and submitted testimony #8207.

Senator Holmberg closed the hearing at 11:41 AM.

Rose Laning, Committee Clerk



House Bill 1012

Senate Appropriations Committee

Senator Ray Holmberg, Chairman

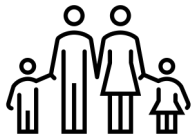
Human Service Zones

Local + State Partnerships For Effective and Efficient Service Delivery

NORTH Dakota | Human Services

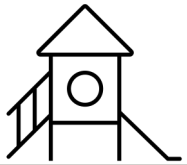
Be Legendary.™

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



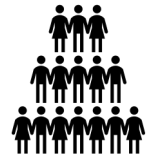
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



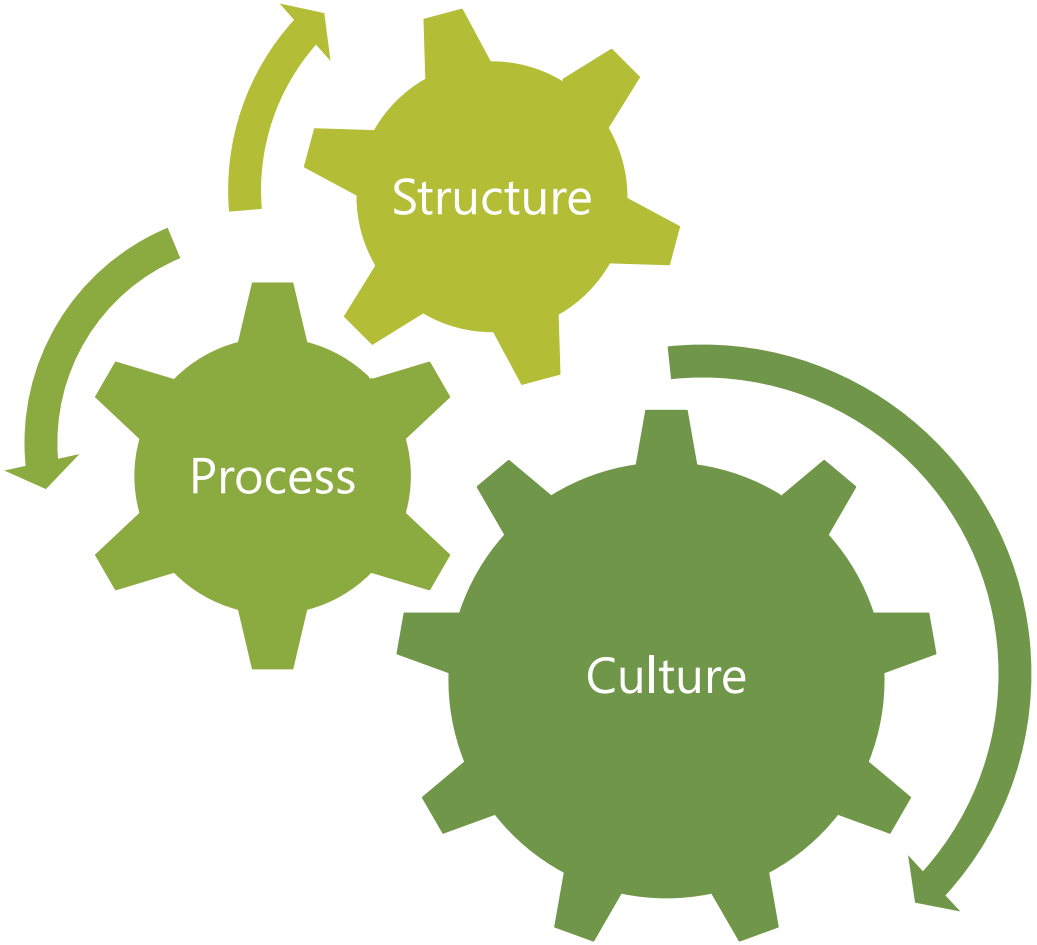
High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

IMPROVING PROGRAMS IS MORE THAN LOOKING AT STRUCTURE: Process and Cultural Change Must Accompany Structural Change



- 3 Core Areas
  - Process
  - Structure
  - Culture
- Focus is on service delivery to the client in the most effective and efficient way possible
- Seek to remove geographic, political and cultural boundaries to deliver smart, efficient and compassionate human services
- Primary Stakeholders
  - Individuals & Families
  - Taxpayers
  - Employees



HUMAN SERVICE ZONES



Gateway for Human Services

- Child Welfare
- Economic Assistance
- Indigent burials
- General Assistance
- County Supported HCBS
- Locally provided programs



Access Points Across ND

- Formerly known as County Social Services
- 19 Human Service Zones
- 46 Offices



Effectiveness + Efficiency

- Person-Centered
- Timeliness
- Quality

HUMAN SERVICES ZONES-MILESTONES

Zone Formation

- Formation of zone boards
- Zones formed 1/1/20
- Zone directors hired by 3/31/20
- Draft zone plans 6/1/20
- Final zone plans 12/1/20

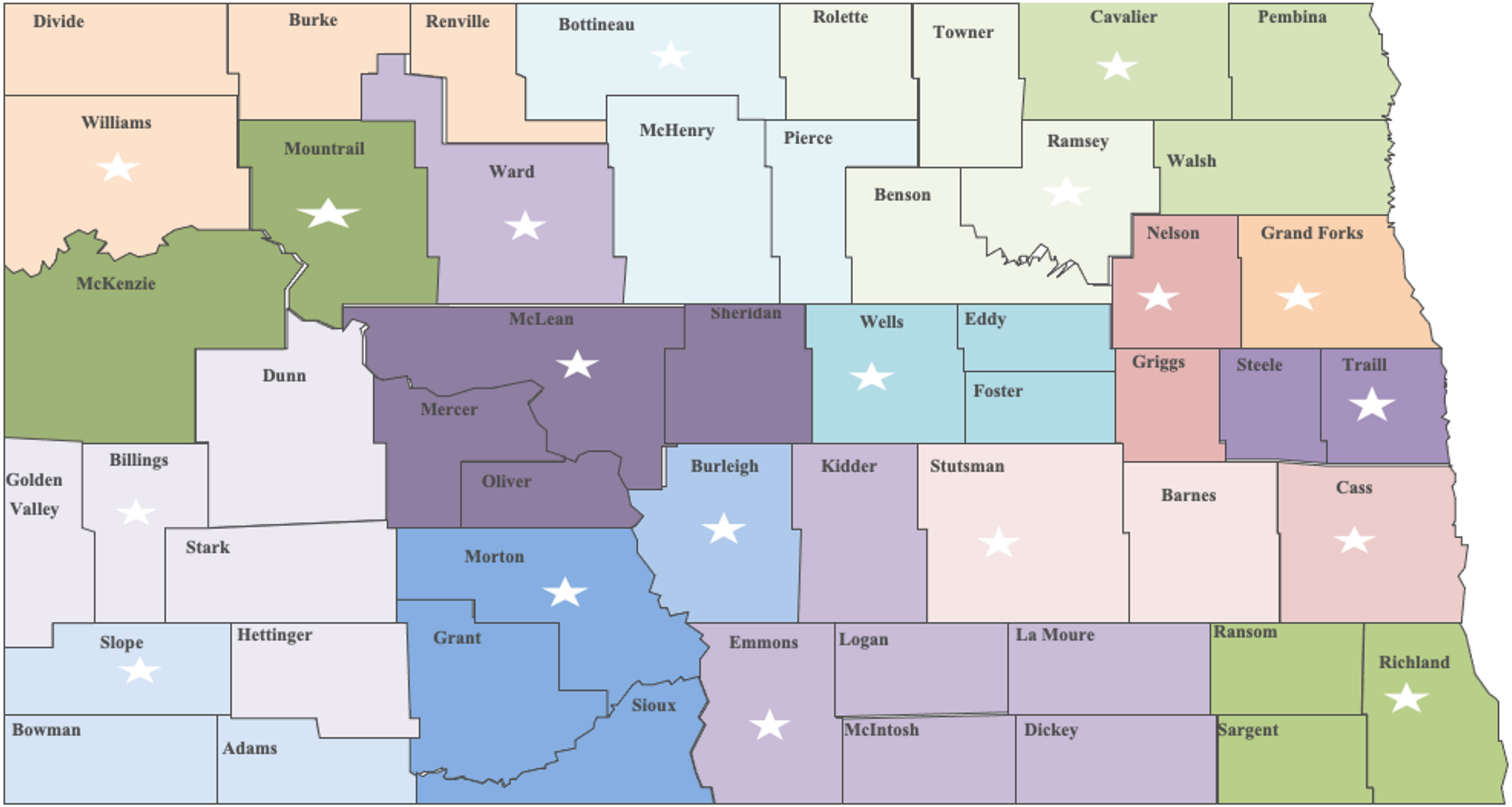
Zone Operations

- Unified and consistent human resources policy and process manual 1/1/21
- Zone director performance appraisal process
- Consistent Chart of Accounts
- Indirect Costs*
- Equity Study*

Program Operations

- Consistent General Assistance policy and process*
- Consistent Indigent Burial Criteria*
- Opt In – State Study*
- Multiple Redesign
  - Child Welfare
  - Eligibility*
  - Central Background Check
  - Institutional CPS
  - Foster Eligibility*
  - Sub Adopt Negotiations*
  - ADRL
  - QSP Enrollment*

*These projects are currently in process.


Divide
Burke
Renville
Bottineau
Rolette
Towner
Cavalier
Pembina
Williams
Mountrail
Ward
McHenry
Pierce
Ramsey
Walsh
Benson
Nelson
Grand Forks
McKenzie
McLean
Sheridan
Wells
Eddy
Griggs
Steele
Traill
Dunn
Mercer
Foster
Billings
Golden Valley
Oliver
Burleigh
Kidder
Stutsman
Barnes
Cass
Stark
Morton
Slope
Hettinger
Grant
Emmons
Logan
La Moure
Ransom
Richland
Sioux
Bowman
Adams
McIntosh
Dickey
Sargent

Total Full Time Equivalents



Counties were authorized 1,207 FTE



DHS budgeted for 985 FTEs in the zones



222 positions under reevaluation

ZONE DIRECTORS



Social Service Directors 2019

37

17+2



Human Service Zone Directors

18



Program + Direct Service Staff

HUMAN SERVICE ZONE ADMINISTRATION

Executive Policy

Leads Family Stability and Community Inclusion strategy and policy to guide service delivery in zones.

Chief Operating Officer

Leads DHS and zone operations and program redesign efforts for the zones.



Dir Zone Operations

Works to guide zones, build collaboration and lead zone operations.

Project Manager

Leads the DHS Office of Transformation supporting redesign projects, change management and process improvement across DHS and Human Service Zones.

FTE TRANSITIONS FROM COUNTY TO STATE



HCBS CASE MANAGERS

- Provide case management for older adults & individuals with physical disabilities receiving state and federally funded home and community-based services and basic care
- Became state employees 1/1/2020

Major Initiatives

- Specialized role of HCBS Case Manager
- Standardized training required for position
- Implemented a statewide centralized intake system for HCBS referrals and informed choice visits to ensure consumers understand their long-term service and support options
- 64 FTE provide support to 3057 unduplicated individuals
- Average 283 referrals and 54 new cases per month

CFS QUALITY ASSURANCE UNIT

SUPERVISOR: LEANNE MILLER



Continuous Quality Improvement Efforts (TBD in 2021)



Facility Licensure Visits



Case Record Reviews



Child & Family Service Reviews

Safety, Permanency, and Well-Being

EARLY CHILDHOOD SERVICES UNIT



2020 Big Wins

- Childcare Licensors are now state employees
- Made progress on the Early Childhood Services (ECS) online application system

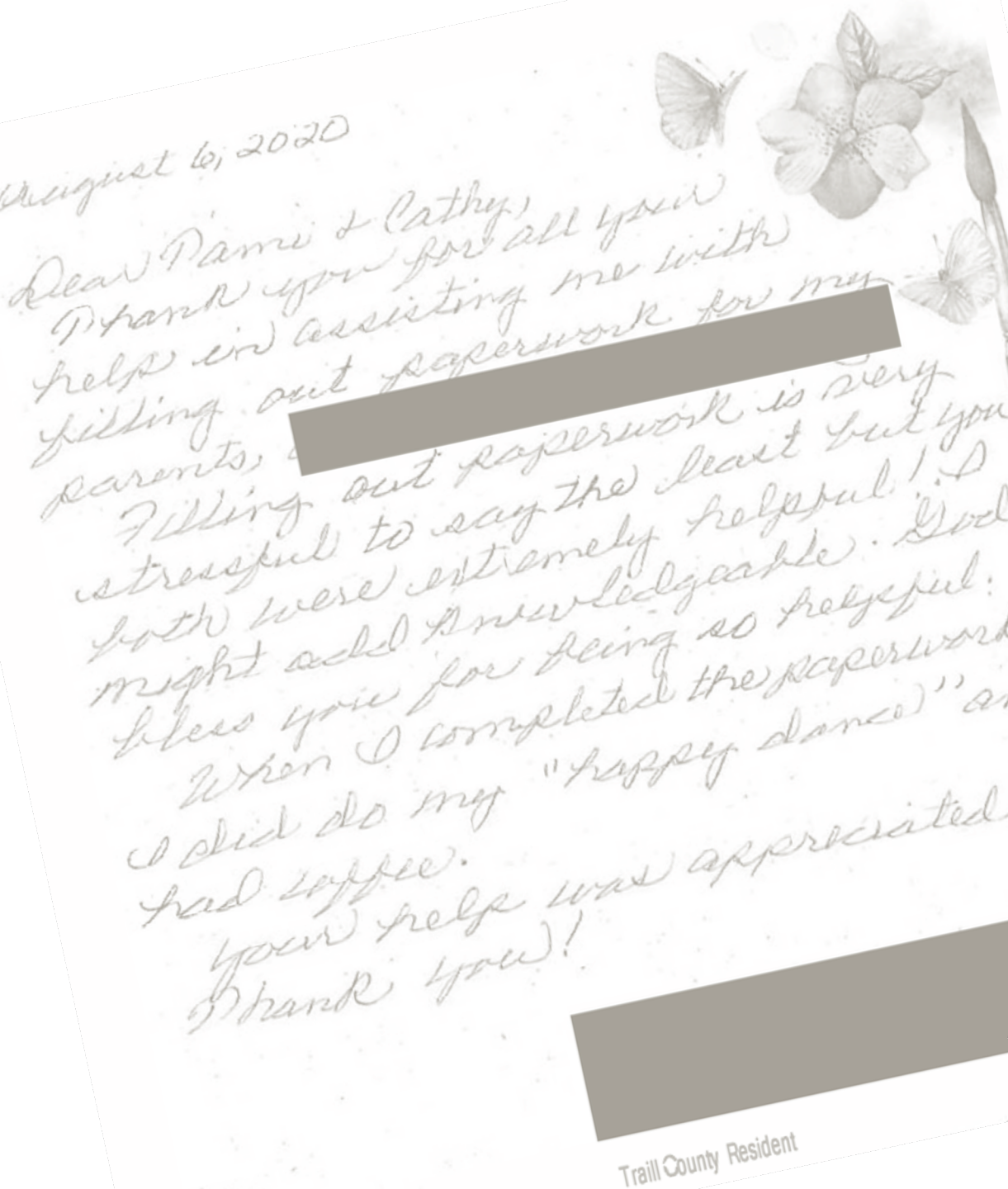


Goals for 2021

- Successfully complete the Child Care and Development Fund (CCDF) Monitoring Visit in Spring 2021
- Continue to work towards completion of the Early Childhood Services (ECS) online application system

MEDICAID LONG TERM CARE ELIGIBILITY UNIT

- Processed and maintain LTC Medicaid applications according to federal timeliness standards
- 16 FTE transferred from Human Service Zones
- Established Q1 2020
- Went live May 11, 2020



August 6, 2020

Dear Pami & Cathy,

Thank you for all your help in assisting me with filling out paperwork for my parents, [redacted]

Filling out paperwork is very stressful to say the least but you both were extremely helpful! I might add knowledgeable. God bless you for being so helpful: When I completed the paperwork, I did do my "happy dance" and had coffee.

Your help was appreciated.

Thank you!

[redacted]

Traill County Resident

12-11-20

Dear Ms. Brevik

This is just a quick note to say THANK YOU for your compassionate demeanor in handling our case.

It was a much needed emphatic ear you gave me on the phone at a time of my peak stress over this unexpected "review" matter. Such an attitude is very rare in my experience.

Happy Holidays

Sincerely

Pierce County Resident

FOSTER ELIGIBILITY + SUB ADOPT

- Authorized for 14 FTE to transfer from the HSZ to the State for a specialty foster eligibility unit
- Authorized for 2 FTE to transfer from the HSZ to the state to support subsidized adoption negotiation
- Unit launches in March 2021
- Will process all foster eligibility, Medicaid determinations for all foster and adopted children and negotiate subsidy for special needs adoptions

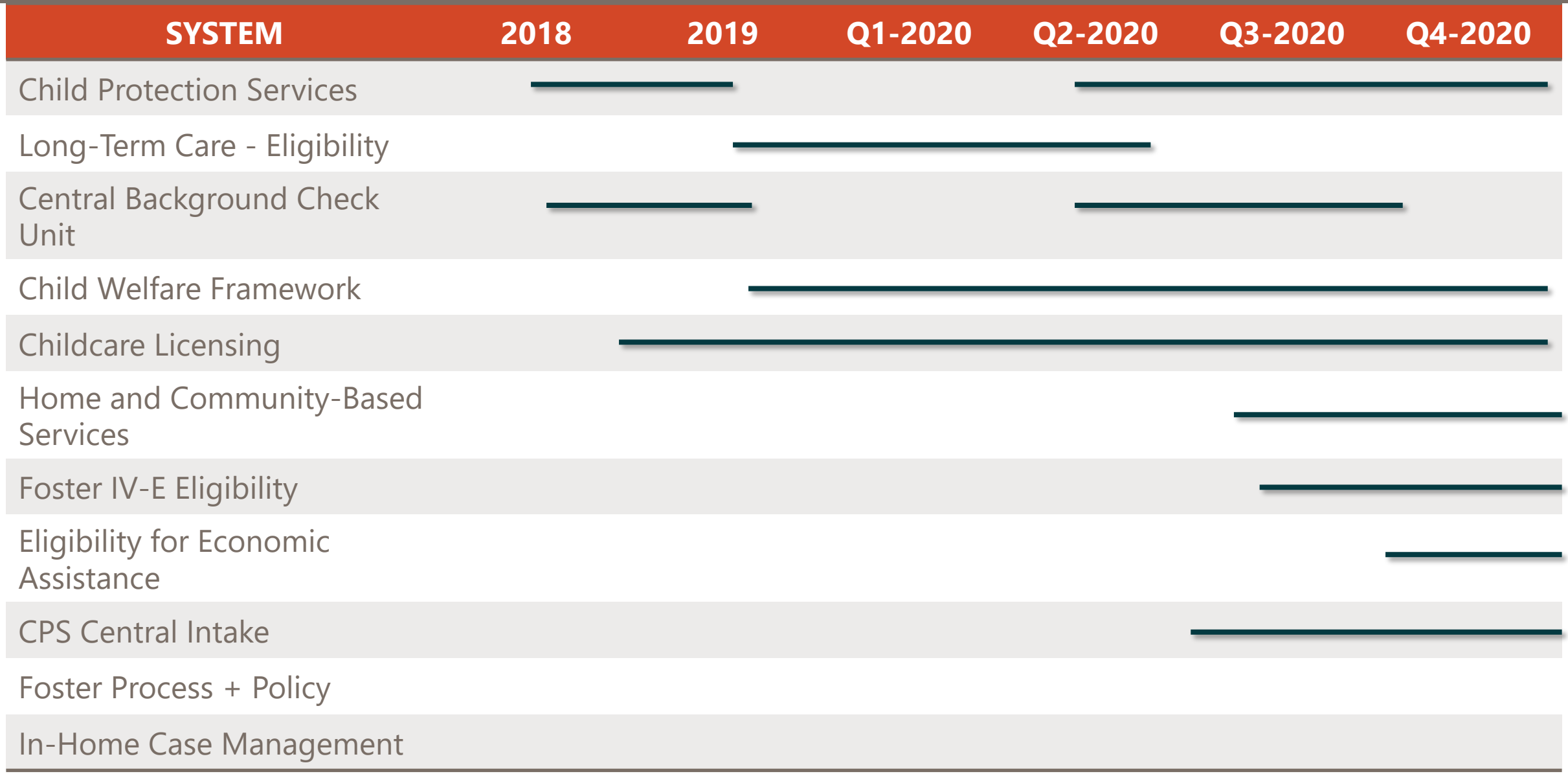
FOSTER CARE LICENSING

- SB2086 Request for up to 16 FTE to for a specialized foster care licensing unit to provide foster care licensing and renewals to foster homes in ND
- Create consistency and a leveled approach to managing foster licenses

IN PROGRESS

- Request for 16 FTE to transfer from the county to state to form a specialty foster care licensing team
- Consistent indigent burial criteria
- Consistent General Assistance policies, criteria and appeals process
- Study for zones to opt into State employment

SYSTEM REDESIGN TIMELINE



EQUITY ADJUSTMENTS

Zone Directors	Compensation equity to align all zone directors within the range
Zone Employee Benefits	Employees shifting to host county benefits which were often more robust
Zone Transfers to State Team	140 FTE that transferred to state were made whole if moving to state caused them to go backwards in salary and benefits

HUMAN SERVICE ZONES
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget	Increase/ (Decrease)	2021 - 2023 budget to Senate
Salaries and Benefits	24,186,262	2,934,739	27,121,001	(72,545)	27,048,456
Operating	4,621,302	(432,412)	4,188,890	-	4,188,890
Grants	144,892,436	956,411	145,848,847	13,065,322	158,914,169
Total	173,700,000	3,458,738	177,158,738	12,992,777	190,151,515
General Fund	-	1,323,223	1,323,223	(11,499)	1,311,724
Federal Funds	-	1,176,874	1,176,874	-	1,176,874
Other Funds	173,700,000	958,641	174,658,641	13,004,276	187,662,917
Total	173,700,000	3,458,738	177,158,738	12,992,777	190,151,515
Full Time Equivalent (FTE)	140.00	0.00	143.00	0.00	143.00

ZONE FUND BALANCES

- Fund balances are reported in January of each year.
- Anything above the fund balance limitation is reduced in the June payment of the following year. Note there were no fund balance reduction in CY 2020.
- If the payment provided to the HSZ to defray costs to provide Human Services, the HSZ would then utilize fund balances.
- HSZ must utilized the full balance of their human service zone human services fund before requesting additional dollars from the Department.
- It is anticipated fund balances will be exhausted in 21-23.

Estimated Fund Balances	In Millions
CY 2020 Beginning Balances Report by HSZ	$10.30
Estimated Beginning Fund Balances Ending CY 2020	$15.02
Less: Estimated Fund Balance Reduction CY 21	$8.85
Remaining Fund Balance CY 21	$6.18

	19-21	21-23
Expenditures > $2,000,000	$500,000	$500,000
Expenditures < $2,000,000	$100,000	$250,000



Contact Information

Sara Stolt, Chief Operating Officer
600 E Boulevard Ave,
3rd Floor, Judicial Wing
Bismarck, ND 58505

Phone: 701-328-1891
E-mail: sarastolt@nd.gov



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8456

ENGROSSED HOUSE BILL 1012

SENATE APPROPRIATIONS

SENATOR RAY HOLMBERG, CHAIRMAN

FIELD SERVICES DIVISION

Rosalie Etherington, Chief Clinic Director/NDSH Superintendent

Jeff Stenseth, Field Services Operations Officer/ SEHSC Regional Director

NORTH Dakota | Human Services

Be Legendary.™

FIELD SERVICES:
Designing Behavioral Health Care



SERVE THOSE MOST FUNCTIONALLY IMPACTED



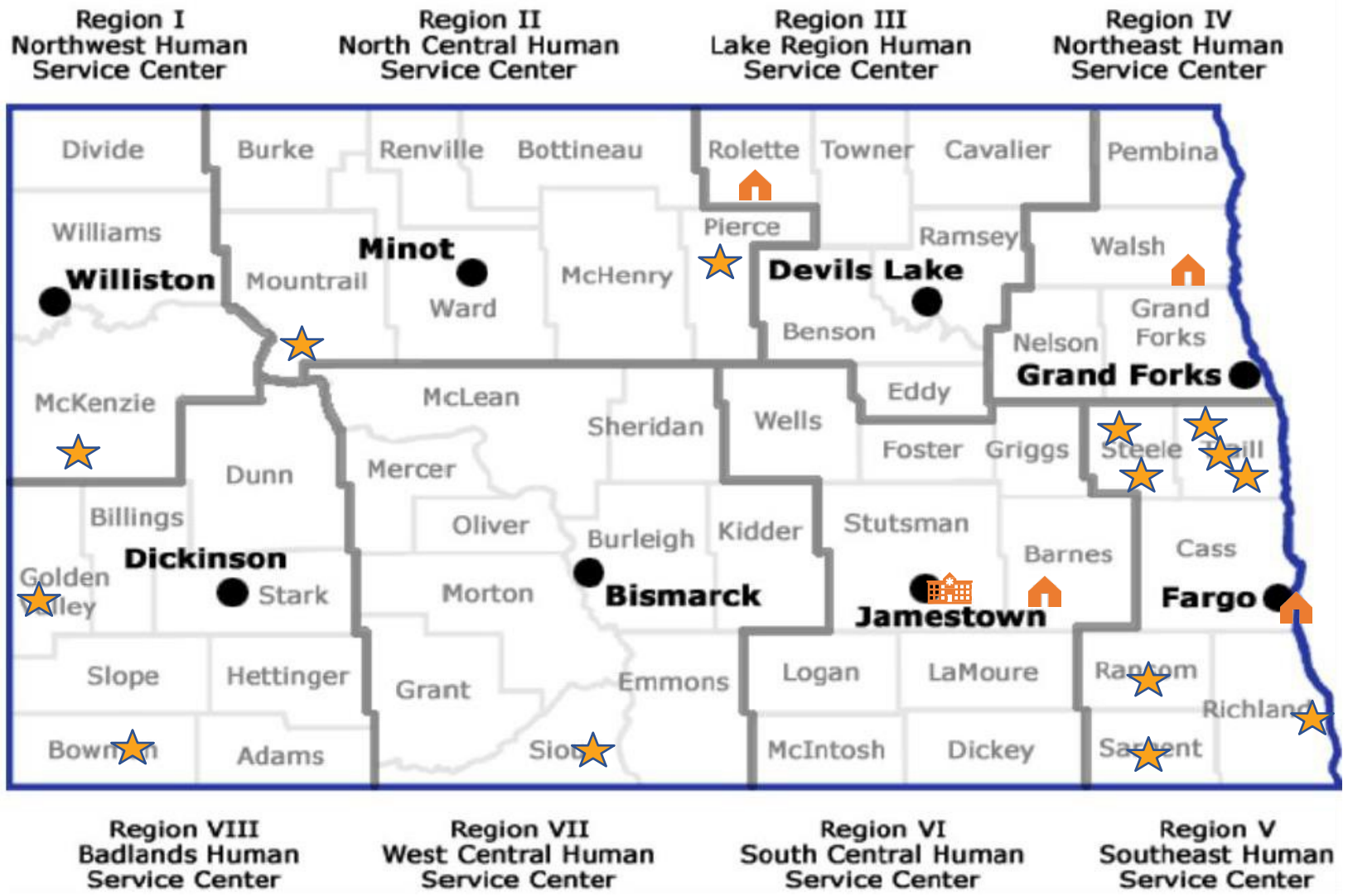
SUPPORT/INCREASE INDEPENDENT FUNCTIONING



SUPPORT INDIVIDUALS ACHIEVING THEIR RECOVERY GOALS

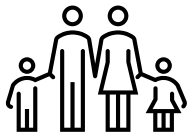
FIELD
PUBLIC BEHAVIORAL HEALTH SYSTEM

8 Regional Human Service Centers
14 Outreach Offices
4 Satellite Clinics
1 North Dakota State Hospital



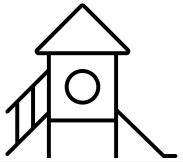
DHS 2021-2025 KEY PRIORITIES
HUMAN SERVICE CENTERS

YOUTH/FAMILY
SERVICE TRANSFORMED



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment

STATEWIDE
CRISIS SYSTEM



Services Closer to Home

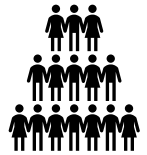
- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service

ACCREDITATION
ACHIEVED



High Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

HUMAN SERVICE CENTERS AT-A-GLANCE
March 2019 – February 2020 *

569,454
Services

18,308
Clients

15,419
Services provided by Telehealth

12,157
Services provided in home

215,246
Services provided in community

5,628
Crisis Services

2,230
Youth (<18) clients served

*New EHR was adopted in March 2019, thus a full calendar year for 2019 was not able to be provided.

24/7 Centralized Call Center

Flexible Crisis Response

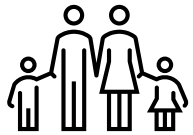
Crisis Stabilization Facilities

COMPREHENSIVE CRISIS CARE SYSTEM

- Anyone
- Anywhere
- Anytime

DHS 2021-2025 KEY PRIORITIES
NORTH DAKOTA STATE HOSPITAL

SPECIALIZED **LOCAL** **EFFICIENT**



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being

Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service

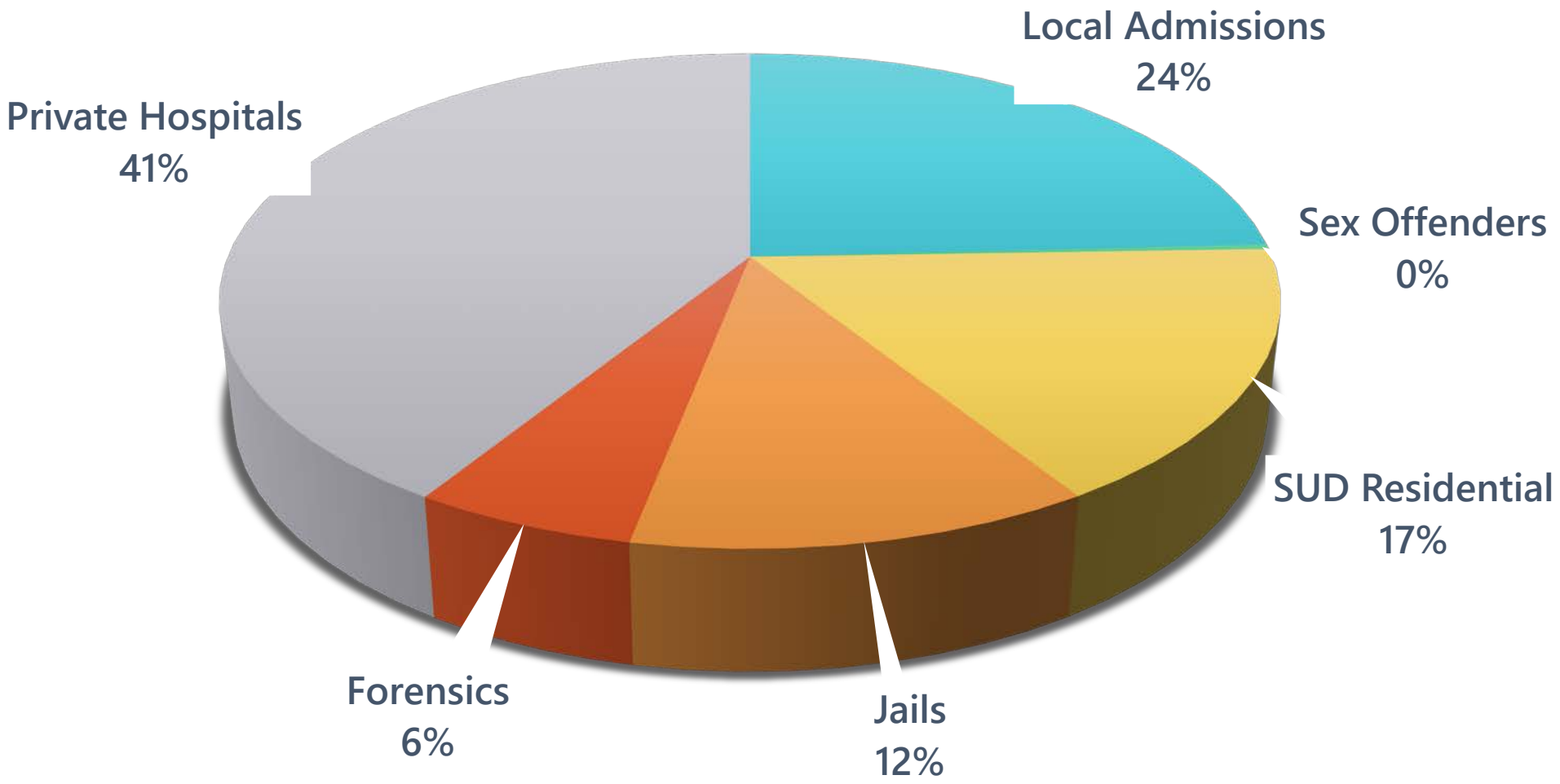
High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

NORTH DAKOTA STATE HOSPITAL
SOURCE OF ADMISSIONS



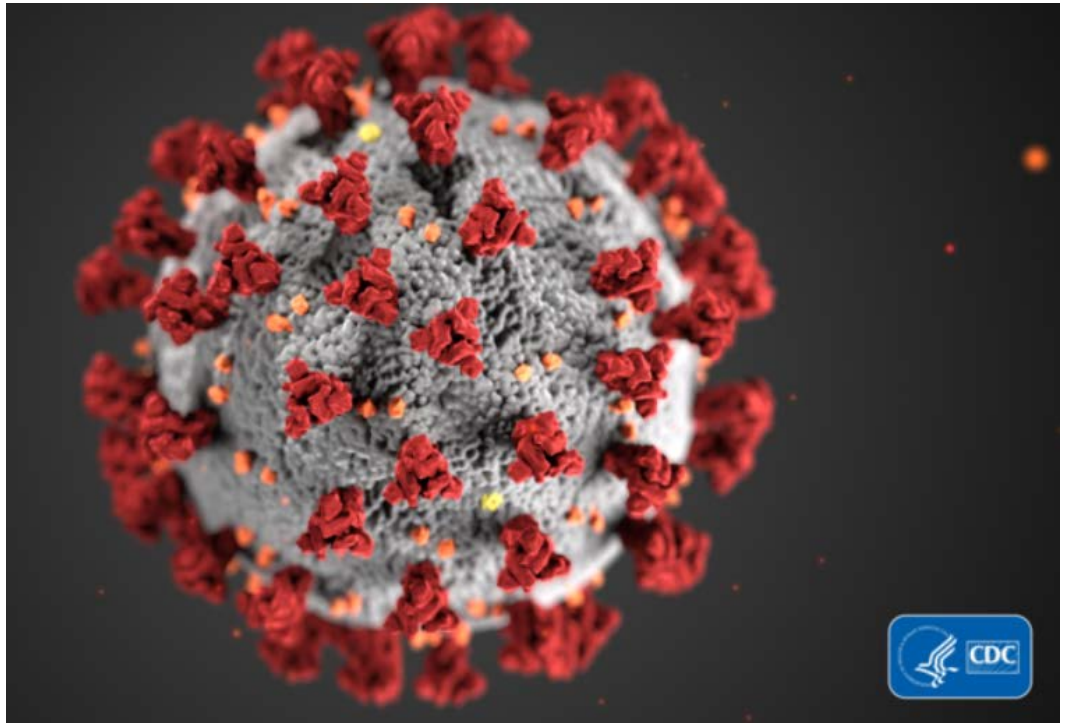
HSC PANDEMIC RESPONSE

- Expanded telehealth capacity to 350 providers
- Prioritized on-site staff and services
- Retained limited in-person care



NDSH PANDEMIC RESPONSE

- North Dakota Bed Surge Plan Participation
- Expanded Infection Control Procedures
- Expanded Medical Care
- Weekly Surveillance Testing
- Visitor and Community Restrictions
- Mandatory Overtime



OVERVIEW OF HSC BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget	Increase/ (Decrease)	2021-2023 Budget to Senate
Salaries and Benefits	117,595,353	6,901,854	124,497,207	(347,327)	124,149,880
Operating	16,435,561	(969,915)	15,465,646	0	15,465,646
Capital	80,000	0	80,000	0	80,000
Grants	28,873,633	(1,398,175)	27,475,458	1,362,299	28,837,757
Total	162,984,547	4,533,764	167,518,311	1,014,972	168,533,283
General Fund	104,546,617	(8,374,845)	96,171,772	1,129,122	97,300,894
Federal Funds	40,391,387	4,295,666	44,687,053	1	44,687,054
Other Funds	18,046,543	8,612,944	26,659,487	(114,152)	26,545,335
Total	162,984,547	4,533,764	167,518,311	1,014,972	168,533,283
Full Time Equivalent (FTE)	637.95	0	637.95	0	637.95

OVERVIEW OF NDSH BUDGET CHANGES

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget	Increase/ (Decrease)	2021-2023 Budget to Senate
Salaries	64,601,743	(623,668)	63,978,075	2,006,289	65,984,364
Operating	13,633,759	(892,797)	12,740,962	300,000	13,040,962
Capital	1,353,299	0	1,353,299	0	1,353,299
Total	79,588,801	(1,516,465)	78,072,336	2,306,289	80,378,625
General Fund	59,723,353	2,924,499	62,647,852	1,961,189	64,609,041
Federal Funds	1,759,125	(543,618)	1,215,507	0	1,215,507
Other Funds	18,106,323	(3,897,346)	14,208,977	345,100	14,554,077
Total	79,588,801	(1,516,465)	78,072,336	2,306,289	80,378,625
Full Time Equivalent (FTE)	401.52	(17.10)	382.02	14.00	396.02

NEW TREATMENT CAMPUS



- Eliminate $148M of Deferred Maintenance
- Finance Construction Without Upfront Capital
- Make Annual Payment Through Savings

IMPROVE CARE AND REDUCE COSTS

ADDITIONAL REQUESTS

- Demolition Authority
- Land for National Guard



IMPROVE CARE AND REDUCE COSTS

Contact information

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Jeff Stenseth
Chief Operating Officer/SEHSC Director
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Engrossed House Bill 1012 1915i Discussion
Senate Appropriations |
Senator Ray Holmberg, Chairman

WHODAS (World Health Organization Disability Assessment Scale)
Rosalie Etherington, State Hospital Superintendent, Chief Clinics Officer

NORTH Dakota | Human Services
Be Legendary.

1

WHODAS (world health organization disability assessment scale)

WHAT IT IS

Generic tool for measuring daily function and how it impacts health and disability across all of medicine and healthcare

WHY USE IT

Excellent measurement precision for all medical and behavioral health disorders across age groups and cultures

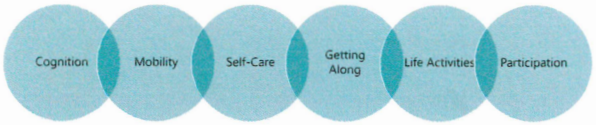
Simple, fast, freely available, and reliable over time

WHY DIAGNOSIS ISN'T ENOUGH

A disorder fails to predict service need, treatment outcome, work performance, or social integration

2

WHODAS – What it Measures?



3

Why Does it Seem So Hard?

New Measures
New is often scary
New things takes practice
What if the WHODAS is wrong?

Left Out
WHODAS may leave some out
But how do we assess youth?
What if a person doesn't quality?

Financial Uncertainty
How to become a provider?
Will Medicaid pay?
Will it be enough?

4

STRATEGY

1. Train and Supervise
2. Measure and Monitor
3. Re-Train and Evaluate for Needed Change

5

Department of Human Services
1915i Contract Changes
21-23 Biennium

Division	Description	Total Contract Amount	Executive Budget Request	House changes	Proposed 21-23 Contract Amount
Behavioral Health	Parent to Parent	75,000	(11,250)	5,625	69,375
Behavioral Health	Brain Injury - Resource Facilitation	558,494	(279,247)	195,472	474,719
Behavioral Health	Brain Injury - Pre-Voc Program	337,499	(168,750)	84,375	253,124
Behavioral Health	Brain Injury - Return to work (Workstart)	348,553	(174,277)	87,139	261,415
Behavioral Health	Peer support Certification	13,590	(13,590)		-
Behavioral Health	Peer support pilot	15,000	(15,000)		-
Subtotal Behavioral Health		**1,348,136**	**(662,114)**	**372,611**	**1,058,633**
Children and Family Services	**Family peer support (Family Health Info & Ed Ctr)**	**175,000**	**(100,000)**	**73,750**	**148,750**
Human Service Center	LaGrave on First	375,000	(187,500)	93,750	281,250
Human Service Center	Prairie Harvest Mental Health	2,829,600	(1,414,800)	353,700	1,768,500
Human Service Center	Cooper House	566,928	(283,464)	141,732	425,196
Human Service Center	Supportive Employment	583,226	(583,226)	291,613	291,613
Human Service Center	Gerridee's Place	901,008	(901,008)	450,504	450,504
Human Service Center	Supportive Employment	62,000	(62,000)	31,000	31,000
Subtotal Human Service Centers		**5,317,762**	**(3,431,998)**	**1,362,299**	**3,248,063**
Total DHS		**6,840,898**	**(4,194,112)**	**1,808,660**	**4,455,446**

8471

Testimony Prepared for the
Senate Appropriations Committee
March 10, 2021
By: Terry Traynor, NDACo Executive Director

RE: Engrossed House Bill 1012 – DHS Budget/Zones

Chairman Holmberg and committee members, thank you for the opportunity to briefly address the ongoing process of social service redesign and the budget to support the Human Service Zones across the state. Zones, and particularly zone employees, are very literally the boots on the ground for delivering so many of the state funded services critical to our most vulnerable North Dakotans.

I want to preface my testimony on the bill by thanking this Committee and the Legislature for passing the redesign enabling legislation and funding last session, as well as DHS staff and the many county officials – zone directors, county auditors, state's attorneys, and commissioners – that have devoted so many hours to implementing this monumental change. My conclusion is that the transition, thus far, has gone well considering the short amount of time that we have been at this, but it is not without its difficulties. Some of which are fiscal and will ultimately be addressed by HB1012.

First and foremost, counties very clearly support the funding requested for Zones in the budget that comes to you from the House. I think it is important to note that these funds support not just zone employees, but also former county and zone employees transferred to state employment through the various redesign initiatives – all of which became, and continues to be, property tax relief. As proposed, this will be the third biennium that the Legislature has set aside $200 million in oil tax revenue specifically to make this redesign successful, and thus far, significantly less has been requested and appropriated.

While efforts have been made since formal zone formation, barely a year ago, to achieve some degree of compensation equity, for many zone employees this goal has not been met. As some zones require much greater employee share for benefits, it has been, and will continue to be, challenging. Obviously, the inclusion of sufficient funds to address inflationary costs of salaries and benefits by the House was critical and must be retained.

Because the Property Tax Relief Fund transfer as proposed in HB1012 is insufficient for fully funding the zones, the budget anticipates spending over $15 million in zone reserves (exhausting all reserve accounts in one biennium). These reserves were built up over many years. They, very honestly, include some state reimbursement, however, they are largely dedicated social service property tax levy funds. We are a team – state and county – working together and pooling our resources to make human service redesign work, but the perception that property taxes (although clearly collected specifically for human service purposes) will be used as a one-time harvest of property taxes to offset state general fund dollars is difficult for many zone board and county commission members to accept.

I recognize that reserve funds should not sit unused indefinitely, and the legislature has mandated that DHS fund the human service delivery needs – by transfers from other divisions if necessary – many local officials are (after barely a year) unsure about the potential emergency needs that DHS may not be able to fund, or fund immediately. I also recognize that not utilizing any of those reserve funds would make your job significantly more difficult, but I must raise this issue as those perceptions exist.

The Senate Human Services Committee, in addressing the "social service redesign" technical corrections bill (SB2086), removed the language giving unilateral authority for the Department to use all the reserves to offset a state general fund appropriation, however the budget before you, as adopted by the House, anticipates zeroing out these reserves. It would be our request that the Senate provide sufficient funding to at least preserve the threshold amount of $250,000 in each of the nineteen zones for the future ($4.75 million).

A final point I wish to address is the meager offset to the property taxes supporting the indirect costs of human service zone support. I thank the Department for budgeting to continue the partial funding at the same level as CY2018 (as addressed in SB2086), but only wish to point out that the costs of space, utilities, janitorial, insurance, IT support, state's attorney salaries and benefits, and all the rest are not stagnant. Over the past three years and into the next two, the property tax burden for these costs has, and will continue to, erode the "relief" you as a legislature have provided. This is becoming critical for the counties that have already reached their 60-mill general fund limit. DHS, zones, and counties are working to analyze and hopefully better standardize how these indirect costs are

identified and I sincerely hope we can present a better picture of this property tax supported piece of the puzzle in the future. However, I would respectively request that consideration be given to some sort of multiplier to the total allocated for indirect cost reimbursement. I have copied part of the amended section of law from SB2086, with our suggestion in red for one approach.

Thank you again for the opportunity to address this important bill.

50-35-04. Calculation of ~~formula~~ payment - Expenditures.

4. The director, during the period between January 1, ~~2020~~2021, and December 31, ~~2021~~2023, shall calculate payment for indirect costs ~~according to a formula established by the department, during the period between January 1, 2020, and December 31, 2021~~. Indirect costs of the human service zone may not become direct costs without written approval of the department. The total payment by the department for reimbursement of indirect costs incurred to support human services may not be less than the prorated amount paid to counties for this purpose in state fiscal year 2018 and increased by the percentage allowed for state salary adjustments during the previous biennium, as identified in the indirect cost plan, unless a cost reduction or cost-savings is achieved by the county.

March 10th, 2021

Chairman Holmberg and members of the committee,

My name is Taylor Restad and I work for the Grand Forks Housing Authority as the Program Director at LaGrave on First. Before I begin, it would be remiss of me today if we didn't give thanks to the Department of Human Services, both Medical Services and Behavioral Health, for including individuals with lived experience, families and friends, as well as providers, the opportunity for input during the development of the North Dakota Medicaid 1915(i) State Plan Amendment.

I'm here today to request an increase in the funding for our line item in the Northeast Human Service Center budget to $515,000. We make this request for two main reasons. First, during the last session our request of $550,000 was decreased to $375,000 - $275,000 for the first year and $100,000 for the second year as the 1915(i) was anticipated to be available as of July, 2020. This year, the Executive Budget allocated $187,500 for LaGrave on First, again, we believe, with the intent for the 1915(i) SPA covering the rest. While we are grateful to be in the budget, it is substantially less than what is necessary to provide 24/7 housing support to the tenants at LaGrave on First. The House returned half of our reduction but that is still $233,750 less than our request.

Second, we ask for $515,000 because of the considerable uncertainties with the 1915(i). Of note, the Grand Forks Housing Authority is one of the biggest fans of the 1915(i). In 2016 we brought in national experts, the Corporation for Supportive Housing, to help identify a sustainable funding source to assist individuals with behavioral health conditions remain in their home and communities, and they recommended a Medicaid 1915(i) State Plan Amendment. Unfortunately, we believe there are issues that have already become quite apparent including, but not limited to:

- ➔ In regard to housing support services, the current 1915(i) includes housing support services to be offered in 15-minute units with a maximum of 156 hours per 12 months. This is not sufficient for everyone, and in particular not for those who have experienced chronic homelessness and therefore have had extensive issues with tenancy in the past. Until the 1915(i) provides daily rates for housing support services, we will continue to request additional resources.
- ➔ For individuals who have a behavioral health condition, they may not be able to self-recognize their condition's impairment on their daily functioning, and therefore are not able to score the required 50 on the WHODAS.
- ➔ The lack of time that Human Service Zone Eligibility workers have to complete WHODAS interviews with individuals.

We are big believers in the 1915(i), and have insight into its potential and the possibilities it holds. The Grand Forks Housing Authority is in the process of becoming a Medicaid biller in

order to provide housing support services and take advantage of this sustainable funding opportunity. We have received a Bush Foundation grant to secure capacity building and technical assistance from the Corporation for Supportive Housing in order to do so to the best of our ability and adhere to national best-practices.

In summary, we ask that you increase funding for LaGrave on First until we all have the opportunity to see how the 1915(i) functions and to ensure we don't let some of our states' most vulnerable people fall through the cracks, potentially becoming homeless yet again. I appreciate the opportunity to submit this testimony before you today. I will answer any questions you may have at this time.

Respectfully submitted,

Taylor Restad

Testimony to the
Senate Appropriations Committee
March 10, 2021
Chad Peterson, Cass County Commission Chair

Regarding: House Bill 1012

Chairman Holmberg and members of the Senate Appropriations Committee, I am Chad Peterson, Cass County Commission Chair, and I am writing to share my broad support for House Bill 1012. I appreciate and share the desire to continue the process that started many years ago and finally came to fruition bringing a logical transition of these services to the appropriate level of government. The only remaining struggle is that this takeover didn't take into account the differences, both present and future, between each newly created zone. I would like to touch on a number of these items that relate specifically to the Cass County and the newly formed Cass County Human Services Zone (CCHSZ). Please note, that just because I am referencing the CCHSZ doesn't mean these examples don't also affect other zones.

The CCHSZ is home to more than 20% of North Dakota's population yet serves 30% of the North Dakota social services caseload. With this caseload comes dynamics that create a very different level of complexity when compared to other zones.

One example is our continuous population increase and the trailing potential for increasing caseloads within the CCHSZ. This caseload will require the need for additional staff or reinventing service delivery. When the zone was created the Cass County Social Services Board (CCSSB) put a request for additional staff forward to the Department of Human Services (DHS). Thankfully, between the legislative leadership and the team at DHS some of these requests were met, but more are still needed as our county continues to grow. We are aware of the reinvention of some service delivery (and example would be economic assistance) and look forward to working with DHS to right that need and streamline service delivery in coming years.

Another area of concern would be funding legal service to support the CCHSZ. In CCHSZ we field more child protective service calls, higher levels of foster care support and greater numbers of child removal cases than many of our peers. For these reasons and many others, we are compelled to have a dedicated, specialized legal team to support the CCHSZ. Please note, this support team is the same team that supported social services prior to formation of the zone. And with very little effort the CCHSZ could quantify the dedicated time for the zone legal staff. Currently the county budget for legal services is roughly $573,635. The zone is currently being reimbursed at $439,950. When the transition is made to the 25% formula local tax payers will be subsidizing what is easily identifiable as a CCHSZ expense. This leaves local taxpayers via our general fund to pay for these additional legal services.

As you are aware Cass County taxpayers paid to build a large complex, the Cass County Annex, that continue to house these services. The zone is only reimbursed $472,071 for cost allocation which includes everything from administrative support to building utilities. An example of what could be a large disparity between zones, we are aware of a number of zones that are reimbursed directly for leases that they have entered into. It would be a curious study to see what this facility would cost to rent should Cass County choose to sell the building and then require rental assistance from DHS.

Staff compensation is another area that should be discussed. In Cass we do our best to ensure all staffing skill levels are paid uniformly throughout the county. The salaries are determined using independent consultant surveys that help us determine market rate for each position. The goal for Cass is to never lead nor lag the market and create a stable workforce. This environment helps promote longevity, which in turn increases productivity and saves taxpayers money. With the state takeover, we've seen pay rates within social services fall behind their peer groups. We would welcome the opportunity to discuss how pay levels are established and bring our team back to a uniform level of compensation.

Indirect costs are a growing area of concern. In some zones it is difficult for a zone to segregate these line items because these accessories are shared by many divisions within a courthouse. However, like legal

services, it is easy for the CCHSZ to determine dedicated costs as little 'office infrastructure' (i.e. copiers, phones, etc.) as the zone is housed in a separate building and very little has ever been shared between social services and other divisions. We would welcome the discussion on this item as well.
As mentioned before, the caseload levels are beyond what most of our peers will ever experience. To control costs and deliver unique services that better serve our population, our team has been incredibly innovative. This innovation has created relationships with both public and private entities outside the courthouse. We've been partners with cities and schools in programs like the Jefferson School Project that helps stabilize families and promote school attendance. This family support often helps minimize the need for interactions with social services. We've also been aided by private groups like the Cooper House in Fargo that provides supportive housing for 42 chronically homeless individuals. I would encourage you to look into these programs, provide funding for innovation and to provide funding at or above current levels for those programs that are already established.

From top to bottom, the team that North Dakota inherited from Cass county is amazing on many levels. If you recall, Cass was the baseline for caseload standards. This was done for a good reason. We are good at what we do. We have specialists in every field out of necessity. And we, now North Dakota, are blessed to have that team. We encourage you to support the CCHSZ, work with us to fund innovation and fund the needs of this and other zones now and into the future.

Again, Chairman Holmberg and members of the Senate Appropriations Committee, I am writing to share my broad support for House Bill 1012.

Testimony Prepared for the
Senate Appropriations Committee
March 10, 2021
By: Kim Jacobson, Agassiz Valley Human Service Zone Director

RE: House Bill 1012 – DHS Budget related to Human Service Zones

Chairman Holmberg and committee members, my name is Kim Jacobson. I am the Agassiz Valley Human Service Zone Director, serving the service area of Traill and Steele Counties, a member of the North Dakota Social Service Director Association, and a member of the North Dakota Association of Counties Board of Directors. Please consider my testimony in support of HB 1012.

The last two years have brought many changes for the local human service delivery system. At the end of the 66th Legislative Assembly, county social service agencies and the department together began a fast-paced path towards the formation of human service zones. The teamwork and collaboration leading up to the 66th assembly provided groundwork for system redesign, visioning, and goal setting. However, planning and doing are two very different things.

Today, I am pleased to report that we have together transitioned to 19 human service zones. We have accomplished many great things, including: developing, negotiating, and entering into human service zone agreements and operational plans; combining county-based workforces into human service zone teams; leading the transition to human service zone board structure; developing innovative service and management collaborations between zones; transitioning locally administered services allowing zones to still meet the unique needs of local communities; developing and launching unified human service zone personnel policy which supports merit system/federal/state law compliance while providing opportunity for locally unique policy when appropriate; transitioning the legal custody of all foster children to the human service zone director; and restructuring to a consistent fiscal coding, management and budgeting system. In fact, in prior legislative hearings the transition to human service zones has been referred to as a well-baked and even frosted cake.

It is recognized that the transition to effective and efficient state/human service zone team will take at least eight years. While we have accomplished a lot of initial and visual steps, it is important to note that we are just **one year** into the human service zone and state team system during a time we have also been dealing with COVID19. Our team-based approach is a strong example of government innovation. However, the operational side of service delivery is very complex. Building a responsive state/zone team system is unchartered territory. Working as one with shared decision-making and accountability while demonstrating local responsiveness is hard work that requires time, attention, and nurture. This is critical to continued success and for responsive services for citizens. However, as you know, adequate funding is key to providing service.

Last session's SB 2124 was a comprehensive and sizable bill. I am very grateful for the support of the legislative body from both an appropriations and policy perspective and the investment in local human service delivery. I also express appreciation for the support of the vision - *a state and local team* - working together in a hybrid model of structure. This allows for unique local need to be met, voices to be heard, and a nimble, local response as we work together to provide system effectiveness, efficiency, and quality.

With any system's change it takes time. It was anticipated that there would be need for technical changes, intent clarifications, and parameters for next steps. Therefore, as expected through this year's legislative budgeting process we have learned many lessons. We have learned that there are some financial issues that need to be addressed so that human service zones can continue to effectively serve the entire state. It important to address the issues now or the cake that we have worked so hard to prepare will be missing big pieces and there will not be enough to serve those in need across the state.

Our Lessons Learned:

Initial base funding shortfall:

The approved appropriation for human service zones in 2019 biennium was ~$10 M short of necessary levels to support local human services. Efforts to redesign programs, especially economic assistance programs, was delayed because of the COVID19 pandemic. The benchmark of 985 FTEs for human service zones was not an accurate projection to base funding for our current system and the phase of the redesign process. As prior biennium

approved budget levels are used to base the next budget, we face a critical and concerning trajectory.

HB 1012 compounds this budgeting concern as the 2021 proposed budget was built off the 2019 biennial budget. This puts us at an even greater shortfall. When human service zones formed on January 1, 2020, most zones had a reserve fund balance. However, the department projects that 100% of the reserve funds statewide will be depleted by July 2022.

Human service zones provide critical safety net services to North Dakotans. In essence, no human service zone reserve fund balance means the safety net will no longer have a financial safety net. The department has reassured us that they are legally and morally committed to ensuring adequate funding of human service zone services. However, even with this reassurance, it is very concerning especially as we are so early in our new structural model and will soon have no reserve fund balances. Due to this trajectory, we are faced with uncertainty about how current and future needs will be met and how local access points and services will be preserved to meet the needs our vulnerable citizens.

Salaries, Benefits, and Equity:

During this legislative assembly, *SB 2086* – a policy bill – seeks to address policy points and clarify legislative intent regarding a variety of items including equity, indirect costs, roles and responsibilities, county "*skin in the game*", and other items. SB 2086 calls for several departmental studies along with reports to Legislative Management during interim. Balancing policy along with adequate appropriation is key to a successful product.

As a statewide system, it is key that we have an equitable total compensation system. We have learned that there is great disparity in salaries in human service zones, between human service zones, between human service team members and state employees housed in the zone, and with the Department. This was largely caused by the history of social service financing being tied to property tax. As you know, social service need and mill valuation are not reflective of one another. However, now with our funding for salaries and benefits coming from a common funding stream, the need for equity becomes increasingly important.

We have also learned that there is significant disparity of health insurance package offering within the human service zone system. For example, a family health insurance policy for Agassiz Valley Human Service Zone team members costs employees over $1000 per

month out-of-pocket. Meanwhile, our neighboring zones and state agency, who we compete with for hiring and retention, have much more robust benefit packages.

As we move forward, we realize that both salary and benefits need to be looked at in a comprehensive manner to provide a level of equity but also to prevent service deserts. Adequate base funding is necessary for the system to work as one. Also, budgetary flexibility is also key so that funds, upon availability, can be redirected to meet identified need in areas such as total compensation equity.

Today, I respectfully ask you to ensure adequate funding for local human service zone services and to support our workforce in the provision of those services. Adequate funding is critical in meeting the needs of our citizens and to support the property tax relief efforts gains through our systems change.

I also respectfully request that HB 1012 be amended to prevent the full depletion of human service zone balances and allowing each human service zone to retain up to $250,000 in reserve fund balances. If additional funds are not added in 2021 to offset full depletion of human service zone reserve balance funds, the 2023 budget request will be significantly higher than the 2021 request. If not, critical services may be lost. Simply said, there will not be enough cake to go around. Plus, the 2023 cake will need to be much larger and/or prepared as a multi-layer cake.

Thank you for this opportunity to provide testimony regarding HB 1012. Questions from the committee are welcomed.

Testimony for HB 1012

Senate Appropriations Committee

March 10, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, I am Steven Reiser, Director of Dakota Central Human Service Zone. I am also a member of the North Dakota Human Service Zone Association. Please accept this testimony in favor of HB 1012.

The counties of McLean, Mercer, Oliver and Sheridan formed a social service district in 2006 and started operating as district on January 1, 2007. The mission of the district was to provide a better service to the county residents and when possible lower costs. In 2007 Dakota Central employed 36 staff. At the end of 2019 Dakota Central employed 31 staff. There can be cost savings and efficiencies found when counties join together but it takes time. Even though caseloads have grown from 2007 Dakota Central is able to employ fewer staff. If you look at 2020 staff numbers Dakota Central is down to 25 staff because of 4 staff transferring to state employment and reducing two more staff.

Zones have done a lot in one year and are working hard to improve services and find efficiencies but there has to be financial stability to the achieve kind of improvements we all hope for.

The amendments added to the bill by the House Appropriations were positive but fall short of what is needed for zone funding. SB 2086 is the policy bill passed regarding zones. In this bill reserve fund limits were increased to $250,000 in smaller zones. I believe the intent of raising this limit from $100,000 was to allow for more decision making at the local level for administrating human service programs. Using all of the reserve funds that zones have now to replace the dollars that the zone budget is short for the last biennium will not allow for this type of close to the client decision making. If 19 zones were allowed to keep $100,000 this would amount to $1.9 million in additional spending. It would be $4.75 million for $250,000 limits.

Thank you for allowing me to testify and I would answer any questions you might have.

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/10/2021 PM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 2:04 PM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- Differences between WHODAS and VI-SPDAT screening
- Brain injury accidents or causes

Doreen Eichele, Dacotah Foundation, testified in opposition and submitted #8417.

Kandia Qual, Program Director, Dacotah Foundation, testified in opposition and submitted testimony #8547.

Dan Madler, CEO, Beyond Shelter, Inc. testified in opposition and submitted testimony #8459, #8460, #8461, #8462.

Dwight Barden, Executive Director, Burleigh County Housing Authority – testified in favor and submitted testimony #8274.

Kimberly and Troy Ohlhauser, Bismarck, ND – testified in favor and submitted testimony #8646.

Dave Flohr, Executive Director, North Dakota Housing Finance Agency – testified in favor.

Rebecca Quinn, ND Brain Injury – testified in favor and submitted testimony #8440 and #8441.

Nan Kennelly, ND Brain Injury Advisory Council – testified in favor and submitted testimony #8430 and #8432.

Jill Elliott, Executive Director, Fargo Housing Authority – testified in favor and submitted testimony #8024 and #8025.

Bruce Murry, Exec. Dir. ND Association of Community Providers – testified in favor and submitted testimony #8750.

Christina Sambor, ND Coalition for Homeless People – testified in favor and submitted testimony #8610.

Additional written testimony: #8270

Senator Holmberg closed the hearing at 3:40 PM.

Rose Laning, Committee Clerk

SENATE APPROPRIATIONS COMMITTEE

TESTIMONY

Committee Chair Holmberg and Members of the Committee, my name is Doreen Eichele, Chief Operations Officer for the Dacotah Foundation. I am here today to give testimony in opposition to the budget cuts made to mental health services offered in HB 1012.

We want to extend our support of the efforts of the Department of Human Services and the local human services centers. We understand that finding funds to provide service is not an easy task and that this committee carries a great burden to meet the needs of the citizens of this State. We believe that funding supportive housing provides a tool to provide supports that effectively impact individuals while giving them dignity in housing and offers options and support to address their basic needs. We feel that not funding these services stops the efforts and progress that has been made toward stabilization, working toward recovery and addressing chronic homelessness in our State.

Field services in their testimony noted that chronic disease robs individuals of health, home and community. The proposed budget cuts would affect the delivery of supportive housing services which have historically been a means of housing stability for persons with chronic behavioral health conditions. Supportive housing services have provided and enabled individuals to engage in supportive services like case management, medical services, and medication stabilization. It is also a means to ending a cycle of chronic homelessness. Once individuals have stabilized they are now able to engage in self-sustaining activities such as employment.

The Department of Human Service identified that from March, 2019 through November, 2020 22,972 individuals were served through their regional human service centers. Of those individuals, 47% of their caseload consists of individuals that have a primary diagnosis of serious mental illness and 42% who have a co-diagnosis of mental illness and substance abuse. They have identified their model for service as based on quality services, proven results, person centered and services provided closer to home. It was also identified that housing was part of the behavioral health re-design. We feel that supportive housing fits that model.

When an individual does not have stable housing options, they are more likely to seek higher levels of services such as hospital admissions, find themselves in unsafe environments, involved with law enforcement, incarcerated or accessing other emergency services. These levels of service have a much larger fiscal impact. Cooper House is a 42 bed permanent supportive housing facility. The first half of the current biennium we received reimbursement of $272,200 for this service or approximately $6481/person. If you compare this cost to the US Interagency Council on Homeless figures which identifies the cost to taxpayers for chronically homeless persons being as much as $30,000 to $50,000 per year, you understand our concern of the impact to our state if we do not continue to fund these services.

We would like to share a couple stories of individuals that would be impacted by the loss of supportive services. This male tenant has lived at Cooper House since 2018. Prior to moving to Cooper House he had been staying at Churches United, a local homeless shelter. He had multiple misdemeanor

drug/paraphernalia, simple assault and criminal trespass charges. He stated that the biggest benefit of having housing is that he is now able to prepare his own food and "eat a little every day". "I am able to stay in one place and no one bothers me like when I was homeless, sometimes I even had to sleep on the bus". When asked about the importance of having staff in the facility to provide supervision he stated, "If there was no staff here the neighbors would eat me alive. Staff keeps me safe if anyone gives you a hard time you tell staff." He further stated in response to the question regarding what it would be like without staff in the building, "It would be very dangerous if staff weren't here. Staff help by checking them out before they come in". Since moving into Cooper House, the tenant is no longer engaging in use of illegal substances and does not consume any alcohol. He has had no new criminal charges. His intensive case management team is able to do outreach with him as they are able to find and assist in his coordination of care regarding his physical, medical and mental health needs.

This 69 year old female has lived at Cooper House since 2012. She expressed how living in permanent supportive housing has been beneficial to her not only for safety but also the assistance of staff in meeting her basic needs. She also expressed concern about non tenants staying in Cooper and the fear of crime in the building if there were not staff in the building monitoring the activity. She stated, "You have to look out for vulnerable people of my age who don't drink and need a place, who aren't ready for nursing homes." This tenant struggles stabilizing her mental health. She responds to her delusions or hallucinations which has caused her to be evicted from other housing options. The tenant works with the Copper House staff on emotional coping support, coping skills and distress tolerance. She is seen regularly by Case Management from Southeast Human Services. This is the longest the tenant has been able to maintain housing.

Edwinton Place is a permanent supportive housing project located in Bismarck. It is similar to Cooper House in Fargo and LaGrave in Grand Forks. It has been open since November, 2020. This program is currently providing housing for 42 individuals and is in need of similar funding for supportive services. We are requesting that this bill would be amended to include this program. All three programs were developed based on identified need in their respective communities. All three programs serve an underserved population and provide a very vital infrastructure that allows services to be introduced to individuals that have great need.

Also identified in the budget cuts is a 10 bed harm reduction, long-term supportive housing program for persons with persistent mental illness and/or chemical dependency located in Bismarck, Gerridee's Place. Individuals receiving services and supports at this location have an extensive history of use of emergency services, engagement with law enforcement and the judicial system. It was opened in 2014 to accommodate a request for a need by West Central Human Services. This program serves individuals at any stage of recovery and implements services that would allow more individuals access with fewer barriers to services and housing while maintaining safety. This service meets the individual where they are in their recovery, provides secure shelter, gives encouragement to remain clean and sober and works with their care team on recovery skills, reduction in harmful behaviors and practice healthy living. In addition, this facility has 4 independent living apartments which allow individuals to still receive support in their recovery process while maintaining their independence. Individuals that have or are currently receiving services have experienced a significant reduction in hospitalization and encounters with law enforcement.

An original tenant that entered this program in 2014 has since moved into independent living in the community. They receive 2 hours per week from Community Case Aide services and Case Management supports and have maintained their recovery. Another original tenant has transitioned into an apartment within the facility and receives medication monitoring from the program. When they are experiencing a lapse in recovery, they still have availability of supports through the Mental Health Staff at Gerridee's. Based on current wait lists for housing vouchers, past criminal history and/or past landlord issues, most individuals will have difficulty finding other housing options and will still need intensive supports.

It is our understanding that the 1915i State plan for Home and Community Based Services has been mentioned as a possible source of funding for some of the supportive services. We feel that this will be a very beneficial avenue for funding and contribute to client stability. The information provided regarding reimbursement for services through the plan would require direct service tied to a specific individual and not support the indirect or group services. Staff can assist individuals to become eligible 1915i when and wherever possible. When reviewing our current tenant roster for Cooper House, we believe that only approximately 10 of the 42 individuals will qualify for 1915i services. While this may augment the current services, once they meet the maximum hours of service and/or score less than 50 on the WHOAS that funding will not be available and the program need will remain without the needed funding.

We also know that with all new programs and funding sources there is always a transition period that identifies opportunities but also sometimes does not meet the overall needs of the program as expected. As we walk through this process with the Department of Human Services, we request that the current funding for supportive housing services be maintained. We would offer that based on last biennium's granting process as other funds become available through 1915i, the programs draw-down would be reduced but without the current funding these supportive services cannot be maintained. We understand that budgets are a concern as we live by them as well but we also know that we serve a very vulnerable population that if not served only impact other services.

We are in support of the mission of the Department of Human Services of "Timely and effective behavioral health services to citizens of North Dakota to improve the quality of life through achieving and sustaining recovery". We just need time to transition and get there with them.

Thank you for your time and consideration of our request to fully fund the supportive housing programs of LaGrave, Cooper House, Gerrideee's Place and Edwinton Place.

SENATE APPROPRIATIONS COMMITTEE

TESTIMONY

Committee Chair Holmberg and Members of the Committee, my name is Kandia Qual, Program Director for the Dacotah Foundation in Fargo. I am here to give testimony in opposition to the budget cuts made to mental health services offered in HB 1012.

Cooper House permanent supportive housing is a proven, cost-effective, person-centered, and humane way to provide stable homes to individuals who have difficulty finding and maintaining housing due to their on-going struggles with severe mental illness, substance use, vulnerability, or previous traumas.

Supportive housing creates stability in the lives of its residents, allowing individuals who have often spent years living on the streets to live full, rewarding lives integrated into the community. Supportive housing allows residents to engage in services that previously they may not have engaged in due to being overwhelmed with trying to find where they would safely lay their head that night or where their next meal would come from. It allows service providers to locate individuals on a regular basis to provide engagement and build motivation for change through offering assistance with their mental health and physical health concerns. It provides individuals a safe and secure home, protecting them from being taken advantage of, trafficked, assaulted, or victimized as often occurs with many homeless individuals.

Having staff present 24/7 in supportive housing projects contributes to the overall success in resident's ability to maintain their housing and supports the movement towards larger goals of addressing their mental health or substance use concerns, obtaining employment or educational goals, and eventually moving out to mainstream housing through a variety of services and supports that our staff provides.

Based on my professional involvement with Cooper House since its origination in 2010, I can attest to the essential nature of the services provided by staff within the Cooper House program and how those services directly contribute to the success of the residents.

The 24/7 staff provides a vast array of services to support the safety and well-being of the residents that live at Cooper House. These services occur 24 hours a day, and can not be safely restricted to just certain hours of the day. The residents seek support or need interventions at all hours of the day and night. Some of the specific services the 24/7 staff provide are as follows:

- Welfare checks in the apartments
    - If a resident has not been seen for 24 hours or if there is a concern voiced staff go to the resident's apartment and enter the apartment to check on the well-being of the resident, and provide mental health or medical interventions if necessary
- Front door security and check-in of residents
    - Staff monitor everyone that enters the building for the safety of all. This assures that individuals that are not allowed on the property do not gain access to the building. Staff also conduct belongings searches to assure weapons, drugs or contraband aren't being brought in by residents.
- Managing visitors and interventions with disruptive visitors
    - Staff monitor visitors entering the building to assure they aren't bringing in alcohol or contraband and that they are allowed in the building. If a visitor is disruptive or unruly or putting a resident's housing at risk through their actions the staff intervene and ensure they leave the building.

- Referral and linkage to outside agencies for service options
    - Staff are familiar with and make referrals/contacts to community-based service agencies. Staff also facilitate person-to-person introductions and a warm hand-off to service providers from agencies the resident isn't familiar with. This assists in better engagement and participation in supportive services that will decrease the intensity of their emergency services usage and improve the overall quality of their lives
- Emergency medical interventions
    - Many individuals have complex medical concerns or physical issues that cause falls or injuries. Staff are aware of these concerns and watch for deterioration or falls/injuries, and assist in accessing emergency services if necessary, provide basic first aid when necessary, and coordinate with the part-time on-site nursing as needed.
- Mental health crisis interventions
    - Staff provides on-site, in the moment, mental health support to individuals struggling with the negative symptoms of their illness. Staff are able to model, coach, and prompt coping skills, remind individuals what their recovery plans indicate they should do in a crisis, and assist in accessing outside clinical supports when needed. These interventions often drastically decrease the use of emergency services and placement in higher levels of care.
- De-escalation interventions for aggression and/or violence
    - Situations arise where individuals aren't getting along for various reasons and aggression or violence escalates. During these situations, staff intervene with therapeutic intervention techniques to de-escalate the situation if possible and involve emergency services when needed.
- Coordination to withdrawal management services
    - As part of the harm reduction model Cooper House follows, we assist in coordinating transfer and admission to withdrawal management services when individuals are attempting to obtain sobriety or having substance withdrawal concerns
- Assist in managing noise or disruptive behavior concerns in the building
    - Individuals in this population often do not realize when their behaviors are disrupting to the peaceful living of others, such as loud music, knocking on doors in the middle of the night, shouting down hallways, etc. Staff intervenes when there are situations reported or observed and coaches individuals on appropriate behaviors when living in multi-person housing situations.
- Allocate and distribute donated food items
    - There are several food services such as donated food bank food items, meals on wheels, and community-provided meal nights at Cooper House. Staff assists with coordinating these events when they occur, monitoring the events for disruption, dispersal of donated food items, and dispersal of meal on wheels meals.
- Safety planning with outside entities for residents struggling with symptoms of mental health
    - Cooper House collaborates with many other entities in the Human Services, Social Services, and Medical fields to formulate safety plans and engage individuals in their safety plans for their mental health or physical health concerns. These plans contribute to the overall safety and well-being of each resident.
- Psychosocial support activities
    - Staff facilitate recreational groups to best support each individual's recovery plan or harm reduction steps

- Informal skills training for daily living skills and mental health symptom management
    - As individuals express symptoms, fears, desires, wants, or needs to staff in day-to-day interactions, the staff provide support for those ideas, goals, and coping skills. Staff do this through mentoring, education, and role-playing. They approach this from a skills integration perspective to better prepare residents to meet their goals for social situations, employment, and mainstream housing.
- Support a harm reduction model for substance use
    - Staff educates individuals on the concepts of harm reduction, working together to create plans that support safer living choices while they contemplate their substance usage options.

Cooper House serves a population that is known to be highly vulnerable due to their cognitive disabilities, mental illness, substance use concerns, and or the trauma they have endured at various points throughout their lives. Most individuals have been chronically homeless due to being evicted from previous residences multiple times due to symptoms of their mental health, behaviors from chronic intoxication, a lack of assertiveness skills where others have exploited them, or have even been sex trafficked in their own homes.

This population requires the services of 24/7 staff in the building for the many safety reasons mentioned above. Staff needs to be available 24/7 to provide person-centered services 'in the moment' that will allow residents to maintain their housing despite these reoccurring behaviors and concerns while they learn and develop the skills necessary to transition to and maintain housing in the mainstream community.

The proposed cuts to HB 1012 would directly impact the ability to continue these essential services as we would not be able to sustain the 24/7 staffing pattern that is currently in place. Currently, Cooper House has 1 staff on per shift, 24/7, through utilizing the full DHS budget we are allotted. That 1 individual staff person performs all the duties noted above throughout their shift to provide services and safety to 42 residents. A change in staffing would leave the building without a front door staff for periods of time during the day which would result in increased safety and welfare concerns. It would also potentially decrease resident engagement in other supportive services intended to enhance the quality of their lives. Staff are often the bridging factor to residents accessing and utilizing these services. They often introduce service providers and build engagement and trust towards providers through the staff's relationships with the residents. Staff also remind residents to stay home for in-home appointments if they are attempting to leave the building around an appointment time and staff reach out to the resident when a service provider can't make contact with them. This would not be possible without the staff present to see and engage with the residents on a continuous basis. A decrease in staffing hours would also result in vastly increased demand for emergency services, such as police and ambulance services, as staff would no longer be present in the same capacity to intervene and assist before events reach the level those services are needed.

We know there has been mention of 1915i being a supplement to the funding currently being proposed. However, this is a new funding source that will require eligibility and take time to enroll residents. It is yet to be determined how it may be implemented and assist the Cooper House Program although we have been recently reviewing the service opportunities and eligibility requirements specifically for Cooper House residents.

Within our current population of 42 residents, there are only 10 individuals that meet the WHODAS scoring of 50 or greater that is required to be eligible for services. There are 21 individuals that have a WHODAS score of 25-50, so 74% of the overall population at Cooper House has moderate to high intensity service needs based on WHODAS scoring, but few actually qualify for the services 1915i would provide. The 10 individuals that would potentially be eligible for services would have a limit of 156 hours per calendar year of service time and every service must be dosed and performed for that specific resident so 1915i wouldn't cover most of the day-to-day general safety and procedure tasks the 24/7 staffing completes.

There is also the concern of the resident needing to be willing to participate in the 1915i services. Housing first models such as Cooper House can not require service participation to obtain the housing. Many residents that enter permanent supportive housing programs require intensive engagement strategies even long after they move in to build trust and motivation to engage in services. Even once eligibility and service authorizations have been established, the attendance of the residents at their services would likely be very sporadic based on their mental health, physical health, and substance usage concerns at the time. Most individuals entering this level of supportive housing are in engagement or pre-contemplative stages of change which contributes to why they score as high as they do on the WHODAS. They often aren't considering changes yet and simply want safe housing or they are just beginning to think about making changes. It takes time to build motivation and help them move through to active stages of change where they have the internal desire and commitment to following through on services regularly. With 1915i reimbursement, there is only reimbursement allowed if a resident is present and participates in the prescribed services. It is predictable, based on clinical stage of change and current follow through at other required appointments concerning their housing and medical, there would likely be a high no-show or cancellation rate which would then prohibit any reimbursement for that scheduled staff time.

For example, an individual may be prescribed 2 hours of care coordination 3 times per week based on their WHODAS scoring and the areas of functional needs. That individual could be scheduled for a 2 hour session on Monday, Wednesday and Friday in a particular week. On Monday, the individual left early in the morning to run errands and because of their traumatic brain injury, by noon they didn't remember they had a session so they didn't return to Cooper House until that evening and missed their session. Tuesday night that resident used substances and weren't feeling well on Wednesday and refused to meet when staff came to the door. Friday that individual was home and met with the staff but due to their symptoms of mental health, they became paranoid about the questions being asked while working on their care plan and they ended the session after 30 minutes. For that individual, the staff are able to bill for reimbursement of 30 minutes of services out of the 6 hours that they were scheduled for. This would be a fairly typical example of service or appointment attendance for the population residing at Cooper House and the typical stage of change most individuals that require this intensity of support are in.

1915i will be a very positive support for the expansion and growth of service opportunities for individuals within the program and the long-term benefits and opportunities to residents overall. The added service options will allow more individuals to build skills through intense 1:1 services which would allow them to transition more easily to mainstream housing. However, it is questionable how it will apply to the majority of the Cooper House population or be a secured steady reimbursement for the funds that are proposed to be eliminated from the current funding. Without full funding for 24/7 staffing, which only covers 1 staff person on duty 24/7, the safety, security, and intentions of the program would be immensely compromised.

We are requesting that consideration be given to maintain the current funding for Cooper House. We feel this is essential for the continued operation of Cooper House and the program's ability to serve the intensity of the target population in a safe and effective manner. Thank you for your time and consideration of our request.

8459

Testimony in Opposition of HB 1012
Senate Appropriations
Chairman: Senator Ray Holmberg
March 10, 2021

Submitted by: Dan Madler, Chief Executive Officer - Beyond Shelter Inc. (BSI), 701-730-2734, dmadler@beyondshelterinc.com, Lobbyist #30

Chairman Holmberg and members of the Committee, my name is Dan Madler, I live in ND District 27 and I am the CEO of Beyond Shelter, Inc. (BSI), a mission driven North Dakota nonprofit developer of affordable housing. I would like to express my opposition to House Bill 1012 as it is submitted to the Senate.

As submitted HB 1012:

- Does not adequately fund supportive services for three Housing First Projects; Cooper House, located in Fargo, ND, LaGrave On First, located in Grand Forks, ND, and Edwinton Place, located in Bismarck, ND and without this funding, the three Housing First Projects will not be successful

- Assumes that the 1915i re-alignment will make up the funding shortfalls. As you have heard and will hear others testify, this will not be the case. Currently a majority of the Chronic Homeless individuals/households currently housed at Cooper House, LaGrave On First, and Edwinton Place are not able to score high enough in the six (6) domains of the WHODAS 2.0 assessment to be eligible for Housing Supports offered under the current 1915i State Plan.

Housing First:

- Provides Permanent Supportive Housing to chronic homeless, individuals/households who have complex medical and emotional needs and who create the biggest financial burden on local medical, law enforcement, and service providers (i.e., WCHSC, SEHCS, NEHCS)

- You have the data, and the data and evidence are clear, Housing First saves North Dakota, ND Communities, and ND taxpayer's money (see Housing the Homeless North Dakota's 10-year plan to End Long-Term Homelessness, Cooper House Impact Report, and Cooper House Financial Community Impact handouts submitted online)

- Projects (Cooper House, LaGrave On First, and Edwinton Place) make WCHSC, SEHSC, and NEHSC more efficient and effective when providing services to Chronic Homeless individuals/households

1915i WHODAS 2.0 mismatch to VI-SPDAT:

- The **VI-SPDAT** is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available. This is the screening tool most often utilized by Cooper House, LaGrave On First, and Edwinton Place, yet as stated earlier, currently a majority of the Chronic Homeless individuals/households currently housed at Cooper House, LaGrave On First, and Edwinton Place are not able to score high enough in the six (6) domains of the WHODAS 2.0 assessment to be eligible for Housing Supports offered under the current 1915i State Plan. **Question**, is there a mismatch?

In summary I would say that now is not the time to cut supportive services to Cooper House, LaGrave On First, and Edwinton Place and I respectively request that this committee:

- Preserve the **$22.6 Million** in total development costs that have been invested to provide the 124 Housing First homes (Cooper House – 42 homes, LaGrave On First – 42 homes, and Edwinton Place – 40 homes)
- Do no harm and fund Cooper House at **$570,000 for the 2021-2023 biennium**
- Do no harm and fund LaGrave On First at **$515,000 for the 2021-2023 biennium**
- Do no harm and fund Edwinton Place at **$640,000 for the 2021-2023 biennium**
- request that DHS work with the Providers to determine if there is a mismatch between the 1915i WHODAS 2.0 and VI-SPDAT

Note: the above total investment request = **$1,725,000** which is an increase of **$800,000** from the 2019-2021 base level funding, and which allows for a period of transition to utilizing 1915i as a possible funding source for Housing First Projects

Thank you for your time and consideration.

8460

Housing the Homeless

North Dakota's
10 - Year Plan to End
Long-Term Homelessness

Prepared by the
North Dakota Interagency Council on Homelessness

October 31, 2018

Office of Governor Doug Burgum
State of North Dakota
600 East Boulevard Avenue
Bismarck, ND 58505

RE: Final Report—North Dakota 10-Year Plan to End Long Term Homelessness

Dear Governor Burgum,

A lot has changed in North Dakota since 2008 when the *North Dakota 10-year Plan to End Long-Term Homelessness* was drafted. The entire state has experienced a catalyst of economic prosperity as people from around the world came to find their fortune, some with nothing more than a few personal belongings and a desire for a better life. As the population and demographics of the state shifted, it remains the North Dakota Interagency Council on Homelessness's belief that every North Dakotan should have the opportunity to succeed in life, and have a safe and stable environment to call home.

The 10-year plan formalized collaborative efforts between seven state agencies, one statewide homeless coalition, and the communities of Bismarck, Fargo and Grand Forks, developing goals and strategies to end chronic homelessness. Creating permanent supportive housing was the primary focus with a secondary focus on providing outreach and prevention services. As improved data provided insight into the multi-faceted challenges vulnerable populations' experience, outreach, prevention and support services became just as critical as housing.

Great strides have been made. However, the efforts to end homelessness continue. Generational poverty must be actively combatted, and youth need stability in order for them to succeed in school and be given the best possibility to grow into self-sufficiency. The chronically homeless need access to more rapid housing projects and customized support services. The safety net also needs to be cast wider for justice-involved individuals, and those facing mental and behavioral health issues. And, we cannot forget about how we can help our senior population age in place and provide resources for families experiencing frequent, short-term homelessness.

The Interagency Council on Homelessness's report highlights the work that was completed over the past decade, it profiles the state most vulnerable populations, and it outlines our recommendations to continue to prevent, reduce and end homelessness.

Respectfully submitted,



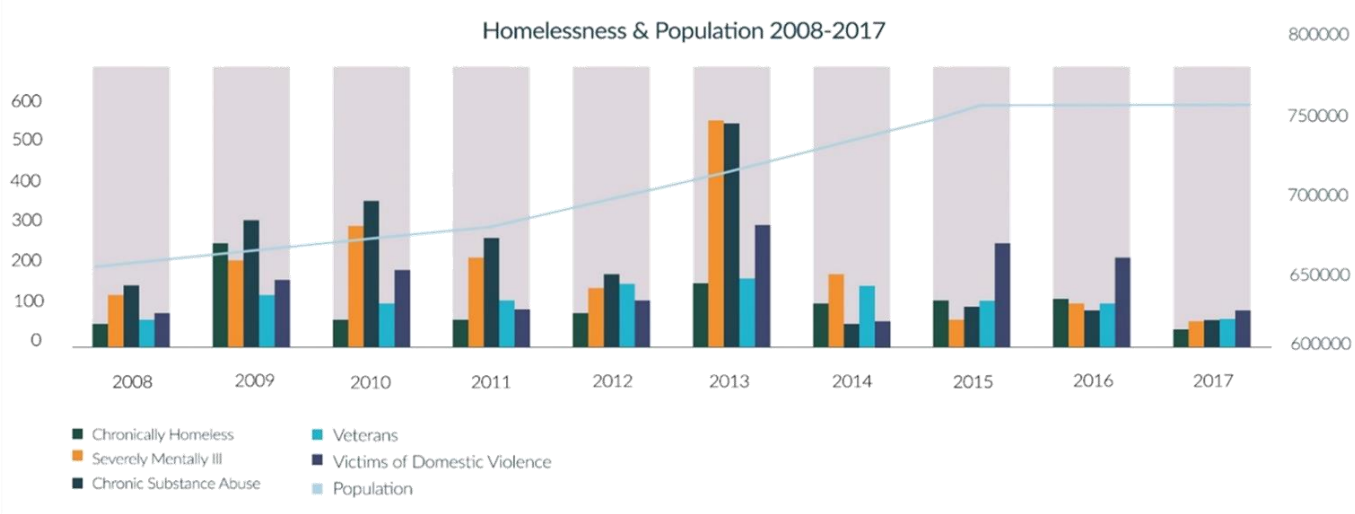
Jolene Kline, Chair
North Dakota Interagency Council on Homelessness

Executive Summary

Executive Summary

North Dakota's vulnerable populations require person-centered approaches to address their unique needs based on their current living situation, physical and mental health, and financial stability. In 2008, when the *North Dakota 10-Year Plan to End Long Term Homelessness* was implemented, North Dakota's primary focus was on permanent supportive housing for the chronically homeless. Although housing stability is the foundation of ending homelessness, over the past decade supportive services have become just as essential to prevent and reduce both short-term and chronic homelessness.

Counting the state's homeless populations is extremely difficult due to multiple definitions of homelessness, the mobility of the population, rural isolation, and the cyclical nature of homelessness for many individuals and families. In addition, people experiencing homelessness are often reluctant to identify themselves as such, therefore, many do not seek assistance. The U.S. Department of Housing and Urban Development (HUD) requires local service providers to conduct a Point In Time (PIT) Count every January to track sheltered and unsheltered men, women and children. North Dakota's 2017 PIT count totaled 1,089 homeless men, women and children, of which 45 were chronically homeless.



According to the U.S. Interagency Council on Homelessness, chronically homeless persons cost taxpayers as much as $30,000 to $50,000 per year. The cost is calculated based on services utilized such as hospitals, shelters, jail, psychiatric centers, and alcohol and drug treatment. Using the base national average of $30,000, North Dakota taxpayers spent approximately $1,350,000 million in 2017 on the state's chronically homeless population. Permanent supportive housing is estimated to lower that cost by 40 percent. Currently, two 'Housing First' facilities, where chronically homeless individuals are rapidly housed, exist in Fargo and Grand Forks. Although proven highly successful in conserving community resources, these projects are difficult to construct as conventional financing is not an option. Developers must leverage numerous federal, state and local financing programs, and solicit donations and private sector partnerships to structure the zero-debt financing the projects require. Low- and extremely low-income individuals can receive rental assistance which helps ensure rental income, unfortunately, only about one in four people who qualify for housing assistance actually receive it due to limited availability.

The North Dakota Interagency Council on Homelessness (NDICH) studied vulnerable populations based on their current housing situation, mental and physical wellbeing, family disposition, and justice involvement. Each of these populations can have safety nets in place that would effectively prevent or shorten their experience with homelessness if resources are effectively implemented.

- ***Chronically Homeless***—individuals and families residing in a place not meant for human habitation, in an emergency shelter, and who have been homeless and residing in such a place for at least one year or on at least four separate occasions in the last three years. North Dakota averages 138 documented chronically homeless individuals every year. The greatest concentration of community resources is spent on this population with most self-diagnosed as severely mentally ill or having chronic substance abuse problems.
    - State and federal funding is critical for financing permanent supportive housing.
    - Person-centered services are needed to stabilize these individuals and reintegrate them back into the community.

- ***Justice Involved***—persons with mental illness and substance abuse problems are overrepresented in our jails and prisons as compared to the general population. Deinstitutionalization, along with a failure to develop easily accessible and useful outpatient alternatives for treatment, has led to correctional facilities housing the highest concentrations of people with mental health and substance abuse concerns in the country.
    - Incarcerated individuals do not get the depth of mental health and addiction recovery services needed to become stable and sober after their release.
    - Difficulty finding affordable housing and employment, especially for felons such as sex offenders.

- ***Native Americans***—the magnitude of Native Americans experiencing homelessness on and off of the reservations is more than likely higher than the 21 percent currently reported. Reservations have the highest concentrations of extreme poverty in the state, and approximately half of all Native American children living in North Dakota are impoverished, more than five times the rate of other races. Over-crowding and inadequate housing conditions put stress on quality of life, as the majority of Native Americans will not force members in their household out if they do not have another housing option.
    - Approximately 78 percent of Native Americans live off of reservations to pursue educational and financial stability, however, many of these individuals lack support networks.
    - Historical trauma and assimilation of culture impacts the effectiveness of behavioral health treatment.

- ***Youth***—in 2017, according to the PIT count, there were 178 documented homeless children ages 0 to 18 years. School-age children, ages 5 to 18 years old, experiencing homelessness was reported much higher by the North Dakota Department of Public Instruction with 2,166 students documented as either sheltered, doubled-up with other families, living in a hotel/motel, unsheltered, or unaccompanied by an adult during the 2015-2016 school year. A major contributor to the financial stability and well-being of children is secure parental employment, unfortunately, many working families with children struggle to make ends meet. The poverty threshold considered sufficient for a family of four with two children to afford basic necessities was $24,036. In North Dakota, 21,716 children were living in families whose income was below this threshold.

- Support services in rural and urban areas can help stabilize families and youth lessening the need for relocation and out-patient treatment.
- State and federal funding critical for single-parent housing, providing life-skills support, daycare, after-school care, and career or educational advancement.

- ***Foster Youth***—in a survey of youth that aged out of the state's foster care system, 40 percent will experience homelessness by the time they are 21 years old. Of those experiencing homelessness, one out of every three has been incarcerated. North Dakota has the third highest youth incarceration per capita in the nation. Although the majority of foster youth obtain a GED or high school diploma and are employed, they face many challenges transitioning into adulthood without a strong support network.
    - Explore barriers to short- and long-term housing for unaccompanied, emancipated, and youth aging out of the foster care system.
    - Support services that are trauma, age and developmentally appropriate to mitigate emotional and behavioral deterrents.

- ***Frail Elderly and Disabled***— North Dakota ranks seventh in the nation in the highest proportion of individuals age 85 years and older. Based on the aging population, extended life expectancy, and likelihood of having a disability, it is anticipated that one out of two North Dakotans will need long-term care services such as nursing facilities, basic care, assisted living, swing bed or home- and community-based care in their lifetime. Disabilities includes ambulatory, visual, cognitive and hearing loss. Persons with a disability are more than twice as likely to be living in poverty as individuals without a disability.
    - Explore more options for rural and urban community-based alternatives for persons with disabilities and behavioral health issues.
    - Support grant programs for home modifications allowing people to age in place.

These vulnerable populations are the most housing insecure and cost-burdened, where 30 percent or more of their income is allocated to housing. Employed individuals earning minimum wage need to work 70 hours a week on average to afford a one-bedroom, market-rate apartment in North Dakota, and seniors living on the state's average social security payment alone can afford $400 per month in rent.

Moving Forward

The following recommendations are broad-based and will require dedication and investments from numerous state agencies to ensure vulnerable populations are receiving adequate services to accommodate their unique needs and to reintegrate them back into North Dakota's communities. Some of the recommendations are within the 2018 North Dakota Behavioral Health System Study and the State of North Dakota's Information Technology Department's Citizen Experience Initiative.

Breaking the Cycle of Generational Poverty

To end the cycle of generational poverty, children and their parents both need to be housing stable. Screening mechanisms need to be in place for service providers, primary care providers and school counselors to be able to identify problematic family dynamics and refer them to a case manager based on their current situation and complexity of need.

- Create more wrap-around service based housing programs for single parents with children.
- Expand outpatient and community-based services that are flexible such as peer support, community health workers, in-home and school-based clinical services and substance use disorder treatment services to address the behavioral health needs of children, youth and their families.
- Expand targeted, proactive in-home supports for families with children and youth at risk of foster care placement and justice involvement.
- Develop a streamlined process for homeless liaisons located in school districts across the state to be able to refer a case manager to assist families in accessing housing in both urban and rural communities.

Children that are not housing stable, are within the foster care system, do not graduate from high school, or have mental health or substance issues have a much higher probability of needing public assistance as an adult. Early detection and prevention are the best methods to help youth navigate difficult living situations.

- Explore barriers to create emergency shelters, low barrier housing, host homes and other short- and long-term housing options for youth and young adults who are unsheltered, fleeing an unsafe situation, or experiencing a housing crisis.
- Coordinate entry processes and support services that are trauma, age and developmentally appropriate.
- Review state and federal policies and processes impacting unaccompanied youth as well as youth aging out of the foster care system to determine any barriers that can be eliminated.

Lessening the Cost

Some individuals have complex medical and emotional needs, which prohibits their ability to live on their own without a social network assisting them. These individuals are classified as the chronically homeless and create the biggest financial burden on local medical, law enforcement and service providers.

- Finance more Housing First facilities creating more homes to stabilize the chronically homeless and provide funding for support and operations expenses.
- Explore the cost and benefit of funding "harm reduction" shelters, where residents can consume substances or come into a shelter under the influence of drugs and alcohol.
- Create consistent funding for state housing and service programs such as Housing Incentive Fund and the North Dakota Homeless Grant.

Government Efficiencies

The key to enhancing government efficiencies is to establish a systematic approach of clearly defined and repeatable steps where outcomes can be evaluated to generate consistent, optimum results. State agencies and local service providers are well connected and reach out to one another for assistance for the individuals and families they are helping, but most agencies expressed the need for more collaborative efforts to leverage resources and to be more responsive.

- The NDICH should be expanded to represent more stakeholders within government agencies, service providers and individuals and families that have experienced homelessness.
- Identify barriers preventing state agencies from accessing and leveraging HUD’s Homeless Management Information System (HMIS).
- Map the entry points for vulnerable populations and how they transition throughout state agencies and local service providers.
- Identify local, state and federal policies and regulations that hinder vulnerable populations and prioritize actions for change.

Covering the cost of public assistance is challenging for federal and state government and at the local community level. However, there are ways for the state to access additional federal funding through Medicaid to provide direct support to individuals and families.

- Pursue 1915(i) Medicaid state plan amendments to expand community-based services for vulnerable populations.
- Review long-term care facilities placement policies and explore options for community-based alternatives for persons with disabilities and behavioral health issues.

Client-Focused Delivery System

In order to expedite information gathering and to ensure current and accurate information is available, the state needs a consistent, end-to-end experience across all channels and departments where information can be obtained for any service, on any device and at any time. State agencies and local service providers expressed challenges they have noticed in their specific area and feedback from clients. Below are some of the ideas that were recommended:

- Housing Inventory - create an affordable housing inventory for each community/region
- Housing Forms - create a single form used by all regional housing authorities
- Database - create profiles for each client within a centralized database, so individuals or families applying for state or local benefits do not have to re-enter information
- Privacy Laws - review state privacy laws to ensure clients are protected, but at the same time do not hinder state agencies from accessing the information they need to be able to help a client that is transitioning services from one state agency to another.
- Consent Form - create a consent form signed by the client to release information to all state agencies and case managers
- User Profile - create an app or web portal where clients can enter their information that is stored and they can return at any time to complete.
- Online Chat - through an app or web portal, create an online chat function for clients to ask questions and be directed to the correct state agency or local service
- Services Portal - structure website into user categories and group information based on the client scenario, such as homeless or risk of becoming; searching for housing, employment or daycare, needing social services, youth, tribal, etc.

North Dakota's Plan to End Homelessness

North Dakota's Plan to End Homelessness

In 2004, President George W. Bush established a U.S. Interagency Council on Homelessness (USICH) to develop and implement a comprehensive, national approach to end chronic homelessness in America. That same year, President Bush and USICH issued an unprecedented collaborative effort between the U.S. Department of Housing and Urban Development (HUD), U.S. Department of Human and Health Services (HHS) and the U.S. Department of Veteran Affairs (VA) to make both permanent housing and supportive services funding available in a coordinated effort.[1] This was the initial investment towards developing a comprehensive national strategy to end chronic homelessness in 10 years.

At the state level, Gov. John Hoeven created the Governor's Interagency Council on Homelessness (NDICH) which consists of seven state agencies and one statewide homeless coalition, and the communities of Bismarck, Fargo and Grand Forks.[2] The intent of NDICH was to coordinate government policies, identify best practices, analyze individual and family needs, educate stakeholders, and solicit input from the faith and advocacy communities, businesses and the general public to prevent and end homelessness in North Dakota.[3] In 2008, NDICH finalized *North Dakota's 10-Year Plan to End Long Term Homelessness.*[4] A consortium of hundreds of individuals from state agencies, tribal nations, community and state stakeholders, and planning organizations participated in community forums, research studies and planning sessions.

Emphasis was placed on creating permanent housing and supportive services for the men, women, and children who would experience long-term homelessness during the next 10 years. North Dakota's goal was to assist local communities in providing housing, rent subsidies and supportive services, with a benchmark of creating 50 new permanent supportive housing (PSH) units each year to eliminate homelessness across the state. In order to reach this goal, five strategies were developed:

Strategy 1: Develop Permanent Supportive Housing

- Develop non-federal sources of "soft money"
- Create additional permanent supportive housing units
- Create partnerships between developers and service providers

Strategy 2: Improve the Ability to Pay Rent

- Eliminate barriers to employment
- Identify new sources for rent subsidies
- Improve access to mainstream supports (entitlement programs)

Strategy 3: Expand Supportive Services to Wrap Around Housing

- Connect supportive services to housing
- Prevent individuals from transitioning into homelessness or uncertainty

[1] U.S. Interagency Council on Homelessness Historical Overview. Retrieved from www.usich.gov/resources/uploads/asset_library/USICH_History_2016.pdf

[2] North Dakota Interagency Council on Homelessness. Retrieved from https://www.governor.nd.gov/boards/BoardDetails.aspx?boardid=124

[3] Exec. Order No. 2004-09 (2004). Establishing the Governor's Interagency Council on Homelessness.

[4] North Dakota's 10-Year Plan to End Long Term Homelessness. 2008. Retrieved from www.ndhfa.org/Publications/Reports/Partner%20Publications/ndich_finalplan.pdf

Strategy 4: Strengthen Prevention and Outreach Programs

- Emphasize protocols to close front door into homelessness

Strategy 5: Collect and Disseminate Data Relating to Long-Term Homelessness

- Collect information on homeless populations and services provided
- Market and measure progress

NDICH agencies assigned to specific goals within each strategy:

Job Service of North Dakota	JSND
North Dakota Department of Corrections & Rehabilitation	NDDOCR
North Dakota Department of Commerce	NDDOC
North Dakota Department of Human Services	NDDHS
North Dakota Housing Finance Agency	NDHFA
North Dakota Indian Affairs Commission	NDIAC
North Dakota Department of Public Instruction	NDDPI
North Dakota Coalition for Homeless People (private organization)	NDCHP

Progress reports were created in 2010 and 2013 and can be viewed on the NDHFA website.[5] The 2018 report captures the accomplishments over the past decade, lessons learned about the complexities of homelessness, challenges faced by the most vulnerable populations, and recommendations moving forward.

[5] NDICH homelessness reports 2008, 2010 and 2013. Retrieved from www.ndhfa.org/Publications/Resources.html

Accomplishments 2008-2018

Accomplishments 2008-2018

Seven state agencies were assigned to specific goals and strategies in the 10-year plan, but the majority of the accomplishments were achieved through partnerships between the agencies and local service providers consisting of faith-based and non-profit organizations working directly with the homeless and vulnerable individuals and families. The following are highlights of accomplishments achieved through this collaborative initiative.

Strategy 1: Develop Permanent Supportive Housing

Units

In 2008, the original goal was the creation of 50 new permanent supportive housing (PSH) units per year to reach the goal of 461 new PSH units by 2018. Across the state, NDICH members, service providers, and the private sector were involved in the construction or rehabilitation of 1,855 rental units for extremely low-, low-, and moderate-income individuals and families. Twenty-four percent of the units were PSH and 10 percent were allocated specifically for homeless individuals. Table 1 breaks down the type of units constructed or rehabilitated since 2008 by region. Figure 26 on pg. 35 is a map of the eight regions.

Housing Units Constructed or Rehabilitated With State Agency Involvement

	Permanent Supportive Housing Units	Homeless Units	Elderly Units	ADA Units
Region I	37	0	143	15
Region II	52	17	67	34
Region III	12	6	25	9
Region IV	50	42	7	17
Region V	133	60	344	106
Region VI	15	0	130	15
Region VII	96	46	69	36
Region VIII	53	13	211	45
State Total	**448**	**184**	**996**	**277**

Table 1. Housing units constructed or rehabilitated with state agency involvement, 2008-2017. Source: NDHFA

PSH encompasses the 'Housing First' model of rapid placement of homeless individuals into independent and stable housing, and serves as a platform from which they can pursue goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending anything less critical, such as getting a job, budgeting properly, or addressing to mental and behavioral health issues.[6]

Two Housing First, PSH projects were completed and are leased-up. In 2010, the Cooper House in Fargo was the first Housing First complex in the state and was made available exclusively to individuals who were documented as chronically homeless. The 42-unit PSH project was recognized by the National Association of Housing and Redevelopment Officers with a best practices award. The Cooper House become the template

[6] National Alliance to End Homelessness: Housing First. Retrieved from https://endhomelessness.org/resource/housing-first/

for LaGrave on First located in Grand Forks, which also provides 42-units, and opened its doors in 2018. At the time of this report, construction started on the Edwinton Place, a 40-unit complex in Bismarck.

Another proven model deployed is PSH housing for single parents and their children with the intent of transforming families from poverty to prosperity two generations at a time. The Jeremiah Program in Fargo prepares determined single mothers to excel in the workforce, readies their children to succeed in school and reduces generational dependence on public assistance. The Jeremiah Program apartments opened its doors in 2018 to serve 20 low-income families. In West Fargo, ground was broken for Grace Gardens which will provide shelter for 30 women and children seeking refuge from domestic violence. Grace Gardens will assist women to become stable and independent, while providing a safe and nurturing space for the children to attend daycare and after school programs.

Funding PSH

It is virtually impossible for developers to build units that are affordable to low- or extremely low-income individuals with only conventional financing. Lenders loan money for housing development based on the anticipated property income, and when rents are set to affordable levels, there is a huge gap between the money needed to build and the money lenders and investors provide. Most affordable housing financing deals involve a mortgage, tax credits and two or three other sources of money, however, it is not uncommon for developers to rely on upward of 10 financing sources as they try to fill the gap. Low- and extremely low-income individuals can receive rental assistance which helps ensure rental income, unfortunately, only about one in four people who qualify for housing assistance actually receives it.[7]

Funding PSH involves creative financing strategies and invested partners providing federal, state, local and private sector resources. Federal funding administered by NDHFA and NDDOC includes National Housing Trust Fund, Low Income Housing Tax Credits, Neighborhood Stabilization Program, HOME Investment Partnerships Program, Community Development Block Grant, and Emergency Solutions Grants. State funding sources include the North Dakota Homeless Grant and the Housing Incentive Fund (HIF).

HIF is a North Dakota based tax incentive providing critical gap financing for the construction, rehabilitation and preservation of multi-family housing targeted to essential service workers and low- to moderate-income households. HIF has been an instrumental tool in financing housing for individuals with disabilities, who are elderly, and those experiencing homelessness.

In 2011, the North Dakota State Legislature created HIF as a financing tool for taxpayers to receive a state income tax credit and help thousands of people who might otherwise have been priced out of the state's housing market during the peak of energy development. Individuals or corporate contributors received a dollar-for-dollar credit against their state income liability for the year they contributed. Contributions could be targeted to a specific project, community or region when applicable.

Over the course of six years, NDHFA allocated more than $89.6 million in HIF funding to 77 projects to construct or rehab 2,380 units in 26 urban and rural communities across the state.

[7] How affordable housing gets built (2016). www.urban.org/urban-wire/how-affordable-housing-gets-built



Figure 1. NDHFA Housing Incentive Fund projects awarded each year comparing HIF award amount and total project costs.
Source: NDHFA

Strategy 2: Improve Ability to Pay Rent

Eliminate Barriers

In addition to PSH, landlords must be willing to rent to individuals and families that have a history of justice involvement and financial instability. NDDHS administers the Money Follows the Person (MFP) program, which includes a housing initiative and regional supportive housing meetings to bring housing and service providers together to create successful transitions for vulnerable populations. MFP housing staff created regionally based landlord and service provider training focusing on fair housing, discrimination and service animals. The training also included presentations on current housing developments and programs that are successfully addressing challenges with tenants, community perception, and short- and long-term effectiveness to implement best practices in each region.

In 2018, NDDHS allocated $150,000 of MFP rebalancing dollars to Opening Doors: Landlord Risk Mitigation Fund which is a statewide program emulating a similar program successfully initiated by the Fargo-Moorhead Homeless Coalition. Opening Doors will provide insurance to landlords who lease to vulnerable populations and includes coverage for excessive damages or lost revenue. NDHFA implemented and is administering the program.

Vulnerable populations who are able to work cannot pay rent without securing reliable and sustainable employment. The NDDOCR authorized the Work Release While Incarcerated program at the Missouri River Correctional Center in Bismarck, ND. The program generated over $250,000 in compensation for inmates to secure funding for future housing and supplied the area with much needed labor in construction and food services.

JSND is leading numerous state- and region-based employment initiatives prioritizing individuals who are low-income, receive public assistance, are basic-skill deficient, incarcerated, or a veteran. On-the-job training, classroom training, trade adjustment assistance and building work experience are critical to assisting

individuals to become more self-sufficient and increase their earning potential. Some of the programs incorporate case managers to create a holistic approach for people to become successful. JSND staff also provide outreach to homeless shelters and correctional facilities on a monthly to quarterly basis if agencies are not able to bring their clients to JSND facilities.

In addition to helping individuals, JSND administers the Federal Bonding Program and the Work Opportunity Tax Credit. Both programs are an employer incentive guaranteeing the job honesty of a harder to employ individual by offering a safety net for employer reimbursement of up to $5,000 to hire ex-offenders, recovering substance abusers, and persons with poor credit or lack of work history.

Seeking and maintaining employment can be challenging, especially without reliable transportation. Many local service providers have funds to assist individuals with public transportation costs, however, public transportation is more accessible in urban areas than in rural areas. The NDDOT administers state and federal funding for transit services in rural, small urban and urban areas for individuals who are low-income, elderly or have disabilities to access employment, medical and educational facilities, and any other locations as needed. Figure 3 outlines the NDDOT's public transit provider service areas.

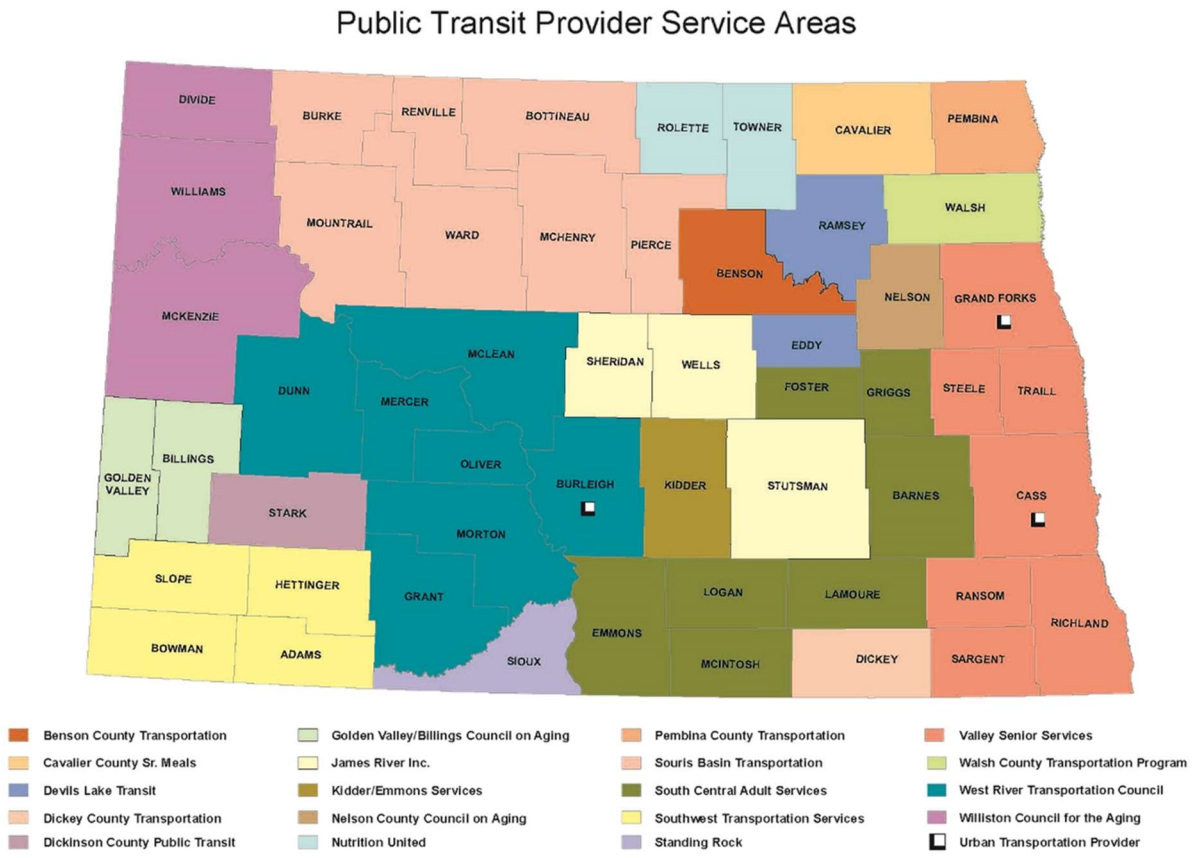


Figure 2. NDDOT Public Transit Provider Service Areas
Source: NDDOT

Rent Subsidies

Regional housing authorities and local service providers have access to funding or housing vouchers issued federally or through state agencies such as NDDOC and NDDHS. The vouchers are intended to assist very low-income, elderly and/or disabled individuals to be able to afford decent, safe and sanitary housing.

NDDOC's Emergency Solutions Grant for emergency shelter and homelessness prevention allows funding to be used for short- and medium-term rental assistance and services to stabilize and rapidly re-house individuals and families. The federal funds are consistently around $450,000 for this program and are distributed annually to more than 20 agencies across the state.

In 2013, the North Dakota legislature appropriated $2 million for the North Dakota Homeless Grant to be administered by NDDOC. The grant was designed after the federal Emergency Solutions Grant, but allowed for more flexibility to address the needs of homeless individuals and provide more rental assistance targeted to PSH. The grant also funds shelter operations, stabilization services, and rapid re-housing. The following biennium, the grant was appropriated $1.5 million and reduced to $300,000 during the 2017-2019 biennium.

HOME Investment in Partnerships program is another federal program administered by NDDOC that has provided subsidies to 666 households, totaling $1.1 million. Tenants can receive security deposit assistance, which contributed $1.2 million to 4,828 households over the past decade.

The U.S. Department of Health and Human Services awarded NDDHS for the Project for Assistance in Transition from Homelessness (PATH) grant. The program provides case management; one-time rental assistance to prevent eviction; security deposit assistance; and representative payee services. Recipients are those who are suffering from mental illness or co-occurring serious mental illness and substance abuse disorders and who are homeless or at imminent risk of becoming homeless. As a preventative measure, the program assists with one to three month's rent. Each of the state's eight regional Human Services Centers share the $300,000 PATH grant funds each year.

Strategy 3: Expand Supportive Services to Wrap Around Housing

Providing supportive wrap-around services is just as important as creating short- and long-term housing options for those in need. Services must address each person's and families' unique needs based on their current and historic housing and personal situations. Free Through Recovery, created in 2017, is a two-year, state-funded $7.5 million initiative administered by NDDOCR. The program pays for addiction counseling and behavioral health services delivered through social service, mental health, religious and cultural organizations throughout the state. The initial focus is on individuals on probation with a higher risk of recidivism. The program will require extensive local partnerships to meet urban and rural community needs creating on-going and consistent wrap-around services.

NDDOCR also has re-entry teams in Bismarck, Fargo, Grand Forks and Devils Lake consisting of community stakeholders that provide wrap around case management and supervision of offenders who are re-entering society. NDDHS, JSND, housing authorities, judges, tribal entities, local law enforcement and others are also involved. Among the outcomes tracked are housing status and this effort has improved housing stability for offenders and has been particularly successful in the Devils Lake area.

Finding employment is critical to becoming self-sustainable. JSND and NDDOCR host *Second Chance Job Fairs* in Bismarck, Grand Forks and Fargo for employers considered "felon friendly" to be able to interview individuals. In addition to job fairs, JSND actively provides workforce updates like job openings, recruitment efforts, and hiring events in communities across the state.

The Fargo area has successfully implemented a medical respite program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Medical Respite is short-term residential care that allows the homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. More than 20 community partners are providing funding for medical supplies, equipment, nursing services, case management, housing and living supplies for both men and women. Individuals can receive rapid housing and case management for six months after securing permanent housing if they agree to the program rules, are medically and behaviorally stable, and will comply with scheduled follow-up appointments. The average cost of Medical Respite care is $25 per day and the cost of acute care is $4,500 per day. Since 2016, the program has saved the Fargo region almost $3 million in acute care costs.

Navigating the process for support programs such as social security, SNAP benefits, Medicaid and Medicare can be challenging to understand the forms and program requirements in addition to the logistical barriers of accessing all of the agencies. NDDHS has designated PATH coordinators to assist helping individuals transitioning out of homelessness to apply for programs to promote recovery and wellness.

MFP is administered by NDDHS and is an $8.9 million grant from the Centers for Medicare and Medicaid Services to help approximately 110 Medicaid clients who are older adults or people with developmental disabilities transition from nursing homes or institutions and reintegrate them into the community. A full year of case management is provided in addition to $3,000 for one-time transition costs.[8]

MFP staff also created two pocket resource guides for six areas in the state providing contact information for supportive services and affordable housing providers. More than 25,000 guides have been disseminated across the state. Another publication created through the Supportive Housing Collaborative is The *Housing Resource Guide,*[9] which was created in partnership between state and federal agencies to bridge information and communication gaps for agencies, individuals and families needing to address the unique needs of persons with disabilities, who are elderly, and are experiencing economic hardship.

Strategy 4: Strengthen Prevention & Outreach Programs

State agencies assigned roles in the plan have worked together through programs such as MFP, Free Through Recovery, Opening Doors and PATH to assist those at risk of long-term homelessness to be able to find housing and successfully reintegrate back into the community. Another example of partnerships is Project Homeless Connect, which was an annual event in communities across the state. The Fargo-Moorhead Homeless Coalition transformed the event into a more on-going, holistic approach through a new endeavor, CARES (coordinated assessment referral and evaluation system). The regional system is a partnership between the Western Central Minnesota Continuum of Care (CoC), North Dakota CoC, Fargo-Moorhead Homeless Coalition, and White Earth Nation located in Minnesota. CARES streamlines access to services and makes the system client-centered.

Focusing on school-aged youth, NDDPI oversees approximately 150 district homeless liaisons to identify students experiencing homelessness, ensure their educational rights and provide a referral for the families or unaccompanied minors. Addressing the needs of homeless youth is a collaborative effort with state agencies and local service providers to determine a process for referring families to case managers.

[8] N.D. Money Follows the Person Grant. Retrieved from www.nd.gov/dhs/info/pubs/mfp/overview.html
[9] North Dakota Supportive Housing Collaborative: Housing Resource Guide. Retrieved from www.ndhfa.org/RentalAssistance/HousingResourceGuide0817.pdf

Project Service Connect has become an annual event in communities across the state. Homeless/Hunger Awareness Week activities have also been initiated. In most of the larger cities in North Dakota and the faith community has taken on an expanded outreach and emergency mission during winter months. These church sheltering operations have been crucial in providing a warm place to sleep for homeless individuals when weather conditions are life threatening.

Strategy 5: Collect & Disseminate Data Relating to Long-Term Homelessness

NDCHP organizes statewide collaborative meetings to share information pertaining to best practices, federal, state and tribal regulations, and serves as a connector between state and federal agencies and the local service providers. NDCHP also organizes the annual HUD Point in Time Count (PIT) with assistance from NDDOC to ensure homeless data counts for urban and rural areas.

Each state agency in addition to NDCHP works closely with the local media to promote program successes and to keep the public informed about the current homeless situation across North Dakota. In times of urgent response, such as severe winter weather, it is essential for the service providers to be able to communicate their needs and provide accurate information about homeless populations.

NDHFA sponsored a Statewide Housing Needs Assessment in 2012 and 2016 conducted by North Dakota State University's Center for Social Research to analyze population and housing trends. The 2016 housing assessment dove into the special needs of the state's subpopulations, which had not been analyzed before. Once the assessments were completed, NDHFA held regional forums with NDSU research staff to discuss the data and what the future looked like for each region. Economic developers, community leaders, legislators, service providers and the general public were engaged through the assessment process.

What We Learned

What We Learned

Counting homeless populations is extremely difficult due to multiple definitions of homelessness, the mobility of the population, rural isolation, and the cyclical nature of homelessness for many individuals and families. In addition, homeless people are often reluctant to be identify themselves as homeless, and many of them remain invisible even to the most diligent social workers. There is no uniform method for counting the homeless, instead indirect estimation, single-contact census, and capture-recapture studies are used to quantify this population.[10]

Local service providers use HUD's PIT methodology to conduct the annual PIT count for the state. The PIT focuses on counting sheltered and unsheltered homeless people. HUD requires communities receiving federal funds from the McKinney-Vento Homeless Assistance Grants program to conduct an annual count of all sheltered people in the last week of January. Electronic administrative records are used to enumerate people living in emergency shelters and transitional housing. Unsheltered counts are required every other year, although most communities conduct an unsheltered count annually. During the PIT counts, communities are required to identify whether a person is an individual, a member of a family unit, or an unaccompanied youth under the age of 18 or age 18 to 24. In addition, communities must identify if a person is chronically homeless, indicating long-time or repeated homelessness and the presence of a disability.[11]

In North Dakota, the homeless PIT count numbers have fluctuated as have the subpopulations. Figure 3 is a breakdown of the North Dakota's homeless subpopulations compared to the state's overall population growth. The subpopulations depict the complex issues surrounding homelessness that extends beyond not being able to afford housing. Local service providers and state agencies were unprepared for the magnitude of homelessness experienced across the state. When the 2008 plan was drafted, energy development catapulted North Dakota's economic development opportunities into the national spotlight attracting tens of

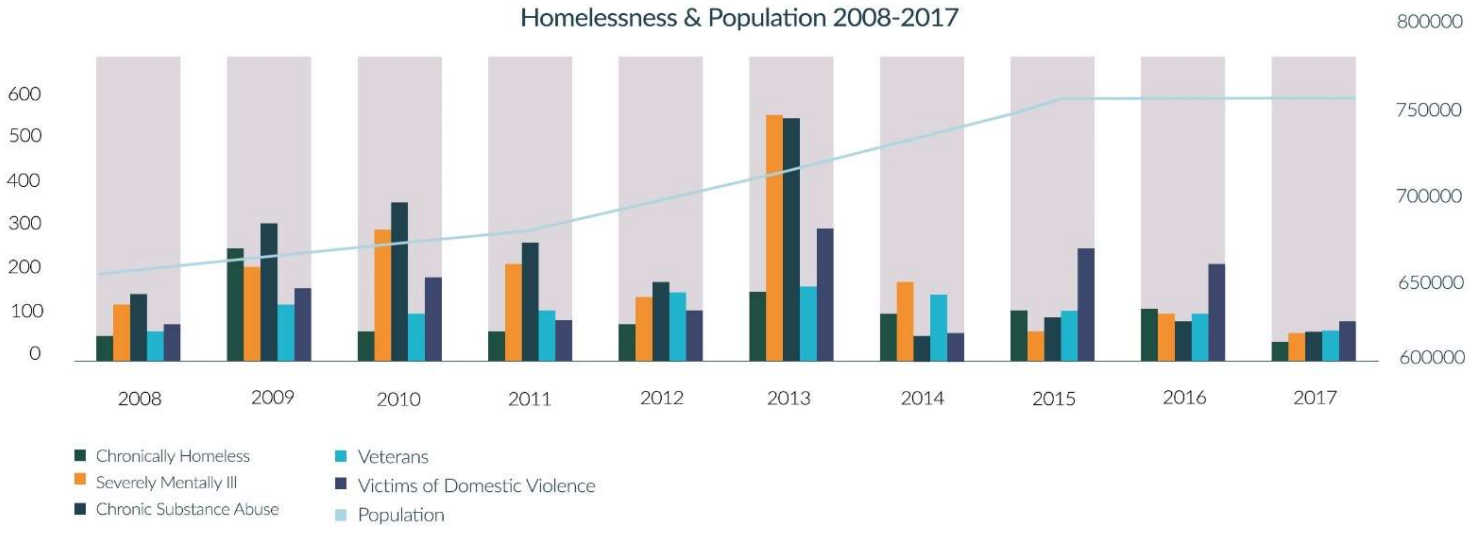


Figure 3. North Dakota's Homeless PIT Count and Population from 2008-2017
Source: North Dakota Homeless Coalition and U.S. Census Bureau

[10] The Methodology of Counting the Homeless. Retrieved from www.ncbi.nlm.nih.gov/books/NBK218229/
[11] What is a Point-In-Time Count? Retrieved from https://endhomelessness.org/resource/what-is-a-point-in-time-count/

thousands of people to the state, some without living arrangements. A statewide housing shortage forced people into homelessness even if they could afford to pay rent or purchase housing due to the limited housing stock available. People were doubling up, living in vehicles, and sleeping in churches. Some employers provided traditional housing options in addition to recreational vehicles or man camps. Along with the population influx and housing shortages, service providers were responding to increased domestic violence, human trafficking, substance abuse and incarcerations, which can be the cause as to why individuals experience homelessness.

Discrepancies between definitions of homelessness is evident based on NDDPI's school-aged youth homeless counts, which includes housing insecure and doubling-up. In 2016, NDDPI reported 2,166 children ages 5-18 either living in shelters, doubled-up, in a hotel/motel, unsheltered or unaccompanied by an adult. NDDPI's 2015-16 homeless student count is two times more than the state's PIT count; however, NDDPI tallies the count over the school year and has more consistent access to this vulnerable population resulting in more thorough identification and reporting.

North Dakota Department of Instruction Data
Homeless Youth Ages 5-18

School Year	Number of Students Identified as in Transition	Sheltered	Doubled Up	Hotel/Motel	Unsheltered	Unaccompanied
2012-2013	2,122	239	975	189	719	
2013-2014	2,395	236	1,096	256	807	171
2014-2015	2,715	196	1,397	246	876	150
2015-2016	2,230	151	1,440	151	371	193
2016-2017	2,166	228	1,186	107	179	223

Table 2. NDDPI Homeless District Liaisons Student Counts
Source: NDDPI

How Much Does Homelessness Cost

According to the U.S. Interagency Council on Homelessness, chronically homeless persons cost taxpayers as much as $30,000 to $50,000 per year. The cost is calculated based on public services utilized such as hospitals, shelters, jail, psychiatric centers, alcohol and drug treatment, and living on the street. PSH is estimated to lower that cost by 40 percent.[12]

The Cooper House, North Dakota's first Housing First project, opened in 2010 and a benefit-cost-analysis was conducted after 12 months of operation. Preliminary assumptions determined that the 66 tenants who lived in the Cooper House cost the public $552,895 the previous year. After being rapidly rehoused the public expense dropped to $348,755 a savings of $204,140 or 41.5 percent.[13] The savings were realized in the following cost centers: healthcare and medical, law enforcement and legal, detox, administration, and emergency shelters.

[12] Ending Chronic Homelessness in 2017. Retrieved from www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

[13] Cooper House Impact Report. Retrieved from http://fargohousing.org/files/pdf/Cooper%20House/Impact%20Reports/Cooper_House_Impact_Report_June_2013.pdf

In Fargo, healthcare facilities, housing providers, and case managers collaborated to create a medical respite program in response to the healthcare gap for homeless individuals. Respite care provides recuperative services for those who many not meet criteria for hospitalization, but are too sick or vulnerable to be discharged on the streets. National trends have documented lower mortality rates as well as a reduction in the inpatient length of stay, emergency department visits, outpatient clinic visits and readmissions to the hospital for homeless individuals who are discharged to medical respite compared to those that are discharged to the streets. In 2016, an analysis of the Fargo Medical Respite program demonstrated a savings of $2,658,150 in acute care costs in less than two years. The Fargo program is a hybrid of a traditional respite program, where patients are recommended to stay for approximately 45 days allowing medical staff to treat the individual and develop a plan to transfer them to housing with support services in place. The MFP Housing Program also gives each participant a small stipend to help them set up their new home as they transition into permanent housing.

Although there is data showing the successful implementation of housing and medical intervention for homeless individuals, much of the national data focuses on large metropolitan areas and does not represent the smaller urban centers and rural communities of North Dakota.

Vulnerable Populations

Progress has been made over the past 10 years to end homelessness, however, certain populations are still at a higher-risk of experiencing both short- and long-term homelessness. Housing, case management and healthcare needs to be customized to each of these groups to ensure the greatest level of stability and long-term success.

Chronically Homeless

Chronically homeless is defined as an individual or family that is homeless and resides in a place not meant for human habitation, in an emergency shelter, and has been homeless and residing in such a place for at least one year or on at least four separate occasions in the last three years. Chronically homeless families include the head of household with a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronical physical illness or disability.[14]

The median number of chronically homeless individuals in North Dakota over the past decade has been 75.5. The lowest count occurred in 2017 at 45, but averaged 138 annually from 2013-2016. The HUD PIT count is the only active means to document all chronically homeless individuals across the state, and it is conducted in January making it difficult to locate and document the unsheltered homeless.

North Dakota's chronically homeless population has more than likely experienced trauma in their childhood and have on-going mental health issues and substance abuse. For example, in 2017 of the 1,089 homeless and 45 chronically homeless individuals, 69 reported themselves as severely mentally ill, and 70 diagnosed themselves as having chronic substance abuse. The numbers for each category would probably be higher if they were medically diagnosed or if a case manager was able to document their condition instead of relying on self-reporting.

[14] HUD Defining "Chronically Homeless," 2015. Retrieved from www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

Housing the chronically homeless is challenging, and there is no one size fits all solution. Across the state, numerous partnerships have formed between federal and state agencies and local service providers to find housing models that best serve each community. Housing First is a rapid housing approach; homeless shelters are a temporary solution; and "harm reduction" shelters have been discussed in numerous circumstances as an alternative to dry shelters that are more prevalent and accepted by the general public. However, these housing models benefit urban areas and not rural communities. Rural-based homeless individuals and families are more "hidden" as they occupy tents, campers, abandoned houses, barns and ice fishing houses. Homeless individuals and families in rural areas have a more difficult time accessing services provided in urban communities.

Justice Involved

Persons with mental illness and substance use problems are overrepresented in jails and prisons as compared to the general population. Across the United States, deinstitutionalization, along with a failure to develop easily accessible and useful outpatient alternatives for treatment, has led to correctional facilities housing the highest concentrations of people with mental health and substance abuse concerns in the country. National data has shown that nearly 70 percent of adults entering jails and more than 50 percent in state prisons have a substance use disorder. Additionally, the number of mentally ill inmates in America's jails and prisons is reported to have quadrupled over the past 20 years. Research suggests that up to 50 percent of jail and prison inmates may have a mental health concern in addition to substance use disorders. Estimates of severe and persistent mental illnesses among incarcerated adults range from 15 to 25 percent, as compared to 5 to 8 percent in the general population.[15]

Data for North Dakota prison facilities in 2015 shows that over 70 percent of individuals entering prison have an active substance use disorder diagnosis. Beyond that, 41 percent of male inmates have a mental health diagnosis in addition to substance use disorders, and around six percent meet criteria for a severe and persistent mental illness. About 50 percent of female inmates have a mental health diagnosis in addition to substance use disorders, with 14 percent diagnosed with a severe and persistent mental illness.[16]

Individuals with behavioral health issues and criminal justice involvement have increased hardship in finding housing as many landlords are allowed to choose whether or not they lease to those with criminal records. If these individuals were treated for their behavioral health issues and not incarcerated as a form of treatment, they would have one less barrier to obtaining housing.

[15] Improving Access to Care for Justice-Involved Persons with Behavioral Health Needs. 2016. Retrieved from https://docr.nd.gov/sites/www/files/documents/media/Charter.pdf. p.4.

[16] Improving Access to Care for Justice-Involved Persons with Behavioral Health Needs. 2016. Retrieved from https://docr.nd.gov/sites/www/files/documents/media/Charter.pdf. p.4.

Characteristics of Justice-Involved Persons Utilizing HSC Services, SFY 2013-17

Characteristic	N	%
Gender		
Female	764	33.9%
Male	1,491	66.1%
Age		
Age 0 to 11	28	1.2%
Age 12 to 17	230	10.2%
Age 18 to 24	422	18.6%
Age 25 to 44	1,116	49.2%
Age 45 to 64	428	18.9%
Age 65 or Older	42	1.9%
Race/Ethnicity		
Latino/Hispanic	77	3.7%
American Indian or Alaskan Native	335	16.5%
Black or African American	89	4.4%
White	1,563	76.8%
Other Race	47	2.3%

Table 3. Characteristics of Justice-Involved Persons Utilizing HSC Services, SFY 2013-17
Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=2,271

Significantly more robust, wrap around services available to individuals within the community is critical, as individuals with justice involvement experience multiple barriers to accessing services. A common theme was that, in general, community-based treatment providers are resistant to serving individuals with criminal justice histories. Unfortunately, it is common for individuals to "burn bridges" with community treatment providers, which further limits their options. Another scenario described a "caste system" in both inpatient and community-based services, in which people who are justice involved face greater difficulty accessing services, receive lower-quality treatment, and are generally considered "less deserving" than those with no justice involvement.[17]

Another frequently cited challenge was access to housing. Felony convictions bar individuals from accessing HUD-funded and other publicly funded affordable housing options, and many private landlords are unwilling to consider renting to this population, especially if an individual is a registered sex offender. The instability of finding housing puts individuals at a higher probability of participating in activities that led to their incarceration. Justice involved individuals are not protected under the Fair Housing Act; therefore, landlords can reject their housing applications.

Even when individuals are able to find housing, they may have difficulty supporting themselves financially. Many have lingering justice involved issues as well as chemical dependency that needs to be addressed before being work-ready. As they address their behavioral and mental issues, seeking full-time employment may not be an immediate option as they need time and case management to adjust to life back in the community.

Another significant barrier to successful reintegration to the community concerns Medicaid eligibility. North Dakota is one of 19 states in which an individual's Medicaid benefits are terminated—rather than merely suspended—as soon as the person is incarcerated. This means that instead of activating coverage upon the

[17] 2018 North Dakota Behavior Health Study. 2018. p 83.

person's release, the person must reapply, impeding their successful transition back into the community. Since individuals are not eligible until they are officially released, prison staff assist individuals on what they need to do to get re-enrolled, but the individual themselves has to enroll again within 30 days of release.[18]

Behavioral Health

In 2016, almost 100,000 North Dakotans aged 18 and older met the criteria for a mental illness diagnosis, and an additional 23,454 people had a serious mental illness. The remaining 83 percent who have not received a diagnosis are nonetheless an important population for consideration, as this population includes young adults who may have behavioral health needs in the future, individuals from hard-to-reach populations who may be struggling with undiagnosed behavioral health challenges, and others for whom low-cost, proactive prevention strategies could prevent mental health conditions from occurring.[19]

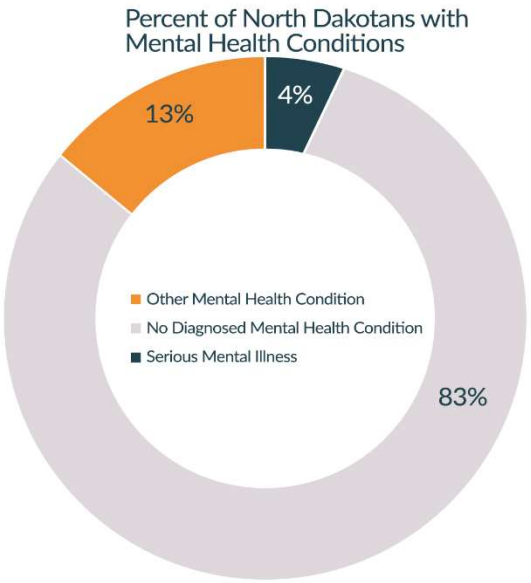


Figure 4. Percent of North Dakotans With and Without a Mental Health Diagnosis
Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016, and U.S. Census Bureau, Population Division Release Date: June 2017

Among children and youth, the prevalence of mental health conditions is similar to national estimates. An estimated 12 to 25 percent of North Dakotan students have an emotional or behavioral disorder. In 2016, the annual average proportion of adolescents aged 12 to 17 with a major depressive episode in the past year was 11 percent, slightly lower than the corresponding national yearly average percentage of 12.8 percent.[20]

Table 4 presents numbers and characteristics of individuals who reported living in a homeless shelter or who received a health center service related to homelessness.[21] Table 4 likely underestimate the number of individuals with behavioral health needs who are homeless as the information only focused on recipients of some outpatient treatment.

[18] 2018 North Dakota Behavior Health Study. 2018. p 86.
[19] 2018 North Dakota Behavior Health Study. p 19.
[20] 2018 North Dakota Behavior Health Study. p 20.
[21] 2018 North Dakota Behavior Health Study. p 26.

Characteristic	N	%
Gender		
Female	695	40.3%
Male	1,030	59.7%
Age		
Age 0 to 11	15	0.9%
Age 12 to 17	10	0.6%
Age 18 to 24	154	8.9%
Age 25 to 44	825	47.8%
Age 45 to 64	672	38.9%
Age 65 or Older	50	2.9%
Race/Ethnicity		
Latino/Hispanic	64	4.0%
American Indian or Alaskan Native	281	18.2%
Black or African American	10	6.6%
White	1,121	72.6%
Other Race	40	2.6%

Table 4. Demographic Characteristics of People Who Are Homeless and Utilizing HSC Services, SFY 2013-2017
Source: HSC event and demographics data extracted January 2018 from the ROAP system; n=1,735

Access to safe, adequate, and affordable housing is a critical element in supporting individuals with behavioral health needs to live independently in their communities. Unmet housing needs are obstacles to recovery and reduce the effectiveness of behavioral health treatment especially in rural areas. Most PSH units are based in Fargo and Bismarck, and other higher-population locations within the state and individuals will more than likely be relocated to these communities to be housed as part of their discharge plan from a mental health or substance use treatment facility. The lack of PSH in rural areas further complicates the accessibility for individuals seeking help outside of urban areas.

Within the Fargo-Moorhead area, three out of four homeless adults have serious health conditions, including mental and physical health problems, substance abuse disorder or evidence of a traumatic brain injury.[22] Based on an independent 2015 PIT survey commissioned by the Fargo-Moorhead Coalition for Homeless Persons, more than half of those surveyed were told by a doctor or nurse within the last two years that they had a serious mental illness, another 40 percent stated they had chronic physical health problems, and 30 percent considered themselves chemically dependent. These behavioral, mental and physical health issues impacted the respondents' ability to work, perform daily activities, manage finances and make sound decisions. Undiagnosed and untreated brain injuries may be an underlying cause of these issues. [23]

[22] Homelessness in Fargo, North Dakota and Moorhead Minnesota. 2016. Retrieved from http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2015/2015-homeless-fargo-moorhead-9-16.pdf

[23] Homelessness in Fargo, North Dakota and Moorhead Minnesota. 2016. Retrieved from http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2015/2015-homeless-fargo-moorhead-9-16.pdf

Native Americans

Native American's are the largest racial group other than whites in North Dakota, and in 2017 Native Americans totaled 21 percent of the state's total homeless population.[24] The amount of Native Americans experiencing homelessness is likely greater than then numbers reported due to the magnitude of homelessness both on and off of Reservations.

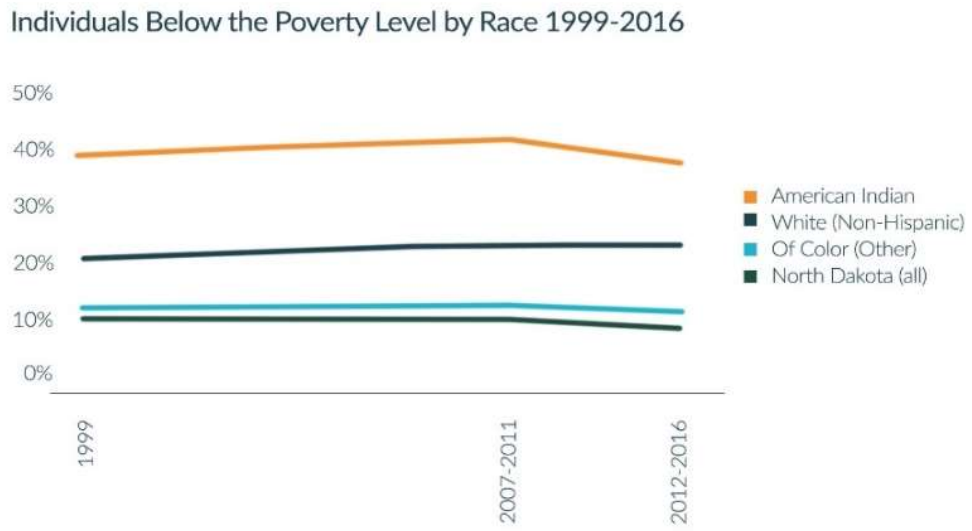


Figure 5. Individuals Below the Poverty Level by Race, North Dakota, 2012-2016
Sources: U.S. Census Bureau, Decennial Census and American Community Survey

The foundation of Native American culture emphasizes taking in family members and other tribal members who need a place to stay results in long-term doubling up of households. Therefore, the number of Native American's that would be considered homeless is more than likely higher than reported in the PIT count. Over-crowding and inadequate housing conditions put stress on quality of life, as the majority of Native Americans will not force members in their household out without another housing option.

Native American's face the highest percentage of poverty across all races in North Dakota, but the severity of poverty varies amongst the state's four Reservations.

[24] 2017 Point-In-Time Count ND. Retrieved from https://static1.squarespace.com/static/5570a318e4b02d3071ca7d2b/t/59934812db29d6ca444d0cde/1502824471561/PIT+Count+2017+%281%29.pdf

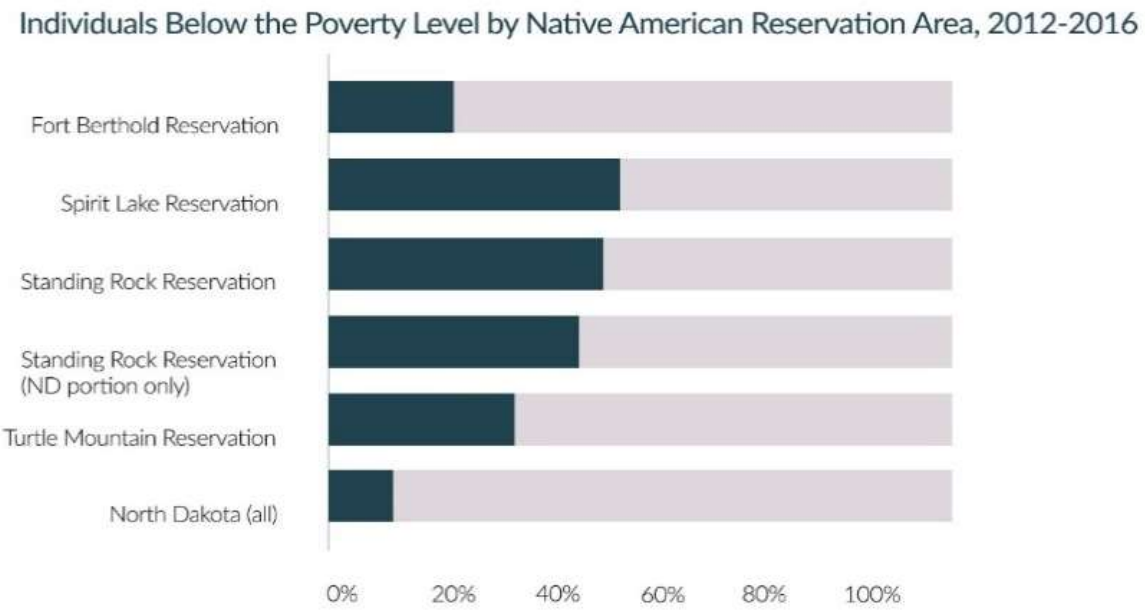


Figure 6. Individuals below the Poverty Level by Native American Reservation Area, North Dakota, 2012-2016
Sources: U.S. Census Bureau, American Community Survey

The poverty rate on the Fort Berthold Reservation is lowest due to the energy development that occurred on the reservation and surrounding area during the last decade. Other reservations do not have the same level of economic development opportunities which is exemplified by the percentage of cost-burdened households.

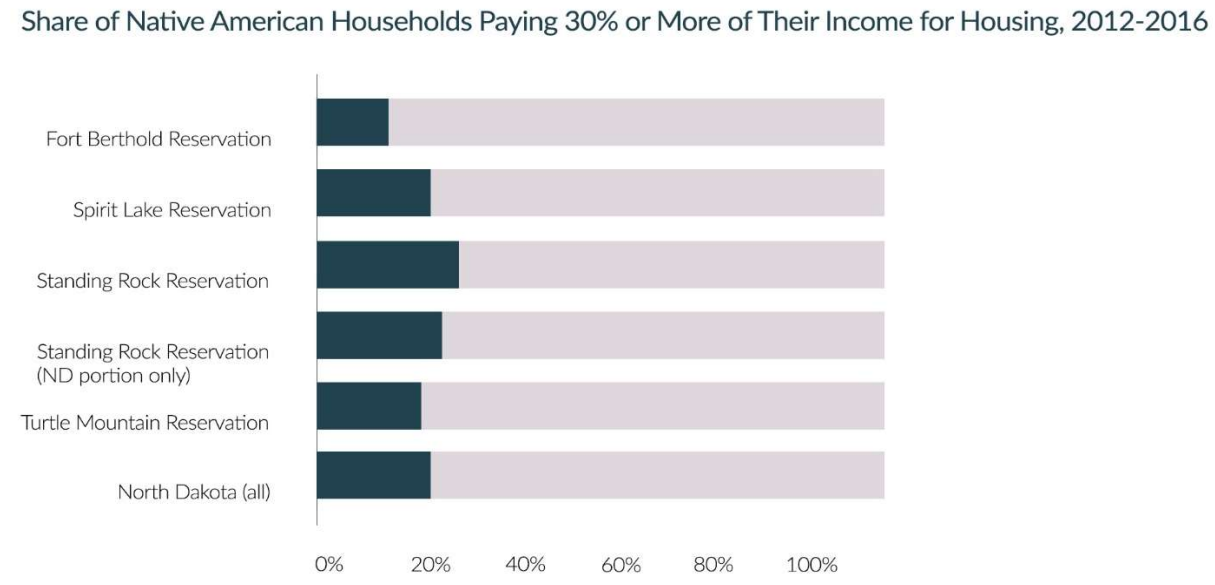


Figure 7. Share of Households Paying 30 percent or More of Their Income for Housing
Sources: U.S. Census Bureau, American Community Survey

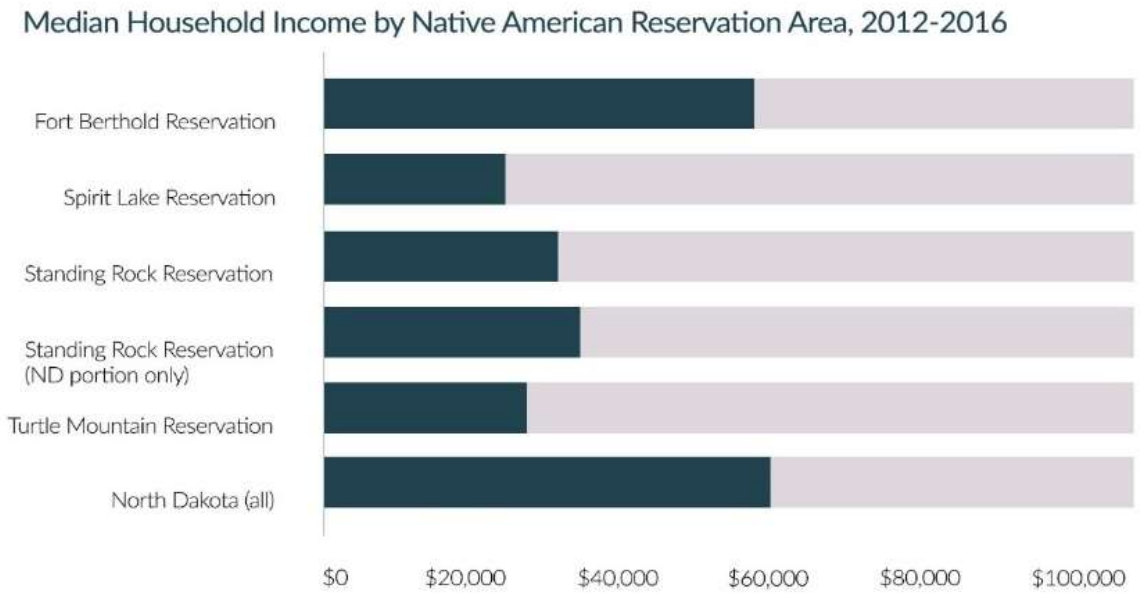


Figure 8. Median Household Income by Native American Reservation Area, North Dakota, 2012-2016
Sources U.S. Census Bureau, American Community Survey

Although there have been increased housing developments on the reservations, affordable housing options for homeownership and rental units is difficult to obtain. Construction of housing developments are usually smaller in total units and infrequent due to funding availability and fluctuating community needs; therefore, it is more challenging to access competitively priced building supplies and contractors willing to complete the project in a timely manner.

More than 40 percent of Native Americans are homeowners; however, mortgage lending on tribal land is an underserved market with unique challenges such as trust land, fractioned land ownership, and limited access to financial institutions. While tribal trust land status is no longer considered a major barrier since the implementation of Section 184 of the Indian Home Loan Guarantee Program, the volume of mortgage lending on tribal trust land is still quite small. Rental property managers on the Reservation deal with the same issues as properties off of the Reservation when renting to vulnerable populations: higher percentage of damaged the units, on-going criminal activity, and the tenants not paying rent on time.[25]

It is estimated that 78 percent of Native Americans live off of the Reservation, and poverty remains one of the most challenging aspects of urban Indian life. Whether or not Native Americans have financial stability off of the reservation, they have either experienced poverty themselves or know a family member who is living in poverty. Housing and homelessness remain at the top list of challenges they face.[26] The outmigration of youth and young families moving to more urbanized areas away from the reservations seeking higher educational and economic opportunities continues to increase. However, many Native Americans transition on and off the Reservation as they struggle to find support networks, fit in culturally, or they are not able to achieve financial stability.

[25] Mortgage Lending on Tribal Land. 20017. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/NAHSG-Lending.pdf

[26] Most Native Americans live in cities, not reservations. 2017. Retrieved from www.theguardian.com/us-news/2017/sep/04/native-americans-stories-california

YOUTH

In 2017, there were 178 documented homeless children ages 0 to 18 years old living in an emergency shelter, transitional living facility, or unsheltered according to the HUD PIT count.[27] School-age children, ages 5 to 18 years old, experiencing homelessness was reported much higher by NDDPI with 2,166 students documented as either sheltered, doubled-up with other families, living in a hotel/motel, unsheltered, or unaccompanied by an adult during the 2015-2016 school year.

Limitations in data collection and self-reporting may have resulted in a lower total number of homeless children or those at risk of homelessness across the state, as the U.S. Census estimated nearly 50,000 North Dakotan children are living in families with an income below 200 percent of the federal poverty level. Half of all Native American children living in North Dakota were impoverished in 2015, more than five times the rate for white children at nine percent.[28]

Further complicating the wellbeing of children is the state's rise above the national average for child maltreatment, which encompasses both abuse and neglect. In 2015, 1,760 North Dakota children were victims of maltreatment; specifically for every 1,000 children ages 0 to 17 in the state, 10.4 were abused or neglected. Of these victims, 77 percent were neglected, 32 percent were psychologically abused, 12 percent were physically abused, and four percent were sexually abused.[29] Physical, sexual and mental abuse during childhood are the leading causes for long-term homelessness as adults.

Juvenile delinquency has potentially high stakes for both individuals and society as a whole. Delinquency is linked to higher crime rates in adulthood and other adverse outcomes such as homelessness. One estimate suggests that between 50 and 75 percent of adolescents who have spent time in juvenile detention centers are incarcerated later in life. A total of 3,471 North Dakota juveniles ages 10 through 17 were referred to court at least once for delinquent or unruly behavior in 2016. [30] Following a national downward trend, the number of North Dakota juveniles referred to court has decreased an average of five percent annually since 2003. [31]

Local service providers have expressed their concern about assisting youth with opioid addiction and the difficulties in getting this population help and housing to keep them off of the streets. Youth with trust issues towards adults is extremely difficult to convince to seek help.

A major contributor to the financial stability and well-being of children is secure parental employment; however, many working families with children struggle to make ends meet. In 2015, the poverty threshold considered insufficient for a family of four with two children to afford basic necessities, was $24,036. In North Dakota, 21,716 children were living in families whose income was not meeting this threshold. Younger children, ages 0 to 4 in the state had a higher poverty rate than older children ages 5 to 17, 16 percent compared to 13 percent respectively. In eight North Dakota counties, at least one in five children was living in poverty. Children living on Native American reservations tend to have the highest child poverty rates in North

[27] Point-in-Time Count ND-500 North Dakota Statewide CoC. Retrieved from www.ndhomelesscoalition.org/new-page-2/
[28] U.S. Census Bureau. 2012-2016 American Community Survey 5-Year Estimates, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
[29] Centers for Disease Control and Prevention (CDC).2016. Retrieved from www.cdc.gov/ace/ and www.ndkidscount.org.
[30] Child Trends (2015). Juvenile Detention. Retrieved from www.childtrends.org/indicators/juvenile-detention.
[31] Child Trends (2015). Juvenile Detention. Retrieved from www.childtrends.org/indicators/juvenile-detention.

Dakota. Data from 2015 indicate that about half of all children in Rolette and Benson counties were impoverished, 49 percent and 48 percent respectively.[32]

The Temporary Assistance to Needy Families Program (TANF), designed to help families in need to achieve self-sufficiency, assisted 4,649 North Dakota children ages 0 through 19 in 2016, down five percent from 4,887 in 2015.[33] The Supplemental Nutrition Assistance Program (SNAP) provided food to 37,758 North Dakota children ages 0 through 18 in 2016, 21 percent of children statewide. In North Dakota public schools, 37,928 children were eligible for free or reduced-price lunches in 2016, 33 percent of total school enrollment. In five of North Dakota's 53 counties, Sioux, Rolette, Benson, Sheridan and Mountrail, at least half of students were eligible for free or reduced-price lunches in 2016.[34]

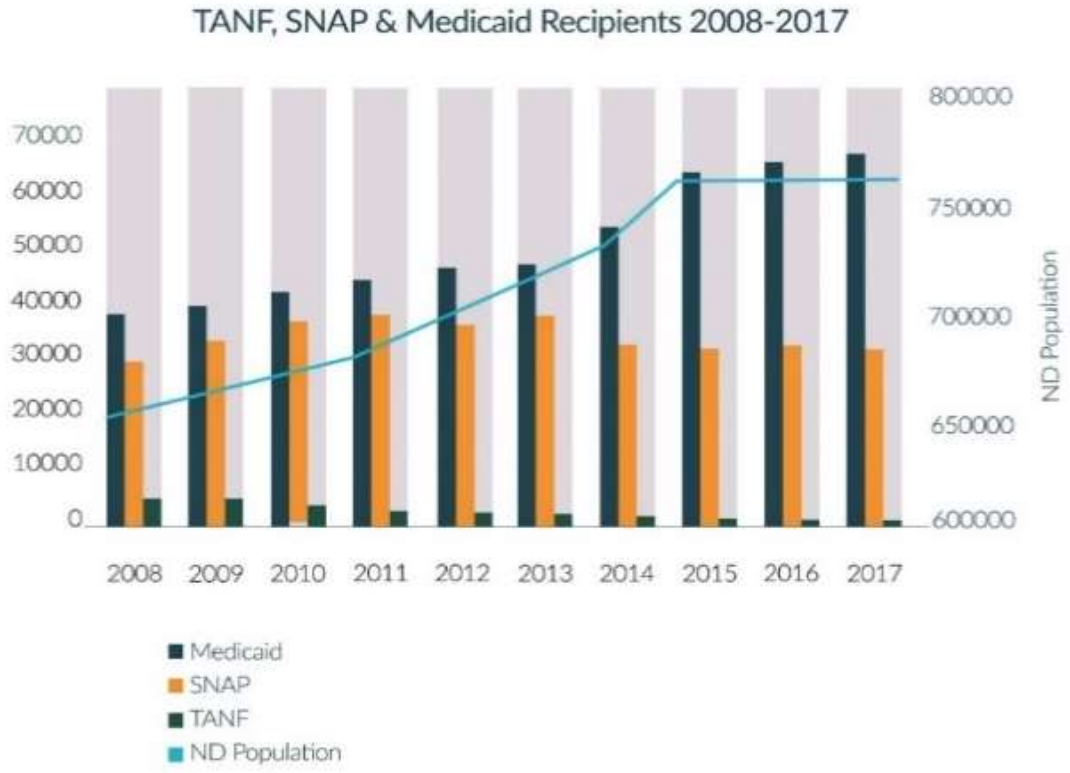


Figure 9. TANF, SNAP and Medicaid Recipients 2008-2017
Source: NDDHS

However, taking care of young children while holding down a job can be challenging. This is especially true for single parents who may have as many child-related demands on their time as married parents, but half as many adults in the household to meet them. To allow parents to work or attain the education necessary to become employed and self-sufficient, 6,610 children benefited from the North Dakota Child Care Assistance program in 2016, 5 percent of all children ages 0 through 13 statewide.[35]

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[32] U.S. Census Bureau. 2017 Poverty Thresholds for 2015 by Size of Family and Number of Related Children Under 18 Years. Retrieved from www.census.gov/data/tables/ time-series/demo/income-poverty/ historical-poverty-thresholds.html.

[33] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

[34] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

[35] 2017 North Dakota Kids Count Fact Book. Retrieved from www.ndkidscount.org/publications/factbook/completefactbook/NDKCFactBook_2017.pdf. p.12.

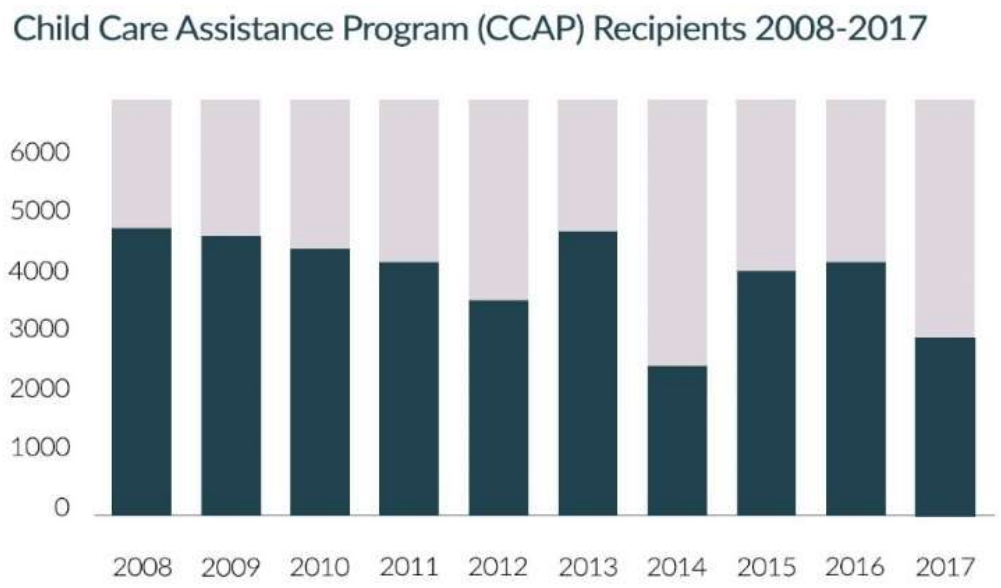


Figure 10. Child Care Assistance Program (CCAP) Recipients 2008-2017
Source: NDDHS

High-quality child care nurtures, stimulates and supports children as they build the confidence and critical thinking capacities they need to thrive in school and life.[36] In North Dakota, single parents pay 34.2 percent of their income for infant-center care. Married parents of two children living at the poverty line pay 66.9 percent of their household income for center-based child care. The cost of infant care in North Dakota is more than the annual cost of college tuition at a four-year college. The average price of center-based child care for an infant costs nearly a year of mortgage in North Dakota.[37]



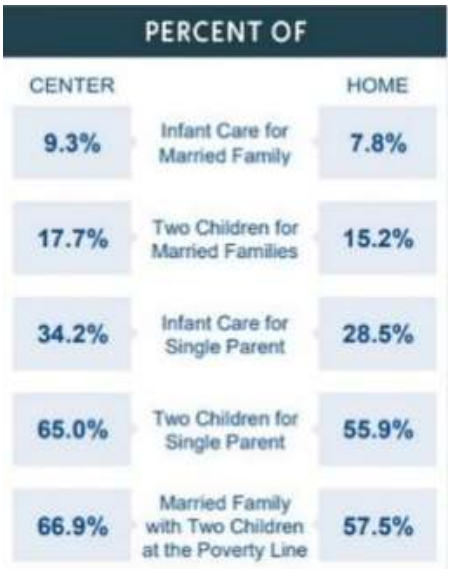


Figure 11. North Dakota Cost of Child Care in 2017
Source: Childcare Aware of America

[36] The Annie E. Casey Foundation (2006). Family, Friend, and Neighbor Care. Retrieved from www.aecf.org/
[37] ChildCare Aware of America. North Dakota. Retrieved from https://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/

Foster Youth

In 2017, 2,048 youth were placed in foster care with the median annual increase over the past decade at six percent.[38] Often youth in the foster care system have lived through multiple traumas and disruptive events such as abuse and/or neglect, multiple foster home placements, lack of continuity in education, and an array of lost relationships such as friends, families, and/or siblings by the time they begin their transition into adulthood. Their life experiences can create additional problems resulting in mental illness and substance abuse, and an increased likelihood of incarceration and homelessness.

On average, 130 foster care youth turn 18 years old each year in North Dakota. At this point, youth can either age-out of the system or enroll in the 18+ Continued Care Program, which allows youth to remain in foster care until they turn 21 years old as long as they are enrolled in higher education. Of those turning 18, approximately 37 percent utilize the 18+ program annually.[32]

North Dakota Youth in Foster Care

	Calendar Year									
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Number of Youth in Foster Care	1482	1615	1701	1678	1812	1990	2109	2264	2329	2408
Number of Youth Turning 18 in Foster Care	92	116	166	131	127	141	131	141	147	108
Number of Youth Using the 18+ Program	NA	NA	NA	NA	42	48	57	53	53	45

Table 5. North Dakota Youth in Foster Care, Turning 18, 18+ Program, North Dakota, 2008-2017
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

In 2015, NDDHS – Children and Family Services Division completed the National Youth in Transition Data Base (NYTD) Cohort Survey, which surveyed current and former foster youth at ages 17, 19 and 21 to measure outcomes for youth following their discharge from foster care. By engaging these individuals at three different ages, the state can better understand the experiences of foster youth following their release from the program. The survey compares North Dakota to the national average in homelessness, substance abuse, incarceration, giving birth to or fathering a child, employment, public assistance, and education. The following five outcomes are outlined in the survey report.[39]

Outcome 1: Experiences with Homelessness

Leaving foster care unprepared to live on their own, puts youth at risk of becoming homeless soon after discharge. At each age level surveyed, North Dakota foster youth experience homelessness more than the national average. These youth have more than likely been homeless before age 17 and will more than likely remain homeless for an extended period then youth not in foster care.

[38] North Dakota Department of Human Services-Children and Family Services Division.
[39] National Youth in Transition Data Base. North Dakota Department of Human Services-Children and Family Services Division.

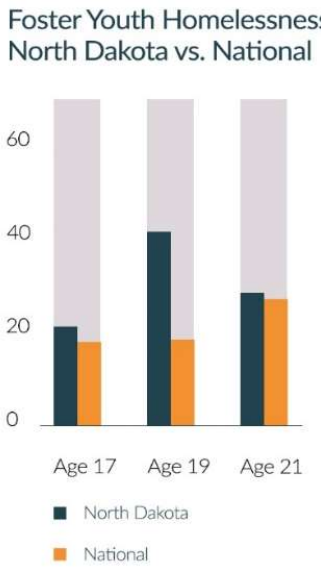


Figure 12. North Dakota Homeless Foster Youth vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 2: High-Risk Behaviors

North Dakota youth percentages are higher than the national average for substance abuse, incarceration and giving birth or fathering a child. These three scenarios hinder successful transition into adulthood among youth in foster care.

At age 17, almost half of the survey respondents had at some point during their lifetimes been referred for substance abuse assessment or counseling, and 20 percent of age 19 respondents and 14 percent of the age 21 survey respondents reported having had a referral to substance abuse assessment or counseling within the past two years. Youth incarceration rates in North Dakota are the third highest per capita in the nation. The data indicate that one out of every three homeless young adults surveyed has been in either foster care or correctional care as a juvenile. Youth emancipating from the Youth Correctional Center pose a particular challenge. Former foster youth continue to find themselves homeless at a significantly higher rate than their peers.

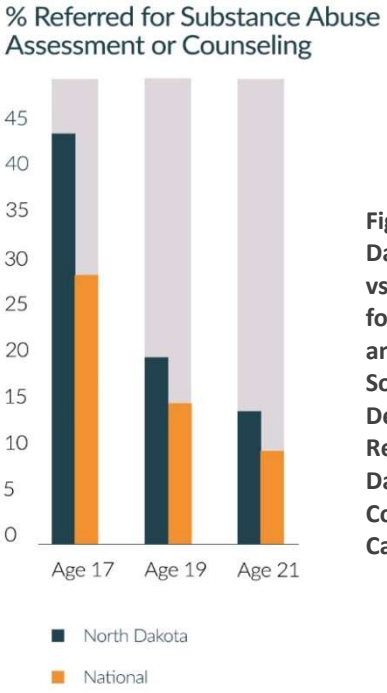


Figure 13. North Dakota Foster Youth vs. National Average for Substance Abuse and Counseling
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

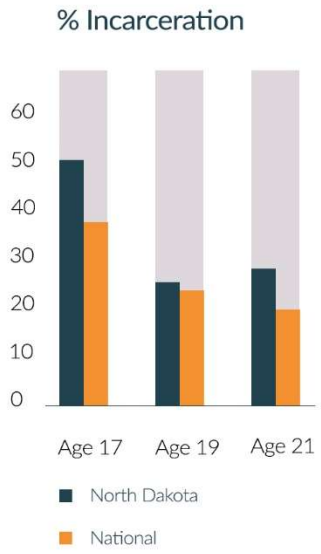


Figure 14. North Dakota Foster Youth Incarceration vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 3: Access to Health Insurance

Access to health care can help ensure that youth receive the prevention and treatment services they need to remain healthy and manage behavioral health issues or substance abuse. Youth in title IV-E foster care are categorically eligible to receive Medicaid. Additionally, some provisions under the Patient Protection and Affordable Care Act increased access to health care for youth formerly in foster care, including the extension of Medicaid coverage to young people up to age 26 in certain circumstances.

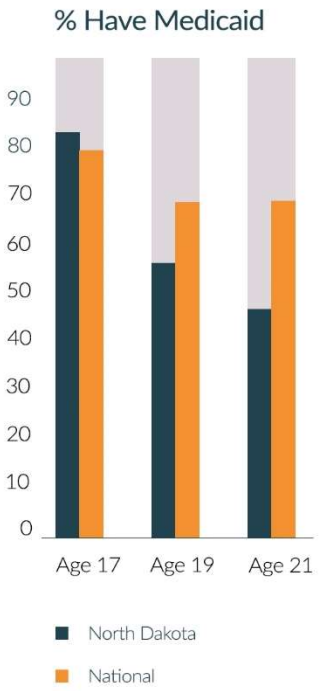


Figure 15. North Dakota Foster Youth with Medicaid vs. National Average
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

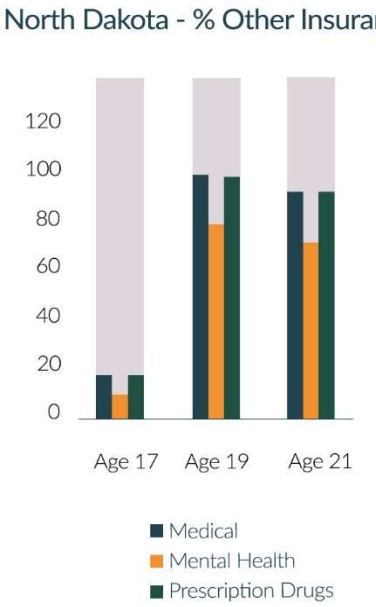


Figure 16. North Dakota Foster Youth with Insurance Coverage
Source: FRAME Demographics Report, North Dakota 18+ Continued Care Cases Data Sheet

Outcome 4: Financial Self-Sufficiency

As youth age and make decisions about whether or not to remain in or return to foster care, financial stability becomes a crucial indicator of their readiness for independence. Over 18 percent of age 17 respondents reported working either full- or part-time; at age 19, 43 percent were working full- or part-time, and at age 21, 61 percent were working full- or part-time. By age 21, 24 percent of North Dakota respondents reported receiving public assistance compared to 38 percent nationally. Fewer respondents reported receiving educational, financial assistance than those responding on the national level.

Outcome 5: Educational Attainment

Achieving a high school diploma or General Equivalency Degree (GED) can be considered a minimal requirement for self-sufficiency and can assist in establishing a solid educational foundation that will prepare youth for future educational pursuits. Respondents were asked to report their current enrollment status in an educational program, and the highest educational certification received. Ninety-seven percent of age 17 survey respondents had not yet received any educational certification, but 91 percent of them indicated they were currently enrolled in and attending some type of educational program. By age 19, 65 percent of survey respondents had received a high school diploma or GED, and by age 21 the percentage had increased to 67 percent.

Frail Elderly

The number of elderly households is projected to increase substantially as a result of the baby boom cohorts aging forward into the next age category. Such households on limited or fixed incomes can be vulnerable to becoming burdened by housing costs. Nearly half of all North Dakota renter-occupied households ages 65 and older were cost-burdened in 2014, and 17 percent of owner-occupied households ages 65 and older were cost-burdened.[40] Increased healthcare costs put additional pressures on housing-burdened households forcing many elderly individuals to abstain from medical treatments and medications resulting in declined heath, eventually forcing them out of their homes and into assisted living and nursing home facilities.

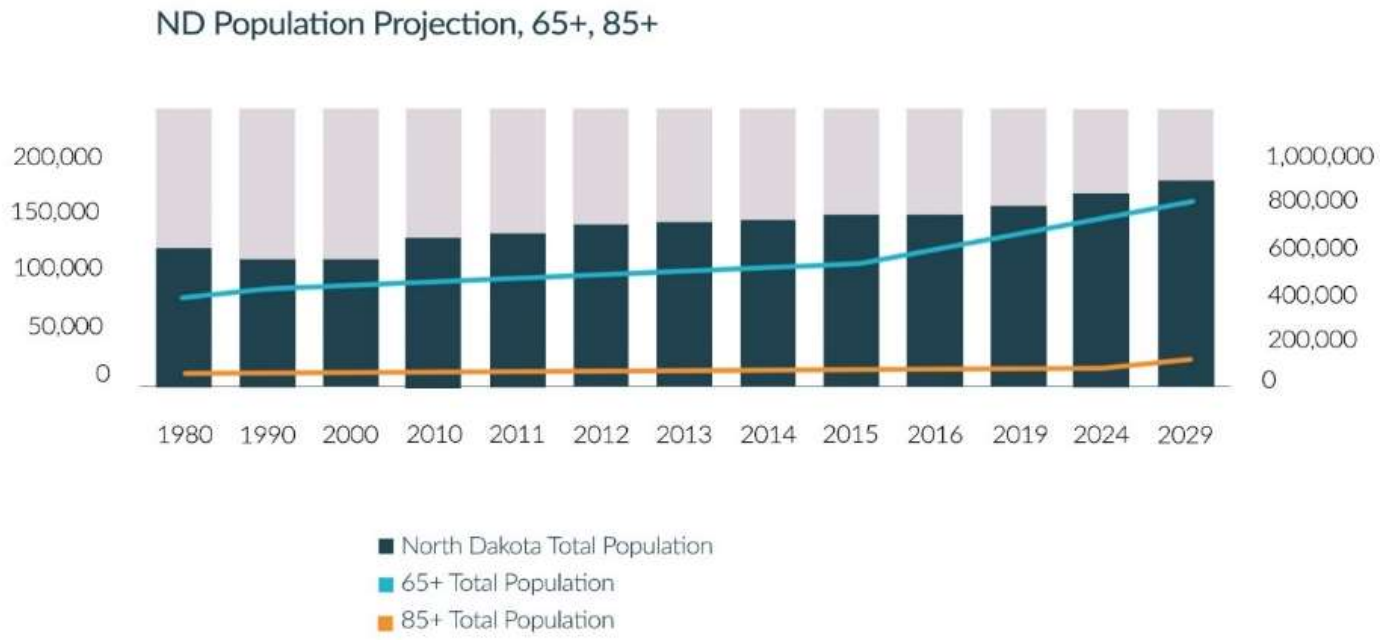


Figure 17. North Dakota Population Projections for the total state, 65+ and 85+, 2029
Source: U.S. Census Bureau, Decennial Census and Population Estimates, Center for Social Research at NDSU

[40] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 13.

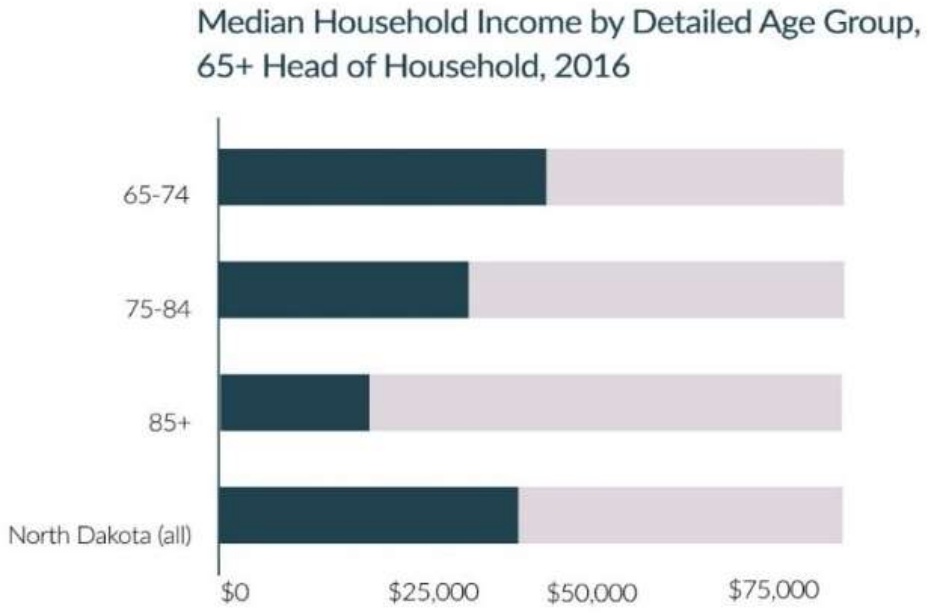


Figure 18. Median Household Income by Detailed Age Group, 65+ Head of Household
Source: Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey

North Dakota ranks seventh in the nation in the highest proportion of individuals age 85 years and older. Based on the aging population and extended life expectancy, it is anticipated that one out of two North Dakotans will need long-term care services such as nursing facilities, basic care, assisted living, swing beds or home- and community-based care in their lifetime. In 2017, there were more than 16,000 individuals in basic care, assisted living or skilled nursing facility. The state has the oldest nursing home residents with 47 percent aged 85-95 years, which is the highest in the nation and is the second highest in the nation with 9.2 percent over the age of 95.[41]

Table 6 below is an overview of the level of care North Dakotans receive outside of their home. Elderly households that are able to retrofit their homes to address mobility challenges are the least cost-burden solution for the individual and the state.

[41] North Dakota Long Term Care Facts & Figures. 2017. Retrieved from www.ndltca.org/image/cache/NDLTCA_Facts_and_Figures_2017.pdf

North Dakota Long Term Care 2017

	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Assisted Living	85%	7%	8%	51%	17%	9%	23%				
Reason	Assitance with daily care, social isolation, limited community services, need for supervision			Advancing medical need and growing cognition issues neccessitate the move to a higher level of care.				$2,341*	75	2,924	95%
	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Basic Care	54%	12%	34%	60%	8%	13%	19%				
Reason	Needs assistance and supervision, confusion			Medical needs, physical liminations and growing cognitive issues are why over half are admitted into a skilled nursing facility				$3,668**	62	1,818	82%
	Moving In From			Moving Out To				Cost Average Per Month	Licensed Facilities	Licensed Units	Occupancy Rate
	Home	Nursing Facility	Other	Nursing Facility	Death	Home	Other				
Nursing Facility	54%	12%	34%	na	na	49%	na				
Reason	Assitance with daily care, need for supervision, falls, dementia, and complex medical needs							$7,871	80	6,141	94%

* Cost ranged from $923 to $4,380 per month. Cost for services average $1,017, with a range of $13 to $4,000 per month

** Cost ranged from $2,300 to $5,100 per month

Table 6. North Dakota Long Term Care 2017
Source: North Dakota Long Term Care Association

Disabled

In North Dakota, 11 percent of the total population, or 72,674 people reported having a disability including ambulatory, visual, cognitive, and hearing to needing assistance with self-care and independent living. The employment rate for persons with a disability is much lower than for those without a disability. The disparity in employment between individuals with a disability and those without is illustrated by the difference in mean annual earnings. In 2014, mean annual earnings for the non-institutionalized population ages 16 and older with a disability in North Dakota was $22,377 compared to $31,754 for persons without a disability. Considering the lower rates of employment and lower mean annual earnings among individuals with a disability in North Dakota, the higher prevalence of poverty among those with a disability is not unexpected. Individuals with a disability were more than twice as likely to be living in poverty as individuals without a disability. Twenty-four percent of persons with a disability lived in poverty compared to 10 percent of persons without a disability.[42]

[42] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 16-8.

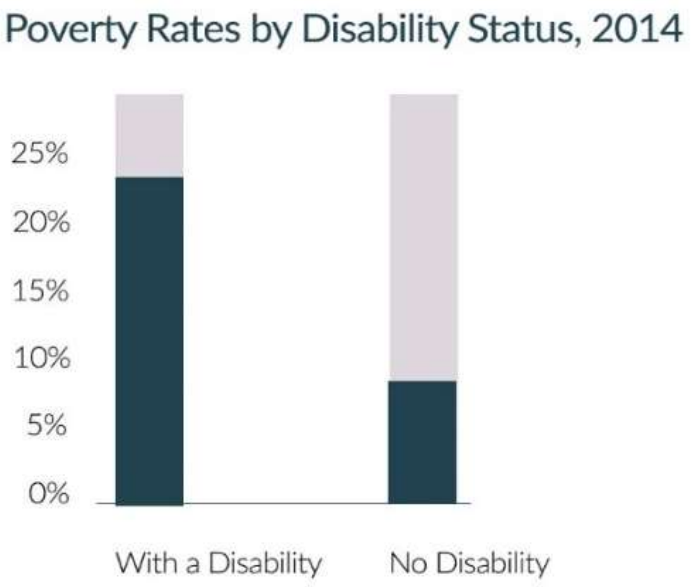


Figure 19: Poverty Rates by Disability Status in North Dakota, 2014
Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates

Persons less than 65 years old with disabilities are projected to increase by 6,108 by 2029, a 15 percent increase. The number of individuals with a disability ages 65 and older is projected to increase by 17,092, a 52 percent increase by 2029. Disability rates were assumed to remain the same until 2029, 6.7 percent for the 0 to 64 age category and 34.4 percent for the 65 and older age group. However, future trends on the proportion of the population with a disability should be monitored. In recent years, the number of people with a disability increased faster than the increase in the number of people without a disability.[43]

[43] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 16-8.

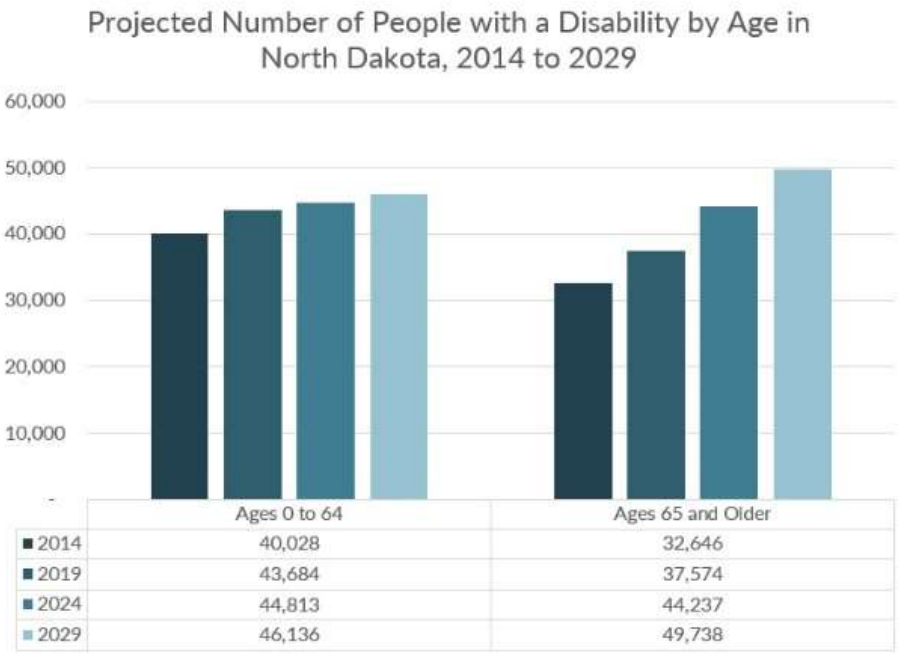


Figure 20: Projected Number of People with a Disability by Age in North Dakota, 2014-2029
Source: U.S. Census Bureau and the Center for Social Research at NDSU

The North Dakota State Hospital provides inpatient and residential care for substance abuse and severe mental illness. Individuals served by the State Hospital often have multiple needs and diagnoses—they may struggle with both mental illness and substance abuse, have developmental or cognitive disabilities, traumatic brain injuries, or other conditions that render them unable to care for themselves. Most patients treated at the State Hospital were discharged to their residence. Nearly all other patients were discharged to some other type of group-living or institution. Of all the discharges from 2010 to 2014, 60 percent were discharged to a personal residence, 14 percent were discharged to intermediate care facilities, 13 percent to correctional facilities, and 12 percent to another inpatient facility. While a majority of state hospital patients were discharged to known locations, a small percentage of discharges were classified as housing insecure. Examples of housing insecure discharge types include homeless shelters, left against medical advice, discharged after a court appearance, and unknown. The number of housing insecure discharges have increased since 2010. In 2010, 12 discharges were categorized as housing insecure. In 2015 the number of housing insecure discharges per year had doubled to 24. Put into another context, in 2015, on average, two discharges per month were housing insecure discharges. [44]

[44] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 18-9.

Veterans

In the past decade, the North Dakota Department of Veterans Affairs and the Fargo VA Health Care System's Homeless Veterans Program has worked with 1,200 veterans experiencing homelessness across the state. North Dakota's VA has 275 HUD-VA Supportive Housing (VASH) Program vouchers that are available to veterans and their families to live in market-rate rental units with the VA providing case management services. Utilization of the vouchers across the state is 90 percent, and no veterans are on a waiting list.[45]

Since 2006, the mortality rate among homeless veterans in North Dakota has dropped from 20 percent to 1.46 percent in 2016. Predominantly the cause of death is medically and age-related. Less than one percent is reported as suicides. Community Action of North Dakota is in the process of submitting data to HUD-VA to have North Dakota declared at "Functional Zero" for homeless veterans.[46]

Challenges of Affording a Home

Affordable housing is a function of both the supply of low-cost housing and the income levels of residents. Table 7 provides a benchmark of income levels for residents in the state and is designed to align closely with various federal housing programs. The benchmark of $69,600 in 2014 is based on median family income (MFI) of North Dakota residents as reported by HUD. Six categories of income are provided for program purposes and are based on a percentage below or above the state's MFI. Monthly affordable housing costs were estimated at 30 percent of the corresponding income category while affordable purchase price was based on a more complex formula that is typical of those used by lenders. The main assumptions include a 30-year loan fixed at 4 percent interest, 5 percent down payment, property taxes at 1.25 percent of the loan, property insurance at 0.6 percent of the loan, and total debt at no more than 20 percent of income.[47]

Income Categories Based on Income as a Percentage of the Median Family Income (MFI) FY 2014 (FY 2014 MFI = $69,600 in North Dakota)

Characteristic	Extremely Low: 0 to 30% MFI		Very Low: 31% to 50% MFI		Low: 51% to 80% MFI		Lower Moderate: 116% to 140% MFI		Upper: Above 140% MFI	Tax Credit: 0% to 60% MFI	
	From:	To:	From:	To:	From:	To:	From:	To:		From:	To:
Annual Income Ranges ($)	$0	$20,880	$20,881	$34,800	$34,801	$55,680	$55,681	$80,040	$97,441 and above	$0	$41,760
Monthly Affordable Housing Costs ($)	$0	$522	$523	$870	$871	$1,392	$1,393	$2,001	$2,437 and above	$0	$1,044
Affordable Purchase Price ($)	$40,351		$67,504		$108,612		$189,313		$227,168	$80,734	
Percent of Owner-Occupied Housing Units that Are Affordable	15.4%		22.1%		43.0%		63.3%		81.7%	29.9%	
Percent of Renter-Occupied Housing Units that Are Affordable	27.9%		69.8%		87.3%		90.2%		91.1%	75.7%	

Sources: Calculations based on data from the U.S. Census Bureau and the U.S. Department of Housing and Urban Development

Table 7. North Dakota Annual Income Level Category Characteristics, 2014
Source: Center for Social Research at NDSU, U.S. Census Bureau, HUD

[45] North Dakota Veterans Administration, Diana Hall, 2018.
[46] Fargo VA Medical Center, Diana Hall, Programs Manager for Housing and Appointment Programs. Email 2018.
[47] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 21.

Based on these assumptions, the purchase price of a home for a family below 30 percent of the MFI would be $40,351. At present, only 15 percent of the owner-occupied housing units in the state are affordable for people in this income circumstance. Similarly, only 28 percent of the rental units in the state are affordable to those below 30 percent of the state's MFI. In contrast, those in the moderate income bracket have a much greater inventory of appropriately priced housing; 70 percent of the current owner-occupied housing stock and 91 percent of rental units would be affordable for moderate-income households.[48]

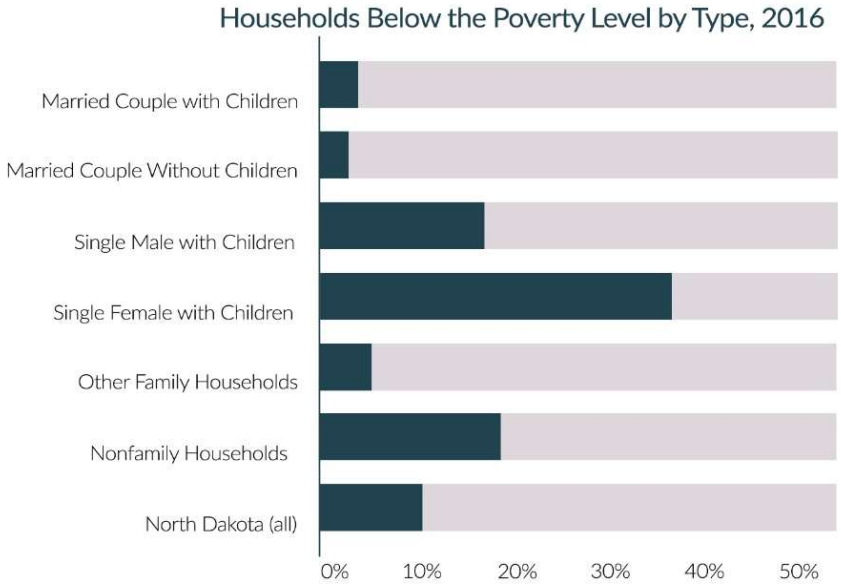


Figure 21. North Dakota Household Below Poverty Level by Type, 2016
Source: U.S. Census Bureau, American Community Survey

It is assumed that renting a home or apartment is more accessible than owning one; however, North Dakotans face extreme challenges to be able to afford an apartment. The state-set minimum wage is $7.25 an hour, and a person earning minimum wage would need to work 70 hours per week to afford a one-bedroom rental at the Fair Market Rent rate. Tenants would need to earn more than twice the minimum wage to only have to work 40 hours a week and be able to afford the Fair Market Rent for a two-bedroom rental home without paying more than 30 percent of their income. In addition to the income challenge, the number of rental housing units available in the state as of 2016 was only 40 per 100 extremely low-income renters.[49]

[48] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 21.
[49] The Gap: A Shortage of Affordable Homes, 2017. Retrieved from http://nlihc.org/sites/default/files/Gap-Report_2017.pdf

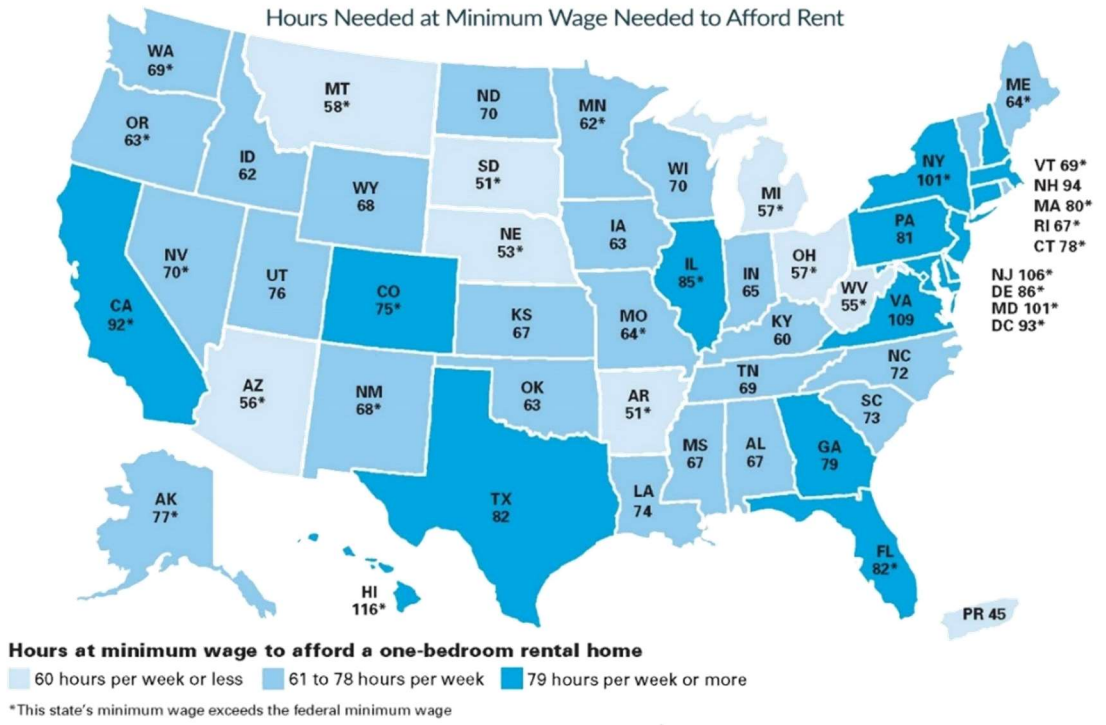


Figure 22. 2017 Hours Needed At Minimum Wage Needed to Afford Rent
Source: National Low-Income Housing Coalition

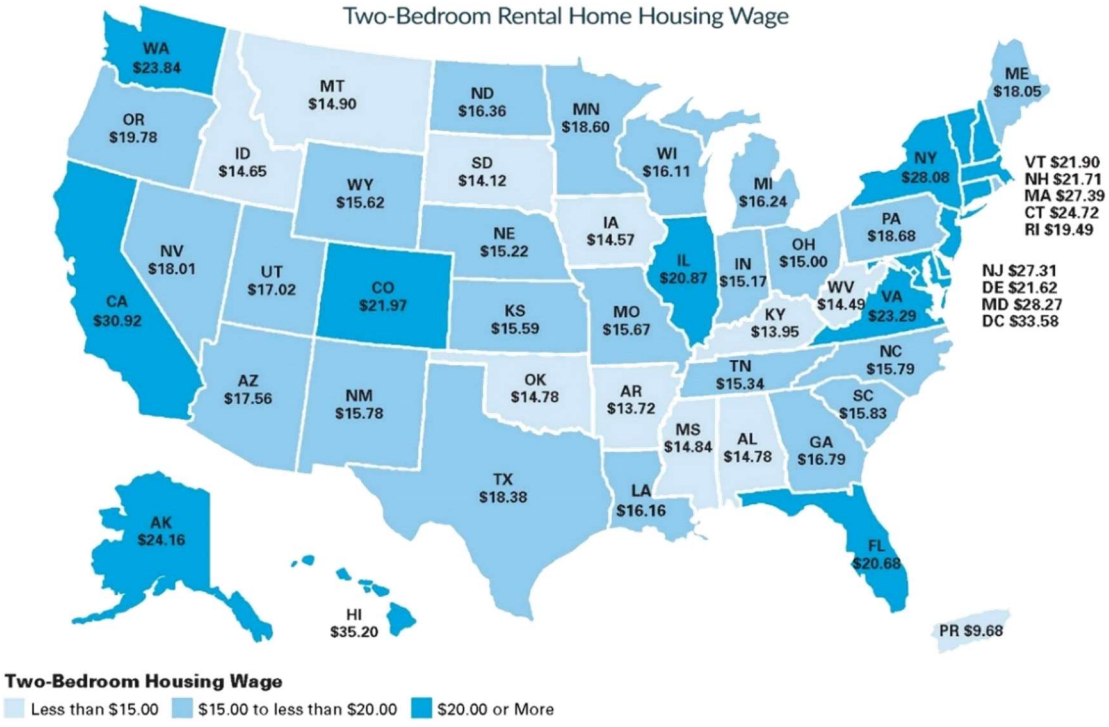
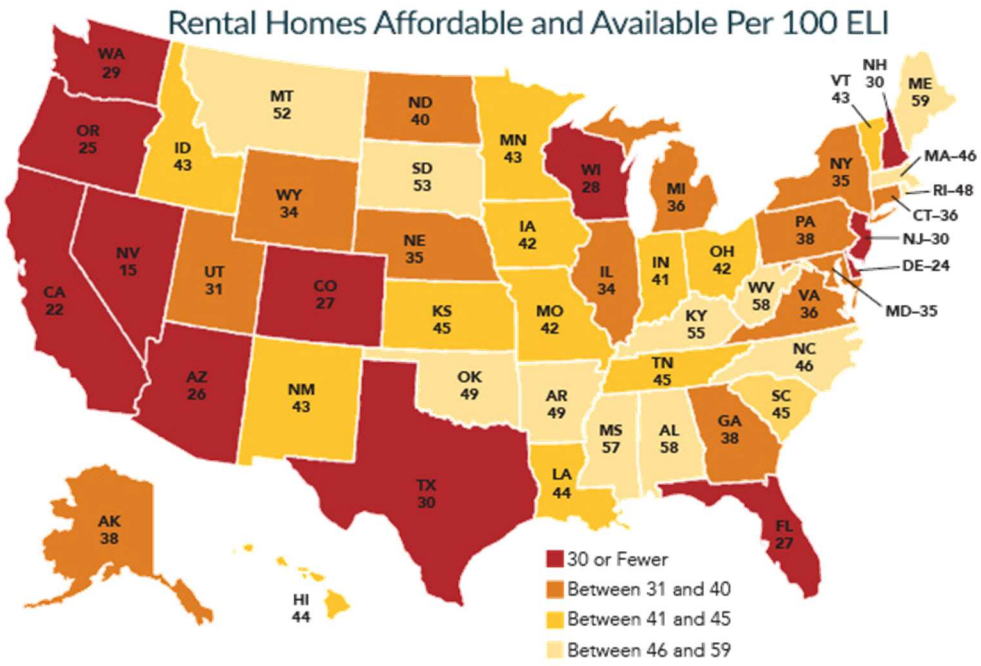


Figure 23. 2017 Two-Bedroom Rental Home Housing Wage
Source: National Low-Income Housing Coalition

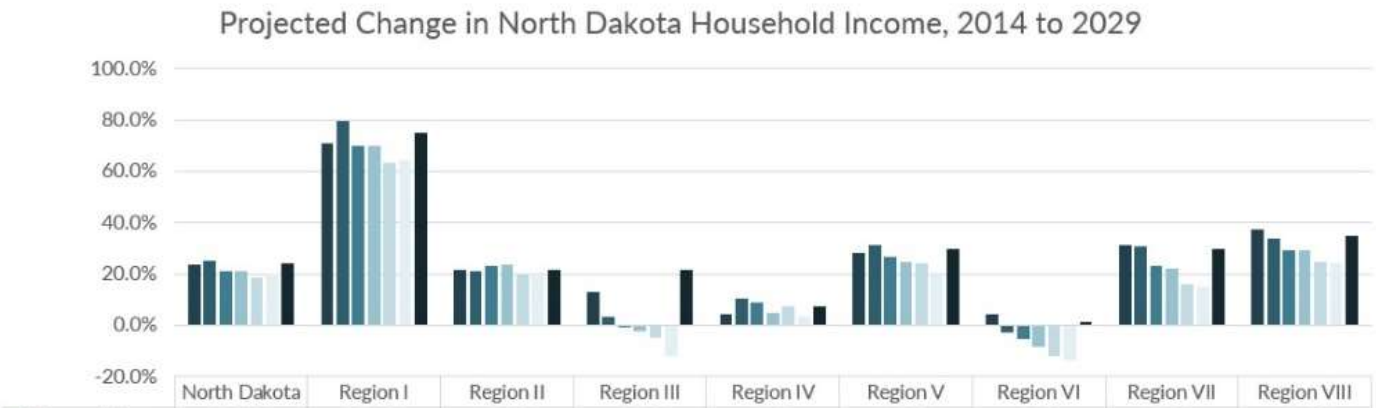


Note: Extremely low income (ELI) renter households have incomes at or below the poverty level of 30% of the area median income

Figure 24. Rental Homes Affordable and Available Per 100 Extremely Low-income Renter Households by State
Source: National Low-Income Housing Coalition

North Dakota is divided into eight housing and planning regions as shown in Figure 24 and each have unique strengths and challenges concerning housing stock, population growth and aging, economic development, and rural, urban and tribal reservations communities. Projected change in the number of households by income is an indicator of potential future housing needs. Double-digit growth is anticipated across all household income levels statewide as shown in Figure 25. Projected change is higher in the lower income brackets than the higher income brackets, and change in households is the greatest for extremely low and very low-income households with projected increases of 24 and 25 percent, respectively. Region I will experience the highest increase across all income groups while the most disparity in growth rates among household income levels is in Region VII where growth in the extremely low- and very low-income categories is double that of the higher income brackets at 31 percent. [50]

[50] 2016 North Dakota Statewide Housing Needs Assessment: Component 1-Population & Housing Forecast. p 27-8.



	North Dakota	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII
Extremely Low	23.6%	71.0%	21.5%	13.1%	4.2%	28.3%	4.2%	31.5%	37.6%
Very Low	25.4%	79.7%	21.3%	3.4%	10.3%	31.3%	-3.0%	30.6%	33.6%
Low	21.1%	69.7%	23.1%	-0.8%	9.0%	26.5%	-5.2%	23.2%	29.3%
Lower Moderate	21.1%	69.8%	23.9%	-2.5%	4.7%	24.8%	-8.5%	21.9%	29.4%
Moderate	18.6%	63.3%	20.0%	-4.7%	7.2%	24.4%	-12.0%	15.8%	24.9%
Upper	19.9%	64.4%	20.7%	-11.7%	3.5%	20.5%	-13.3%	15.0%	24.2%
Tax Credit	24.0%	74.8%	21.4%	21.4%	7.4%	29.6%	1.3%	29.9%	34.7%

Figure 25. Projected Change in North Dakota Households by Household Income 2014-2029
Source: U.S. Census Bureau, Center for Social Research at NDSU

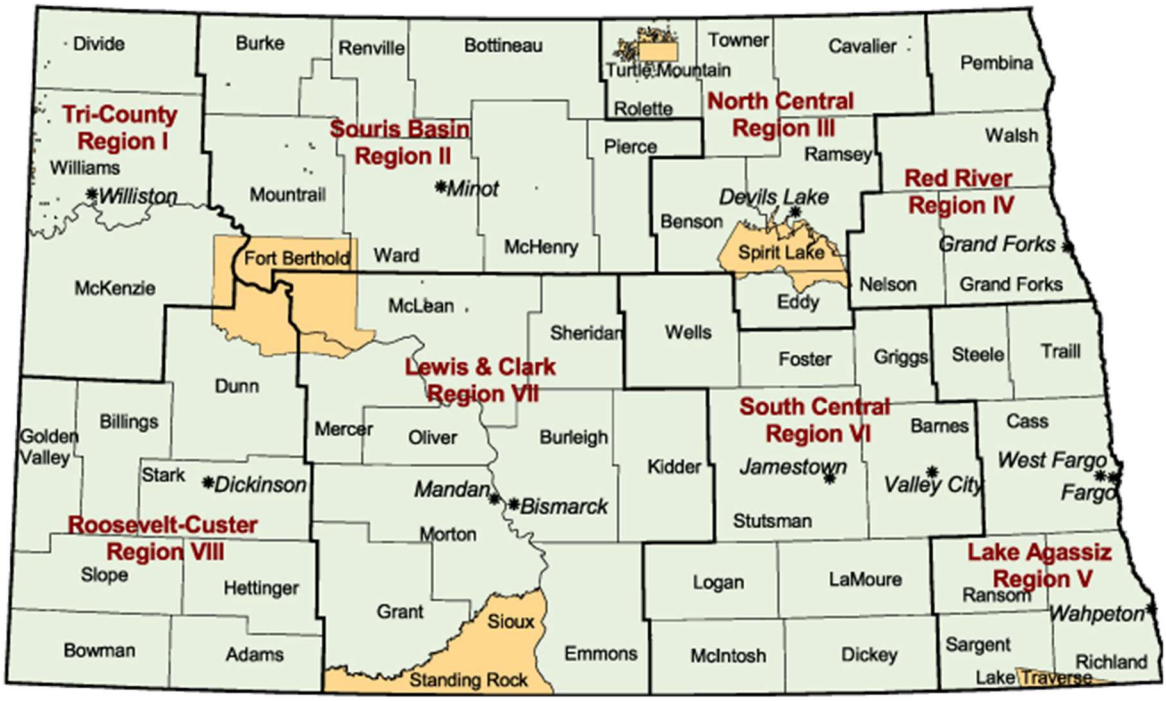


Figure 26: North Dakota geographic locations and boundaries used in the 2016 North Dakota Statewide Housing Needs Assessment
Source: Center for Social Research at NDSU

Housing Development & Voucher Programs

State and federal programs provide assistance through various mechanisms to assist extremely low, very low and low-income households. Several programs are project-based for finite periods, and a substantial number of those housing units will come to the end of the program participation period by 2029. The potential loss of housing units in both rural and urban areas could present substantial challenges for low-income households, especially considering the projected statewide increase in the number of such households. Planning to address the effects of the potential loss of this inventory will be critical to assuring that the state's most vulnerable citizens have adequate access to affordable housing.[51]

The U.S. Department of Agriculture (USDA) Rural Residential Housing Program makes loans to qualified housing developers as an incentive to build multi-family rental properties that meet the needs of low-income, elderly and disabled individuals and families in communities with a population of 35,000 or less. In addition to low-interest loans for development, USDA also provides rental assistance for low-income households. In 2015, USDA had 2,477 housing units in 146 multi-family properties in 99 communities around North Dakota. Three-fourths of USDA's housing units receive rental assistance. By 2029, 635 units or 26 percent of USDA housing will reach maturity and no longer be enrolled in the program. While the number of properties set to expire appears to be relatively small, the loss of even a few low-income housing units could have substantial impacts, especially in communities with low inventories of rental properties.[52]

HUD's Low-Income Housing Tax Credits (LIHTC) provides federal income tax credits to individuals, partnerships, LLCs or other entities, such as housing authorities and other legal entities, for the construction or renovation of properties that serve the needs of low- income households. Currently, there are 5,683 housing units in the LIHTC program. Like USDA's low-income housing, a substantial portion of the LIHTC properties, 37 percent or 2,124 units, in North Dakota will reach maturity by the end of 2029. Most of the maturing properties are located in the state's largest cities. Given the projected increase in the number of low-income households in the state's five largest urban centers, the need for affordable housing for such households is likely to increase making the potential loss of this housing inventory problematic. [53]

HUD's Housing Choice Voucher program, administered by public housing agencies, assists very low-income, elderly and disabled individuals and families. During the first quarter of 2016, 6,514 housing units in North Dakota were supported by the program. HUD's Public Housing program is administered by local housing authorities, which also owns and manages the rental housing for eligible low-income, elderly and disabled individuals and families. There are 1,709 units of public housing in North Dakota managed by 15 public housing authorities.[54]

NDHFA provides rental assistance with project-based programs known as Section 8 Performance-Based Contract Administration (PBCA). Currently, NDHFA has project-based assistance contracts with 98 properties with a total of 2,964 housing units. When contracts expire, properties may opt out of the program. NDHFA also administers the HUD Moderate Rehabilitation (Mod Rehab) program, and as of 2016, there were 10 properties with 157 units. The Mod Rehab program was repealed in 1991, and no new projects are allowed, therefore, once a property opts out, it cannot reapply. Because both programs are closed, properties in the PBCA program and the Mod Rehab program will likely decrease over time.[55]

HIF was authorized by the North Dakota Legislative Assembly in 2011 and has become one of the most successful tools to create affordable housing in the state. Housing units in the program are to benefit low- to moderate-

[51] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 9.
[52] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 23-4.
[53] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 27-9.
[54] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 30.
[55] 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 31-2.

income households or below 140 percent of area median family income. Like the LIHTC program, units are income- and rent-restricted to the target households. NDHFA has allocated more than $89.6 million to 77 projects to support 2,380 new units in 26 communities across the state. HIF was reauthorized in 2017 by the North Dakota Legislature, but no funding was allocated to the program.[56]

MFP is administered by NDDHS and is an $8.9 million grant from the Centers for Medicare and Medicaid Services to help approximately 110 Medicaid clients who are older adults or people with developmental disabilities transition from nursing homes or institutions and reintegrate them into the community. A full year of case management is provided in addition to up to $3,000 for one-time transition costs.[57] Funding for the program will no longer be available after 2019 and operation of the program will cease in 2020.

[56] NDHFA and 2016 North Dakota Statewide Housing Needs Assessment: Component 2-Special Housing Topics. p 32.
[57] N.D. Money Follows the Person Grant. Retrieved from https://www.nd.gov/dhs/info/pubs/mfp/overview.html

Moving Forward

Moving Forward

The North Dakota 10-Year Plan to End Long-Term Homelessness focused on the immediate need for PSH and affordable housing as the cornerstone of ending homelessness. In order to prevent, reduce and end homelessness, a more systematic and collaborative approach to early intervention is needed to identify individuals that need short-term, assistance-based solutions and those that need more intensive, ongoing care to conserve local, state and federal resources.

According to the U.S. Interagency Council on Homelessness, in 2017 a chronically homeless person costs taxpayers as much as $30,000 to $50,000 per year.[58] That same year North Dakota counted 1,089 homeless individuals, of which 45 were chronically homeless. Using the base national average of $30,000, North Dakotan taxpayers spent $1,350,000 on emergency medical care, inpatient bed visits, detox programs, jails, prisons and psychiatric institutions for those chronically homeless individuals.

After reflecting on progress and roadblocks at the state and local level to address homelessness, members of the NDICHP and local service providers identified specific groups that are more vulnerable and would benefit the most from concentrated efforts. The following recommendations are broad-based and will require dedication and investments from numerous state agencies to ensure vulnerable populations are getting adequate services to accommodate their unique needs and help them be functioning and contributing members of North Dakota's communities. Some of the recommendations are within the 2018 North Dakota Behavioral Health System Study[59] and the State of North Dakota's Information Technology Department's Citizen Experience Initiative.

Breaking the Cycle of Generational Poverty

To end the cycle of generational poverty, children and their parents both need to be housing stable. Screening mechanisms need to be in place for service providers, primary care providers and school counselors to be able to identify problematic family dynamics and refer them to a case manager based on their current situation and complexity of need.

- Create more wrap-around service based housing programs for single parents with children. The Jeremiah Program and Grace Gardens, both located in Fargo, provide safe and affordable housing, support for continued education, quality early childhood education, life skills training and a supportive community. Parents can focus on personal and professional development to become self-sufficient. During the day, young children are enrolled in reliable daycare, receiving early childhood education opportunities so they are school ready. School-aged children are in a controlled environment where they feel safe and receive the support they need to succeed in school. Research conducted for the Jeremiah Program determined that every dollar spent on the Program resulted in a $4 savings in public services across two generations.[60]

- Expand outpatient and community-based services that are flexible such as peer support, community health workers, in-home and school-based clinical services and substance use disorder treatment services to address the behavioral health needs of children, youth and their families. Stabilizing the

[58] Ending Chronic Homelessness in 2017. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

[59] 2018 North Dakota Behavioral Health System Study. Retrieved from http://www.nd.gov/dhs/info/pubs/docs/mhsa/2018-4-nd-behavioral-health-system-study-final-report-hsri.pdf

[60] Jeremiah Program-Our Impact. Retrieved from https://jeremiahprogram.org/our-impact/

family in their home in their community will lessen the need for relocation and out-patient treatments.

- Expand targeted proactive in-home supports for families with children and youth at risk of foster care placement and justice involvement. There is a need for targeted support for children and youth as well as for parents whose children are at risk of out-of-home placement and justice involvement. Parental behavior is the main barrier to family reunification, therefore if more services were provided, youth may not need to enter the foster care system. Many youth who are justice involved also have a parent or close relative with justice-involvement.

- Develop a streamlined process for NDDPI homeless liaisons located in school districts across the state to be able to refer a case manager to assist families in accessing housing both in urban and rural communities.

Children that are not housing stable, are within the foster care system, do not graduate from high school, or have mental health or substance issues have a much higher probability of needing public assistance as an adult. Early detection and prevention are the best methods to help youth navigate difficult living situations.

- Explore barriers to create emergency shelters, low-barrier housing, host homes and other short- and long-term housing options for youth and young adults who are unsheltered, fleeing an unsafe situation, or experiencing a housing crisis. There is an unfilled gap for those ages 16 to 24 that need refuge in a safe space without being housed with chronically homeless adults.

- Coordinate entry processes and support services that are trauma, age and developmentally appropriate. Ensuring youth are housing stable is critical to their overall well-being especially for them to be able to create permanent and healthy connections with adults and continue to pursue educational or employment opportunities.

- Review state and federal policies and processes impacting unaccompanied youth as well as youth aging out of the foster care system to determine any barriers that can be eliminated. Unaccompanied and emancipated youth experience legal barriers that prevent them from accessing housing, employment, and government documents.

Lessening the Cost

Some individuals have complex medical and emotional needs, which prohibits their ability to live on their own without some sort of social network assisting them. These individuals are classified as the chronically homeless and create the biggest financial burden on local medical, law enforcement and service providers.

- Finance more Housing First facilities creating more homes to stabilize the chronically homeless. When basic needs are taken care, residents can focus on treating their issues, ultimately saving lives and reducing costs. The Cooper House in Fargo and LaGrave on First in Grand Forks provide permanent housing to the chronically homeless. Residents are charged rent, can have limited access to alcohol and receive services at their request. This housing model helps control public service costs these residents would have used for emergency shelter, emergency room visits, incarceration, and

detox centers. An independent study from Eide Bailly reported housing 66 individuals in the Cooper House saved the public $204,140 in service costs over 12 months.[61]

- Provide funding for support services and operational expenses. If service providers are not able to staff the facility and provide onsite, person-centered treatment, individuals living at the facility will not be successful in their recovery, stabilization, and integration back into the community.

- Explore the cost and benefit of funding "harm reduction" shelters, where residents can consume substances or come into a shelter under the influence of drugs and alcohol. Traditional homeless shelters have strict sobriety rules. If individuals are not sober or if they want to continue to consume substances, their only option is to do so in public. Individuals in the harm reduction shelter may form a pattern of consistency and service providers can develop relationships to help them reduce substance use or focus on sobriety and find more permanent housing options. Studies have identified the effectiveness of harm reduction shelters to curb consumption by creating a stable environment, therefore reducing the cost of public resources.
  - Withdrawal Management Unit also referred to as a Detox Shelter have proven successful in the city of Fargo and is adjacent to the Gladys Ray Shelter and the Veterans Drop-In Center. The Unit provides short-term residential and social (non-medical) detoxification services in a clean, supportive and calm environment designed to assist individuals through the difficulties and dangers from substances in a non-medical setting.[62] This format is more cost effective when it can be leveraged instead of seeking emergency medical treatment.

- Create consistent funding for state housing and service programs such as HIF and the North Dakota Homeless Grant. Developers and local service providers can leverage the funding with private investments and charitable donations to create customized local solutions based on community needs in rural and urban areas. The upfront investment in state funding is critical in delivering upstream and midstream services to vulnerable populations.
  - Explore the cost and benefit of state funded housing vouchers to be leveraged in emergency situations.

Government Efficiencies

The key to enhancing government efficiencies is to establish a systematic approach of clearly defined and repeatable steps where outcomes can be evaluated to generate consistent, optimum results. State agencies and local service providers are well connected and reach out to one another for assistance for the individuals and families they are helping, but most agencies expressed the need for more collaborative efforts to leverage resources and to be more responsive.

- NDICH consists of seven state agencies, one state-wide homeless coalition, and the communities of Fargo, Grand Forks and Bismarck. Moving forward it is recommended that the same state agencies be a part of NDICH; however, involvement is expanded to engage multiple people from each agency especially if the agency has more than one division involved in any aspect of preventing, reducing or ending homelessness.

[61] Cooper House Impact Report 2010. Retrieved from http://fargohousing.org/files/pdf/Cooper%20House/Impact%20Reports/Cooper_House_Impact_Report_June_2013.pdf

[62] Gladys Ray Shelter & Veteran's Drop-In Center. Retrieved from http://fargond.gov/city-government/departments/fargo-cass-public-health/gladys-ray-shelter-veteran-s-drop-in-center

- The NDICH would convene twice a year fostering an environment where each agency thinks and works beyond specific duties of their agency/department to achieve services and results that are broader in scope. The goal is to have more of the "right" people at the table to rethink processes that restrict developing new perspectives without hindering innovation or opportunity development. Each agency needs to critically think about the programs offered to be able to develop synergies and identify gaps that impact vulnerable populations. Engaging a diverse stakeholder group from the vulnerable populations and their family members will be insightful in creating comprehensive solutions.
- Develop a communication process to inform other state agencies and the public pertaining to the focus areas, tasks, and progress made through NDICH endeavors.

- Identify barriers preventing state agencies from accessing and leveraging HUD's Homeless Management Information System (HMIS). HMIS is a software application designed to record and store client-level information on the characteristics and service needs of homeless persons throughout a Continuum of Care (CoC) jurisdiction. Service providers currently utilize HMIS to coordinate service provisions, manage their operations and better serve vulnerable populations.

- Map the entry points for vulnerable populations and how they transition throughout state agencies and local service providers. The intent is to streamline the intake/assessment process and ensure they have access to the services they need at a specific point in time. The map will diagram how people and information are shared, gaps, overlapping functions and where efficiencies can be made.
  - Minnesota Department of Human Services – Housing and Supports Division created the Housing Benefits 101 website as tool to assist people who need affordable housing and support systems to maintain their housing, and understand the range of housing and support services available. The website allows each person to identify their current housing situation whether they are looking for a home; moving out of a facility, group home or foster care; need to relocate; are at risk of losing their home; or are experiencing homelessness. The client-centered focus streamlines research and resources that each person needs.[63]

- Identify local, state and federal policies and regulations that hinder vulnerable populations and prioritize actions for change. For instance, the definition of homelessness, case manager, and youth creates issues. Felony convictions inhibit individuals from acquiring housing as well as other social services and create a stigma when employers are reviewing employee applications.

Covering the cost of public assistance is challenging for federal and state government and at the local community level. However, there are ways for the state to access additional federal funding through Medicaid to provide direct support to individuals and families.

- Pursue 1915(i) Medicaid state plan amendments to expand community-based services for vulnerable populations. The 1915(i) state plan amendment has been the most common avenue for states to pursue funding for community-based services that include a wide range of home and community-based services as a state plan option. Adding services through 1915(i) could significantly reduce demand for emergency, inpatient, and long-term care services that are not reimbursed by Medicaid, which could reduce overall system costs in the long run.

[63] Minnesota Housing Benefits 101. Retrieved from https://mn.hb101.org

- Review long-term care facilities placement policies and explore options for community-based alternatives for persons with disabilities and behavioral health issues. In a recent study, it was documented that approximately one in four individuals under the age of 65 were receiving behavioral health-related services in long-term care facilities, which can cost $96,000 per year. With the right supportive services, these individuals could live in community-based PSH units, which are more cost effective solutions.

Client-Focused Delivery System

In order to expedite information gathering and to ensure current and accurate information is available, the state needs a consistent, end-to-end experience across all channels and departments where information can be obtained for any service, on any device and at any time. State agencies and local service providers expressed challenges they have noticed in their specific area and feedback from clients. Below are some of the ideas that were recommended:

- Housing Inventory - create an affordable housing inventory for each community/region
- Housing Forms - create a single form used by all regional housing authorities
- Database - create profiles for each client within a centralized database, so individuals or families applying for state or local benefits do not have to re-enter information
- Privacy Laws - review state privacy laws to ensure clients are protected, but at the same time do not hinder state agencies from accessing the information they need to be able to help a client that is transitioning services from one state agency to another.
- Consent Form - create a consent form signed by the client to release information to all state agencies and case managers
- User Profile - create an app or web portal where clients can enter their information that is stored and they can return at any time to complete.
- Online Chat - through an app or web portal, create an online chat function for clients to ask questions and be directed to the correct state agency or local service
- Services Portal - structure website into user categories and group information based on the client scenario, such as homeless or risk of becoming; searching for housing, employment or daycare, needing social services, youth, tribal, etc.

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Financial Community Impact

Per a Cooper House Impact Report & Cost Study completed by Eide Bailly:

- Cooper House saves taxpayers money. There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that study was conducted, through October 31, 2011
- Costs tied to emergency shelters virtually disappeared once individuals moved into Cooper, dropping 98% from $139,200 to $3,200
- Detox costs also dropped dramatically, falling 71%, from $75,360 to $21,840
- Jail expenses fell 48% from $169,455 to $87,768

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community & Tenant Impact

Cooper House has made a positive impact to the Community of Fargo and in the lives of the Tenants

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The RIGHT THING for "GI JANE" – Veteran, Chronically Homeless & Dually Diagnosed:

- Periodic episodes of homelessness for 3 years; Has successfully maintained housing at Cooper House for 24 months
- 1 Year Prior to moving to Cooper House: Hospital/Emergency Room Charges $38,500
- 1st year at Cooper House: Hospital/Emergency Room Charges $1,000
- Now engaged with case management and Veterans Administration Services

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community & Tenant Impact

The RIGHT THING for "Pete" - Chronically Homeless & Dually Diagnosed

- Homeless for 20 years; Has successfully maintained housing at Cooper House for 25 months
- 1 Year Prior to moving to Cooper House: 201 days in Detox at a cost of nearly $30,000, Emergency Room/Hospital Charges 30,000
- By 2nd year at Cooper: 0 days in Detox, Emergency Room/Hospital Charges approximately $6,000
- Newly engaged in Case Management

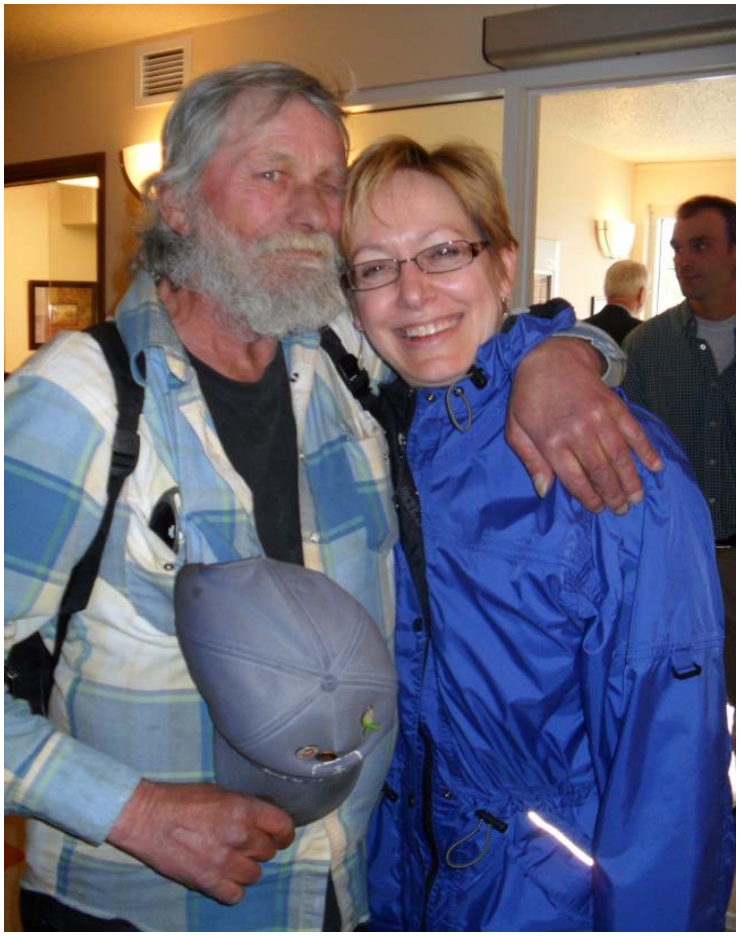
Note: CY2013 Vacancy Rate was 2.3% which equals an average of 1-unit per month.

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Project Description

- ❑ No expectation of sobriety, however there is an expectation of mutual respect

- ❑ Relies on strong partnerships with community-based service providers to meet the varied needs of tenants

- ❑ Front Desk is Staffed 24/7
  - ➔Check Tenants & Guests In and Out
  - ➔Monitor the Security Cameras
  - ➔Perform Wellness Checks
  - ➔Work to Link Tenants with appropriate services



COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Project Description

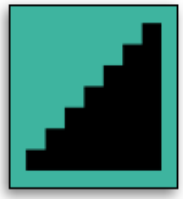
- Employs a "Housing First" model, which recognizes a home as a stable platform for delivering supportive services to help the tenant stabilize their life and keep them housed.

"We give people A HOME FIRST, then offer a variety of services to help them improve their lives."



Our **On-Site Nurse** breaks down barriers and builds trust with tenants to help them manage their chronic health conditions BEFORE they escalate to an Emergency Room visit or a hospital stay.

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Stakeholders/Partners/3rd Party Service Providers



Beyond Shelter, Inc.

A Regional Nonprofit Developer of Affordable Housing

















COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



Typical kitchen in an efficiency apartment



Typical living area in an efficiency apartment

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



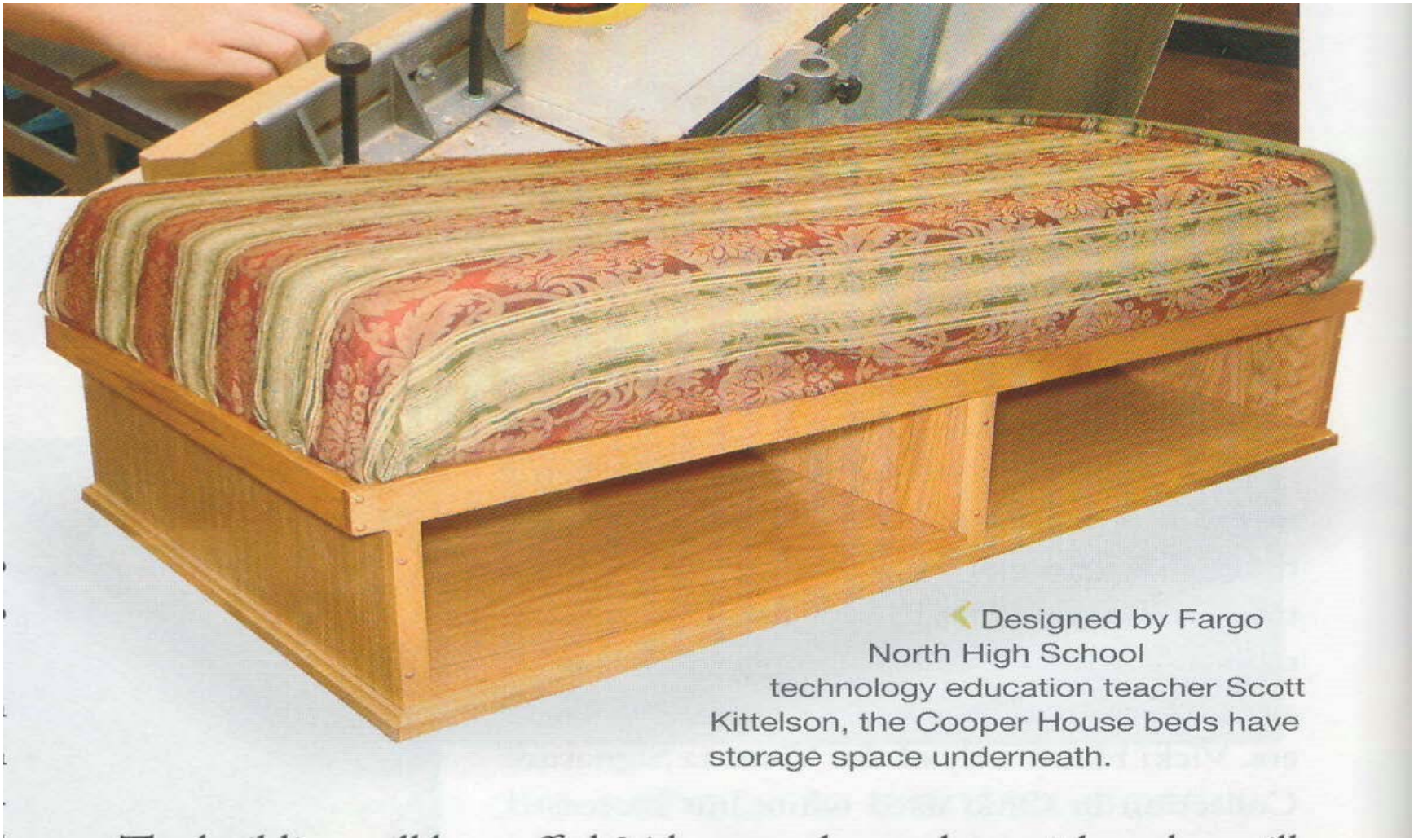
Typical living area in an efficiency apartment



Typical bedroom in a one bedroom apartment

All 42-Beds were built by Fargo North High School technology students

COOPER HOUSE, FARGO, ND
PERMANENT SUPPORTIVE HOUSING
Community Support



Designed by Fargo North High School technology education teacher Scott Kittelson, the Cooper House beds have storage space underneath.

8462



Experience the Eide Bailly Difference

Cooper House Impact Report

A Study of the Impact of Housing
North Dakota's Chronically Homeless Population

EideBailly®

CPAs & BUSINESS ADVISORS

Cooper House Impact Report & Cost Study

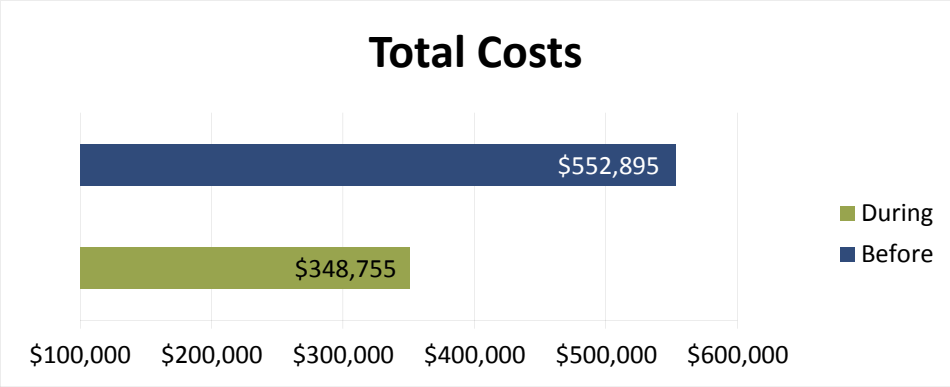
Eide Bailly was engaged by the Fargo Housing & Redevelopment Authority (FHRA) to compile cost data for a group of residents of Cooper House, a supportive housing for the homeless project managed by FHRA. We have compiled data showing the costs to society prior to when these people secured housing at Cooper House and then 12 months during their time housed at Cooper House. Because people move in and out not all dates line up over the same time frame. We have attempted to collect data showing 12 months prior to being housed at Cooper House and during their stay at Cooper House. We have not audited, reviewed or tested this information beyond simple due diligence while collecting it.

Background:

Cooper House opened in Fargo, ND in May of 2010. The Cooper House apartment's provide permanent supportive housing for homeless persons and is a stabilizing next step in the lives of people coming out of shelters or transitional housing programs. It consists of 42 apartments, 32 of which are efficiencies and 10 are one bedroom units. The apartments are rented exclusively to individuals who are documented as homeless. Preferences are given to those experiencing chronic or long-term homelessness, veterans, and people with disabilities. Homeless is defined as an individual or family who lacks a fixed, regular, and adequate nighttime residence. Chronic or long-term homelessness is considered to be anyone being homeless for 12 consecutive months or 4 times in the past 3 years.

Mental Health Technicians are on staff 24 hours, seven days a week at Cooper House, and a part time Licensed Addiction Counselor and a full time Case Manager are in the building daily, working with the clients and offering needed services. Family Health Care Center provides a part time nurse on site who provides medication management, infection control, health assessment, and referrals and follow up.

Cooper House employs a "Housing First" hybrid model, where people are provided a home first and then are offered a variety of services to help improve their lives and keep them in housing.



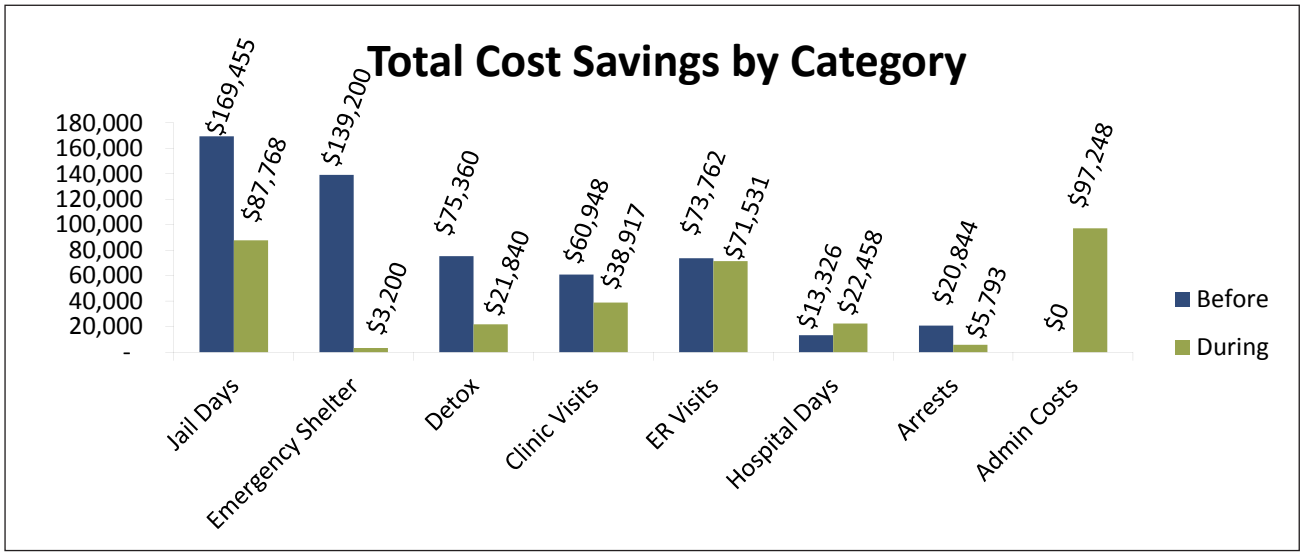
Conclusion:

Based on the results from the cost study, it is evident that housing the chronically homeless is "the smart way to do the right thing." There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that this study was conducted, through October 31, 2011. Being proactive in helping the homeless population is shown to help save the tax payers money and to make the community a better place to live.

The Study:

This study is meant to be a snapshot of the impact of housing North Dakota's chronically homeless population. The data of this study was collected with the consent of 66 tenants (the Study Group) who have lived at Cooper House at various times since it opened. Area service providers, shelters, law enforcement, the court system, and healthcare providers have all cooperated in providing the information gathered throughout this study. Once the information was consolidated then an average per person per month cost was calculated and this was used to calculate the group average.

Below is an overview of the costs comparisons for a one year period prior to being housed and a one year period ending October 31, 2011.



Note: There are two significant public cost drivers not captured by this study. Those of the judicial system which includes all costs related to court processing, arrests, and those costs related to state hospital days attributed to court ordered rehab. For some individuals this was up to dozens of times prior to living at Cooper House.

Healthcare & Medical Costs:

Based on the information received from Sanford Hospital, the Cost Study Group, costs went from $148,036 to $132,906 for a 10% decrease in costs or a savings of $15,130. The healthcare and medical cost data was compiled through October of 2011.

Law Enforcement & Legal costs:

Based on the information received from the Fargo Police Department, the cost associated with arrests declined from $21,000 to $6,000, which resulted in a decrease of $15,000, or 72%. The jail day costs were reduced from $170,000 to $87,800 for an $81,687 or 48% decrease.

Overall, legal and law enforcement saw a cost savings of $96,738 for those living at Cooper House, with some individuals having 100 less jail days than before they were homeless. The law enforcement and legal cost data was compiled through October of 2011.

Detox Costs:

Based on the information received from the Fargo Police Department, the average cost per detox visit is $120, not accounting for police officers time to collect and transport individuals to the facility. The total cost for detox visits decreased from $75,360 to $21,840. For the Cost Study Group, this is a cost savings of 71% or $53,520. In addition, this particular Study Group has seen 446 fewer visits. The detox cost data was compiled through October of 2011.

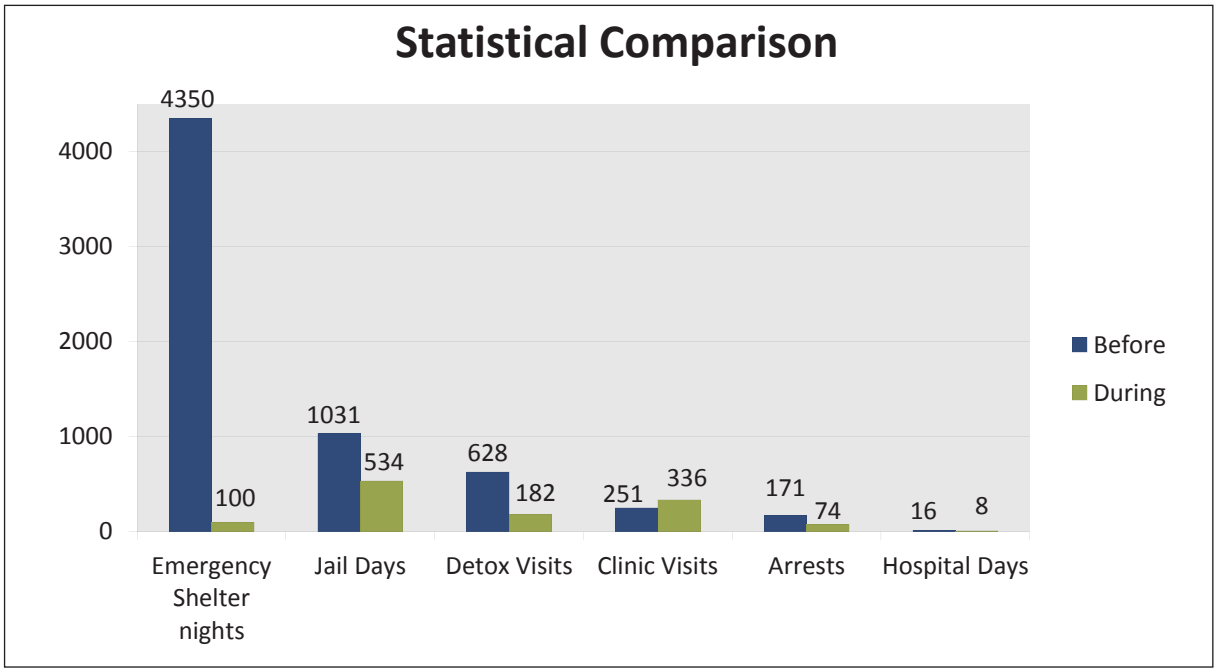
Administration Costs:

The capital outlay of the administration costs is $97,248. This service is provided by Dacotah Foundation through a contract with Southeast Human Services. The front desk is staffed 24/7 and these individuals are considered key to the success and integration back into the community. They staff check tenants and guests in and out of the building, monitor the security system, help with wellness checks, and work to link tenants to appropriate services.

Emergency Shelter:

Based on the information provided by only one of several homeless shelters in Fargo, the Study Group costs were reduced from $139,200 to $3,200, for a total cost savings of $136,000 or 98%. The number of emergency shelter nights was reduced from 4,350 to 100. The emergency shelter cost data was taken from averaging the costs for 2010 and 2011 to determine the average cost per year. The number of times accessed was taken compiled through October 2011.

Below is a statistical comparison of the number of times a service was accessed for the Cost Study Group before and during their residency at the Cooper House:



Places of Birth:

Many of the participants in the cost study call North Dakota their home and have lived here their entire life. Below, the red stars indicate where a portion of the Cost Study Group individuals are originally from.



Please note that not all costs were captured during the study. Some services accessed are not accounted for here and the cost of working with these individuals on the street is understated. For example, only one of several homeless shelters and one of the two hospitals were contacted for this study. Meals from community based organizations are also not accounted for here. In addition, costs accumulated here are only based on the individuals costs accumulated while living in Fargo and do not account for costs incurred in other locations.

Written Testimony pursuant to House Bill 1012 (2021)
Appropriations – Human Resources Division
Senate Appropriations
Chairman: Senator Ray Holmberg
March 9, 2021

Submitted by: Dwight Barden, Executive Director – Burleigh County Housing Authority (BCHA)
701-255-2540
Dwight@bchabis.com

Burleigh County Housing Authority has partnered with Beyond Shelter, Inc. in Fargo to develop a permanent supporting housing project for the homeless in Bismarck called Edwinton Place. It is located at 1121 S. 11th Street, Bismarck just south of Cash Wise on Expressway. This project has 40 – one bedroom apartments. This was developed under the Federal Housing First model. The intent is to get these homeless individuals housed and in a stable environment. Most of these tenants, coming from homeless situations are dealing with mental illness and/or drug/alcohol addictions and are in need of supportive services. BCHA is the landlord we are not a service provider. But without the services, this type of project could not survive.

Edwinton Place has been open for just over one year. We have served 45 individuals during that time. 67% of the individuals are age 45 or older with 83% White, 12% American Indian/Alaska Native and 5% Black. Persons identifying as having a disabling condition due to mental health is 74% and alcohol and drug abuse is 76%. Over half the individuals identified as having 3 or more disabling conditions. 100% came from emergency shelters or unsafe housing environments. 56% identified as having no income at move in. All individuals have extremely low income which means an annual income of less than $20,200.

Our first tenant that moved in was a Veteran and he moved in on Veterans Day 2019. Another tenant has been able to reconnect with her daughters because she has been clean and sober for several months and living in a stable environment.

We have contracted with the Dacotah Foundation to provide 24/7 Housing Support Specialist staff. They are Mental Health Technicians, certified by DHS, and they provide year-around 24/7 front door coverage, as well as the necessary tenancy supports and interventions to create and maintain a safe and supportive environment for tenants. They screen visitors, track tenants coming and going, establish limits and monitor alcohol being brought in, do wellness checks if they haven't been seen each day, engage with tenants and give staff updates on behaviors that may need some attention, de-escalate situations when they can and call for back up when they need it.

In addition to the 24/7 support, we have also provided space for support services to come in such as West Central Human Services, Housing and Employment Specialists from Community Options, Sanford Health provides case management and assists the tenants in accessing and maintaining health insurance. On-site staff coordinate food bank drop offs from Great Plains Food Bank and meals on wheels.

Edwinton Place is housing for tenants that are similar to the ones that live at Cooper House in Fargo and LaGrave on 1st in Grand Forks. In the 2019 legislative session, you were supportive and funded the 24/7

staff at Cooper House and LaGrave on 1st with Section 22 of SB 2012. Edwinton Place has not received any of this funding due to not being under construction at that time.

With Edwinton Place, we did expect that the Medicare provision of section 1915i, which you passed last legislative session, would be available to cover these qualified costs. At this time the funds are still not available and these costs are no longer part of the State 1915i plan. These would be eligible costs only if the housing supports are made available through a daily rate rather than 15 minute units with a maximum of 8 hours daily, for a total of 78 hours per 6 month period. The other issue to this is that the housing crises do not always happen from 8 to 5 therefore providing tenancy supports is needed 24/7.

The tenants do receive housing assistance. But due to the restrictions on the Federal Voucher Program and allowable rents from some of the funding sources that were used to develop this project, there is not enough funding available to pay for the 24/7 support services that are needed.

I do not have the funding numbers for Cooper House and LaGrave on 1st but the Cost at Edwinton is $640,000 per biennium or $667.00 per individual per month.

Thank you for your time and support. This funding investment truly helps those most in need and the most vulnerable of our States population.

I also reach out and offer if you have questions or would like to see Edwinton Place to please contact me.

I oppose HB1012 as it currently is written as it does not include funding for these much needed supports.

HB 1012 Testimony
Senate Appropriation Committee
Senator Ray Holmberg, Chairman
March 10, 2021

Good afternoon Chairman Holmberg and Members of the Committee. My name is Kimberly Ohlhauser, and this is my husband Troy Ohlhauser. We are from Bismarck, ND living in district 30. We are here to share our story regarding our daughter, Chloe.

Our story started back in October 2014 when our daughter was sexually assaulted. She was 8 years old. She was already diagnosed with ADHD and she had a learning disability in relation to social skills, reading and English.

We have done three residential treatment facilities in ND and UT between 2016 and June 2020. The first residential placement my husband and I had to do a no-fault deprivation and give up custody of our daughter to Burleigh County to get her the help she so needed. After going to the second residential treatment facility, we learned that Chloe has autism and is developmentally disabled, along with PTSD, mood dysregulation disorder, and social issues with family, school, and any person of authority.

For the last six and half years this has impacted not only Chloe but my husband and I as well. We have dealt with being physically assaulted by our daughter, her taking off from the house, threatening self-harm which she has a history of. Stealing our credit cards and shopping online due to poor impulse control and breaking our personal property. Our daughter acts like an addict and always wants that immediate gratification. This is the only way we can describe how she is at times. We have had to deal with many let downs after Chloe has been discharged from the residential treatment facilities without going to a step-down program after her second residential placement and a therapeutic foster home after the third residential placement, none of which happened. My husband and I have been in counselling for our mental health and learning how to cope with a special needs child who also has PTSD which can be exhausting physically, mentally, and emotionally. The best way to describe our situation is most of the time we feel like a hostage in our own home and there is literally nothing we can do about it.

We currently have the following services: Case Management, Developmentally Disability program at West Central, Pride respite, counseling once a week, occupational therapy, and speech therapy weekly. We work closely with her case manager in high school, and she sees a psychiatrist once a month but still this is not enough and does not help us when we are in crisis.

We had PATH for respite care, however, Medicaid will only pay for one year per lifetime. Chloe also has done partial hospitalization at CHI St. Alexius as well.

Between July 2020 and November 2020, we as well as her respite workers at Pride have had to call the police on Chloe at least 20 or more times. We were told by some police officers that they cannot continue to chase after her, pick her up when she takes off from our home. This creates a much bigger problem because if we do not call the police when she takes off from our home, my husband and I could be charged with child neglect due to her diagnosis of being developmentally disabled. Chloe mentally is unable to make good decisions most of the time and she doesn't know her own physical strength when she is angry and emotionally unable to control her impulses.

The police youth bureau has also been involved with Chloe since coming home in June of 2020. Each time my husband and I have had her cited by Bismarck Police Department we receive a letter from the Police Youth Bureau within two to three days stating they are not going to do anything due to it being a mental health issue and to follow up with the programs we are involved with.

We have now reached a point where there is nothing any of the agencies can do for us when we are in crisis, which is not their fault.

When Bismarck had a safe bed my husband and I utilized it when in crisis. When Chloe would go to safe bed for 48-72 hours it gave Chloe a chance to calm down and self-regulate. My husband and I got the rest we needed to recharge from the constant abuse we received from our daughter, off and on, the past six and half years.

The head of psychiatry at CHI St Alexius will no longer admit Chloe to the hospital due to it being behavioral issues.

Youth Works will not let her come there during a crisis due to Chloe needing a higher level of care than they can provide.

We had respite care through PATH which Medicaid will only pay for one year per lifetime. We have exhausted that.

We are going through a vicious cycle like many other families are currently going through.

Our wish is for North Dakota to have safe bed again and extensions of coverage for the PATH support program to assist other families like us while we are in crisis.

It would be more cost effective to have safe bed in place rather than going to the hospital or calling the Police and having them tell us there is nothing they can do and wasting their resources and time.

My husband and I will continue to advocate for the mental health services needed in our state for our children and children's children.

We want to thank you Chairman Holmberg and committee members for your time and patience in letting us share our story.

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Troy Ohlhauser
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701 934-1003

67th Legislative Session

Senate Appropriations

Chairman Holmberg and other members of the Committee. I am Rebecca Quinn and serve as program director at the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. The Center for Rural Health is contracted by the Department of Human Services to operate the North Dakota Brain Injury Network. My testimony today is on behalf of all the individuals and families impacted by brain injury in North Dakota.

Throughout the development of North Dakota's brain injury services, there has been identified the need for a centralized brain injury hub to provide information, support, and training. The North Dakota Brain Injury Network meets these needs by providing a centralized, statewide source of information regarding brain injury and delivers resource facilitation services to individuals with brain injury. In order to continue to serve as the central source of information and support for brain injury in the state, I ask that you please restore the funding for NDBIN.

There has been discussion about the use of the 1915i Medicaid State Plan Amendment and the possibility of services being shifted to be provided under this program. While 1915i may be a newly available service, it may not be the best fit for many individuals. Depending on the age of the individual, financial eligibility, level of impairment, and functional need there is a need to have available numerous different service options and combinations that can be tailored to meet an individual's needs. 1915i may be able meet the needs of one individual, another individual may have needs that cannot be met by it or they may not qualify. However, we would be remiss to think these services will meet the needs of individuals with brain injury without the ongoing training, guidance, and support of NDBIN.

Respectfully submitted

Rebecca Quinn
Center for Rural Health
University of North Dakota, School of Medicine and Health Sciences

NDBIN Activities July 2019-January 2021

- Resource Facilitation
  - Resource facilitation for brain injury is an evidenced based service that assists individuals along the path of recovery and increasing independence. This vital service has been adopted by over 40 states and is seen as a core for state brain injury service development by the Federal TBI grant program.
  - This biennium NDBIN has provided resource facilitation to a total of 266 individuals, received 92 new referrals, and had contacts with more than of 1,600 individual or family members
  - A few quotes from our satisfaction survey:
    - *Felt supported and understood.*
    - *Always prompt in answering questions and providing support and assist.*
    - *Keep on Keepin on with how you are doing your work! Thank you for all your support for those who need and are searching for others to help them in their daily lives.*
    - *I had no problem whenever I called Rebecca to ask a question. She always got back to me and either asked further questions to clarify or gave me answers to what I was seeking.*
    - *You do I & R services and help individuals get connected to a service. This is a great need.*

- Mind Matters Conference
  - Unfortunately, had to cancel in 2020, but plan to host a 2-day virtual event: March 25&26th
  - Past conference attendee quotes:
    - *I like having the information to share with clients that struggle with TBI*
    - *Love the Mind Matter conferences*
    - *We are fortunate to have such an important conference in ND.*
    - *Oh my-all speakers were amazing! Connecting with everyone and sharing what works-what does not.*
    - *Well organized-good job and thank you!*
    - *I thought the conference was great. I enjoyed all the speakers-nice variety and topics and good information.*

- Online Brain Injury Training
  - June of 2019 NDBIN launched 5 online training courses
  - Courses included:
    - Introduction to Brain Injury
    - Cognitive and Behavioral Consequences of TBI in Adults
    - Primary Care and TBI
    - Pediatric TBI
    - Substance Use and TBI
  - 1,287 individuals enrolled, 625 having completed, 412 evaluations

- Certified Brain Injury Specialist (CBIS) Training
    - Nationally recognized credential for professionals working in brain injury services. This certification is administered by the Brain Injury Association of America and involves formal coursework and a written examination.
    - NDBIN provided CBIS training in ND in July of 2019, Dec 2019, June 2020, Dec 2020
    - Total of 65 officially certified CBIS in ND as of 1/19/2021.
    - NDBIN hosts a quarterly call for all CBIS to share information and collaborate.

- Webinar Wednesdays
    - These FREE webinars cover a range of brain injury topics and are designed to meet the needs whether you are a brain injury/stroke survivor, caregiver, or provider. Variety of continuing education credits are offered and they are archived online.
    - Total of 26 webinars, 251 total evaluations.

- Virtual Support Groups
    - Facilitated 22 support groups, including 15 virtual.
    - Began partnership with University of Mary Occupational Therapy program to have students co-lead groups.

- Adapted the REAP for ND
    - This is an evidenced based return to learn guide developed by CO and adapted to over 20 states.
    - What is REAP?
        - R = Remove/Reduce physical and cognitive demands
        - E = Educate the student athlete families, educators, coaches, and medical teams of the potential symptoms
        - A = Adjust/Accommodate for the student athlete academically
        - P = Pace the student athlete back to learning, activity, and play
- Virtual Concussion Symposium
    - Hosted a Concussion Symposium with over 100 attendees
    - Keynote by the author of REAP

- Website
    - Maintained a comprehensive website with over 34,780 unique page views
    - Searchable online resource guide, maintained events calendar
    - Developed new content regarding caregivers, special education, and related services

- North Dakota Brain Injury Guide
    - Partnered with the North Dakota Stroke Association to publish a new North Dakota Brain Injury Guide for new survivors. In process of being distributed to hospitals, clinics and private providers.

Upcoming Programs:

- Survivor Connections
    - New program to be launched spring of 2021.
    - Phone based program for new individuals with brain injury to connect them with trained volunteers to provide support for those new to the injury.
    - So far have developed program, recruited & trained 3 survivor volunteers.

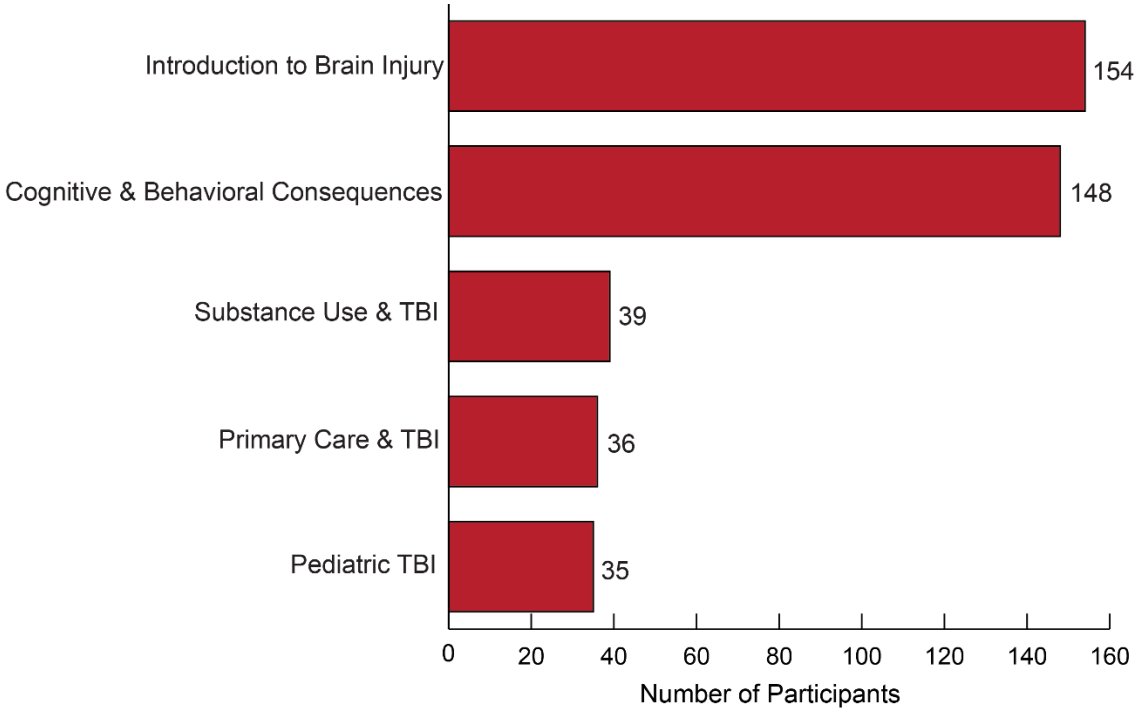
- Brain Injury Basics Training
    - 1st training to be held February 19th, 2021.
    - New training developed to be less intensive than the Certified Brain Injury Specialist, but more engaging than the online courses.
    - This training is based on an interactive approach and will provide direct care staff, peer support specialists and caregivers of individuals with brain injury a general knowledge of brain injury and what that means for the individuals they serve, practical techniques for handling difficult behaviors of individuals with brain injury, as well as building rapport for the individuals within their care.

- Book Club
    - Launched January 2021.
    - A virtual brain injury book club on the first Thursday of every month.

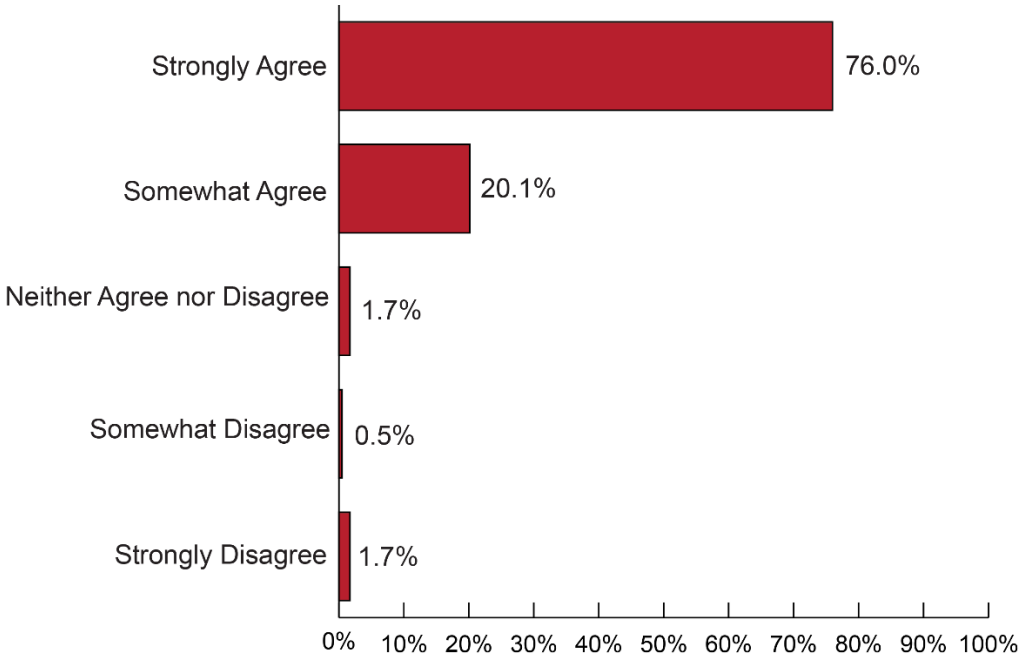
- Virtual Office Hours
    - Launching February 2021.
    - Anyone with questions or needs related to brain injury can join NDBIN for these virtual office hours.

Online Brain Injury Courses-412 total evaluations completed

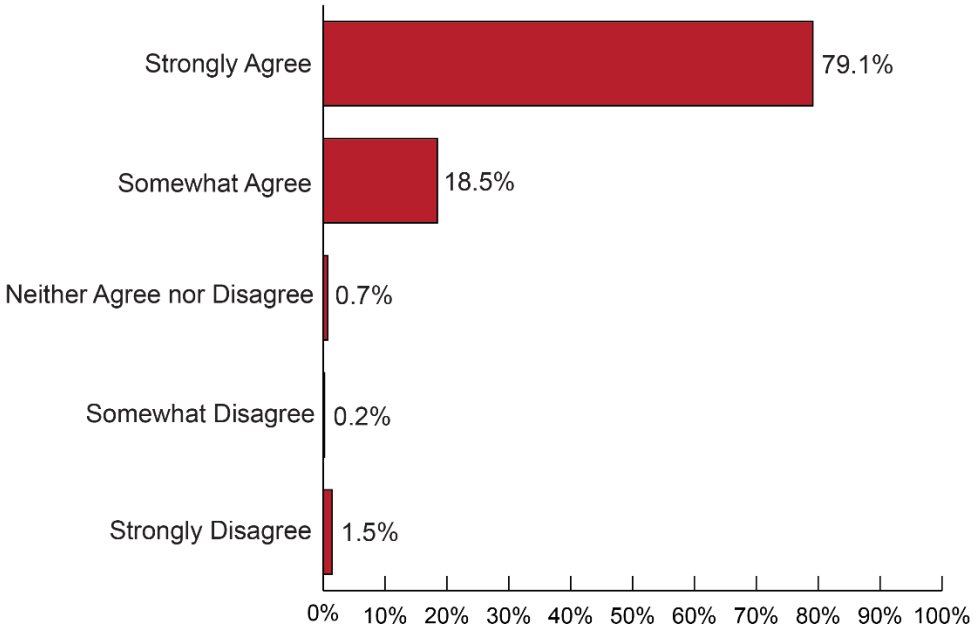
Course Attended:



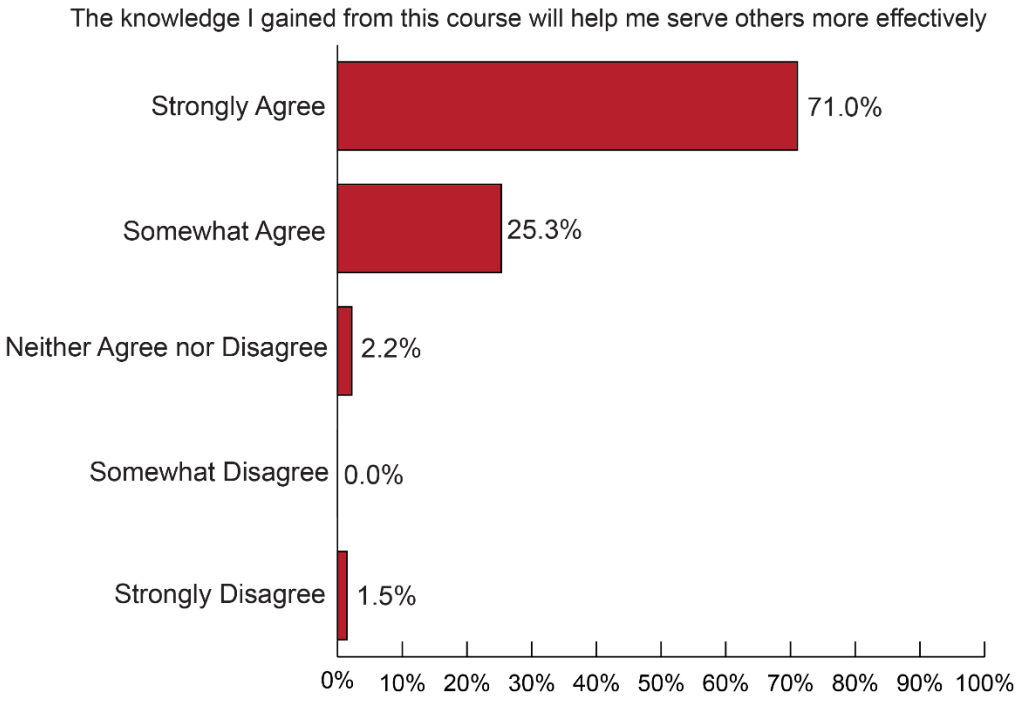
I found the course information to be helpful:



The material presented was appropriate for the intended audience:



The knowledge I gained from this course will help me serve others more effectively:



Webinar Wednesdays-26 total webinars, there were 251 total evaluations completed

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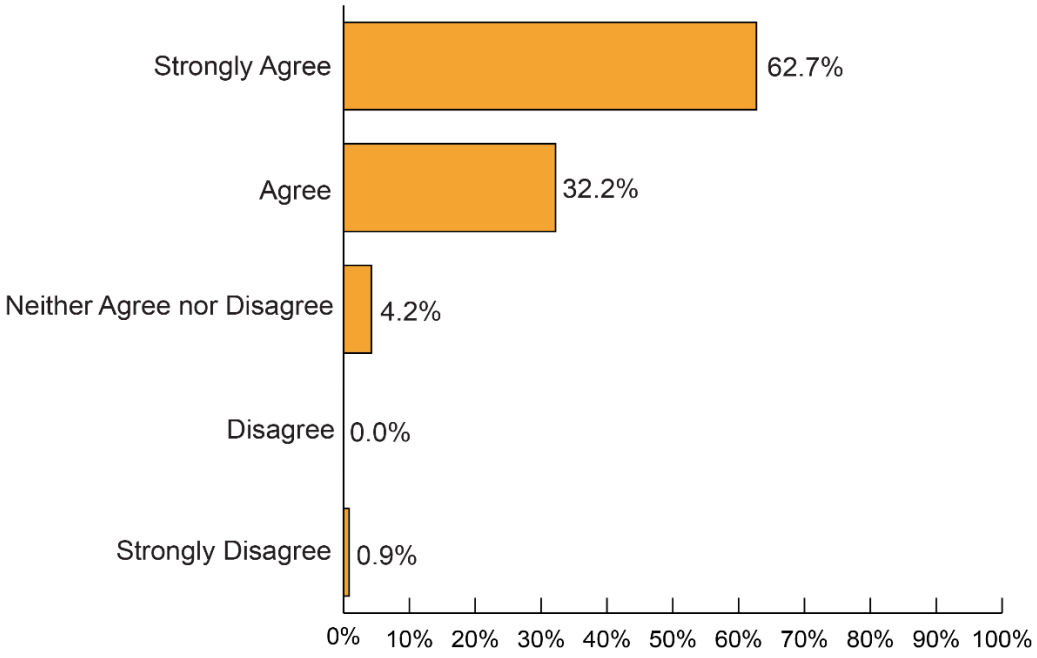
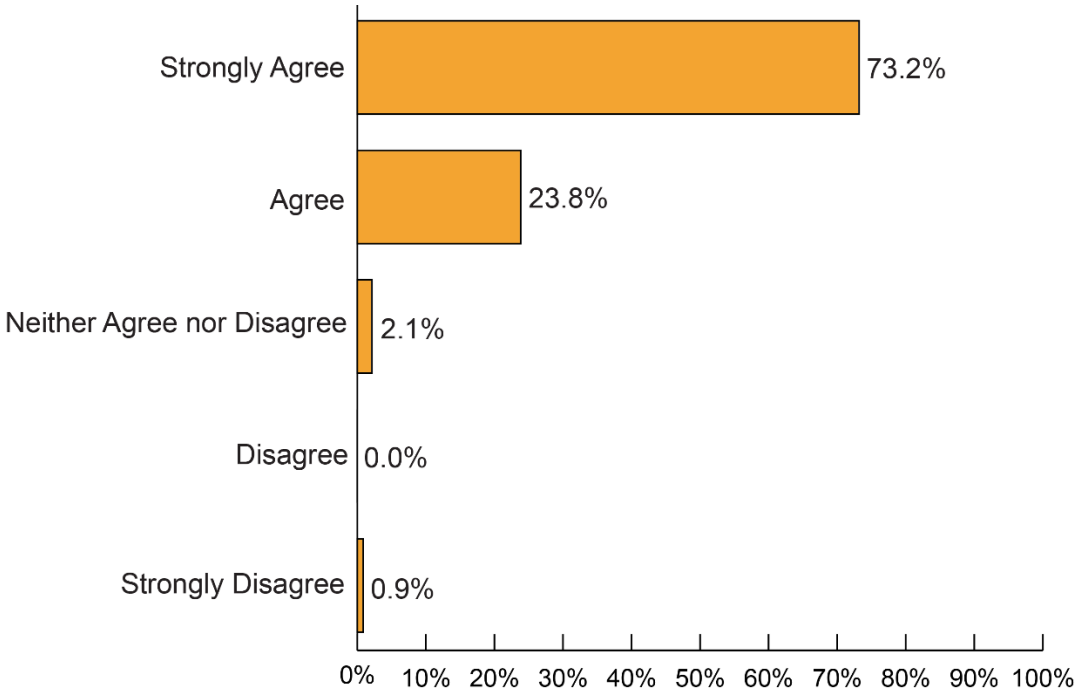
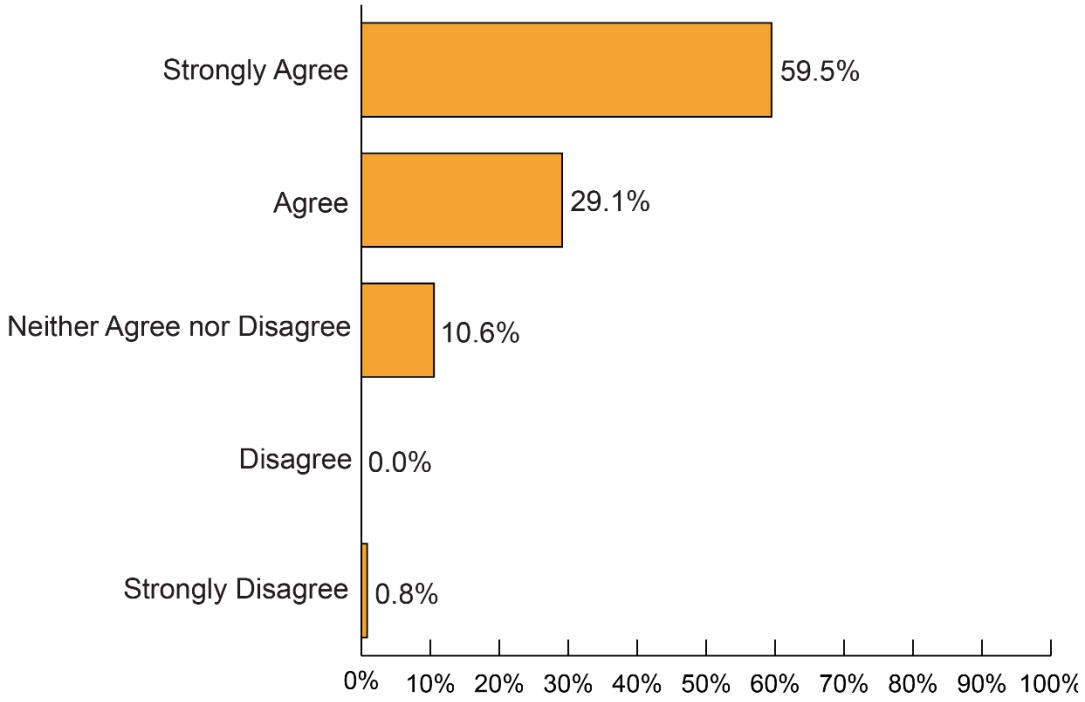
The training objectives were met:

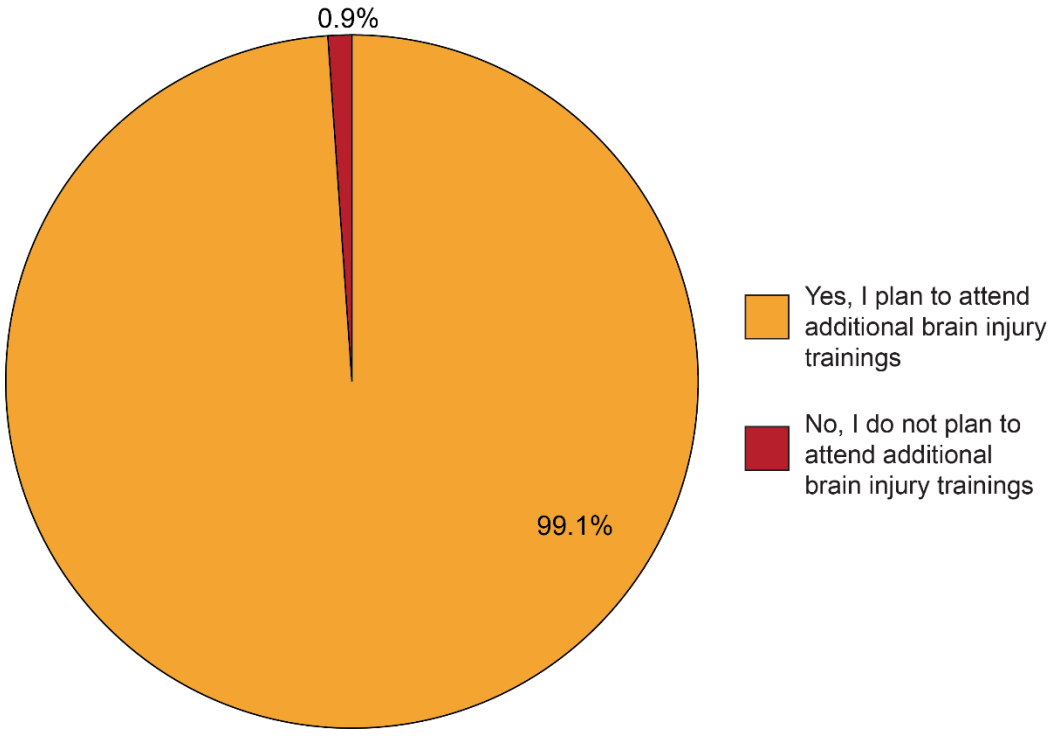


The trainers were knowledgeable about the topics:



The training will be useful in my work:





8441

Teva Lange
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My name is Teva Lange. I was born and raised in North Dakota and work as a Licensed Addiction Professional for the ND Department of Corrections. This letter finds you in efforts to show my support for the North Dakota Brain Injury Network (NDBIN) organization and its impact for my family and myself. My first experience with brain injury (BI) comes from a caregiver/family member role. I married a wonderful man in 2004 who at the age of 23 suffered from an aneurysm as a result from a rupture of an arteriovenous malformation (AVM) within his brain. He underwent a cerebral surgery and as a result experienced a stroke needing intensive speech and physical therapy in 2001. I did not know him at the time of his injury, and by the time I met him he was working full time and appeared "normal." His injury was invisible to me, but not to him. My lack of knowledge and empathy to his daily struggles caused conflict and frustration early in our marriage. NDBIN for me started for personal reasons; however, this organization has fostered my desire to learn and helped me professionally bring resources and awareness to clients I work with, coworkers, peers, family and friends.

NDBIN provides a wealth of resources to our state. Of these resources, I would like to provide a brief summary of how I have personally utilized and gained from this program/organization.

- Since 2016, I have subscribed and received educational newsletters on brain injury, which I use as a personal and professional resource to provide to family members, colleagues, and clients in the DOCR.
- NDBIN has personally come into the Department of Corrections and provided presentations on brain injury to residents housed there.
- In 2019, I was part of the first Certified Brain Injury Specialist Training and received my CBIS certificate. Since then I have access to network and refer out to at least 60 or more certified professionals because of their trainings.
- In 2020, staff within the NDBIN encouraged myself and other colleagues to apply for a scholarship to attend the National Association of State Head Injury Administrators (NASHIA) Conference. With their encouragement, I submitted an application and awarded the scholarship.
- Lastly and most importantly. **I have referred countless clients to this support network.** I work with a high percentage of clients in the prison setting that are impacted by brain injury. Some of the times, they do not even consider their brain as injured or have not been informed. Overdose (lack of oxygen), being knocked out in a fight, extreme drug use, any risk behavior where their head was jarred, or even the reality of them falling as a child. All these could be a factor causing a ripple impact of impulsiveness decisions, struggle in school/comprehension, or difficulty in managing emotion. This understanding and pairing up with their history is the awareness needed to start the process of learning to manage how to live with a brain injury.

The ability to refer clients that are getting out of prison to resources in their community (print off support group meetings, provide a phone number to someone who understands brain injury and provide basic understanding/information about brain injury to spark their awareness) is priceless.

The North Dakota Brain Injury Network (NDBIN) has been a great resource for personal and professional reasons. With education and awareness I have been able to be a better spouse and a better professional to the clients I work with. My hope is to continue to grow in my understanding and to help others be more aware of expectations/management strategies that will assist both the BI survivor and those that care for them.

Therefore, here is where I need your help and support. It is my understanding that there is a proposal to reduce the North Dakota Brain Injury Network funding by 50%. **I ask that you reconsider this proposal and restore the brain injury funding in HB 1012.** Governor Burgum has made such a strong initiative in our great state with fighting for awareness, decreasing stigma and more resources for people that suffer from the disease of addiction. A high percentage of those people to live in "RECOVERY" means coping/managing and getting support. I encourage you to read and speak with NDBIN on the impact of Brain Injury not only on the person but on their family/care givers. You will see that *a person who suffers from brain injury is not just suffering acutely, but **chronically***. If you are a supporter of RECOVERY please understand that NDBIN offers support to those striving to live in RECOVERY and again, **I ask that you reconsider this proposal and restore the brain injury funding in HB 1012.**

Thank you for your time and consideration in addressing this concern. This organization means a lot to me. In 2015, my husband Rick, was found to have another AVM located his brain and since has gone through two radio knife surgeries without success. He is now on disability at the age of 42. He actively is being treated for seizures, migraines, and anxiety. He underwent testing scoring below functioning level within physical and mental means. He is stable, however we are going to be addressing in the near future a cerebral surgery to remove his AVM. The amount of effort and support needed as a caregiver has been all encompassing. NDBIN and their staff have been an outlet in allowing me to understand how to best help my husband. For the clients I work with that may not have the support my husband has NDBIN is there for them. Please help me in advocating for continued APPROPRIATE funding for them to maintain the work they do. If you have any questions feel free to contact me in the future.

Sincerely,



Teva Jo Lange, LCAC CBIS
Licensed Clinical Addiction Counselor
Certified Brain Injury Specialist

To Whom it May Concern,

It has come to my attention that funding cuts are having a drastically amount of the needed funding being considered for the ND Brain Injury Network.

I have had the impacts of several different types of head injuries in my 70 years. In the beginning of my injuries at the age of 15 or 16 it has been a psychological nightmare to live with. The struggles I had growing through the different injuries and not having any type of help for healing and recovering. There are still struggles I live with daily, for instance trying to write this letter so that you can understand or realize how greatly this funding is needed to be able to continue its guiding me with resources that are not available. Especially in this rural western part of the state, on our reservations and to reach other people who have no knowledge of what life has been or is like for me or others who live with this.

I am telling you about how their programs help support me. I am one of North Dakota's American Indians who uses their online support groups, and the webinars of their education for people who have experienced, lived through and struggle living with these very difficult traumatic brain injuries(concussions) that people, doctors, hospitals, educators, legal systems, schools and a whole list of other offices, programs that haven't any knowledge of how to help us. I have been a part of this Brain Injury Network since it has begun. Since Rebecca Quinn has been in the office I have seen this program expand enormously and hoping for it to continue for me and it's reaching onto the reservations and other American Indians that live off the reservations, including the educating of all the legal and legislative systems.

I am asking for your consideration of the greatly needed funding of this Brain Injury Network.

Sincerely,

Skipp Miller

Still alive and functional

North Dakota Legislators,

My name is Carma Hanson and I am the Coordinator of Safe Kids Grand Forks, an injury prevention coalition based out of Altru Health System in Grand Forks. Our mission is to reduce the number of unintentional injuries and deaths to children under age 19 – their leading cause of death. Safe Kids Grand Forks has a coverage area that includes northeast North Dakota and northwest Minnesota and through our efforts, we partner with many agencies that conduct like-type work. Together, we have over 250 parents and colleagues that assist in our work to keep kids safe at home, at school, at play and on the way.

The North Dakota Brain Injury Network (NDBIN) is one of our partner agencies and together, we collaborate on many projects related to brain injuries. As you can imagine, brain injuries in children can occur in a number of ways, including preventable injuries such as sports concussions, falls from playground equipment or bike and car crashes. Our work as Safe Kids Grand Forks is to prevent those injuries from happening and we share that mission with the NDBIN. Once an injury has occurred, they then take over with the wonderful work that they do to assist clients with services, provide support for living with a brain injury, assist with support for the caregivers of those with brain injuries and connect the client with support and resources to help them in their recovery process.

The work that this group does is outstanding and I would encourage you to reconsider the funding allocation that has been presented in the DHS Funding Bill 1012. This proposal suggests a 50% reduction in funding for the NDBIN. While we are in a time when all funding needs to be carefully considered, I would caution that this drastic cut could have significant impacts on those suffering from brain injuries. This type of injury is complicated and careful intervention and rehabilitation is critical to those inflicted with this type of trauma. Safe Kids Grand Forks and our team have benefited greatly from the work of the NDBIN as they educate providers on concussion and brain injury management and help set protocols for coaches, teachers, athletic trainers and others involved with kids with TBI's. They also provide direct services to clients across the state as they navigate the very complicated world of living with a brain injury.

Rebecca Quinn, the Program Director for the NDBIN can speak eloquently about the services that are provided from kids – adults in their program. She has established a network of care and resources across the state that assists people of all ages, injury severities and income levels. The impact of a financial cut to the extent suggested would significantly impact their programming abilities and I would challenge you to reconsider that proposal.

I thank you for your time to read this letter of support for the North Dakota Brain Injury Network. Please do not hesitate to reach out to me should you have further questions that I can address.

Sincerely,

Carma Hanson

Carma Hanson, MS, RN

Coordinator – Safe Kids Grand Forks

It is great to have such a wealth of resources and your work in coordinating all of it is much appreciated!

Amy Brossart-Robinson, M.S., CCC-SLP
Clinical Assistant Professor
Department of Communication Sciences & Disorders
University of North Dakota (UND)

Thank you! I also wanted to thank you for all the work you are doing across our state for those with brain injury and providers. Really helpful and impressive, thanks so much!!~ It has been crazy. We are still seeing everyone by telemedicine, which has proven quite effective. Also great to be able to address initiation, planning and really all areas of cognitive and executive functioning in patients natural environments. Anyway, we are fortunate to be able to carry one, even in this bizarre times. Have a happy and healthy Holiday!! Thanks,

Janet Grove, MS CCC-SLP, CBIS
Licensed Speech-Language Pathologist
Certified Brain Injury Specialist
Progressive Therapy Associates

During these trying COVID times of stress and negativity, the Pollyanna in me wants to spread cheer!

Thank you for all that you do to elevate the lives of those with BI. Each time I am on calls with you I am SO impressed. You show genuine compassion, insight and kindness to those you talk to. I have wondered if people treat me kindly because I'm "brain damaged", but I truly believe that you treat everyone kind because that is who you are.

Thank you,

Sandi

I continue to see how active NDBIN is in this crazy time. I keep hoping that hospital admissions will slow down but like the entire State of ND hospitals, we are overrun. I was still working last night and already know today will be no different. You continue to have great topics and meetings. I just have not been able to attend. Just wanted you to know it is not due to lack of interest or support.

Marie Brekken, PA-C
Physical Medicine & Rehabilitation
Sanford Health Fargo

67th Legislative Session

Senate Appropriations

Chairman Holmberg and other members of the Committee. My name is Nan Kennelly. I am speech-language pathologist and certified brain injury specialist from Fargo, and a provider for cognitive and communication disorders related to brain injury. I serve as the current Chair of the North Dakota Brain Injury Advisory Council.

I am providing testimony on behalf of the Brain Injury Advisory Council, a statutory-defined (NDCC 50-06.4-10) and Governor-appointed state advisory council. The Mission of the North Dakota Brain Injury Advisory Council is to improve the quality of life for all individuals with brain injury and their families through brain injury identification, awareness, prevention, research, education, collaboration, support services and advocacy.

A 2016 North Dakota Brain Injury Needs Assessment found that for people with brain injury in North Dakota, services and supports for the condition are **few, are disparate, and are disjointed.**

The Brain Injury Advisory Council has serious concerns about the proposed budget reductions for brain injury in the Department of Human Services budget. These programs have been slowly built over the last 10 years and represent the *only state funded programs exclusively* dedicated to brain injury in the state. With services for this complex population being *already so limited* it would be a disservice to ND residents and families living with brain injury.

It is particularly concerning that the DHS budget reductions appear to be made with the mistaken assumption that the programing could shift to federally funded programs, with an expectation that the Medicaid 1915(i) program will provide offsetting benefits.

Members expressed concern for these shifting DHS budget priorities, including:

- The restrictive definition of brain injury within the Medicaid 1915(i) program, focusing on neuro-cognitive disorder diagnoses at the elimination of other brain injury diagnosis, will limit brain injury services to certain individuals.
- Since Medicaid 1915(i) services requires financial eligibility for Medicaid, economic means testing will greatly restrict the number of individuals eligible for brain injury services, compared to current practices.
- The reduction of NDBIN program funding will limit the level of technical assistance support and service coordination statewide, compared to current service levels. The NDBIN is not a direct service agency and should not be conflated within discussions concerning Medicaid 1915(i) service programming.
- The reduction of technical and facilitative support to the operations of the ND Brain Injury Advisory Council.

In summary, the ND Brain Injury Advisory Council has serious concerns about proposed budget cuts to existing programming, as well as the mistaken rationale that the 1915i services will duplicate NDBIN, which they do not. The Advisory Council feels these budget cuts and reduction of service go against our mission to improve the quality of life for all individuals with brain injury and their families.

Thank you for your time and I welcome any questions.

Respectfully submitted,

Nan Kennelly

Chair, ND Brain Injury Advisory Council

8432

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67th Legislative Session
Senate Appropriations

March 10, 2021

Chairman Holmberg and other members of the Committee. My name is Nan Kennelly. I am a speech-language pathologist and certified brain injury specialist from Fargo, and a provider for cognitive and communication disorders related to brain injury. I serve as the current Chair of the North Dakota Brain Injury Advisory Council. I own a private practice in Fargo, ND, Onword Therapy. I lead a support group for individuals and families living with brain injury, and I am a vendor for the Social and Recreation program through the Department of Human Services.

I am providing testimony today as a provider who serves ND residents and families living with brain injury, and to object to proposed budget cuts for brain injury programming in ND, and to the North Dakota Brain Injury Network (NDBIN). Many of my patients attend our support group and participate in the social and recreation program funded by DHS. The benefit of this program runs deep, as social engagement is one of the biggest changes after brain injury. Additionally, our staff and patients attend the ND Brain Injury Conference put on by NDBIN each year for professional continuing education and supportive education for our patients. I see firsthand the benefit that ND brain injury programming has on those I serve.

I am especially concerned with a justification provided to me for budget reductions for brain injury programming. I have been told that since 1915i was approved for ND, the budget cuts were hoping to avoid duplication of service. I am here to tell you that this is a misconception. To qualify for 1915i services, an individual must qualify for Medicaid. This does not represent most of ND residents living with brain injury. In my 15 years of private practice, I can count on one hand the number of brain injury patients we served that had Medicaid. That is a very small percentage compared to the thousands of patients I have treated with brain injury. In my experience, the vast majority of ND residents living with brain injury have commercial insurance, Medicare or Workforce Safety. Additionally, the definition for brain injury for 1915i varies from the ND definition of brain injury, leaving out a large percentage of people that would otherwise qualify for service and support. While the 1915i is a victory to add to services that were lacking for Medicaid recipients, it does not benefit most of ND residents living with brain injury who are currently being served through DHS and NDBIN funding.

Please consider this testimony a request to **maintain the brain injury funding in HB 1012 restored by the House including the funding for the North Dakota Brain Injury Network.** Any further reduction would have detrimental effects on our patients, the programming our practice provides, the support we can refer from NDBIN, and the overall progress we have made in recent years in ND brain injury programming and support.
Thank you for your time and I welcome any questions.

Sincerely,

Nan Kennelly, MS CCC-SLP, CBIST
Licensed Speech-Language Pathologist
Owner | Onword Therapy

Testimony of Jill Elliott, Chief Deputy, Fargo Housing & Redevelopment Authority

In opposition to HB1012 and requesting full funding of Dacotah Foundation

for supportive services at Cooper House in Fargo

March 10, 2021

Senate Appropriations

Human Resources Division

Good Afternoon, Senator Ray Holmberg, committee members, and guests,

My name is Jill Elliott, and I serve as Executive Director & CEO for the Fargo Housing & Redevelopment Authority. I have had the pleasure of "living my mission disguised as a job" with the FHRA since 1978. I have been part of the planning, development, and management of Cooper House for almost two decades.

Thank you for reconsidering the severe cuts to the Dacotah Foundation Supportive Services budget for Cooper House. I thank you for previously fully funding the 24/7 front door staff for Cooper House, since it opened in 2010 up to this point. It is indeed the "secret sauce" that makes this project work. I feel that without 24-hour service we could not safely house our most vulnerable tenants as we do now. This service is imperative to continue housing chronically homeless, dually diagnosed individuals that really have no other options. I respectfully ask that full funding for the next biennium be restored to $570,000. This covers one front desk person for 24 hours a day seven days a week. I believe we will go back 15 years without this needed service.

As a brief background to my testimony, the Fargo Housing & Redevelopment Authority witnessed countless homeless persons causing chaos downtown and suffering unimaginable circumstances on the streets. Every year we would add many names to the list that had succumbed outside in the elements. We knew as a state and community we could do better. In 2001, our community began researching ways to meet the needs of chronically homeless, dually diagnosed individuals. We had an active group called Street Smart comprised of Downtown Business owners, our local police, Sanford Hospital, the City of Fargo, our Housing Authority, and area human service agencies. Jessica Thomasson, Fargo's City Planner at the time, was an integral leader for our team visiting different sites in the region during the development of a long-term plan to address the growing need to address homelessness. Out of this determined group came Cooper House that was built in 2010. It serves only chronically homeless, disabled persons that score the highest on the vulnerability index, called VI-SPDAT. Simply put: the index identifies those individuals most likely to die on the street.

Our tenants have survived years or even decades of homelessness, suffer from one-to-three disabling conditions, have suffered sexual and physical abuse, and have lost their vital connections to most family and friend years ago. These are not choices; they are the inevitable result of these many factors in their unique and individual lives. There is hope if the structures are in place and supported.

Cooper House is based on a harm reduction model. Severe chronic health issues are handled right away with the onsite part time nurse. Long standing diabetes, liver failure, kidney failure, head injuries, dental decay, blood pressure and amputation issues are treated compassionately with our nurse paid thru

homeless health and a Continuum of Care grant. Service providers are connected if the tenant is willing. Tenants are assisted in signing up for Eligible benefits such as traditional Social Security, SSI, Medicaid, food stamps. A meal is served daily. Prior to the COVID pandemic, we had on site help groups for mental health, an "Ask a Cop" program, and an active resident council – opportunities impossible to access without an address.

I have always determined worthy housing projects as appealing to both the head and the heart. The heart: All people deserve to live in a safe environment out of the elements where they can address long standing issues. The Head: Homelessness is extremely expensive to city, state and federal funds with no real move to a solution. This population are very high-end users of Emergency Rooms, hospitals, police, detox centers, ambulances, and court systems. After the first year opened, the Fargo Housing & Redevelopment Authority, police, Sanford, BSI and Department of Human Services completed an impact study of the impact of housing 66 Cooper tenants. These tenants were tracked on actual ER visits and hospitalizations, police intervention, jail stays, detox stays, and emergency shelter stays. We were not able to get statistics from the court system but know this would add much. The following year we hired Eide Bailly to complete this report. I have attached the results with a resounding savings to taxpayers.

Cooper House is the smart way to do the right thing. Leaving the funding as proposed is inconsistent with other established priorities and programs, like Governor Burghum' s Main Street North Dakota initiative. Leaving our most vulnerable folks unhoused will certainly hurt the ideals and goals that he's established and fighting for.

All Cooper House tenants and guests must check in through the front office staff and are checked in a logbook. Let me repeat that: no one has access to their apartment except through the 24-hour front desk staff. This is one person for 42 residents 24/7. It is a very economical way to serve a very difficult population. Since May, and due to the ongoing pandemic, we have not allowed guests. At one point early last spring, Cooper House had a 62% COVID positivity rate. Two residents died from the virus, despite a part-time nurse and detailed COVID protocols. Since banning guests, however, the positivity rate has been exceptionally low.

Homeless folks all seem to have a code that once homeless you are bound to help your homeless friends and allow them to stay with them against all house rules. Cooper has visiting hours and all guests are escorted out at 8 pm. Many evictions are caused by actions of guests who have nothing to lose with bad behavior. Tenants often remark that I really didn't want them here, but I could not say no. I am so appreciative that the staff escorted them out before they caused any more trouble. Front staff watch numerous cameras on every floor and watch for tenant issues that may need intervention.

Cooper House could not continue serving this tremendously vulnerable population with 24/7 front desk staff. I have heard the justification that 1915i program would fill in the void. We are all thrilled with the approval of the 1915i program, however that is a tenant-based program matching a case manager to a tenant. Their services are billed in 15-minute increments for very specific services that are approved by the state. No 1915i funds could be diverted to staffing the front entry system and cameras for a facility. There are no hours that the front office desk cannot be staffed. No one could enter the building then. Or if left unstaffed with the building unlocked, we would have mass chaos. I do not believe this building could be managed without this team. That will turn the most vulnerable out to the streets. Nursing Homes typically reject them as patients, landlords reject them as tenants. State hospital stays are not

the best route to live out your life and extremely expensive. Please reconsider these cuts to send us back into early 2000. As Paul Wellstone often said, “We all do better, when we all do better.”

Perhaps even more to the point, one of our residents once said to me, after sharing his story of his years of troubles, “Cooper House is the only place I’ve ever had hope.”

That hope remains a possibility only if places like Cooper House have your support, so I ask that you restore full funding to Dacotah Foundation’s critical supportive services.

Thank you.

8025



Experience the Eide Bailly Difference

Cooper House Impact Report

A Study of the Impact of Housing
North Dakota's Chronically Homeless Population

EideBailly®

CPAs & BUSINESS ADVISORS

Cooper House Impact Report & Cost Study

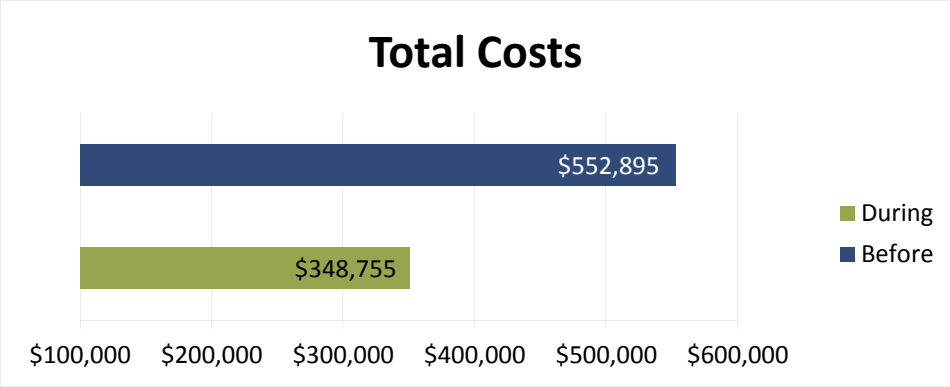
Eide Bailly was engaged by the Fargo Housing & Redevelopment Authority (FHRA) to compile cost data for a group of residents of Cooper House, a supportive housing for the homeless project managed by FHRA. We have compiled data showing the costs to society prior to when these people secured housing at Cooper House and then 12 months during their time housed at Cooper House. Because people move in and out not all dates line up over the same time frame. We have attempted to collect data showing 12 months prior to being housed at Cooper House and during their stay at Cooper House. We have not audited, reviewed or tested this information beyond simple due diligence while collecting it.

Background:

Cooper House opened in Fargo, ND in May of 2010. The Cooper House apartment's provide permanent supportive housing for homeless persons and is a stabilizing next step in the lives of people coming out of shelters or transitional housing programs. It consists of 42 apartments, 32 of which are efficiencies and 10 are one bedroom units. The apartments are rented exclusively to individuals who are documented as homeless. Preferences are given to those experiencing chronic or long-term homelessness, veterans, and people with disabilities. Homeless is defined as an individual or family who lacks a fixed, regular, and adequate nighttime residence. Chronic or long-term homelessness is considered to be anyone being homeless for 12 consecutive months or 4 times in the past 3 years.

Mental Health Technicians are on staff 24 hours, seven days a week at Cooper House, and a part time Licensed Addiction Counselor and a full time Case Manager are in the building daily, working with the clients and offering needed services. Family Health Care Center provides a part time nurse on site who provides medication management, infection control, health assessment, and referrals and follow up.

Cooper House employs a "Housing First" hybrid model, where people are provided a home first and then are offered a variety of services to help improve their lives and keep them in housing.



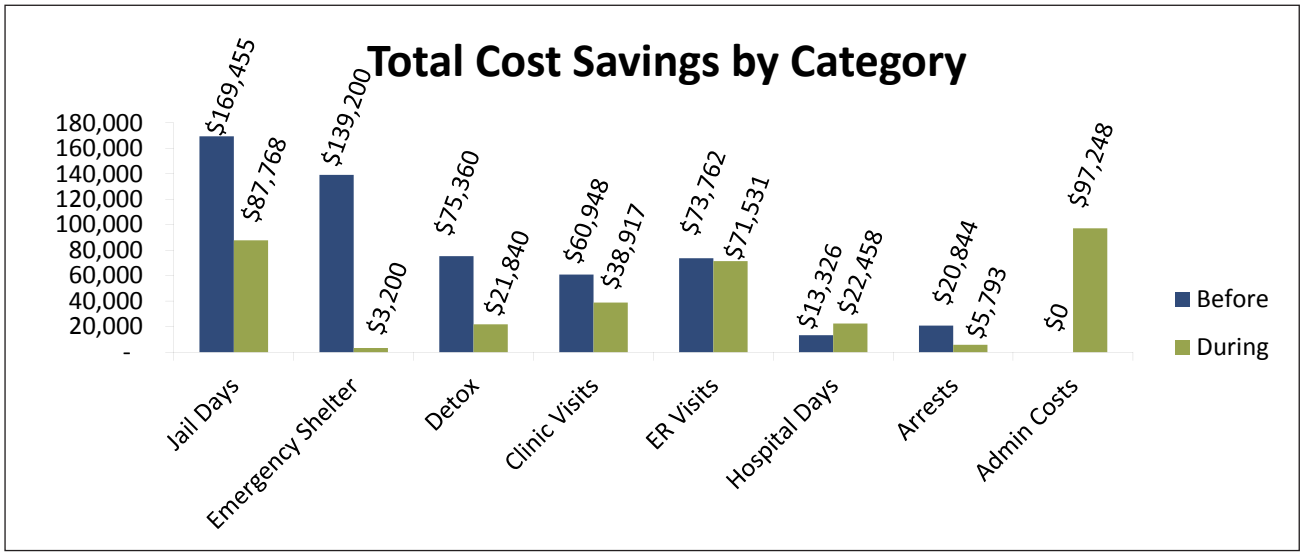
Conclusion:

Based on the results from the cost study, it is evident that housing the chronically homeless is "the smart way to do the right thing." There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that this study was conducted, through October 31, 2011. Being proactive in helping the homeless population is shown to help save the tax payers money and to make the community a better place to live.

The Study:

This study is meant to be a snapshot of the impact of housing North Dakota's chronically homeless population. The data of this study was collected with the consent of 66 tenants (the Study Group) who have lived at Cooper House at various times since it opened. Area service providers, shelters, law enforcement, the court system, and healthcare providers have all cooperated in providing the information gathered throughout this study. Once the information was consolidated then an average per person per month cost was calculated and this was used to calculate the group average.

Below is an overview of the costs comparisons for a one year period prior to being housed and a one year period ending October 31, 2011.



Note: There are two significant public cost drivers not captured by this study. Those of the judicial system which includes all costs related to court processing, arrests, and those costs related to state hospital days attributed to court ordered rehab. For some individuals this was up to dozens of times prior to living at Cooper House.

Healthcare & Medical Costs:

Based on the information received from Sanford Hospital, the Cost Study Group, costs went from $148,036 to $132,906 for a 10% decrease in costs or a savings of $15,130. The healthcare and medical cost data was compiled through October of 2011.

Law Enforcement & Legal costs:

Based on the information received from the Fargo Police Department, the cost associated with arrests declined from $21,000 to $6,000, which resulted in a decrease of $15,000, or 72%. The jail day costs were reduced from $170,000 to $87,800 for an $81,687 or 48% decrease.

Overall, legal and law enforcement saw a cost savings of $96,738 for those living at Cooper House, with some individuals having 100 less jail days than before they were homeless. The law enforcement and legal cost data was compiled through October of 2011.

Detox Costs:

Based on the information received from the Fargo Police Department, the average cost per detox visit is $120, not accounting for police officers time to collect and transport individuals to the facility. The total cost for detox visits decreased from $75,360 to $21,840. For the Cost Study Group, this is a cost savings of 71% or $53,520. In addition, this particular Study Group has seen 446 fewer visits. The detox cost data was compiled through October of 2011.

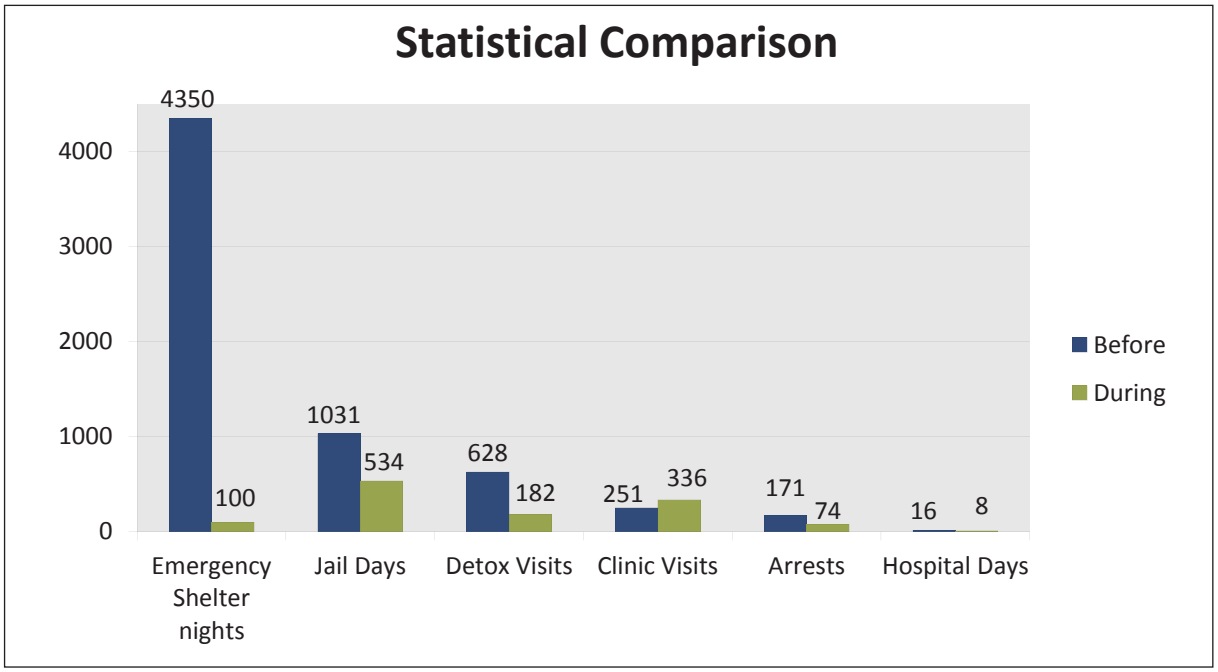
Administration Costs:

The capital outlay of the administration costs is $97,248. This service is provided by Dacotah Foundation through a contract with Southeast Human Services. The front desk is staffed 24/7 and these individuals are considered key to the success and integration back into the community. They staff check tenants and guests in and out of the building, monitor the security system, help with wellness checks, and work to link tenants to appropriate services.

Emergency Shelter:

Based on the information provided by only one of several homeless shelters in Fargo, the Study Group costs were reduced from $139,200 to $3,200, for a total cost savings of $136,000 or 98%. The number of emergency shelter nights was reduced from 4,350 to 100. The emergency shelter cost data was taken from averaging the costs for 2010 and 2011 to determine the average cost per year. The number of times accessed was taken compiled through October 2011.

Below is a statistical comparison of the number of times a service was accessed for the Cost Study Group before and during their residency at the Cooper House:



Places of Birth:

Many of the participants in the cost study call North Dakota their home and have lived here their entire life. Below, the red stars indicate where a portion of the Cost Study Group individuals are originally from.



Please note that not all costs were captured during the study. Some services accessed are not accounted for here and the cost of working with these individuals on the street is understated. For example, only one of several homeless shelters and one of the two hospitals were contacted for this study. Meals from community based organizations are also not accounted for here. In addition, costs accumulated here are only based on the individuals costs accumulated while living in Fargo and do not account for costs incurred in other locations.

HB 1012
NDACP Testimony
Senate Appropriations Committee
Hon. Ray Holmberg , Chairman
March 10, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, greetings, and thank you for this opportunity. I am Bruce Murry, Executive Director of the North Dakota Association of Community Providers (NDACP.org). NDACP is the membership organization of 30 licensed providers of services to North Dakotans with developmental disabilities (DD). We serve about 90% of people with DD in North Dakota.

As a registered lobbyist (#330) for NDACP, I would like to introduce several board members who will give in-person, video, or written testimony from their respective areas of expertise:

- Julie Erickson, CEO of Grand Forks Growth and Support Center, Grand Forks;
- Scott Anderson, Program Service Director for Development Homes, Inc., Grand Forks;
- Lorena Poppe, CEO of Poppy's Promise, Bismarck, NDACP Vice President;
- Scott Burtsfield, CEO of Vocational Training Centers (VTC), Fargo;
- Brooke Austin, CEO of Community Living Services, Fargo, who in turn will introduce at least two people currently receiving services proposed for elimination:
  - Jackie Krei of Fargo, and Jackie Long of Fargo;
- Donna Byzewski, LBSW, MS, Guardianship Division – Intellectual Disabilities Director, Catholic Charities North Dakota, Fargo
- Tom Newberger, CEO of Red River Human Services Foundation, Fargo; and
- Jon Larson, CEO of Enable, Inc., Bismarck, our NDACP President.

NDACP has a relatively modest legislative platform for the 2021-2023 biennium, in recognition that uncertain times face the energy and agricultural sectors in our state.

- Maintenance of the House's restoration of approximately eleven million dollars ($11,000,000) to provider rates for residential habilitation and intermediate care facilities for people with intellectual and developmental disabilities (ICFID), but also,
  - Maintenance of the Governor's proposed two million, four hundred thousand dollar increase ($2,400,000) to day support services such as individual employment, group employment, and prevocational services, with a matching reduction to Intermediate Care Facilities for people with Intellectual Disabilities (ICFID) and residential habilitation;
- Restoration of $240,000 in funding for mandated DD provider accreditation with the Council on Quality and Leadership (CQL);
- Inflationary increases to DD providers of 3% each year of the 2022 - 2023 biennium, especially due to economic and wage pressures in various communities;

- Maintaining the House's appropriation of up to $250,000 to NDDHS to financially stabilize DD providers disproportionately affected by the COVID-19 emergency — especially In Home Support providers who suffered the greatest losses;
- Restoration of all cuts to Section 11 State General Fund services to people with DD who don't qualify for the DD Medicaid Waiver;
- Fully fund the 1915(i) Medicaid Amendment with special attention paid to ensure it remains accessible to people with DD/ID, and review of the proposed World Health Organization Disability Assessment Schedule threshold score of 50 — a very severe score;
- Fully fund reforms and behavioral health initiatives from the Life Skills and Transition Center;
- Retention of a substantial state tax credit to employers who hire North Dakotans with developmental disabilities and mental illness, in HB 1405 (2021). HB 1405 received a unanimous do-pass recommendation from Senate Finance and Taxation Committee on March 9, 2021.

Many members also support restoration of funding for recreation and leisure centers with consideration of serving additional communities; a close review of the infant development and Part C budgets to ensure timely services can be brought to bear to minimize developmental delays; and strengthening of rates in related home and community based services to North Dakotans with other kinds of disabilities — QSP services under Aging Services and for brain injury, as well as 1915(i) Medicaid Amendment behavioral health services.

NDACP is persuaded that building a new State Hospital as proposed in HB 1012 makes sense to move more mental health services to the community. It is difficult to move beyond brick and mortar legacies built by generations past, but it is probably time.

Many of you know we have welcomed Angela Dinius as Workforce Development Director for NDACP. She and I are both happy to answer any questions that may arise about NDACP, its members' services to people, and our priorities. Our contact information is below.

Thank you for your kind attention.

NDacp

Bruce Murry
Executive Director

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NDacp

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Workforce
Development Director

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workforce@ndacp.org

North Dakota Association of Community Providers

Testimony on HB 1012
Christina Sambor, North Dakota Coalition for Homeless People
Senate Appropriations
March 10, 2021

Mr. Chairman and Members of the Committee:

On behalf of the North Dakota Coalition for Homeless People, I testify today requesting that the Senate Appropriations committee restore funding to supportive housing services. HB 1012 contains a reduction in vital funds for these services and has already passed the North Dakota House of Representatives with those cuts intact. The requisite funding needed for the projects impacted are as follows: $570,000 for Cooper House, Fargo | $640,000 – for Edwinton Place, Bismarck | $515,000 – for LaGrave on First, Grand Forks.

These projects provide permanent supportive housing for people who have experienced chronic homelessness and are a vital asset in addressing homelessness. Permanent supportive housing is effective and is an investment that provides cost savings to the community. The DHS budget assumes the reduction in funds for supportive housing services can be replaced by North Dakota Medicaid 1915(i) reimbursement. This raises the following concerns:

- The 1915(i) plan has not been in existence long enough to be a proven or adequate replacement for these funds. The 1915(i) plan is a positive thing for ND and for homeless services, but it is too soon to tell if it will be an effective funding strategy for permanent supportive housing.
- It is unknown if enough residents of these projects will qualify to make up the gap in funding.
- Without these funds, supports and other components such as 24/7 security would be dramatically reduced or eliminated. Two major concerns from this loss of funding:
    - Reduced services would lead to decreased chances of long-term housing stability.
    - Reduced security would impact resident safety and could increase police calls/interaction at these locations (a costly community resource).

Overall, this loss of funding without a guaranteed replacement will likely bring unintended harm to the vulnerable people it is meant to serve. Housing advocates are appreciative of DHS being a collaborative partner in permanent supportive housing and it is desired for this to continue and increase. Full funding is needed for the next biennium to ensure long term solutions to services for addressing chronic homelessness can continue, including use of the 1915(i).

In summary: The 1915(i) may provide a savings to the DHS budget in the future and may even prove to increase/improve services long term—however, it is too soon to tell. Funding for the next biennium is important to continue services while determining how 1915(i) may be beneficial moving forward.

THE CITY OF Fargo FAR MORE

CITY OF FARGO POLICE DEPARTMENT

Chief David B. Zibolski

105 25th Street North, Fargo, North Dakota 58102
Office: 701-241-1400 Fax: 701-297-7789
www.fargopolice.com

March 3, 2021

Senate Appropriations Committee
Senator Ray Holmberg, Chair
600 E Boulevard Avenue
Bismarck, ND 58505

Re: Support of HB 1012 to fund the Cooper House in Fargo, North Dakota

Dear Chairman Holmberg and members of the Committee,

I am the Chief of Police in Fargo, North Dakota, and I am writing you today in strong support of HB 1012, which requests to provide $570,000 in funding to support continued operations of the Cooper House. As you may be aware, the Cooper House has operated in Fargo for nearly ten years, focusing as a Housing First project. In doing so, they provide housing to 42 permanent residents, as well as provide 24/7 service that includes mental health, addiction, and chronic homelessness.

The Cooper House has not only provided housing for 42 individuals who would otherwise be homeless and on the streets of Fargo, but has been an excellent public safety partner for our department to work with in addressing these issues. Their existence and service provide needed options for our department members who encounter chronically homeless individuals, and as such, create a cost savings in both time and resource spending by our department. Their professional staff assist attendants with day-to-day needs, aids them in handling conflicts, and monitors the amount of alcohol brought into the facility, with the goals of acquiring sobriety and better day-to-day functioning. The facility is a joint effort with the Dakota Foundation, the Fargo Housing Authority, the Southeast Human Service Center, Family Health, and Cass County Social Services.

I personally spoke with several of our officers who have day-to-day engagement with the Cooper House and who express the importance of this funding appropriation to ensure its continued operations. The continued support of the Cooper House not only provides necessary and needed service to our homeless community, but also reduces the cost and personnel commitment of other law enforcement interventions, which are often times less effective.

The Fargo Police Department strongly supports the $570,000 appropriation request in HB 1012 and I urge you to vote in favor of this bill. Should you have any additional questions, please feel free to contact my office.

Sincerely,

David B. Zibolski
Chief of Police

DBZ/pls

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/11/2021 AM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 8:30 AM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- Transition Center residents
- New Fire Station and fire tower on Grafton property
- Origination of resident's disability
- Signers on DOJ agreement
- Long term care requirements
- Child abuse and neglect
- Ombudsman program
- Cost of home-delivered meals

Chris Jones, Director, Dept. of Human Services publicly thanked Sue Forester for her 40 years at DHS.

Sue Forester, Superintendent, Life Skills Transition Center – testified in favor and submitted testimony #8744.

Nancy Nikolas Maier, Director, Aging & Adult Services, DHS – testified in favor and submitted testimony #8745.

Jessica Thomasson, Executive Policy Director, DHS – testified in favor and submitted testimony #8746.

Cory Pedersen, Director, Children and Family Services, DHS – testified in favor.

Senator Holmberg closed the hearing at 11:52 AM.

Rose Laning, Committee Clerk



House Bill 1012

Senate Appropriations

Senator Ray Holmberg, Chairman

Life Skills and Transition Center

Providing supports and services so people can move back to homes of their choice.

NORTH Dakota | Human Services

Be Legendary.™

LIFE SKILLS TRANSITION CENTER
What we do

Traditional (ICF/IID) Services

- Residential Services
- Vocational Services

Home and Community-Based Waiver Services

- Residential Habilitation Services
- Vocational Habilitation Services
  - Day Habilitation
  - Pre-vocational Services
  - Small Group Employment
  - Individual Employment

Statewide Crisis and Support Services

- Applied Behavioral Analysts
- CARES Crisis Coordinators
- CARES Services
- Transition to the Community Supports

LSTC Residential Crisis Units

- Adult Crisis Beds
- Youth Crisis Beds

LIFE SKILLS TRANSITION CENTER
Accreditation

Dec. 2019 - LSTC achieved accreditation by Council on Quality Leadership (CQL) for **Person-centered excellence**

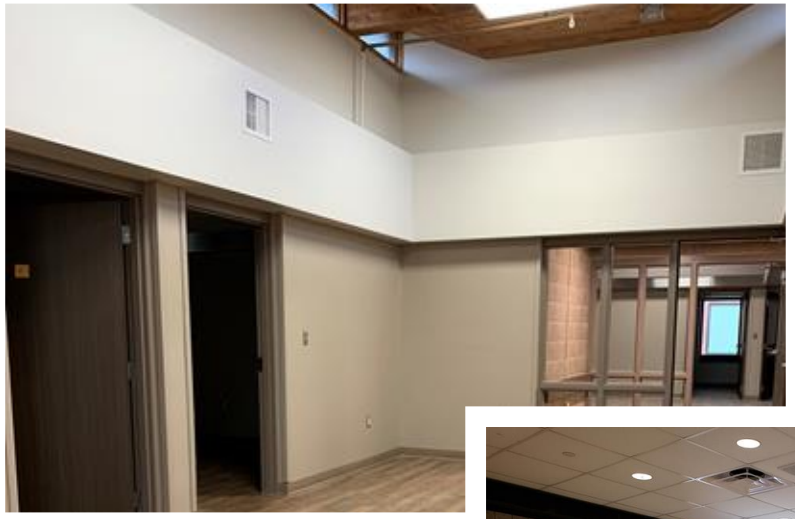
From the report:

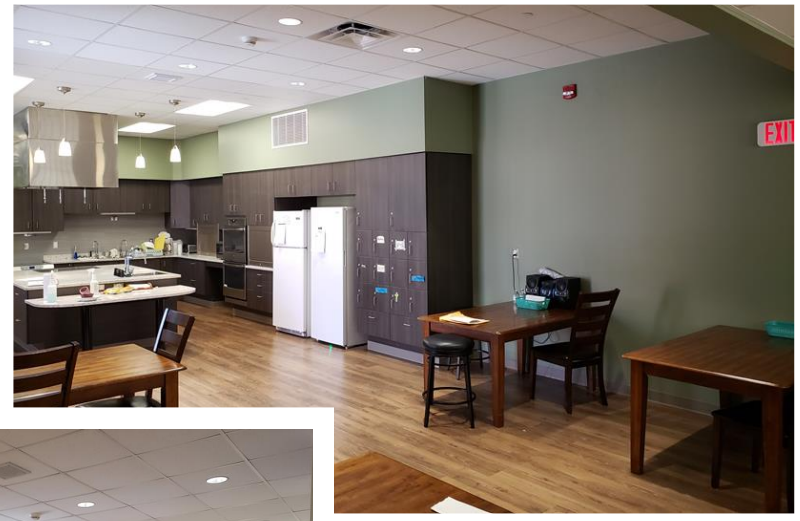
"LSTC recognizes its value as a safety net … aims to arm people with supports and resources, they need to be supported in a less restrictive environment."



LIFE SKILLS TRANSITION CENTER
Our space

Reduced footprint
The LSTC is in the process of consolidating residences and services to become more efficient in resource utilization and delivery of services.









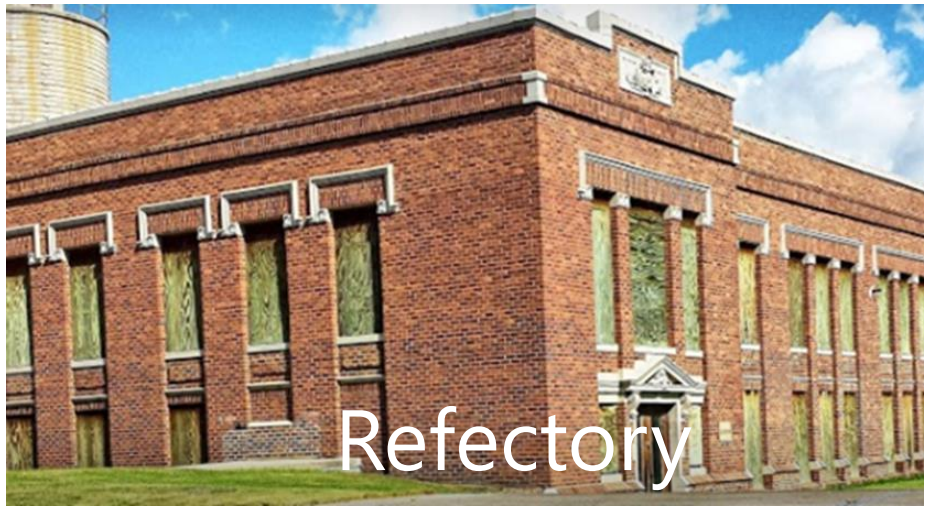


LIFE SKILLS TRANSITION CENTER
Our space

Other Capital Projects

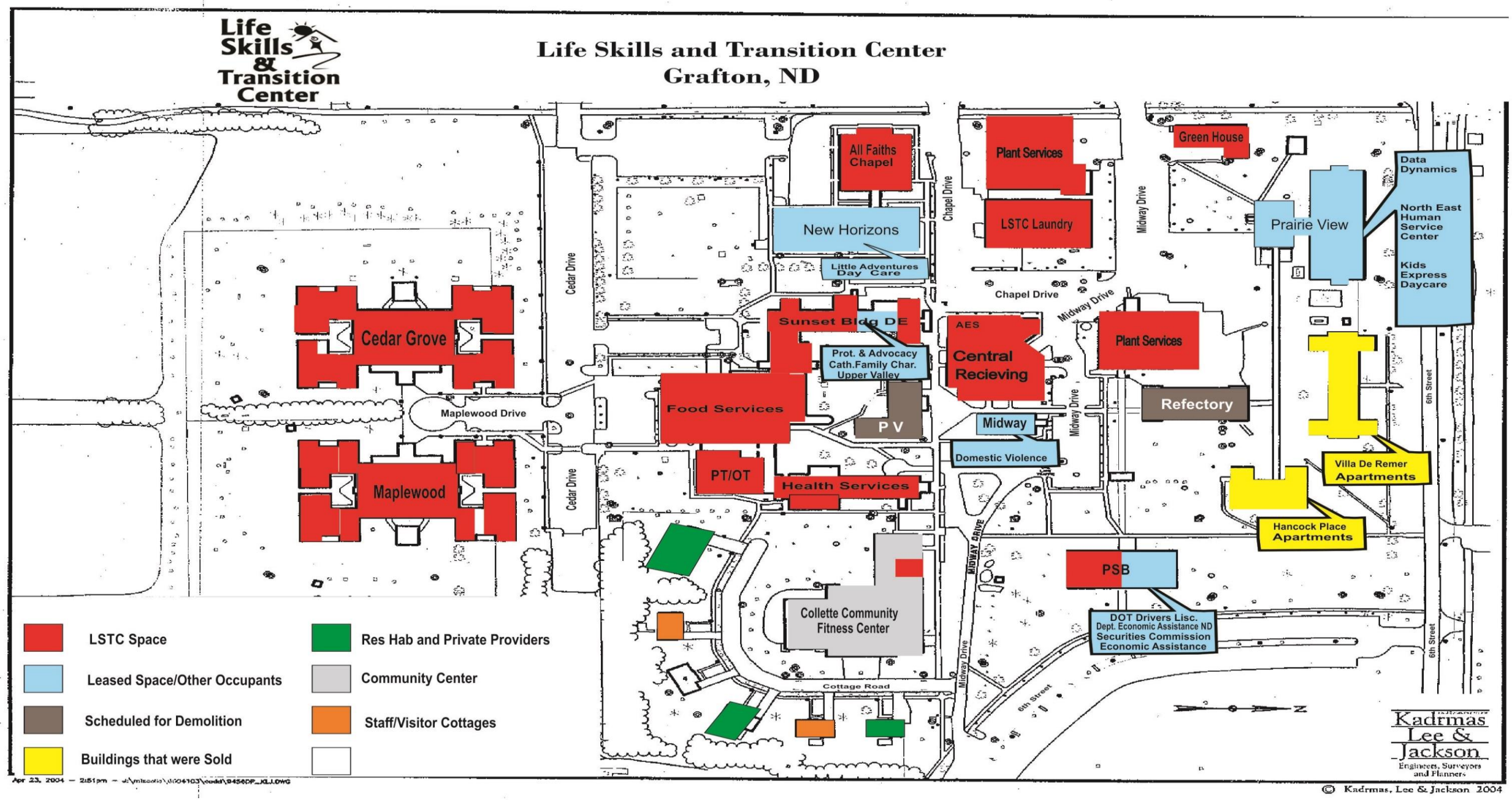
- Window replacement (April 2021)
- Transfer switch replacement (March 2020)
- Roofing (Aug. 2020 and Nov. 2021)
- Demolition (Oct. 2020) (at right)










Life Skills & Transition Center
Life Skills and Transition Center
Grafton, ND
All Faiths Chapel
Plant Services
Green House
Data Dynamics
North East Human Service Center
Kids Express Daycare
Prairie View
New Horizons
LSTC Laundry
Little Adventures Day Care
Chapel Drive
Midway Drive
Cedar Drive
Cedar Grove
Sunset Bldg DE
AES
Central Recieving
Plant Services
Prot. & Advocacy Cath.Family Char. Upper Valley
Food Services
P V
Refectory
Maplewood Drive
Midway
Domestic Violence
Villa De Remer Apartments
Maplewood
PT/OT
Health Services
Hancock Place Apartments
PSB
Collette Community Fitness Center
DOT Drivers Lisc.
Dept. Economic Assistance ND
Securities Commission
Economic Assistance
Cottage Road
6th Street
LSTC Space
Leased Space/Other Occupants
Scheduled for Demolition
Buildings that were Sold
Res Hab and Private Providers
Community Center
Staff/Visitor Cottages
Kadrmas Lee & Jackson
Engineers, Surveyors and Planners
Apr 23, 2004 – 2:51pm
© Kadrmas, Lee & Jackson 2004

LIFE SKILLS TRANSITION CENTER
Census and Admission Trends

	Adult	Youth
2018 – June 30	53	15
2019 – June 30	52	20
2020 – Dec 31	46	19

	Adult		Youth	
	Adm	Dis	Adm	Dis
2019	7	2	5	3
2020	5	5	11	7

Reasons for Admission to LSTC

- Physical aggression within the family home or residential setting (towards family, employees, or other vulnerable people that they live with)
- Significant property destruction
- Self-abuse
- Other unsafe behaviors

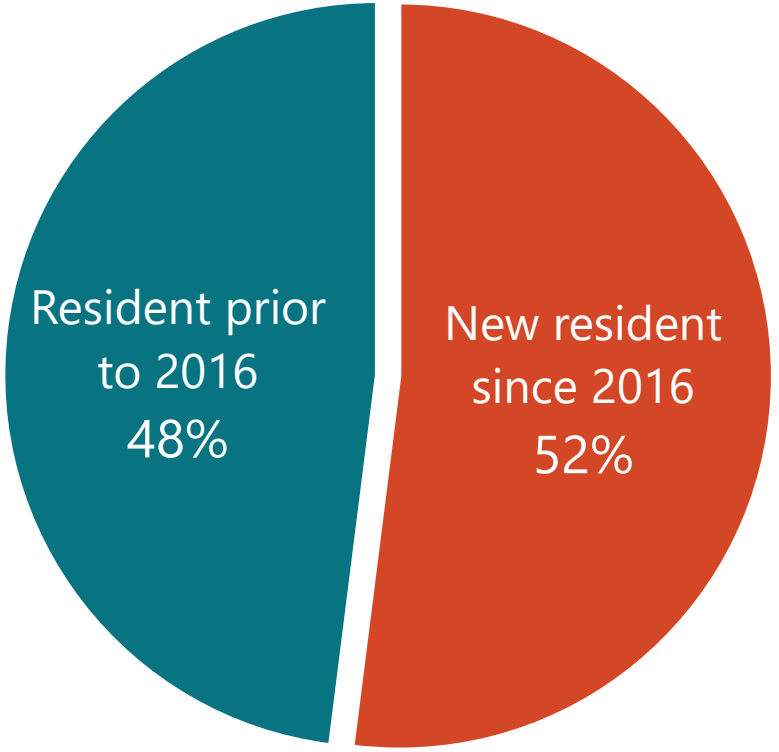


Increase in admissions with higher cognitive abilities (13 of 15 with mild/moderate IDD)

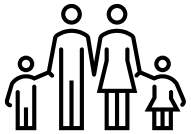
LIFE SKILLS TRANSITION CENTER
Residential Turnover

Transition Planning begins upon admission to LSTC

Care Team works together to identify long-term solutions for individual that reflect their choice and their needs

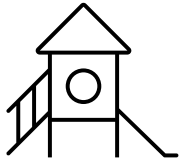


DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



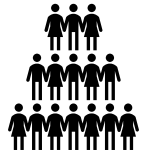
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health



Services Closer to Home

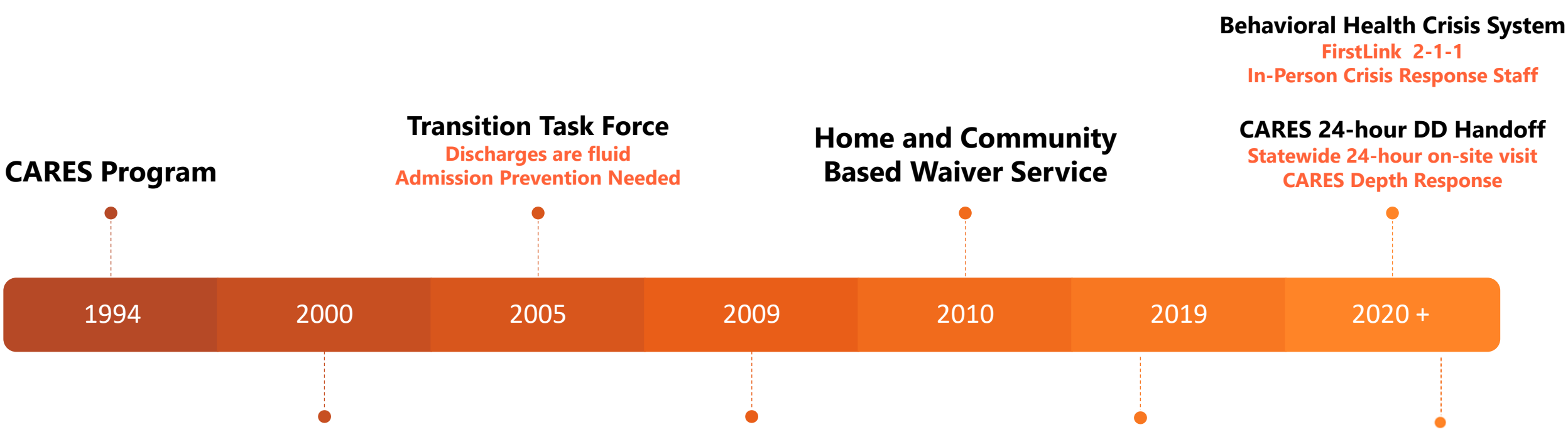
- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

DHS Key Priority

BIG Idea

Accelerate our efforts to transition adults and youth to smaller community settings.

TRANSFORMATION OF LSTC SERVICES



2020 LSTC Statewide Crisis Services

Cares Application
Total: 19
Youth: 9
Adult: 10

Technical Assistance
Events: 62
People: 47

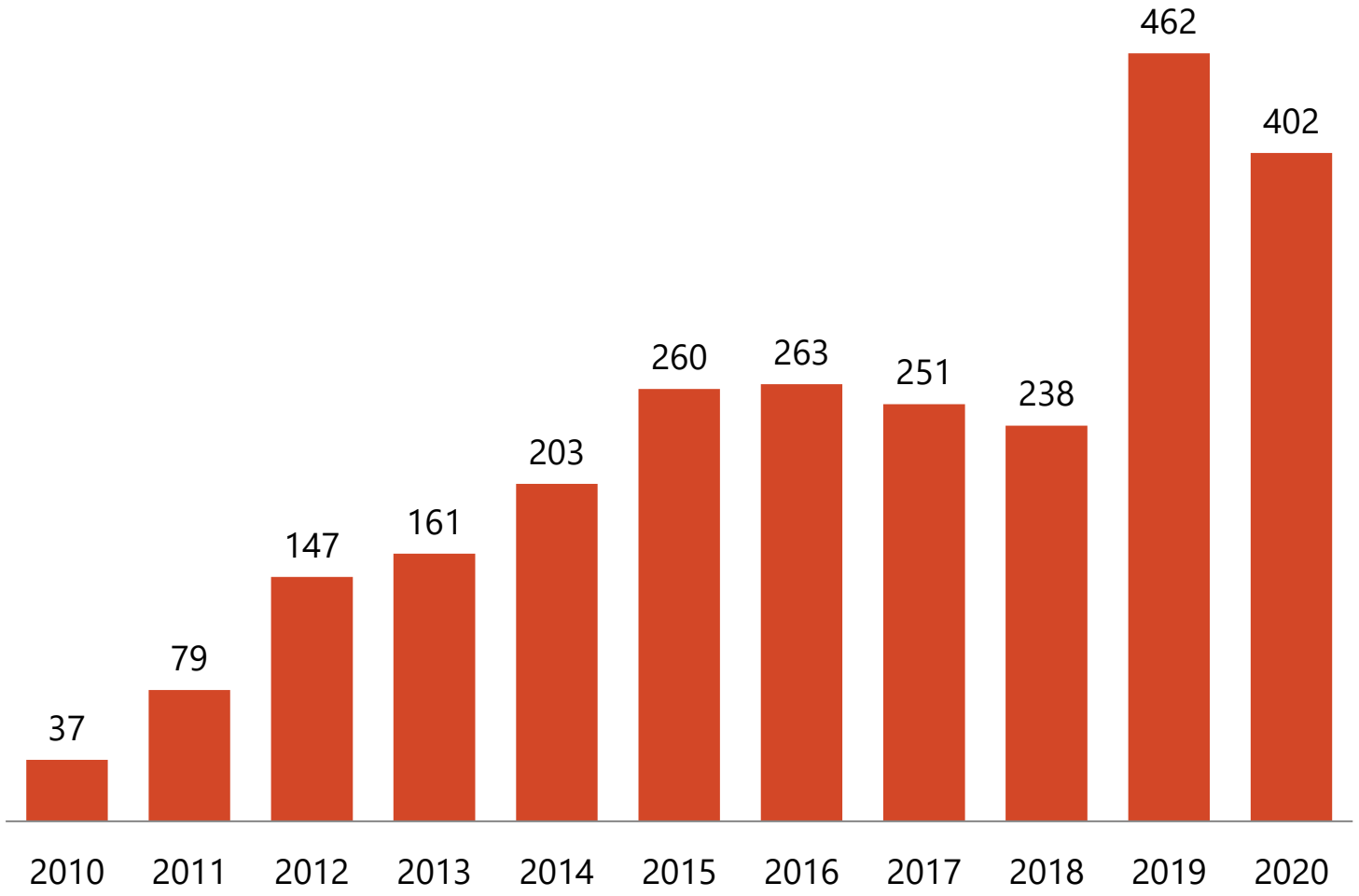
In-Home Crisis Service
Events: 24
People: 4
Service Hours: 230

Transition Supports
People: 21
Service Hours: 2,028

Crisis Admissions
Events: 6
People: 6

In Home Observations
Events: 18
People: 7
Service Hours: 138

DD Behavioral Health Services



Caseload 2020: 402

- Regions: All 8
- Providers: Over 20
- Communities: Over 30

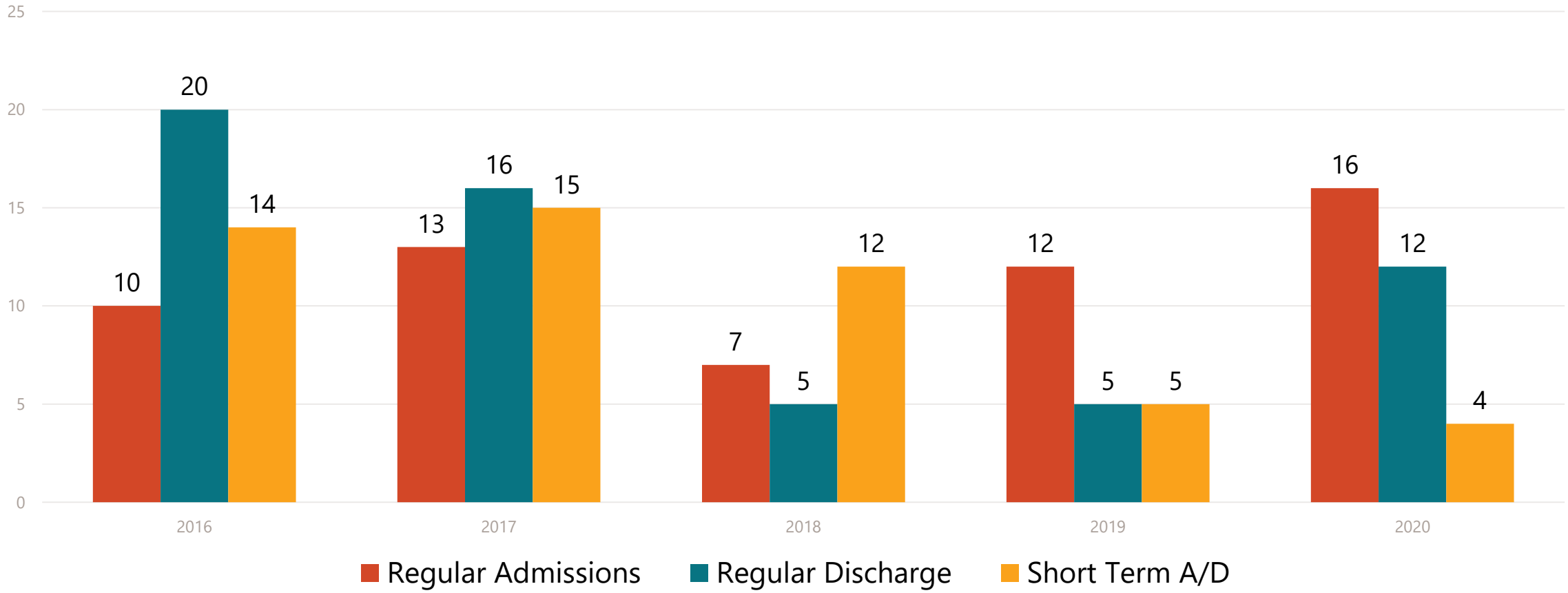
Applied Behavior Analysts:

- Positions: 10 (9 + 2x0.5)
- Filled: 9 of 11 slots
- Credentials as of 12/20:
  - 7 Licensed/Registered
  - Training: 2 of 9 slots

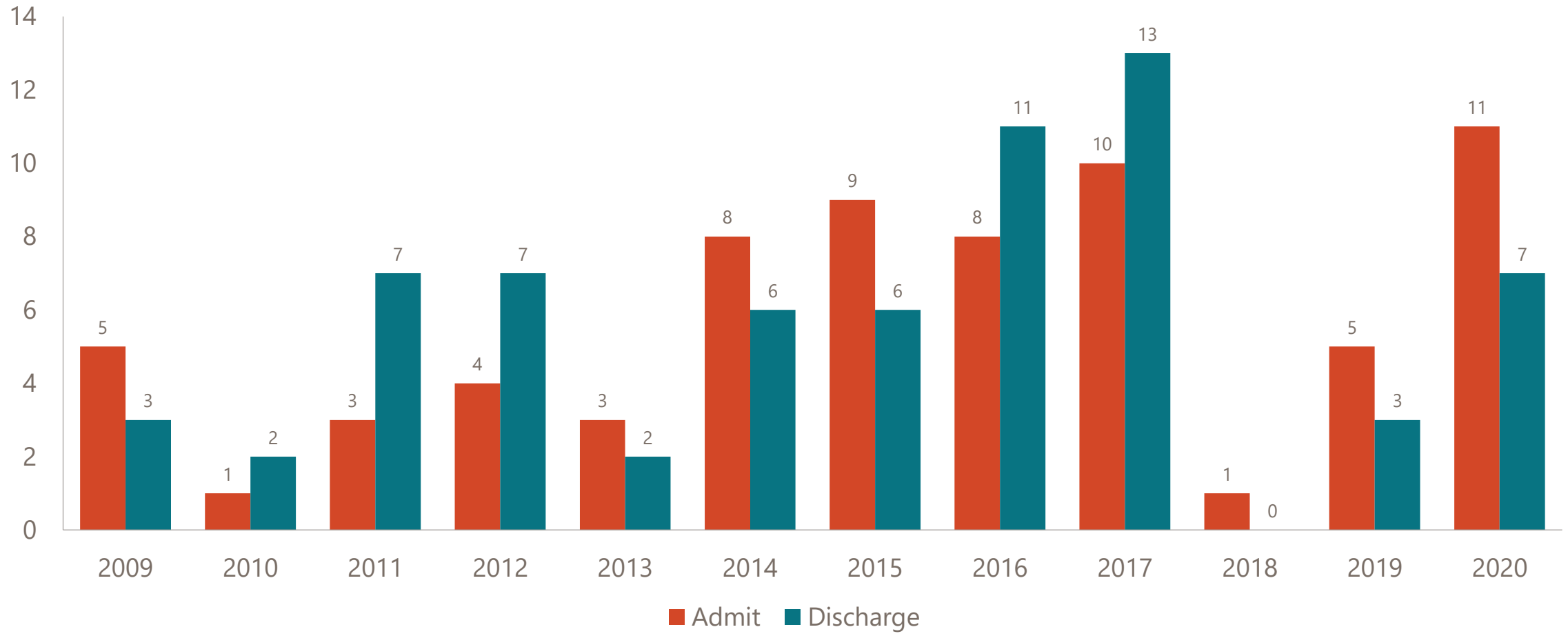
Barriers:

- 2-year recruiting per slot
- Training young ABA's
- COVID-19 impact

LIFE SKILLS TRANSITION CENTER
Admission and Discharge Trends

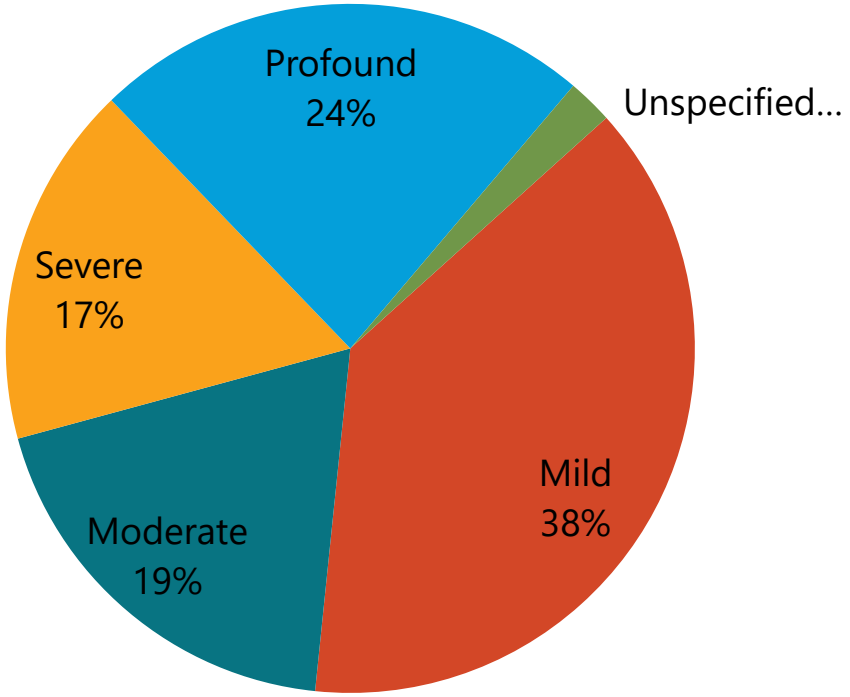


LIFE SKILLS TRANSITION CENTER
Youth Admission and Discharge Trends

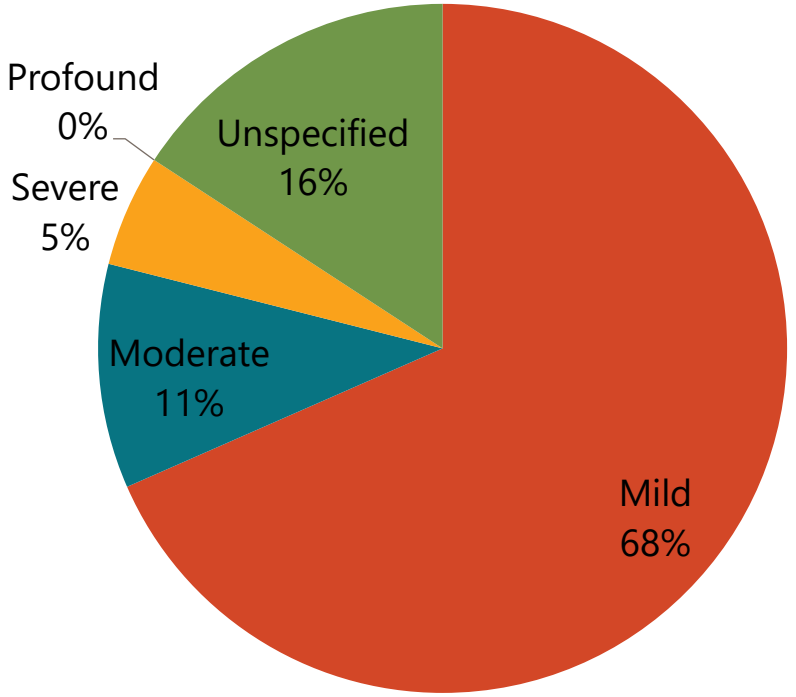


LIFE SKILLS TRANSITION CENTER
Disability Level – Adult and Youth

2020 LSTC **Adult** by
Level of Intellectual and Dev. Disability



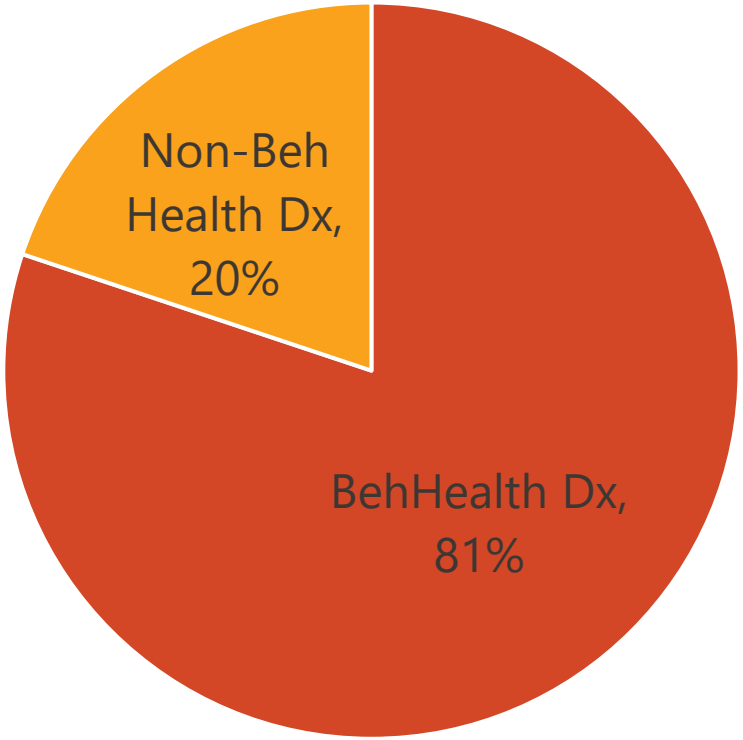
2020 LSTC **Youth** by
Level of Intellectual & Dev. Disability



LIFE SKILLS TRANSITION CENTER
Youth - presence of behavioral health diagnosis

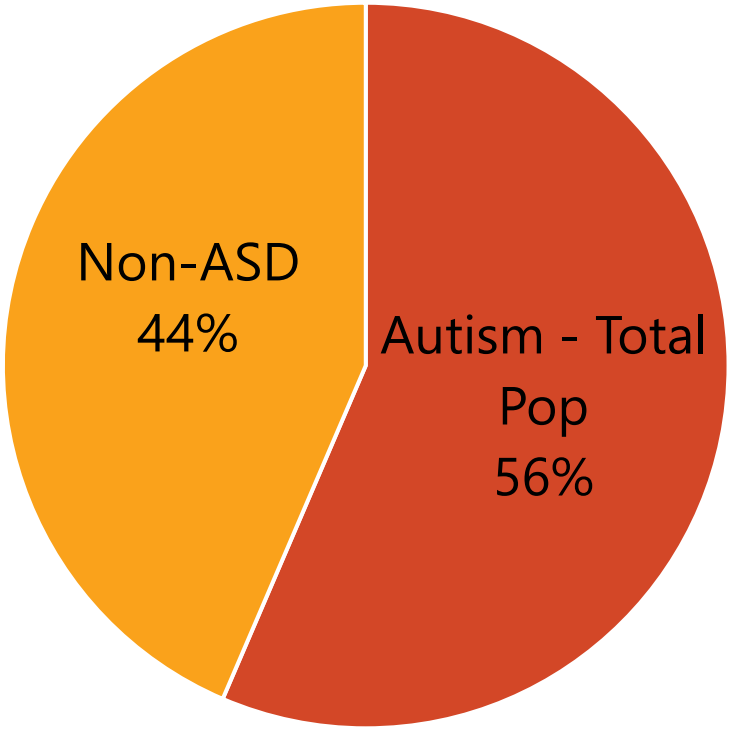
YOUTH AT LSTC

0%	**Profound intellectual disability**
5%	**Severe intellectual disability**
11%	Moderate intellectual disability
68%	Mild intellectual disability
16%	Unspecified intellectual disability
58%	**Autism Spectrum diagnosis**
81%	**Behavioral health diagnosis**

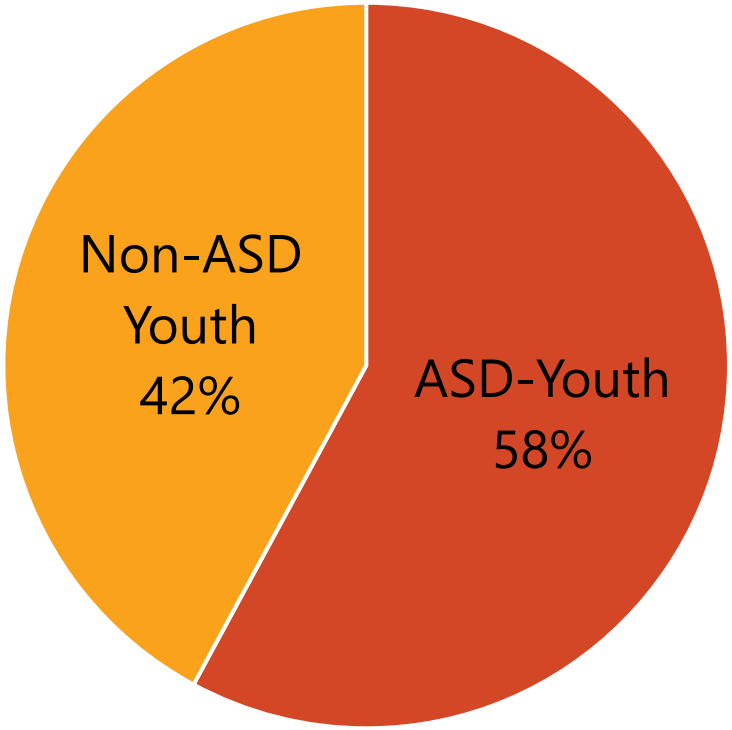


LIFE SKILLS TRANSITION CENTER
Prevalence of Autism Spectrum Diagnoses (ASD)

Proportion of Total ICF Population 2020



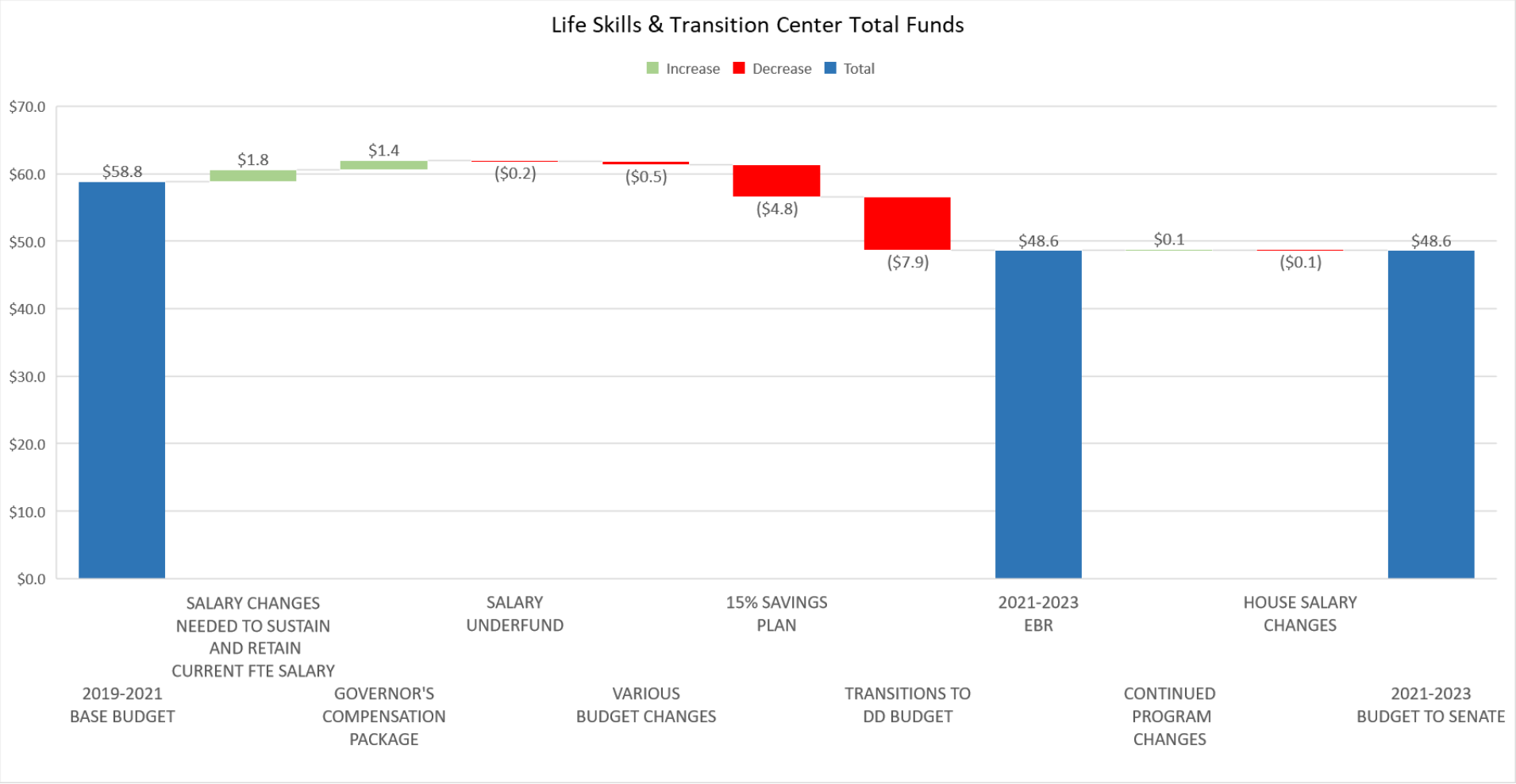
Proportion of Youth Population 2020



Life Skills & Transition Center Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget	House Changes Increase/ (Decrease)	2021 – 2023 Budget to Senate
Salaries and Benefits	48,807,542	(8,851,333)	39,956,209	(87,131)	39,869,078
Operating	9,141,275	(1,324,010)	7,817,265	100,000	7,917,265
Capital	846,131	0	846,131	0	846,131
Total	58,794,948	(10,175,343)	48,619,605	12,869	48,632,474
General Fund	29,426,161	(7,777,688)	21,648,473	41,962	21,690,435
Federal Funds	26,880,105	(2,430,575)	24,449,530	(0)	24,449,530
Other Funds	2,488,682	32,920	2,521,602	(29,093)	2,492,509
Total	58,794,948	(10,175,343)	48,619,605	12,869	48,632,474
Full Time Equivalent (FTE)	322.84	(14.50)	308.34	0	308.34

OVERVIEW OF BUDGET CHANGES (IN MILLIONS)



15% Savings Plan

- LSTC Savings
  - Operational ($0.2) million
  - FTE ($1.4) million
- Net Savings ($3.2) million

Transitions to DD ($7.9) million

- Budget incrementally as people move to the community

The Net Savings DHS will realize from the 15% Savings Plan and Transition to DD Budget will be $3.3 million.

House Changes ($.1) million

- Includes $100,000 for Temp Psychiatrist



Other budget impacts

Permission to convey a portion of two parcels of land commonly referred to as “the bowl” to the Grafton Park Board

Senator Fors has presented an amendment on behalf of the Grafton Fire Department requesting permission for the LSTC to covey a portion of land for a new Fire tower and Fire Station.



Additional unanticipated budget request: $183,040

- Unanticipated retirement of psychiatrist from Northeast Human Service Center
- Added to amendment that administration-fiscal will present before the committee.
- Critical need due to Behavioral Health diagnosis and acuity

Keys to successful acceleration of transition to community

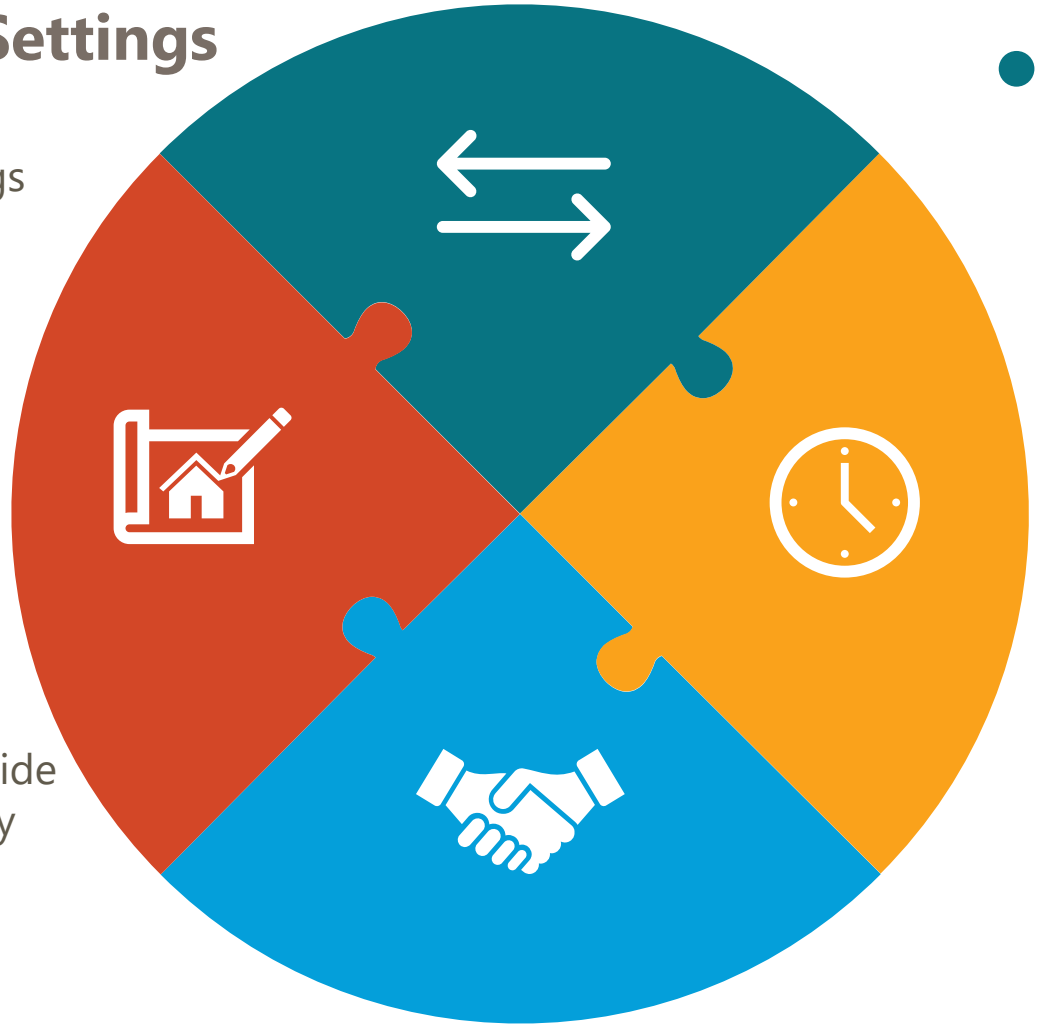
Marshalling our resources to support a person's ability to make an informed choice about the most integrated setting that is right for them

New Community Settings

Create new small scale specialized residential settings (behavioral focus) in 2-3 communities

Shared Understanding of LSTC Role

Re-establish LSTC as a setting that specializes in crisis and stabilization services



Community Crisis Support

Continue to build LSTC crisis support team capacity to provide on-site response to emergency crisis in various community settings within 24-hours

Crisis Stabilization

Build staffing model and operational processes to support admission to LSTC within 48-hour

LSTC Net Budget Savings Plan Requires Partnership

Collaboration between LSTC, DD, and Children Family Services as well as ND community providers.

Census reduction of 16 youth and 10 adults to homes in their community.

The transition of people will occur gradually throughout the biennium as appropriate settings are developed by community providers.

Each person and their family/guardian will be involved in the development of their Person-Centered Transition Plan.

The LSTC is recognized as a setting that specializes in crisis and stabilization services.

Meet Janie.



Meet Janie's Family.

Janie is 14. Janie is on the Autism Spectrum. She receives services through the Medicaid DD waiver.

She was living at home in Velva with her parents and two sisters, attending school part time.

Things at home were escalating. Her intensifying behaviors became too much for the family to handle. Everyone was exhausted.

Janie's family received in-home support (40-60 hrs/wk).

As things escalated, they worked with their DD case manager and DD diversion coordinator to identify options.

In-community options were limited. A crisis placement at LSTC was approved.

- Mom works part time at the elevator. Dad works full time at the nursing home.
- All three girls attend the local school (ages 7, 9 and 14).

A young girl is struggling. So is her family. What do we do?

Understanding how systems can help families find stability amidst crisis

Service Continuum

Independent no Supports → Independent with Supports → Supervised Housing → Monitored Housing → Acute Care

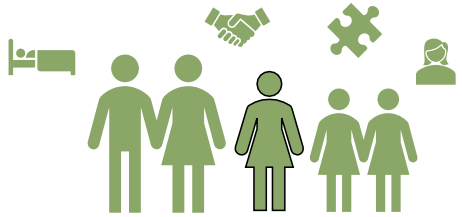
Most Integrated — Least Integrated

Service Strategy

Early Intervention | Care Plan | Transition Plan | Discharge Plan

Intellectual/ Dev Disability

At home with family no Services → At home with family with services → Family Care Option → Foster Care → Therapeutic Foster Care → ICF Youth → ICF Group Facility - LSTC → Hospital



Crisis

Team looks for solutions

In home supports

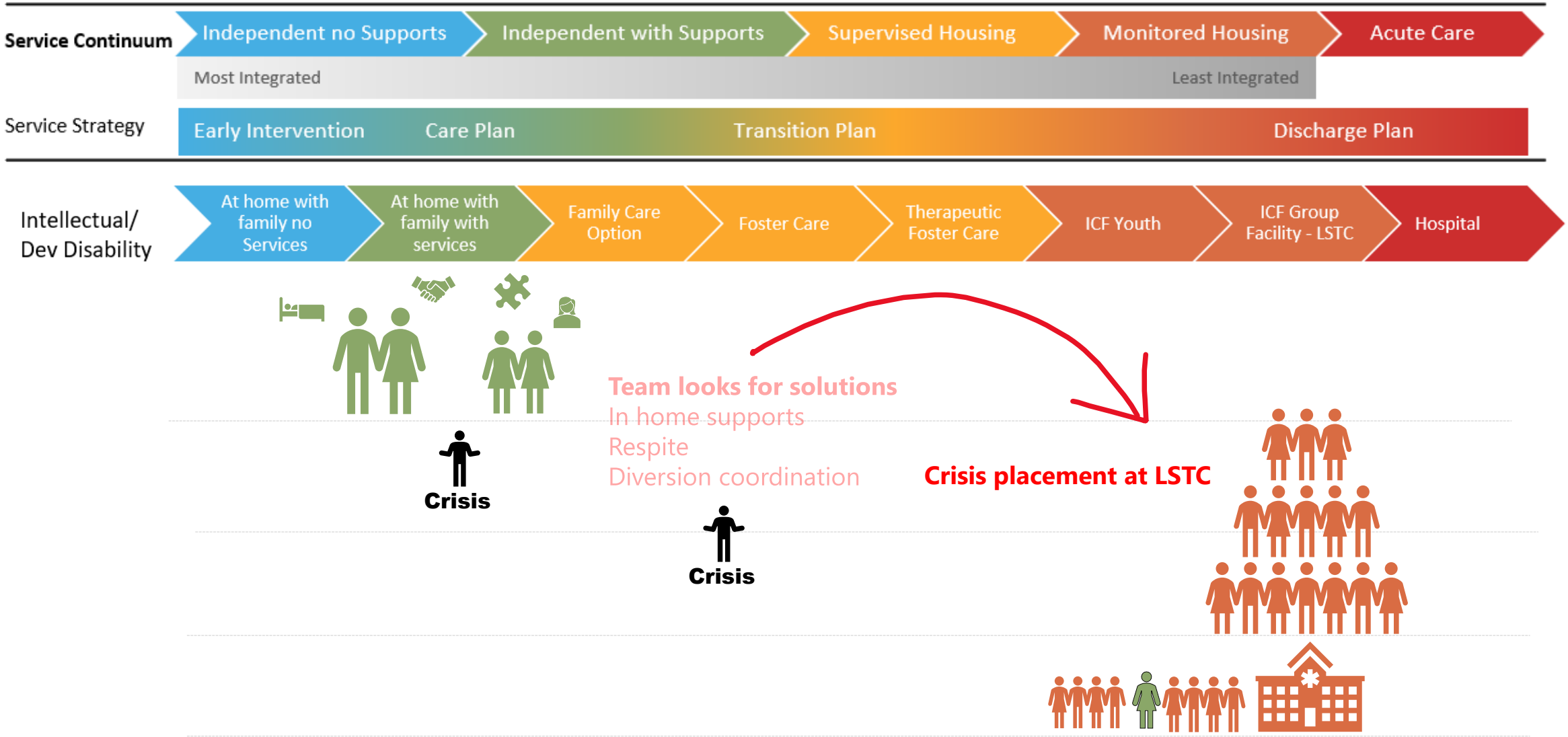
Respite

Diversion coordination

Crisis

A young girl is struggling. So is her family. What do we do?

Understanding how systems can help families find stability amidst crisis



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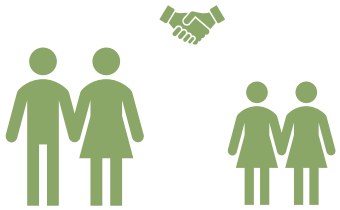


Crisis

Team looks for solutions
In home supports
Respite
Diversion coordination

Crisis

Crisis placement at LSTC

Stabilization (8 mo)
Structure & Routine
Educational supports
Svc during transition





Placement at Youth ICF

LIFE SKILLS TRANSITION CENTER

Successful stabilization happens with comprehensive support

- **Interdisciplinary team** to review, assess, case plan, and support
- Implementation of **Positive Supports** by professionals with expertise in both developmental disabilities and mental illness
- Professional **assessment of functional communications**/behavior
- Accessible, regular **interdisciplinary healthcare** consultations
- **Consistent structure and routine**
- Services and **supports to re-integrate** into family home, community group home, school and vocational environments





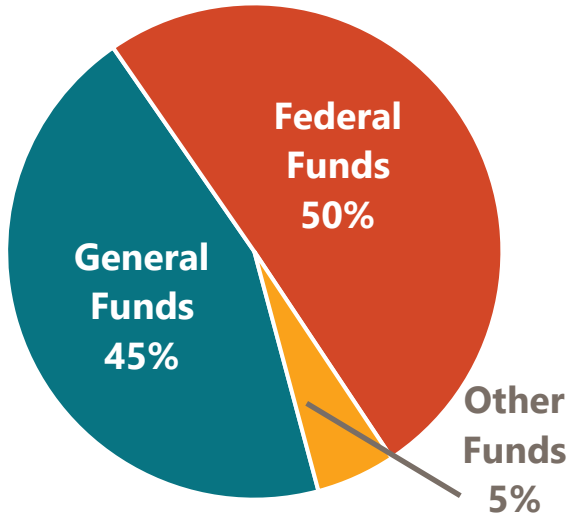
LSTC Budget Summary

19-21 Budget	**$58,794,948**
21-23 Budget (exec)	**$48,619,605**

Reduction of 14.5 FTEs; $10,175,343 budget reduction (50% in federal funds)

- Reduce census by 26 (16 youth, 10 adults) via both transitions and diversions
- Shift operations to re-orient toward crisis and stabilization service
- Reduce general fund contribution to adaptive equipment service, seeking alternate revenue sources

NOTE: Interconnection between LSTC, CFS and DD budgets as service models shift





Contact Information

Sue Foerster, Superintendent
Life Skills Transition Center
701 W 6th Street
Grafton, ND 58237

Phone: 701-352-4302
Toll Free: 1-800-252-4911
ND Relay TTY: 7-800-366-6888
E-mail: sfoerster@nd.gov





8745

DOJ SETTLEMENT
AGREEMENT SUMMARY
SENATE APPROPRIATIONS SENATOR HOLMBERG, CHAIRMAN

March 11, 2021

NORTH Dakota
Be Legendary.™

SETTLEMENT AGREEMENT BETWEEN U.S. DOJ & STATE OF ND

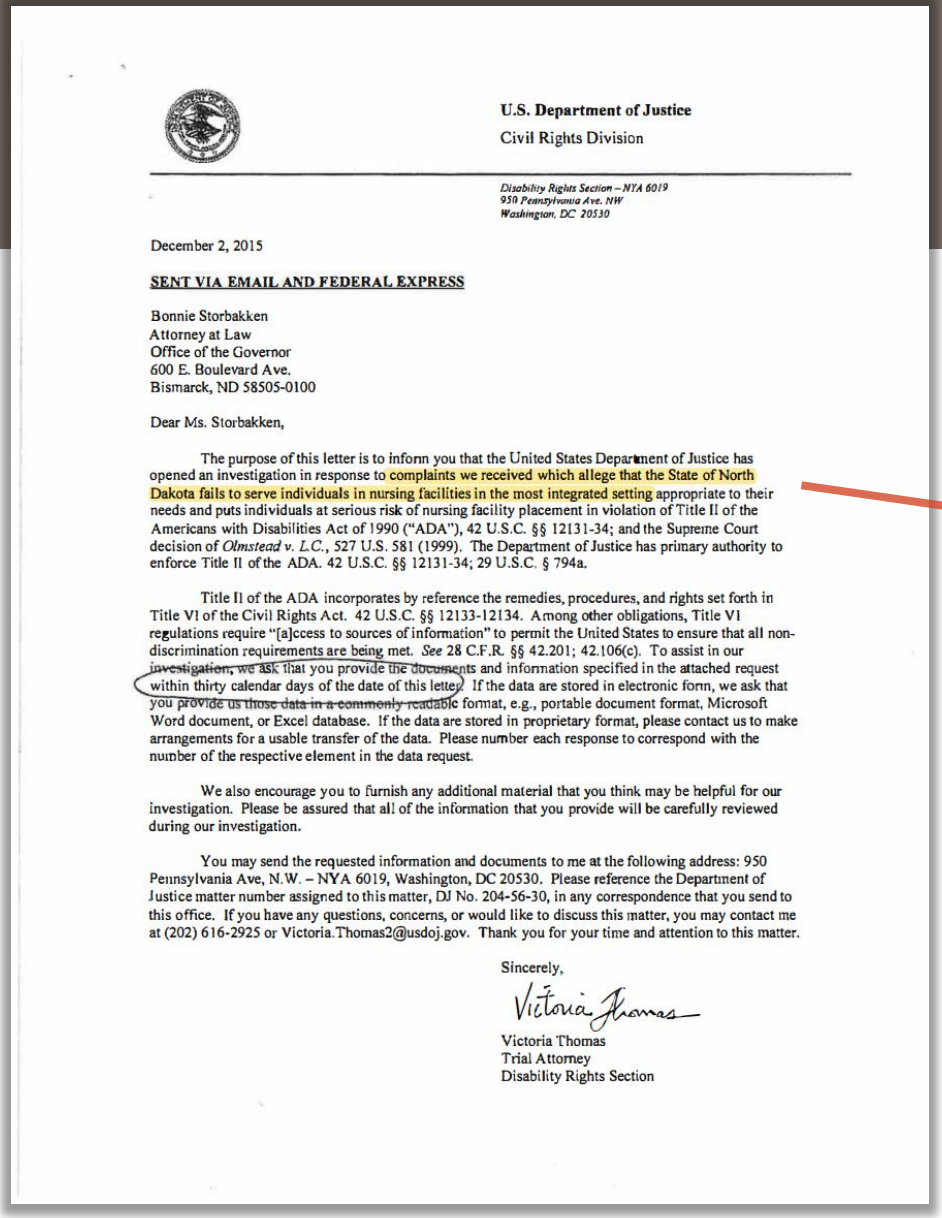
Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective December 14, 2020

Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.



NOTIFICATION FROM DOJ



U.S. Department of Justice
Civil Rights Division

Disability Rights Section – NYA 6019
950 Pennsylvania Ave. NW
Washington, DC 20530

December 2, 2015

SENT VIA EMAIL AND FEDERAL EXPRESS

Bonnie Storbakken
Attorney at Law
Office of the Governor
600 E. Boulevard Ave.
Bismarck, ND 58505-0100

Dear Ms. Storbakken,

The purpose of this letter is to inform you that the United States Department of Justice has opened an investigation in response to complaints we received which allege that the State of North Dakota fails to serve individuals in nursing facilities in the most integrated setting appropriate to their needs and puts individuals at serious risk of nursing facility placement in violation of Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12131-34; and the Supreme Court decision of *Olmstead v. L.C.*, 527 U.S. 581 (1999). The Department of Justice has primary authority to enforce Title II of the ADA. 42 U.S.C. §§ 12131-34; 29 U.S.C. § 794a.

Title II of the ADA incorporates by reference the remedies, procedures, and rights set forth in Title VI of the Civil Rights Act. 42 U.S.C. §§ 12133-12134. Among other obligations, Title VI regulations require "[a]ccess to sources of information" to permit the United States to ensure that all non-discrimination requirements are being met. *See* 28 C.F.R. §§ 42.201; 42.106(c). To assist in our investigation, we ask that you provide the documents and information specified in the attached request within thirty calendar days of the date of this letter. If the data are stored in electronic form, we ask that you provide us those data in a commonly readable format, e.g., portable document format, Microsoft Word document, or Excel database. If the data are stored in proprietary format, please contact us to make arrangements for a usable transfer of the data. Please number each response to correspond with the number of the respective element in the data request.

We also encourage you to furnish any additional material that you think may be helpful for our investigation. Please be assured that all of the information that you provide will be carefully reviewed during our investigation.

You may send the requested information and documents to me at the following address: 950 Pennsylvania Ave, N.W. – NYA 6019, Washington, DC 20530. Please reference the Department of Justice matter number assigned to this matter, DJ No. 204-56-30, in any correspondence that you send to this office. If you have any questions, concerns, or would like to discuss this matter, you may contact me at (202) 616-2925 or Victoria.Thomas2@usdoj.gov. Thank you for your time and attention to this matter.

Sincerely,

Victoria Thomas
Trial Attorney
Disability Rights Section

DECEMBER 2015

> "...complaints we received which allege that the **State of North Dakota fails to serve** individuals in nursing facilities in the most integrated setting..."

49
PER 1000

PEOPLE OVER 65 IN CERTIFIED NURSING FACILITIES

HIGHEST RATE IN THE U.S.

Sources: Henry J Kaiser Foundation, US Census Bureau (2016)

VARIETY OF CONCERNS

EXAMPLES PROVIDED BY DOJ

- **Unnecessary segregation** of disabled individuals in skilled nursing facilities
- Adults in skilled nursing facilities who would **rather be in their community**
- **Imbalance of funds** to skilled nursing facilities and community-based services
- **Lack of awareness** about existing transition services and available tools

KEY TERMS | DOJ SETTLEMENT
Americans with Disabilities Act

The Americans with Disabilities Act (ADA) requires public agencies to **eliminate unnecessary segregation** of persons with disabilities and provide services in the **most integrated setting appropriate** to the needs of the individual.

In **1999** the Federal Supreme Court **Olmstead** decision **affirmed** the **ADA** requirements.



KEY TERMS | DOJ SETTLEMENT
Most Integrated Setting

A *living environment* that allows individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

For Example

Single Family Home
Apartment
Townhome
Condominium
Farm or Ranch
Adult Foster Care
Living with family

KEY TERMS | DOJ SETTLEMENT
Community Integration Mandate

Public entities are required to provide **community-based services** when:

- Community-based services are **appropriate** for the individual; and
- The individual **does not oppose** community-based treatment; and
- Community-based treatment can be **reasonably accommodated**, taking into account:
  - Resources available to the entity and
  - Needs of others receiving disability services.



BENEFITS OF DOJ AGREEMENT

1. **Expands and raises awareness** about community-based care options available to adults with physical disabilities

2. Allows individuals to make **informed choices**, including the option to receive care while enjoying the benefits of community living in the least restrictive setting

3. Builds upon the investments made by the 2019 Legislature and our **shared goal** of improving services to citizens

KEY TERMS | DOJ SETTLEMENT
Informed Choice

The process by which the State ensures that Target Population members have an opportunity to make an informed decision about where to receive services.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

For Example

- Person-centered planning
- Info about benefits of integrated settings
- Facilitated visits or other experiences in integrated settings
- Opportunity to meet with peers (other individuals with disabilities who are living, working and receiving services in integrated settings)
- Reasonable efforts to identify and address concerns

What do we need to do to help someone make an informed choice about how they may want to access services in the most integrated setting that is right for them?



AGREEMENT VISION

- Long-term care system & supports reform
- Increase access to community-based services
- Increase awareness about service options
- Increase provider capacity & training

Builds upon **shared goal** of improving services to citizens providing care closer to home

AGREEMENT COMPONENTS

I. Introduction
II. Jurisdiction
III. Definitions
IV. Target Population
V. Subject Matter Expert
VI. Implementation Plan
VII. Case Management
VIII. Person Centered Plans
IX. Access to Community Based Svc
X. Information, Screening & Diversion
XI. Transition Services
XII. Housing Services
XIII. Community Provider Capacity & Training
XIV. In-reach, Outreach, Education & Natural Supports
XV. Data Collection & Reporting
XVI. Quality Assurance & Risk Management
XVII. Enforcement
XVIII. General Provisions

IV. TARGET POPULATION MEMBERS (TPM)

COMMUNITY MEMBERS

- Adults with disabilities living in an integrated community setting, but at risk of Medicaid-funded nursing facility care.
- Adults with disabilities in need of additional community-based services to continue living in an integrated community setting.

NURSING FACILITY MEMBERS

- Adults with disabilities who reside in a nursing facility and receive Medicaid-funded long-term care services.
- Adults with disabilities who reside in a nursing facility who are at risk of becoming eligible for Medicaid-funded services.

Who are we trying to reach?

Target population

Basic Eligibility

- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.



IF in skilled nursing setting

- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

IF in hospital or home setting

- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL

KEY TERMS | DOJ SETTLEMENT
Physical Disability

"Physical Disability" – means an impairment that substantially limits major life activity, including one or more major bodily functions, see 42U.S.C 12102: 28 C.F.R 33.108 such that the individuals meets ND's Nursing Facility Level of Care (LOC) by requiring for example, assistance with activities of daily living such as toileting, eating, or mobility.

ND Admin code 75-02-09, as may be amended.

WHO IS NOT A MEMBER OF THE "TARGET POPULATION"

Individuals under age 21

Individuals who are not Medicaid eligible

Individuals who are not expected to need services for at least 90 days

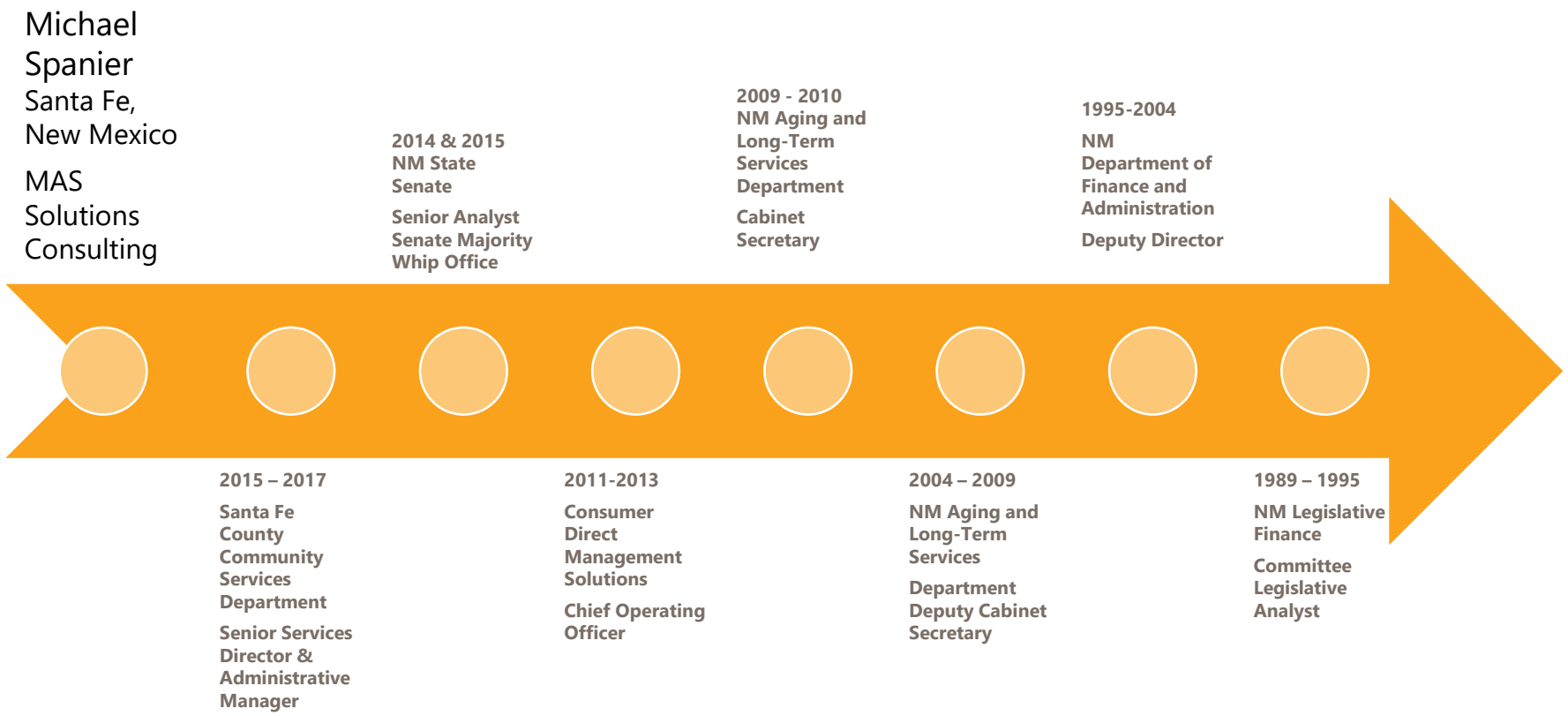
Individuals with an intellectual disability or mental illness who do not screen at a nursing facility level of care



V. SUBJECT MATTER EXPERT

Individual chosen by the parties with expertise in management, administration and finance of HCBS

Provide technical assistance and compliance reviews

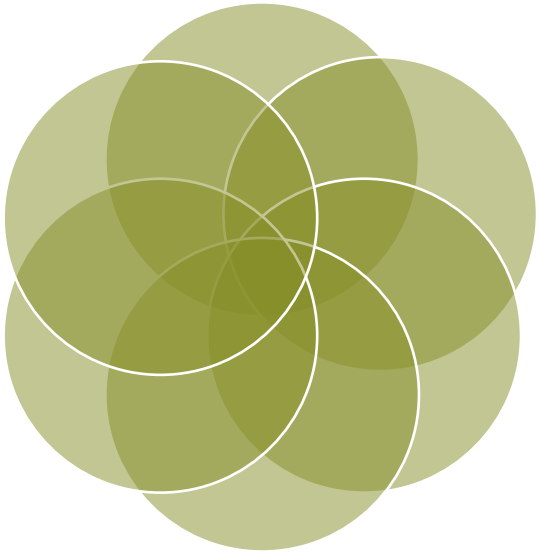


VI. IMPLEMENTATION PLAN

Within 120 days of effective date produce draft plan

Establish a method to address challenges to implementation

Review relevant services, capacity and barriers



Assign agency and division responsibility for achieving benchmarks

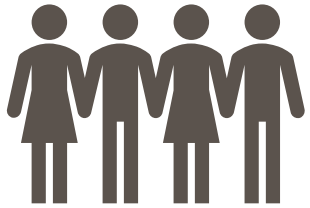
Engage Stakeholders

Identify benchmarks and timelines for meeting Agreement's requirements

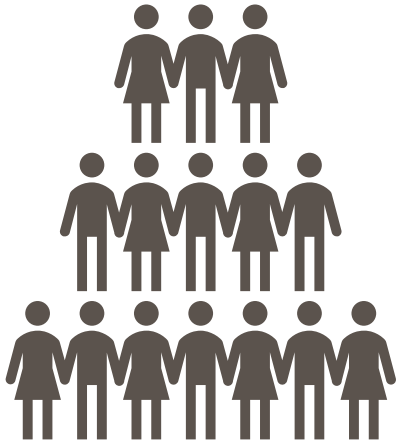
State received approval from DOJ to extend deadline 45 days.

Plan due 5.28.21

VII. CASE MANAGEMENT



64 HCBS Case Managers



Served 2300 individuals
(Nov 2020)

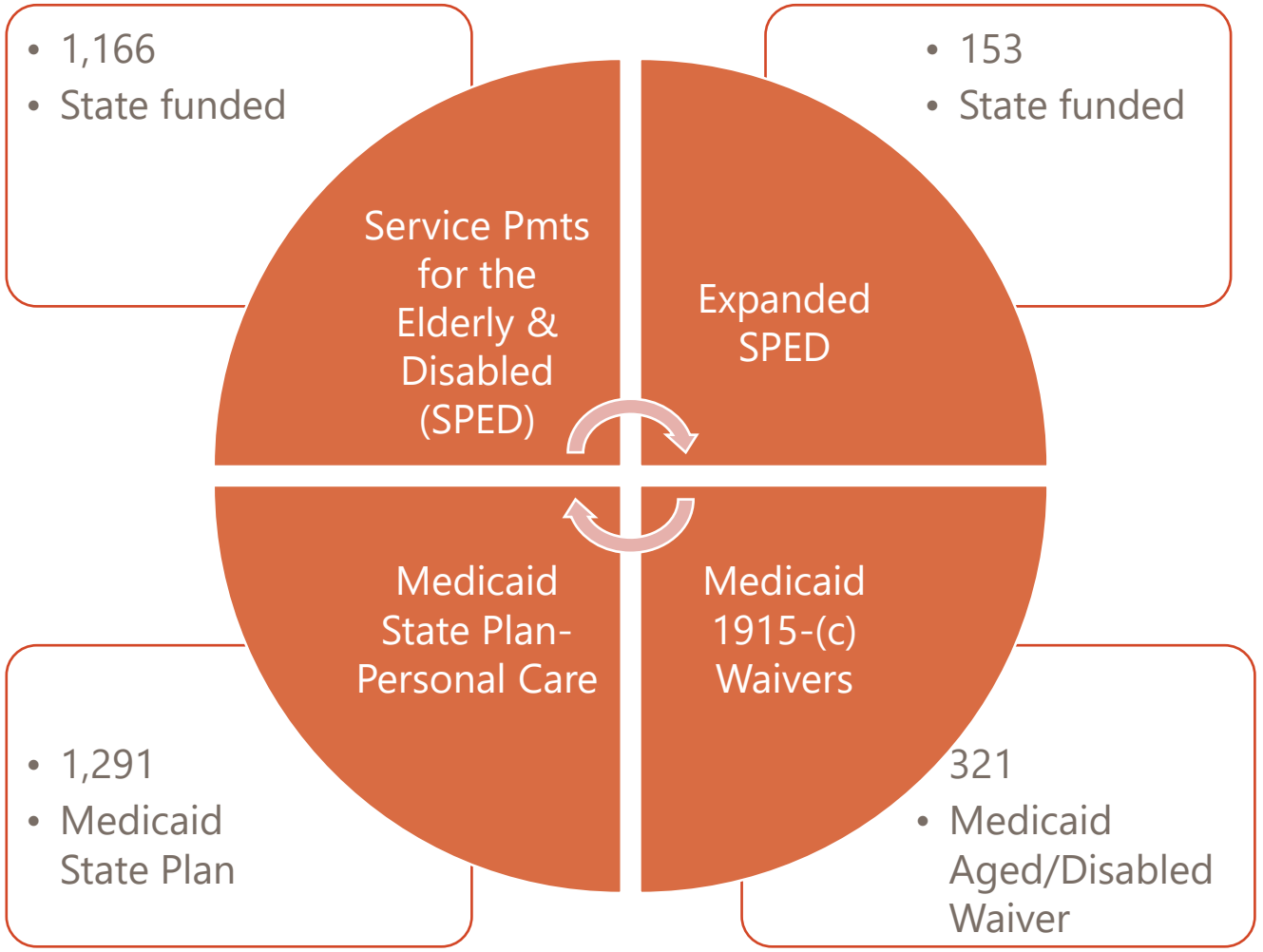
- Provide case management for older adults & individuals with physical disabilities receiving:
  - Service Payments for the Elderly and Disabled (SPED)
  - Expanded SPED (Ex-SPED)
  - Medicaid 1915-(c) Waivers
    - Aged and Disabled
    - Tech Dependent
  - Medicaid State Plan Personal Care (MSP-PC) in community
- Conduct informed choice referral visits

AGING & ADULT SERVICES
Home and Community Based Services

2,300

HCBS supported 2,300 unduplicated recipients

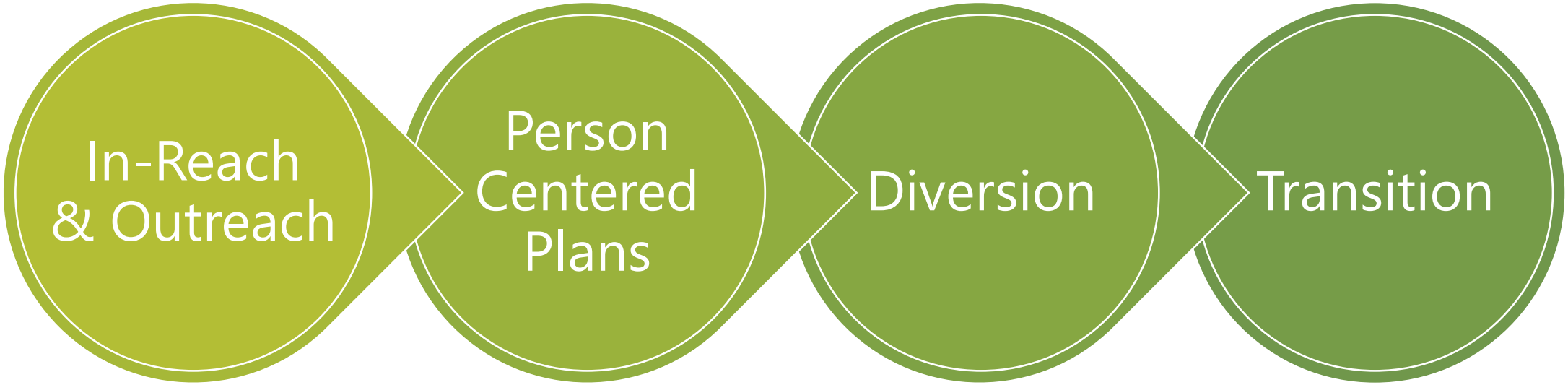
- Primarily serves older adults and individuals with physical disabilities
- Recipients must be both functionally and financially eligible
- May have client cost share based on income
- Federal and state funds



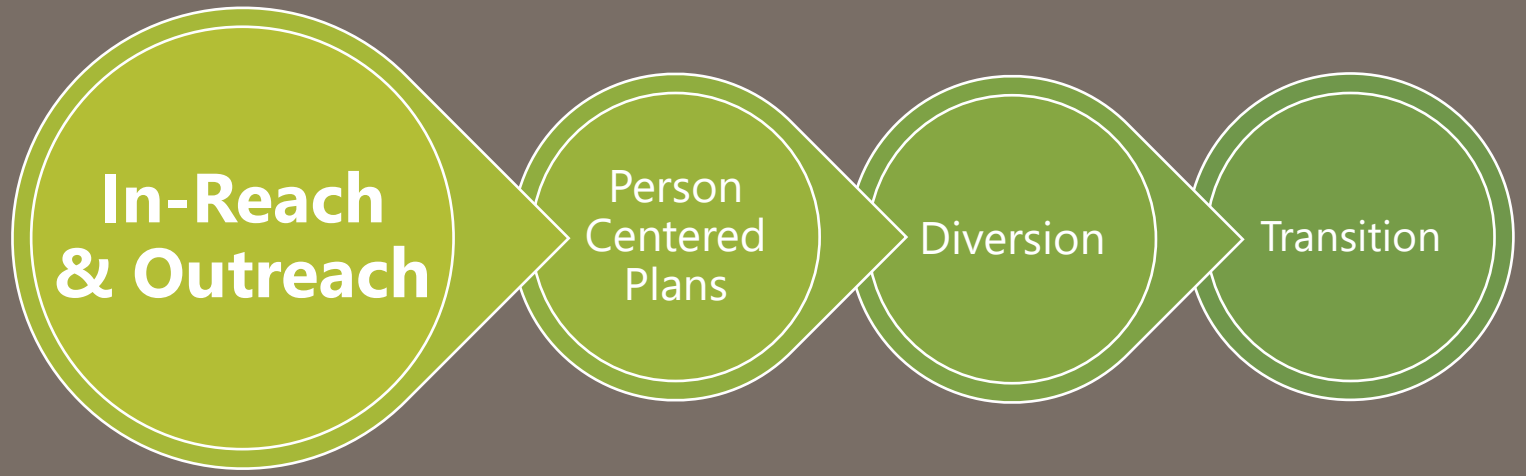
AGING & ADULT SERVICES
Types of *Support Services* available via HCBS

- Adult Day Care
- Adult Foster Care
- Adult Residential Care
- Attendant Care
- Case Management
- Chore Service
- Community Support Services / Residential Habilitation
- Community Transition Services
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care
- Family Home Care & Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Care Services
- Respite Care
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Living

ND / DOJ AGREEMENT STRATEGY



XIV. STRATEGY



IN-REACH

Informing individuals in skilled nursing facilities and hospitals of their care options

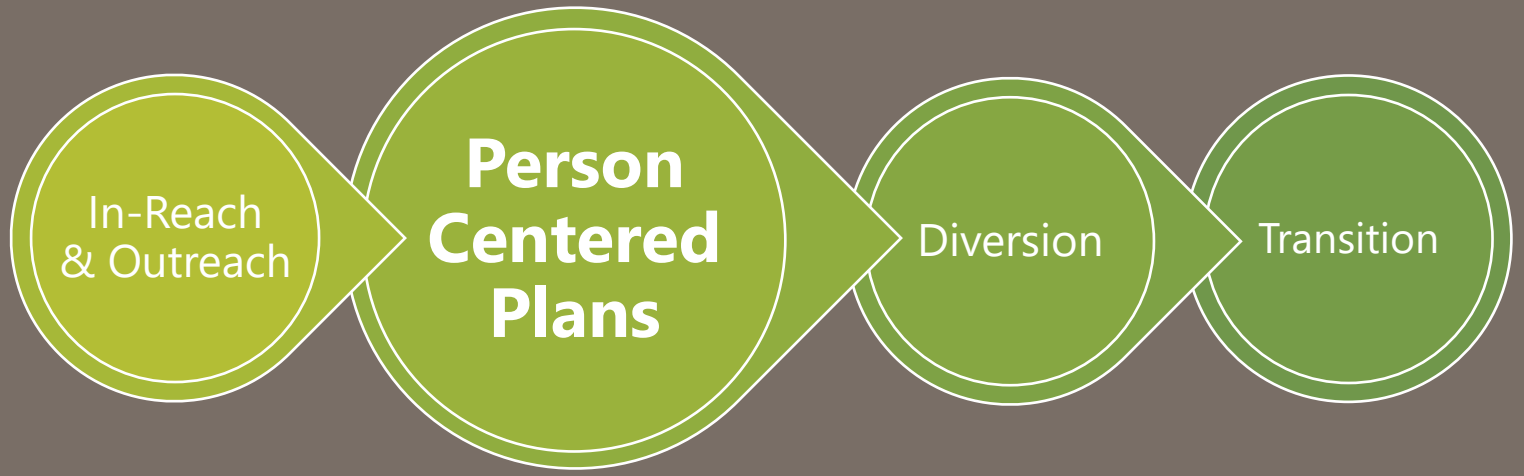
OUTREACH

Informing individuals and stakeholders in the community about their care options

GOALS

Within 9 months	Year 2	Year 4	Year 5 and after
•Individual or group in-reach to all skilled nursing facilities	•Develop peer support system	•Individual in-reach to at least 1,000 Skilled Nursing Facility target population members	• In-reach to all newly admitted or identified Skilled Nursing Facility target population members

VIII. STRATEGY



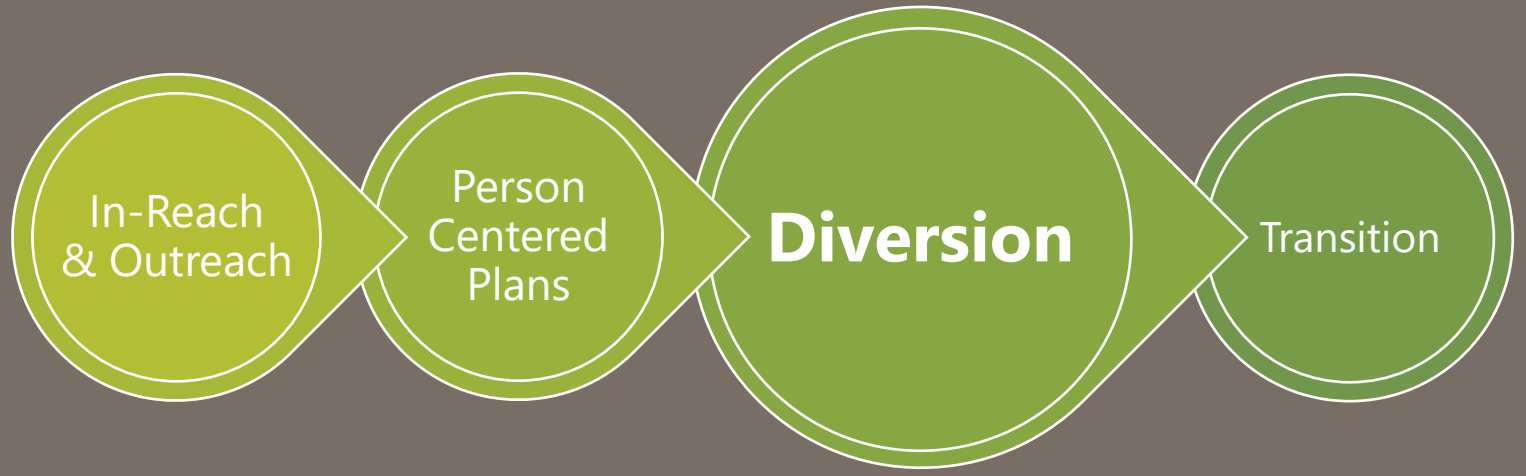
PERSON CENTERED PLANNING

Medicaid mandated process, developed by individual and case manager to identify supports and services that are necessary to meet the individual's needs in the most integrated setting

GOALS

Year 1	Year 2	Year 4	Year 6	Year 8
•290 Target Population Members (TPM)	•Additional 290 TPM	•Additional 650 TPM	•Additional 670 TPM	•Additional 670 TPM

X. STRATEGY



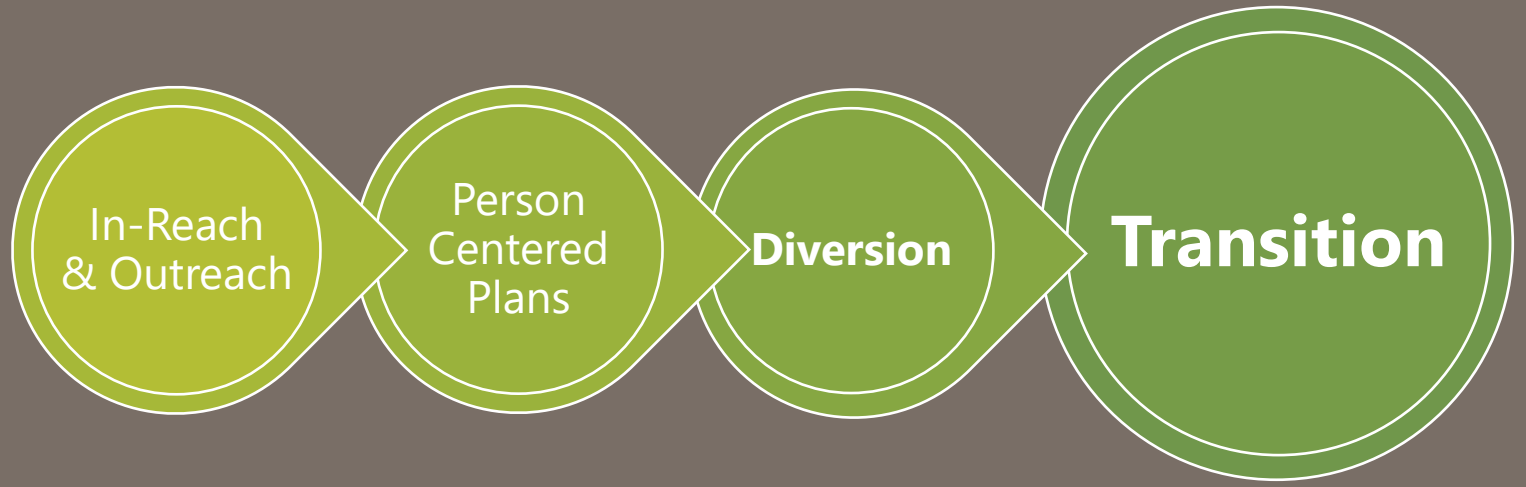
DIVERSION: COMMUNITY LIVING

Set of activities that allow a target population member to avoid placement in a skilled nursing facility and remain living in their home and community

GOALS

Year 2	Year 4	Year 6	
•100 Target Population Members (TPM)	•150 additional TPM	•150 additional TPM	Total 400 diverted

XI. STRATEGY



TRANSITION TO COMMUNITY

Services to prepare an individual currently residing in a skilled nursing facility to return to an integrated community setting

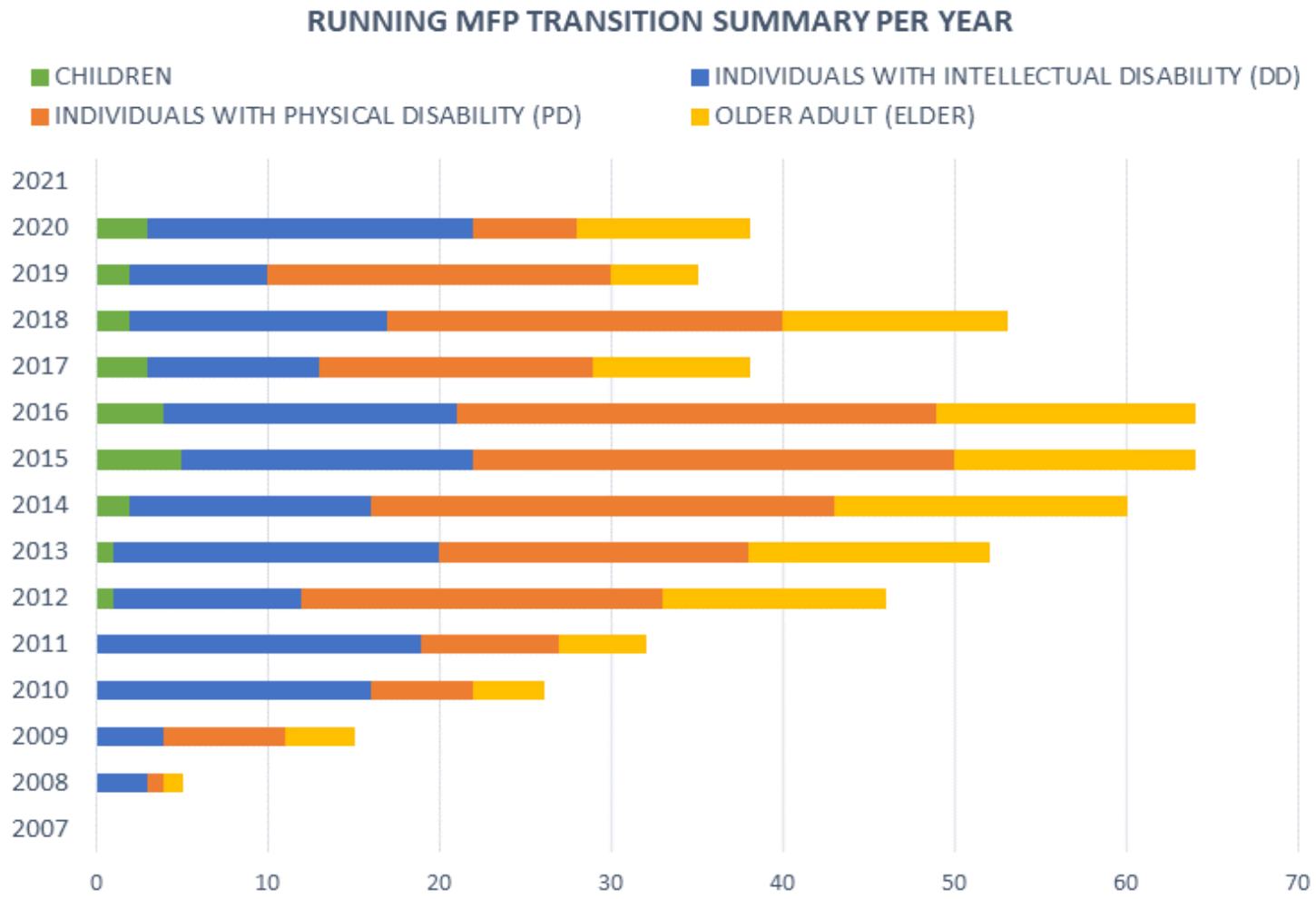
GOALS

Year 2	Year 4	Year 6	Year 8
•Transition 100	•Transition 60% identified through person centered planning (PCP)	•Transition 70% identified through PCP	•Transition all remaining individuals identified PCP

AGING & ADULT SERVICES
Money Follows the Person

Federal Grant designed to assist states to increase the use of home and community-based services (LTSS System Rebalancing)

- Eliminate barriers that prevent individuals from receiving LTSS in the settings of their choice
- Original award - $8.9 million (2007)
- Award through 2020 - $29 million (fed) and $1.7 million (state)
- Transitioned 528 individuals from institutional settings back to the community



XII. HOUSING SUPPORTS

INTEGRATED HOUSING

Federal, state, or local assistance to TPM who need help accessing available integrated housing and support for TPM where lack of housing has been identified as a barrier to community-based services

GOALS			
Year 1	**Year 2**	**Year 3**	**Year 4-8**
•Assist 20 Target Population Members (TPM)	•Assist additional 30 TPM	•Assist additional 60 TPM	•Assist additional number of TPM based on aggregate need

KEY TERMS | DOJ SETTLEMENT
Permanent Supported Housing

Affordable, permanent housing coupled with housing supports and other community-based services. Individual lives in a private home alone, with family, significant other, or roommates of their choosing.

December 2020 U.S. Dept of Justice
Settlement with State of North Dakota

Notes

- Tenants must have access to community provider for intermittent on-call, planned and back up community-based services
- Must be scattered site housing

KEY TERMS | DOJ SETTLEMENT
Integrated Housing

Housing **cannot be provided in** group homes, nursing facilities, boarding homes, residential care facilities or assisted living residences; or any building where more than 25% of the occupants are TPM.

Requires state to **provide** funding for **rental assistance** including reasonable expansion of existing capacity by funding and providing rental assistance to support permanent housing for TPM.

Requires state to **provide** for **assistance** with **identifying** housing, **coordinating** housing modifications, applying for subsidized housing, as well as help **preserving** tenancy if temporarily admitted to a Nursing Home.

XIII. PROVIDER CAPACITY AND TRAINING



State will ensure an adequate supply of qualified trained community providers to enable target population members to transition and live in most integrated setting



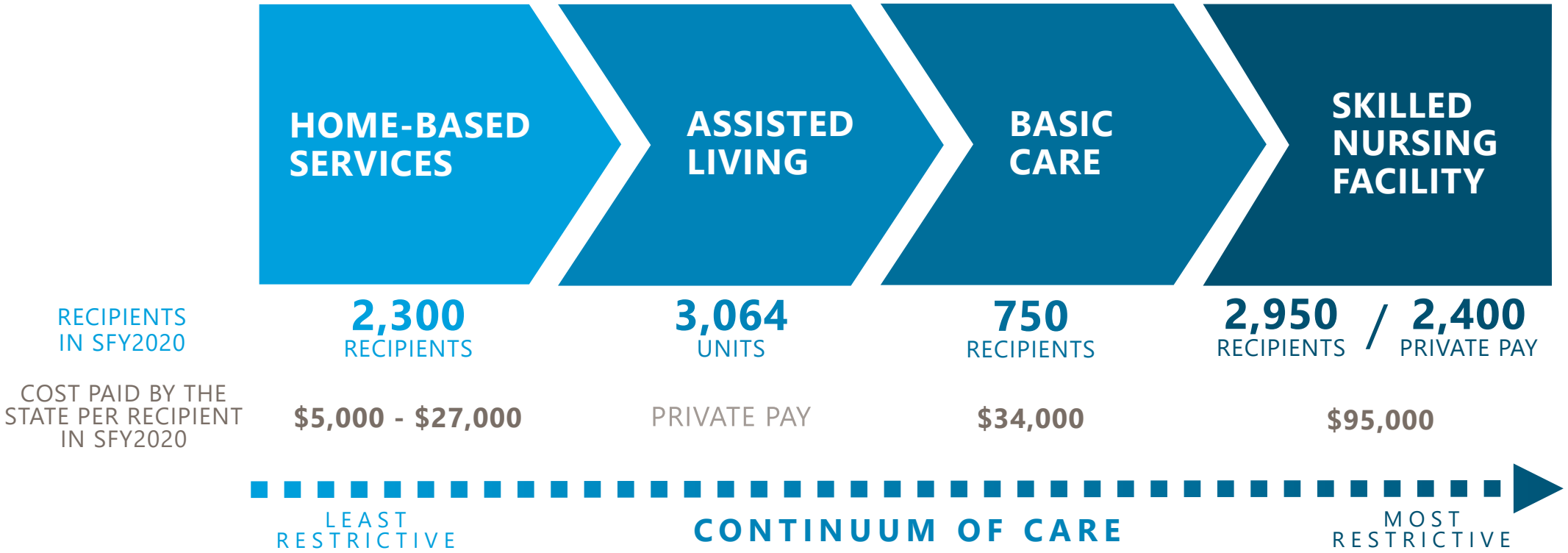
Provide guidance and training to nursing homes and other community providers who make a commitment to provide community-based services



Draft plan to addresses provider capacity, reimbursement rates, incentives to serve individuals with significant medical/supervision needs, those living on Native American reservations and in rural areas

CONTINUUM OF CARE

LONG-TERM CARE SERVICES & SUPPORTS

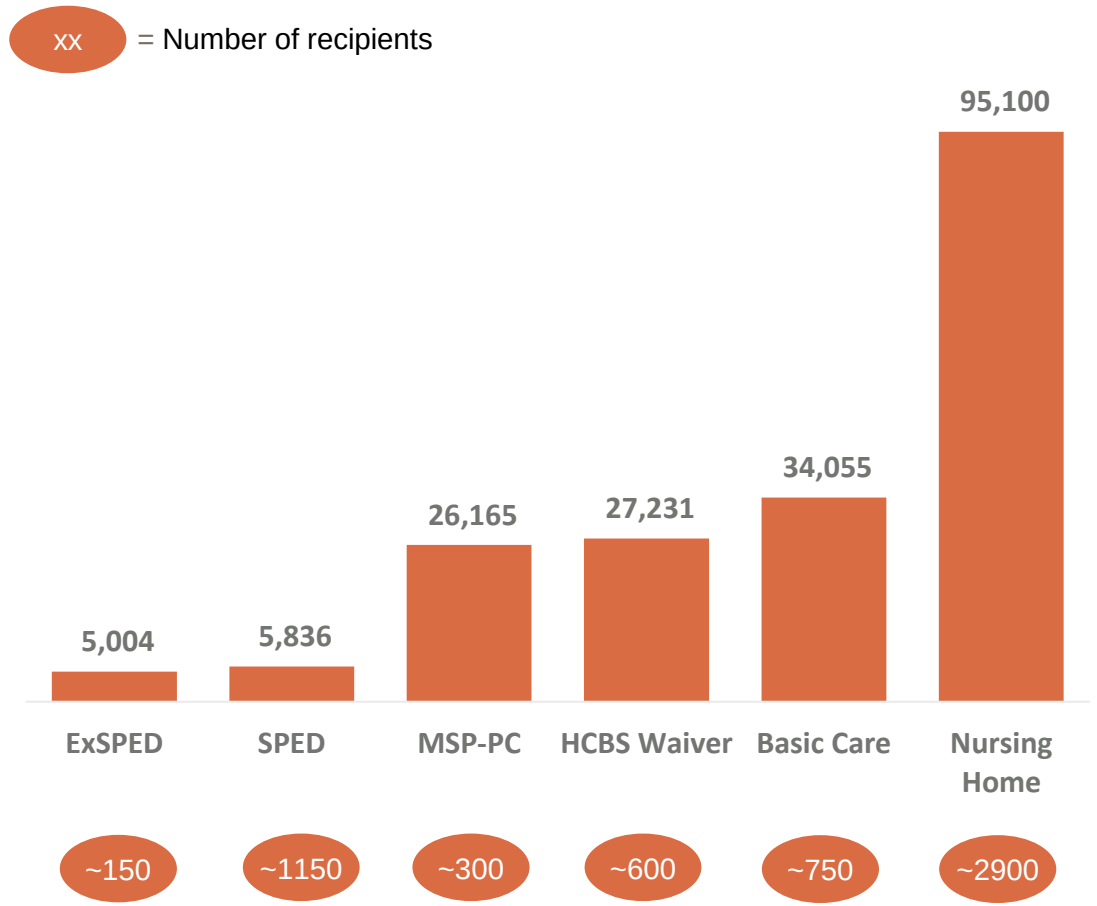


DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

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- Expanded SPED (Ex-SPED): Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- Home and community-based services (HCBS) waiver: This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- Medicaid State Plan personal care (MSP-PC): Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- Basic Care: Room and board and personal care services for persons eligible for Medicaid.

OPPORTUNITIES FOR COLLABORATION

Internal and external partners



SECTION XVII. ENFORCEMENT

- The Agreement was entered in good faith between the United State and the State. The state agreed to implement the terms of the Agreement and fulfill the requirements under Title II of the ADA.
- After receipt of each of the State's data reports, the United States and State will confer to assess the State's compliance with this Agreement.
- If the United States believes that the State has violated this Agreement, it will notify the State and include reasonably specific information regarding the violation.
- The United States and the State will negotiate in good faith to resolve any dispute.
- If the United States and the State are unable to agree on a resolution within 90 days of the United States' notice of violation, the United States may commence a civil action in the U.S. Court for the District of North Dakota to enforce the terms of this Agreement or the ADA.
- The Agreement will terminate eight years after the Effective Date if the Parties agree that the State has attained substantial compliance with all provisions and maintained that compliance for a period of one year.

Budget recommendations related to DOJ Settlement for Older and Disabled Adults HCBS

2021 HB 1012

Service	Recommendation	2021-23 DHS Budget - HB 1012 as approved by House			
		General Funds	Federal Funds	Other Funds	Total Funds
HCBS Supervision	Increase rate from $2.49 / 15 min unit of service for both individual and Agency QSPs to $4.79 for individual QSP and $6.58 for Agency QSP / 15 min unit of service.	$566,683	$651,991	-	$1,218,674
HCBS Family Personal Care	Increase rate from maximum of $76.67 / day to no more than $150 / day.	$1,393,154	$1,602,882	-	$2,996,036
HCBS Non-Medical Transportation	Increase rate from $3.27 / 15 min unit of service to $8.74 / 15 min unit of service.	$85,557	$44,248	-	$129,805
HCBS Non-Medical Transportation Escort	Increase rate from $3.53 / 15 min unit of service for both individual and agency QSPs to $4.79 for individual QSPs and $6.58 for Agency QSP / 15 min unit of service.	$152,158	$10,075	-	$162,233
Rental Assistance	Budget estimate would allow for approximately 375 months of housing assistance over the course of the biennium.	$300,000	-	-	$300,000
Settlement Administration and Reporting	1 FTE in Aging and Adult Services (funded by Money Follows the Person grant dollars for this biennium)	-	-	$150,000	$150,000
Annual Level of Care Screening - Nursing Facility Residents	Increased volume of level of care assessments, completed via contract	$50,000	$150,000	-	$200,000
Claims system integration	System enhancements	$16,465	$49,395	-	$65,860
	TOTAL	**$2,564,017**	**$2,508,591**	**$150,000**	**$5,222,608**



Contact Information

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DOJ Agreement Coordinator

Director, Aging and Adult Services
Division, Department of Human Services

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Bismarck, North Dakota 58501-1208
Phone: 701-328-4601
Toll-Free Aging & Disability Resource LINK: 1-855-462-5465
E-mail: carechoice@nd.gov



8746

NORTH Dakota | Human Services

Be Legendary.™

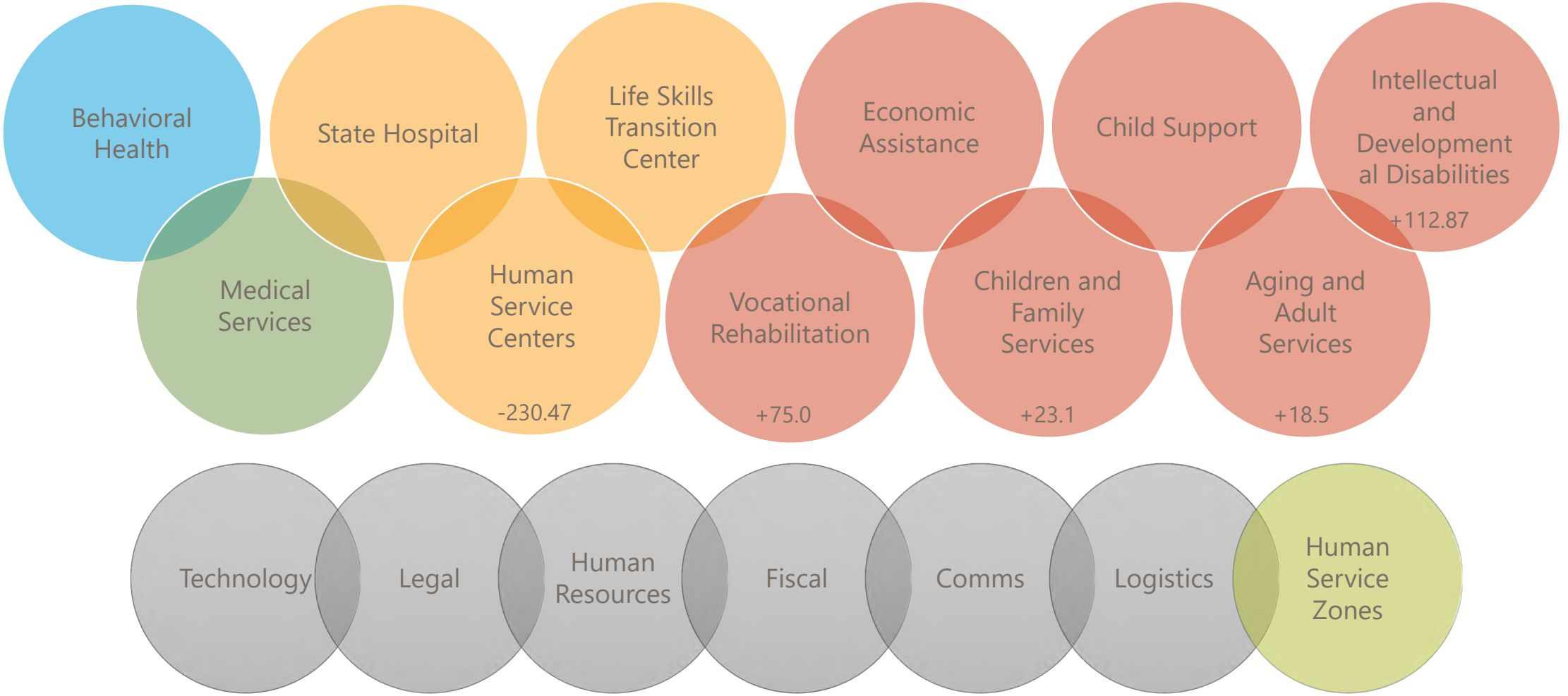
House Bill 1012 | Program & Policy Budget Overview

Senate Appropriations

Senator Ray Holmberg, Chairman

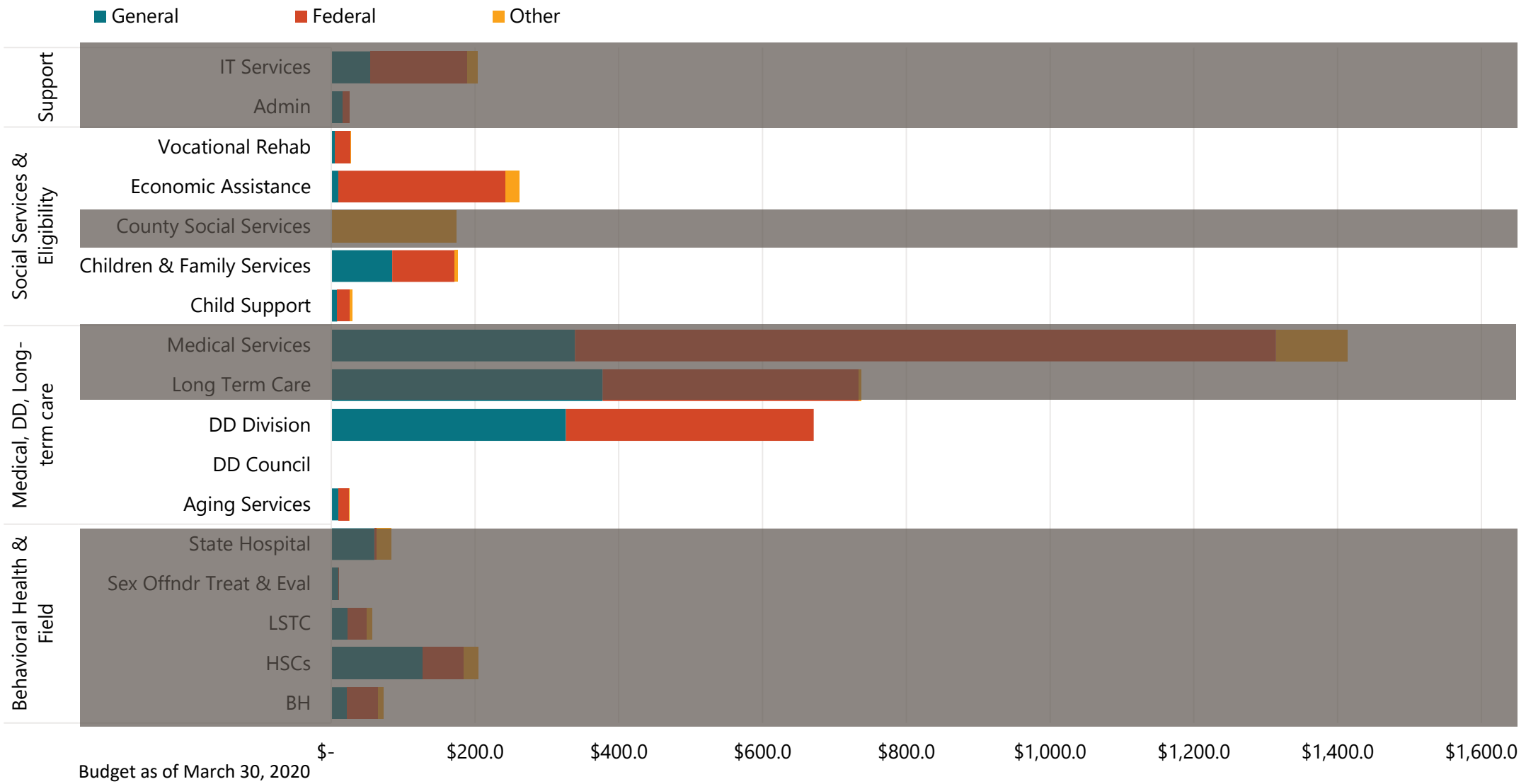
ND DEPARTMENT OF HUMAN SERVICES

Helping North Dakotans realize their potential through targeted, evidence-based interventions that deliver meaningful results



2019-2021 LEGISLATIVELY APPROVED BUDGET

Total budget (millions) by division



Budget as of March 30, 2020

Helping people realize their potential

Who We Serve



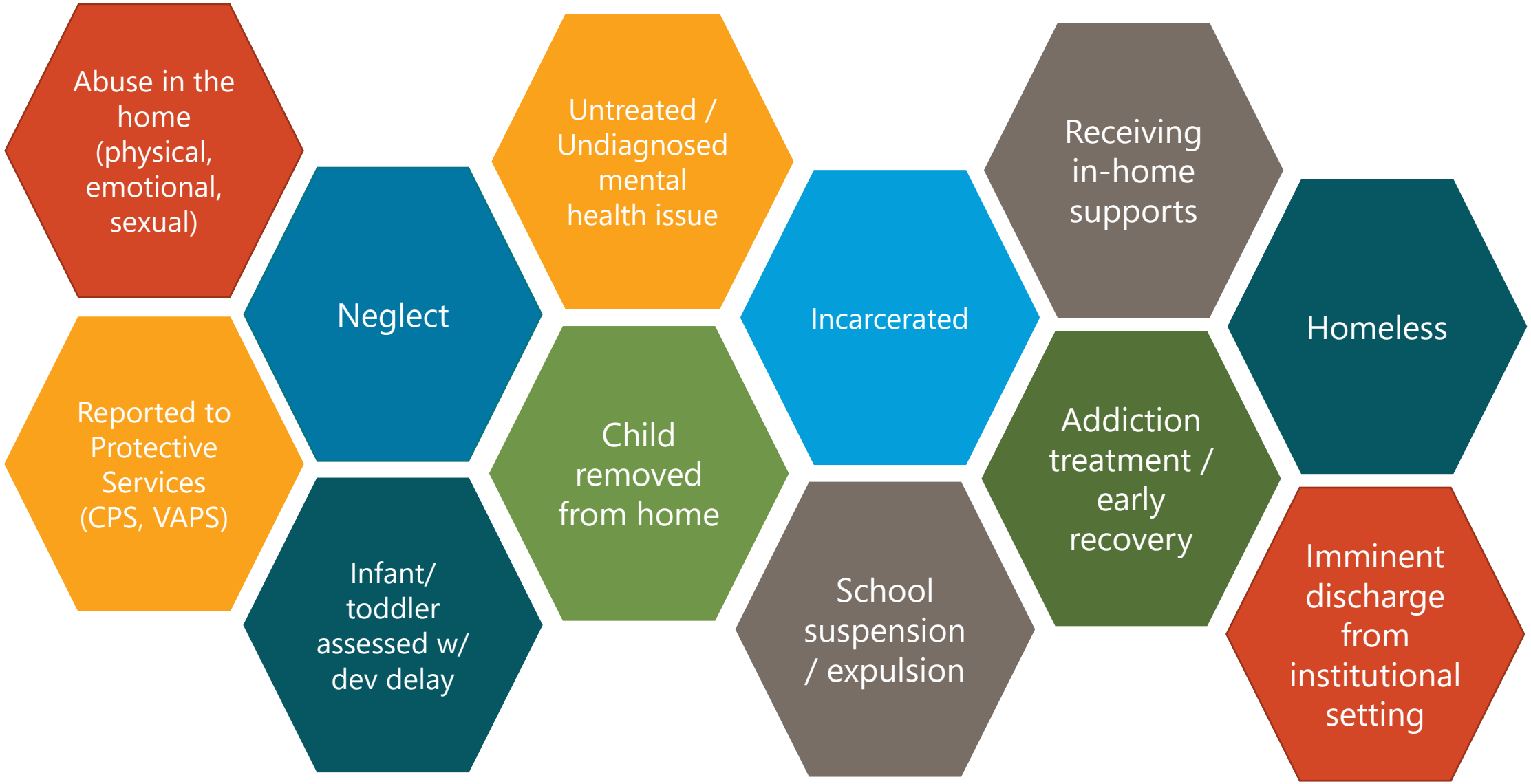
Who we serve: Who's At risk of disruption/instability?

Individuals who have not previously engaged with a human service provider or who may be experiencing an instability-triggering event



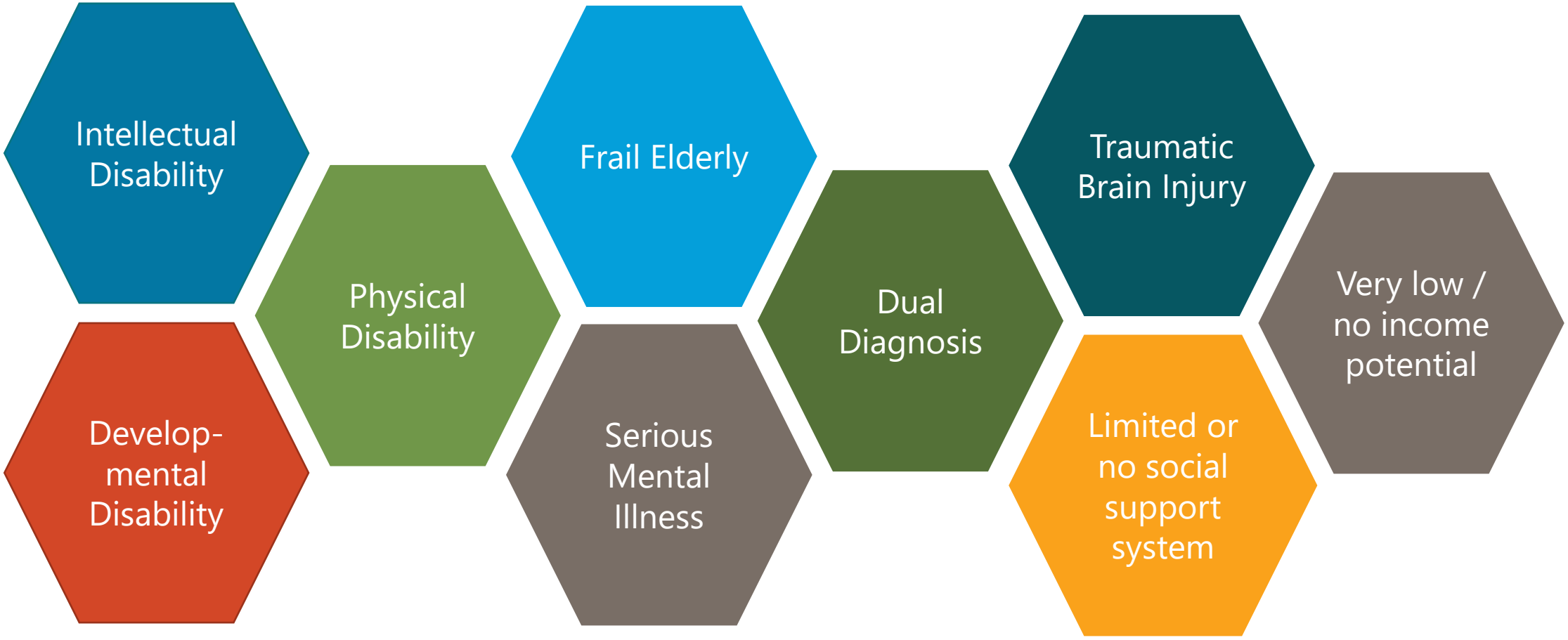
Who we serve: Who needs help restoring stability?

Individuals who have engaged with services provided by the Zones, DHS and/or private providers or contracted partners, but who may not have a long-term need



Who we serve: Who needs supportive services to live as independently as possible?

Individuals who have a chronic health and/or disabling condition that will indicate long-term service needs



Human Services is the infrastructure for wellbeing

Prevention | Early Intervention | Crisis Intervention | Long term supports

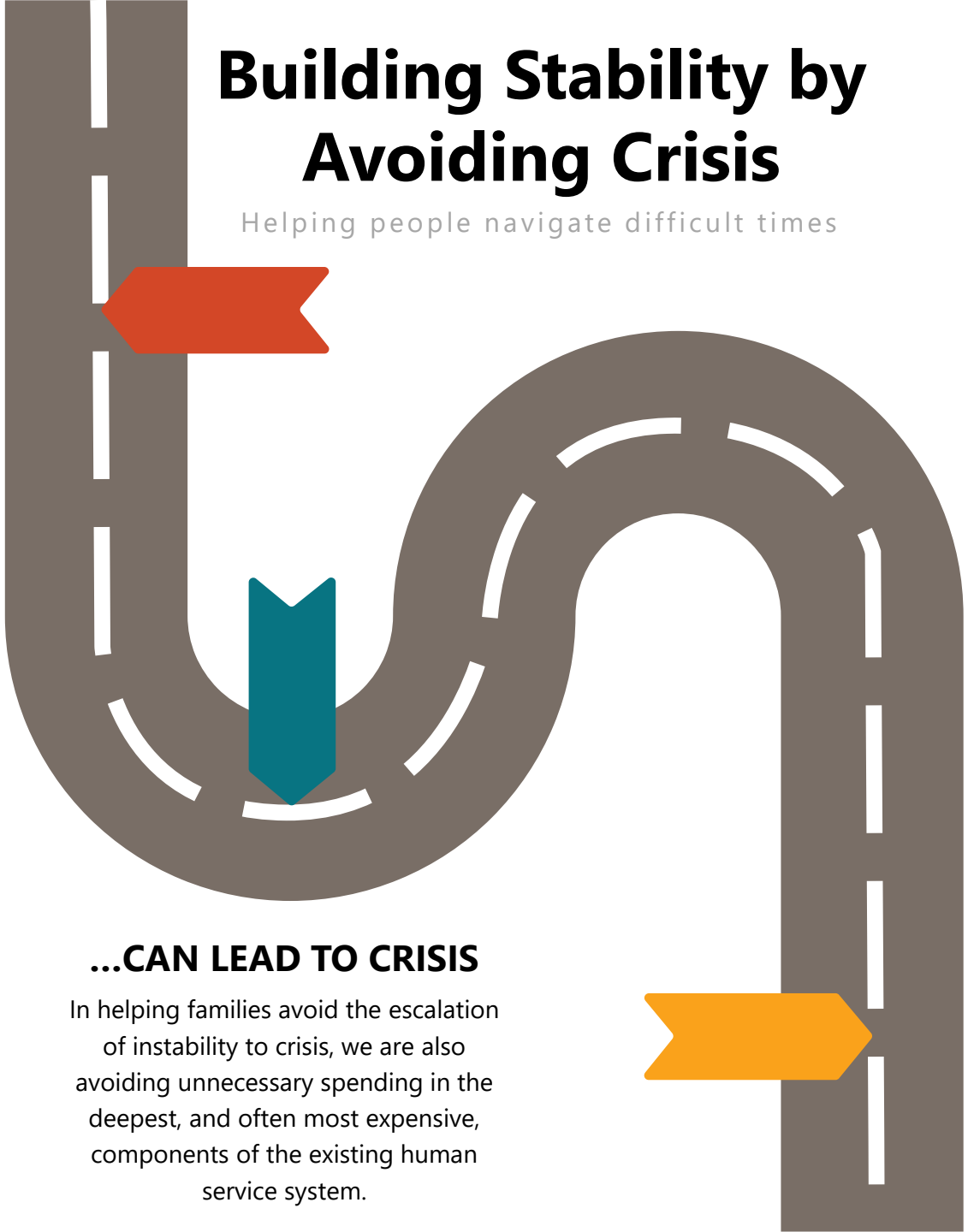


Building Stability by Avoiding Crisis

Helping people navigate difficult times

DISRUPTION

When families experience disruption, their ability to be a fully engaged, productive member of the community and the workforce is compromised.



...CAN LEAD TO CRISIS

In helping families avoid the escalation of instability to crisis, we are also avoiding unnecessary spending in the deepest, and often most expensive, components of the existing human service system.

SERVICES SUPPORT STABILITY

Intervening early will both save money and strengthen families. It will allow us to reserve deep end services for the times when they are truly needed, and help people avoid deepening their journey into crisis by diverting from institutions, keeping families together, and helping and sure that people have a place to call home.

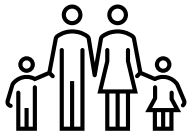


Communities are stronger when everyone has the opportunity to realize their full potential

What do we need to do to help someone find their way through a situation that threatens to push them into crisis, and instead help them find their way to stability.

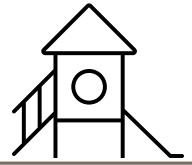


DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



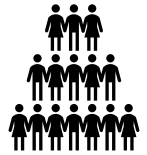
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

The threads that run through every person's life

Foundations of Wellbeing are Interconnected



Economic Health

Having the resources you need to meet basic needs contributes to stability and is a foundation you can build on

Behavioral Health

Having good mental health and a healthy relationship with substances boosts your ability to weather life's storms

Physical Health

When you are in good physical health you can better navigate the activities of daily and community life

The stability that comes from good **economic** health can **improve behavioral** health.
The stability that comes from good **physical** and **behavioral** health **enables economic** health.

What do we need to do to help someone make an informed choice about how they may want to access services in the most integrated setting that is right for them?



KEY CONCEPTS

- Most Integrated Setting
- Informed Choice
- Diversion
- Transition
- Level of Care
- Stability
- Evidence Based
- Redesign
- Quality
- Person-centered

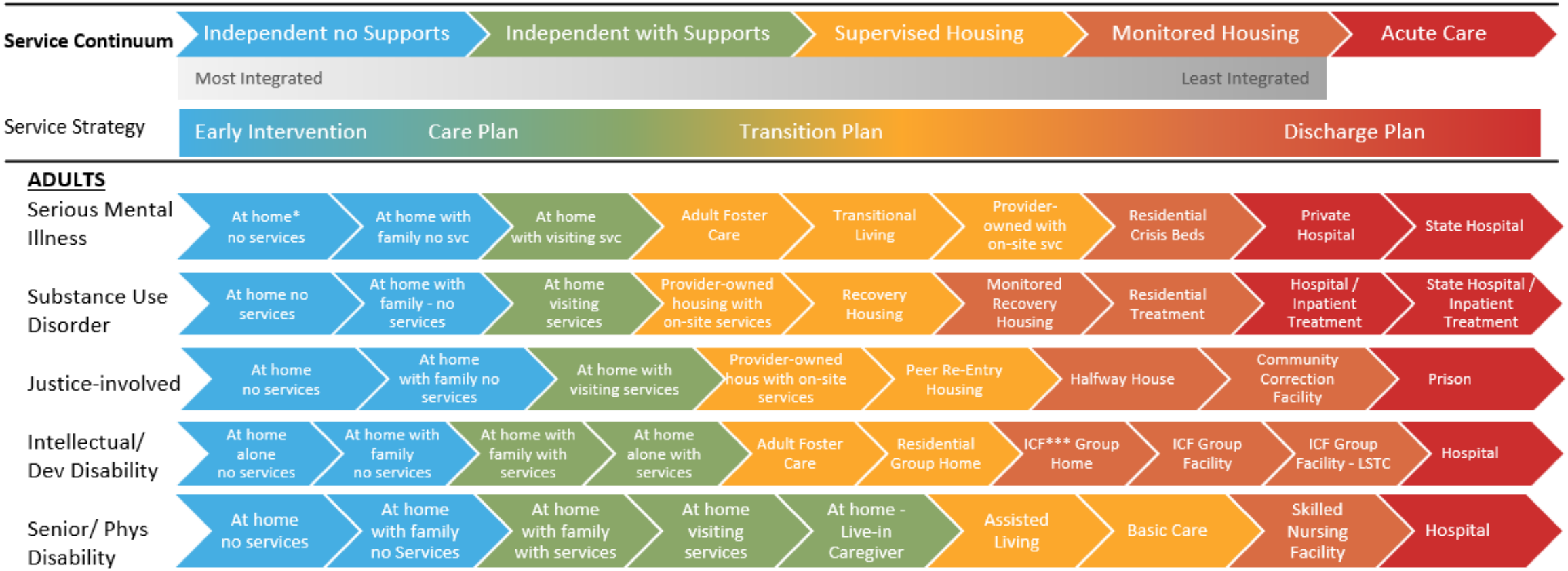


What do we need to do to make sure we are delivering the right service in the right place at the right time?



The Service Continuum - Adults

A critical concept defined



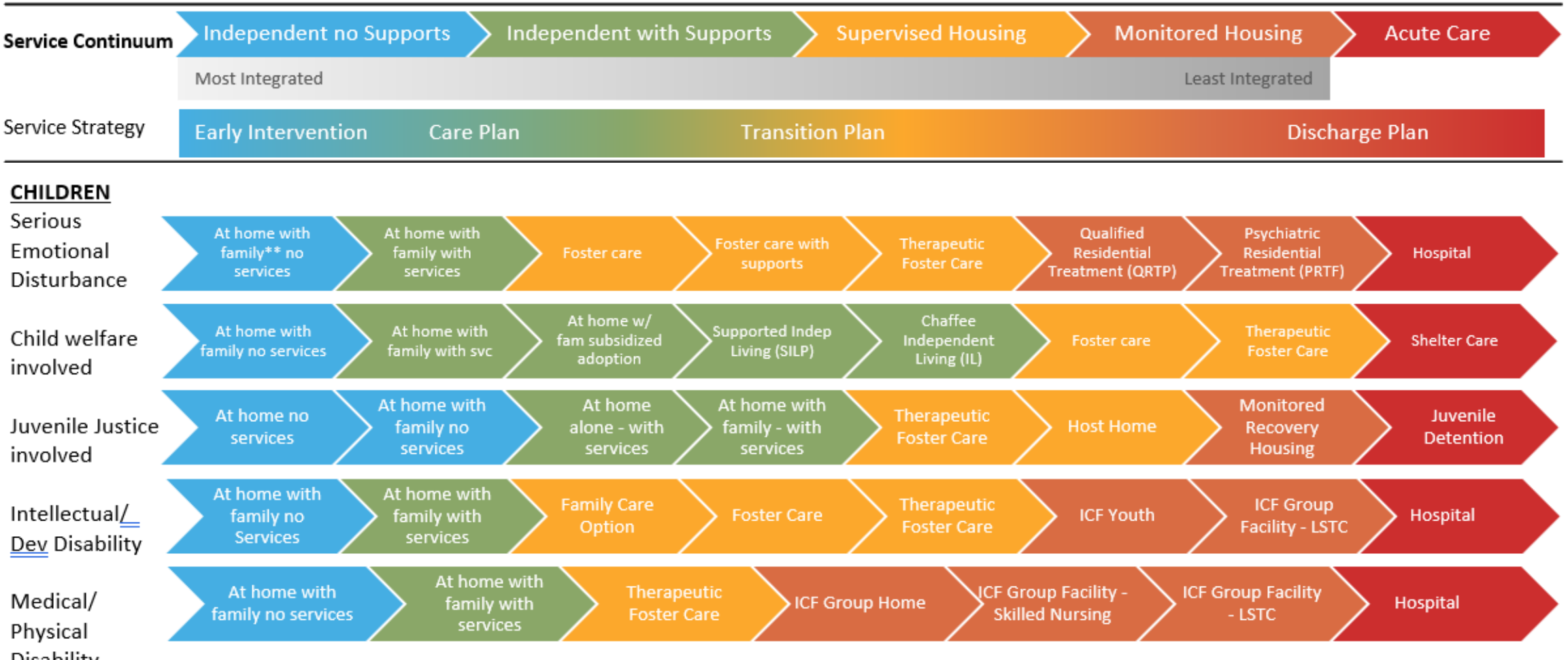
**Home = includes any type of home setting that is the responsibility of the individual (single family home, condo, apartment, mobile home)*

***Family = includes birth family, kin-caregiver, adopted family*

****ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)*

The Service Continuum - Children

Illustrating the work of transition and diversion



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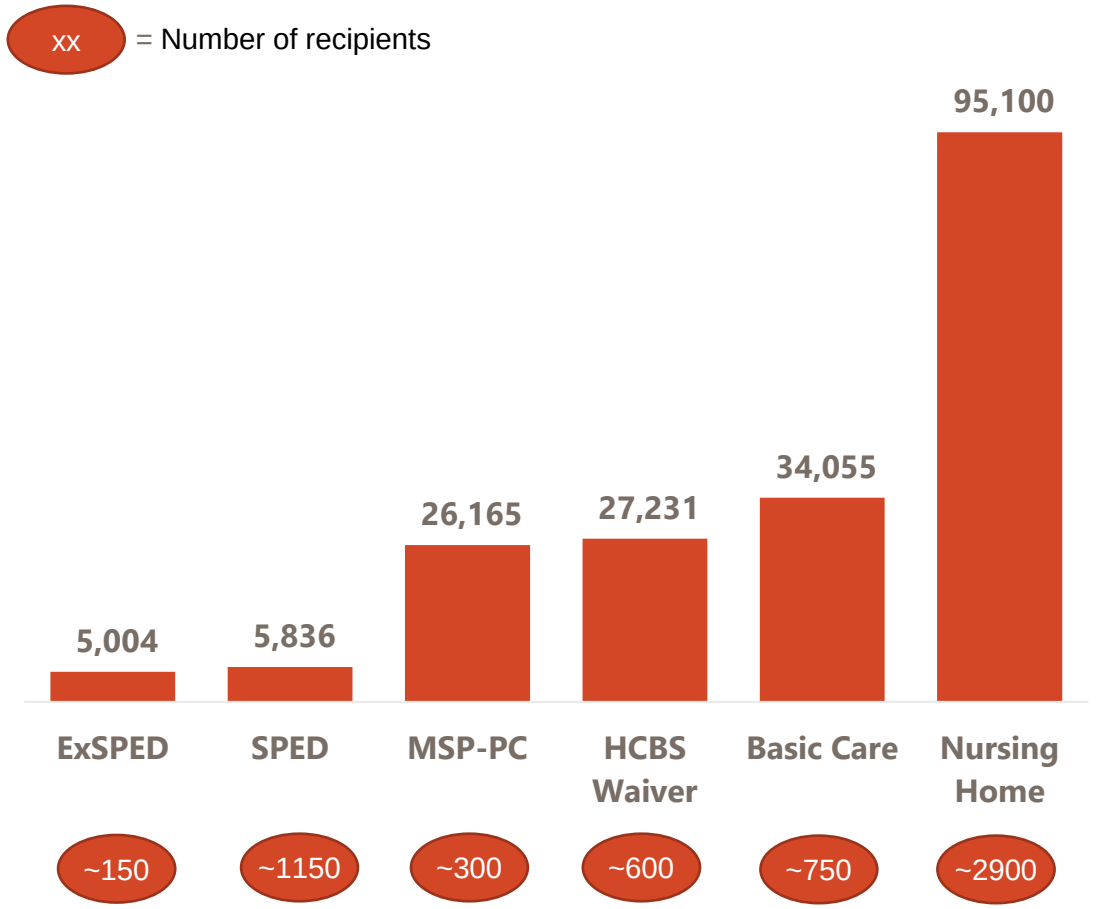
DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Total cost by type of service

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2020



Program Descriptions / Detail

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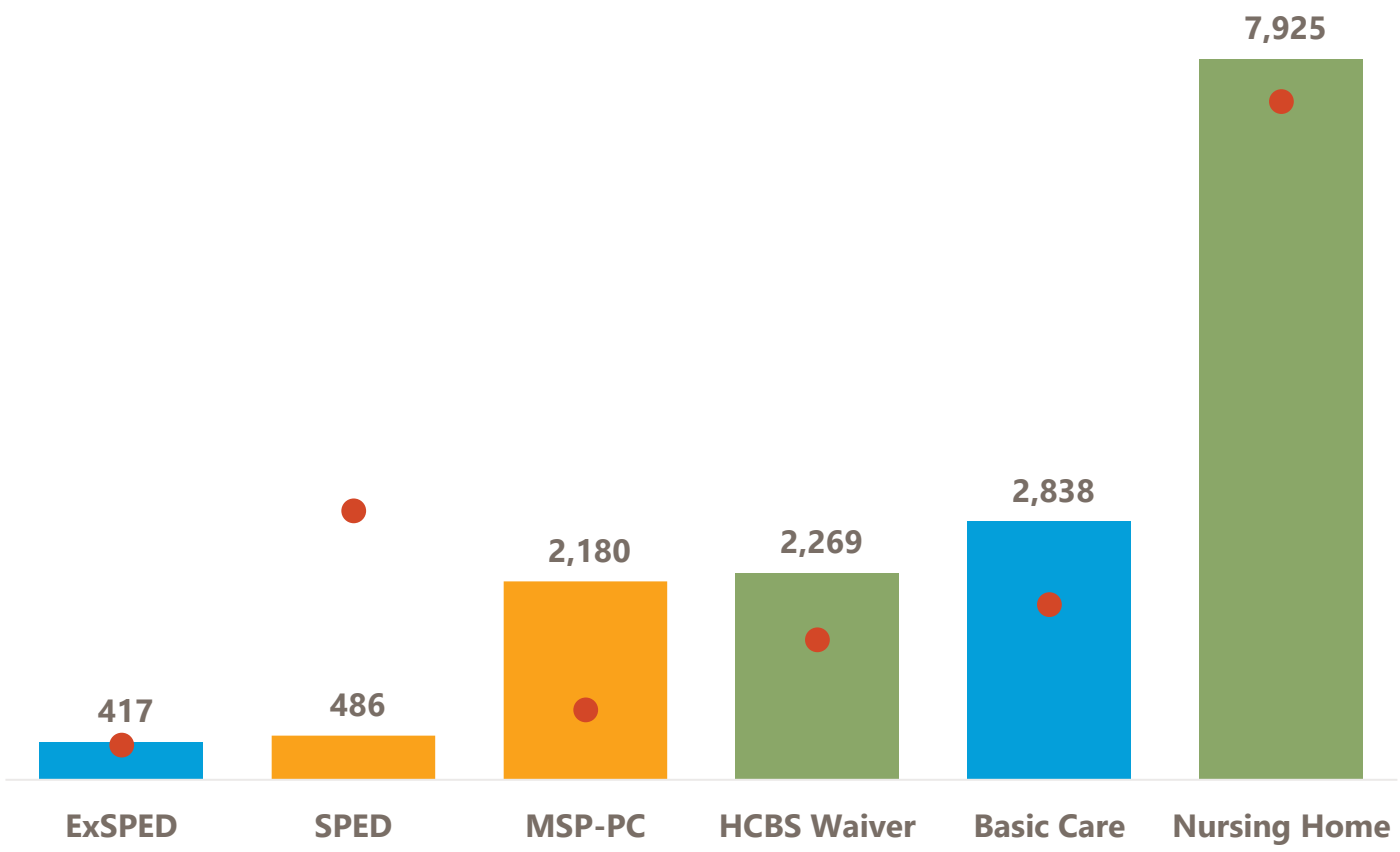
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

AGING & ADULT SERVICES
Cost per month per person per type of service – SFY20



Types of Care with same criteria for eligibility *(level of care, assets, income)*

Expanded SPED = Basic Care

$417 / mo v $2,838 / mo

DIFFERENCE IN COST : $2,421

DIFFERENCE IN SVC :

Rent, Meals, Supervision, Medication Administration

HCBS Waiver = Nursing Home

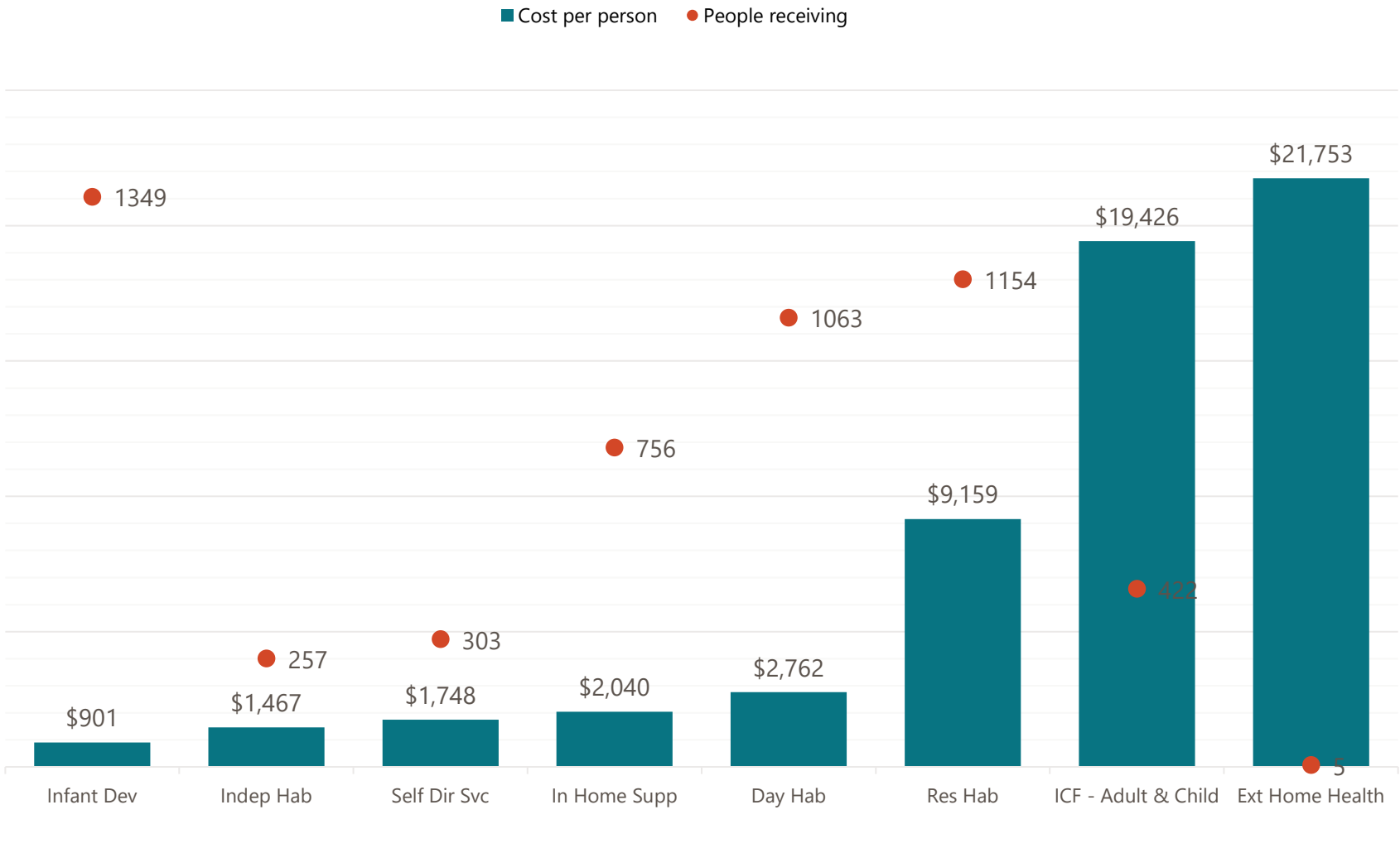
$2,269 / mo v $7,925 / mo

DIFFERENCE IN COST : $5,656

DIFFERENCE IN SVC :

Rent, Meals, Supervision, 24/7 Nursing

DEVELOPMENTAL DISABILITIES
Cost per month per person per type of service – SFY20

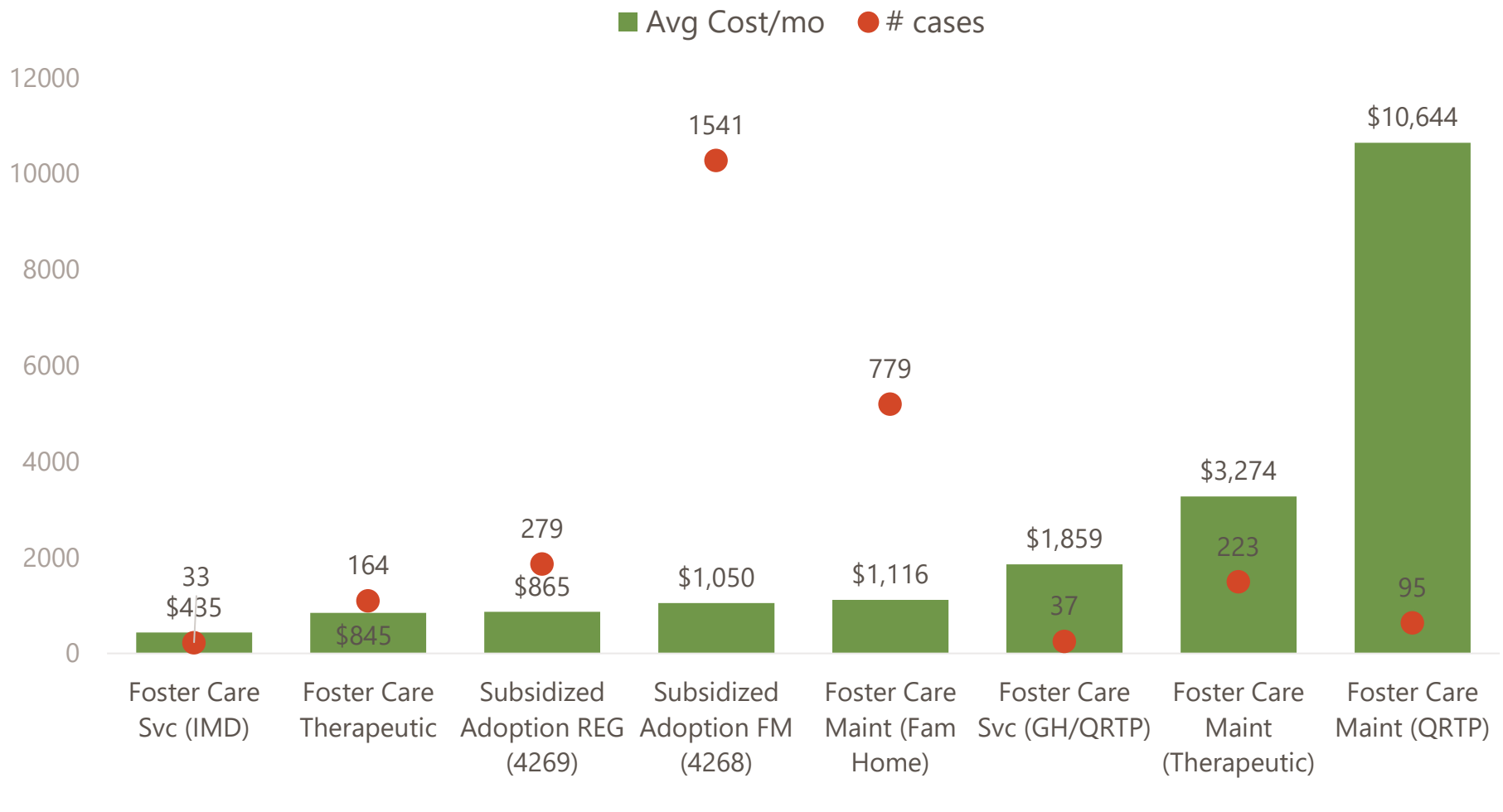








CHILDREN & FAMILY SERVICES
Cost per month per person per type of service – SFY20









CHILDREN AND FAMILY SERVICES
Program Purpose

The purpose of the Children and Family Services division is to help families who are struggling avoid disruption by having access to the help they need to build stability and well-being together.



CHILDREN AND FAMILY SERVICES
What we do

Safety

- Child protective services
- Child fatality review panel
- State Child protection team
- Parent Resource Centers
- Alliance for Children's Justice

Permanency

- Foster Care
- Adoption
- Guardianships
- Interstate compacts for the placement of children
- Unaccompanied minor services
- Independent living services
- Licensing for QRTPs and LCPAs

Well-being

- Family preservation services
- Intensive In-home therapy
- Nurturing Parent programs
- Parent aides
- In-home case management
- Respite care
- Family centered engagement

Early Childhood

- Early childhood coaching and quality
- Child care licensing
- Home Visiting
- Early childhood inclusion supports

CHILDREN AND FAMILY SERVICES

In ND child welfare services are delivered by local, state, tribal and private providers using both federal and state funds

Dept of Human Services

- **Human Service Centers**
  - Crisis teams
  - Intensive In-home services (therapy & treatment, skills training, behavior mod)
  - Targeted case management
- **Children & Family Services**
  - Training and coaching of field staff
  - Oversee quality service delivery
  - Administration of policy

Private Human Service Providers

- Safe shelter for crisis
- Human trafficking supports and safe beds
- Unaccompanied minor services
- Foster homes, including therapeutic
- Targeted case management

Tribal Social Services

- FRAME entry and foster eligibility determinations
- Joint practice model and ICWA training
- Native American Training Institute supports (training, billing, svc delivery)
- New FMAP service contracting
- IV-E agreements boost access to funding

Human Service Zones

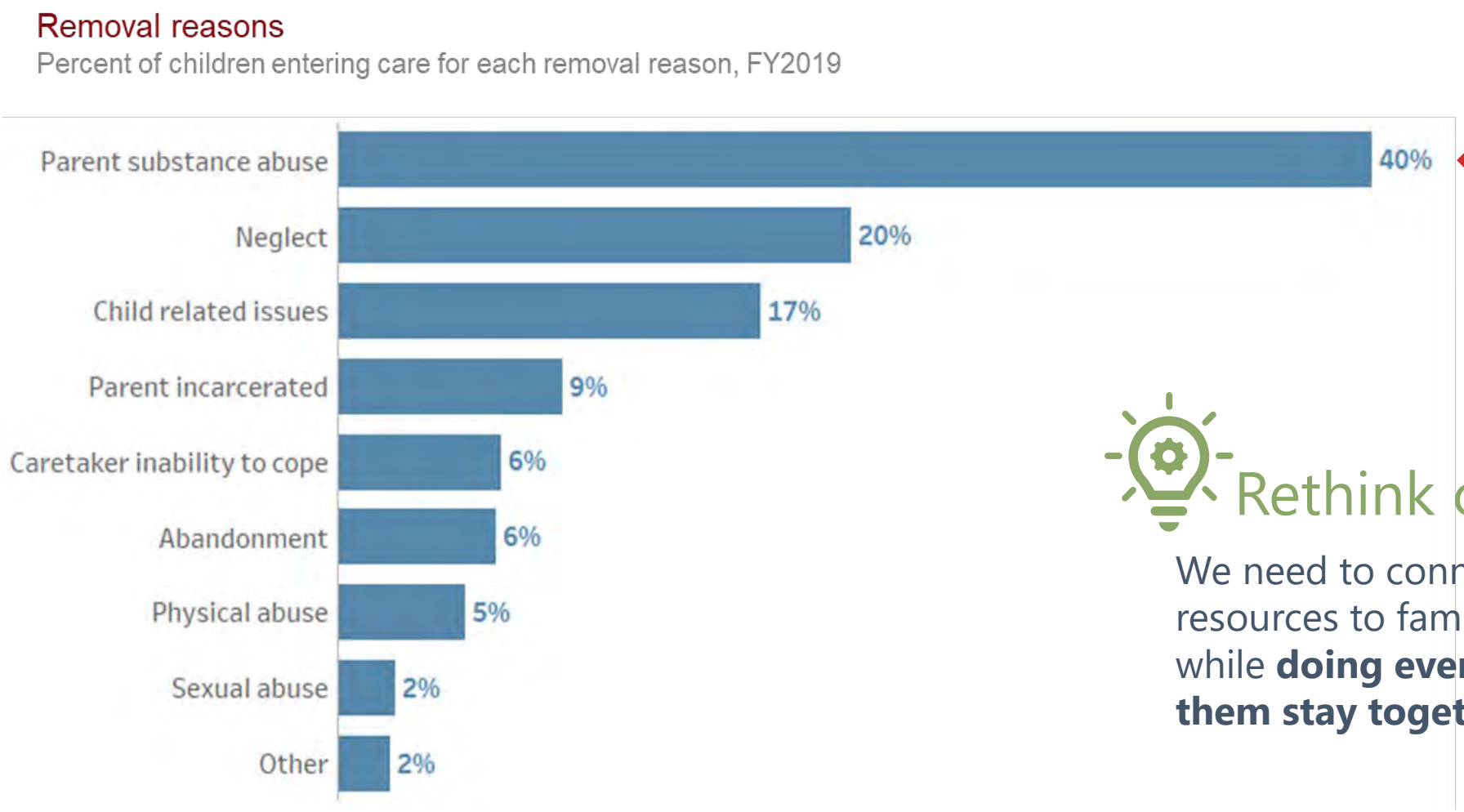
- Assess present and impending danger
- Safety planning
- Case management
- Assess and build parent capacities
- Provide safe supports for children and families
- Refer and broker services needed for families
- In home supports
- Parent aides
- License foster homes
- Intake for child abuse and neglect reports



What's driving us

- Abuse and neglect related to substance abuse in families
- Increasing challenging behaviors in K-3
- Adolescent suicides
- Inconsistencies in child protection practices
- Delays in completion of child safety assessments
- Clear return on investments made early

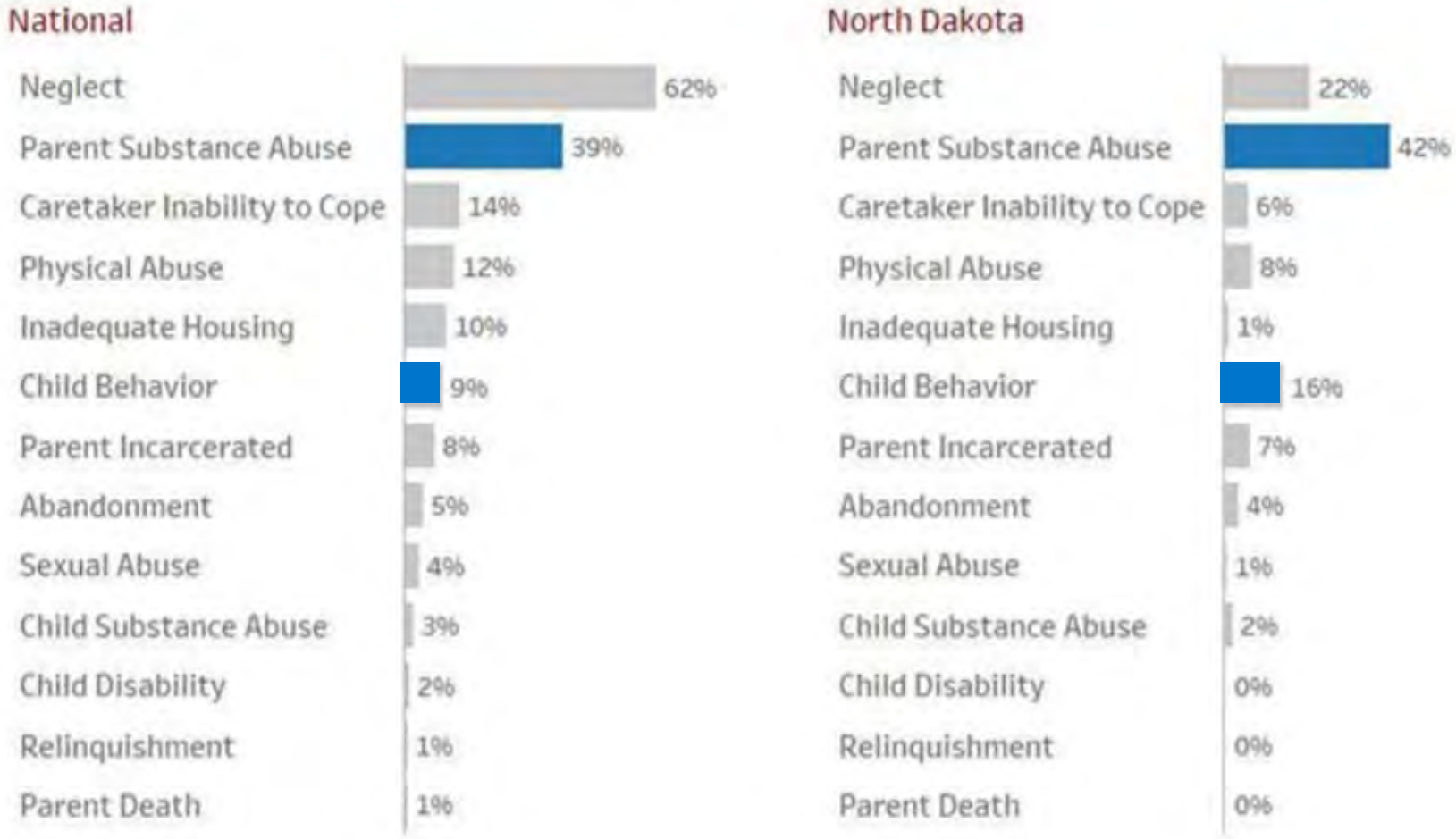
Substance abuse and unaddressed mental health needs are major de-stabilizing forces in families



Rethink child welfare

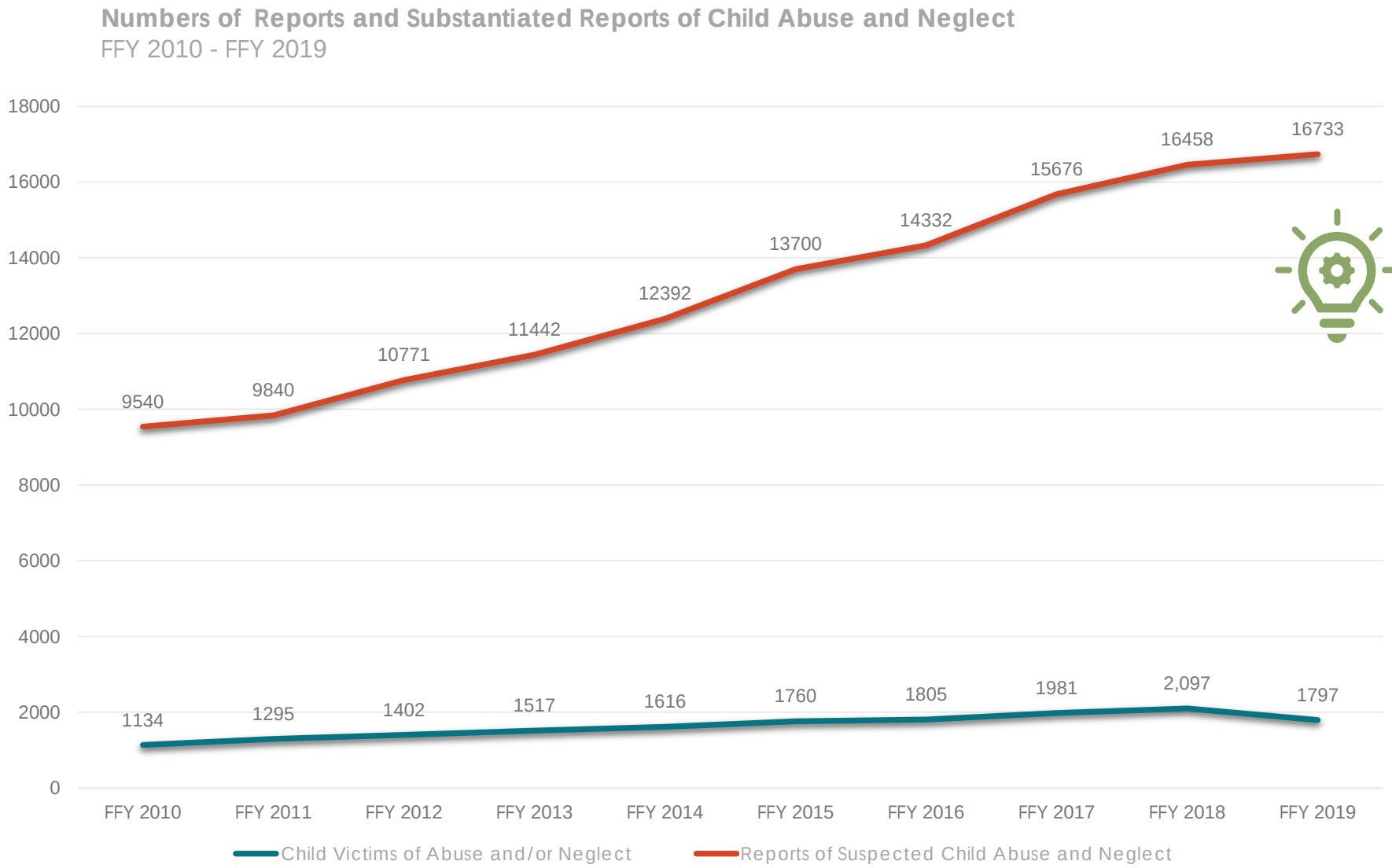
We need to connect behavioral health resources to families who are struggling while **doing everything we can to help them stay together safely.**

Parental Substance Abuse and Child Behavior are cited more often as reasons for removal in North Dakota than in the U.S.



Data source: FFY 2017 state-submitted AFCARS data. Denotes percent of children entering foster care for each removal reason; multiple reasons may be selected for a single child.

10-12 percent of child abuse/neglect calls are ultimately substantiated as abuse/neglect

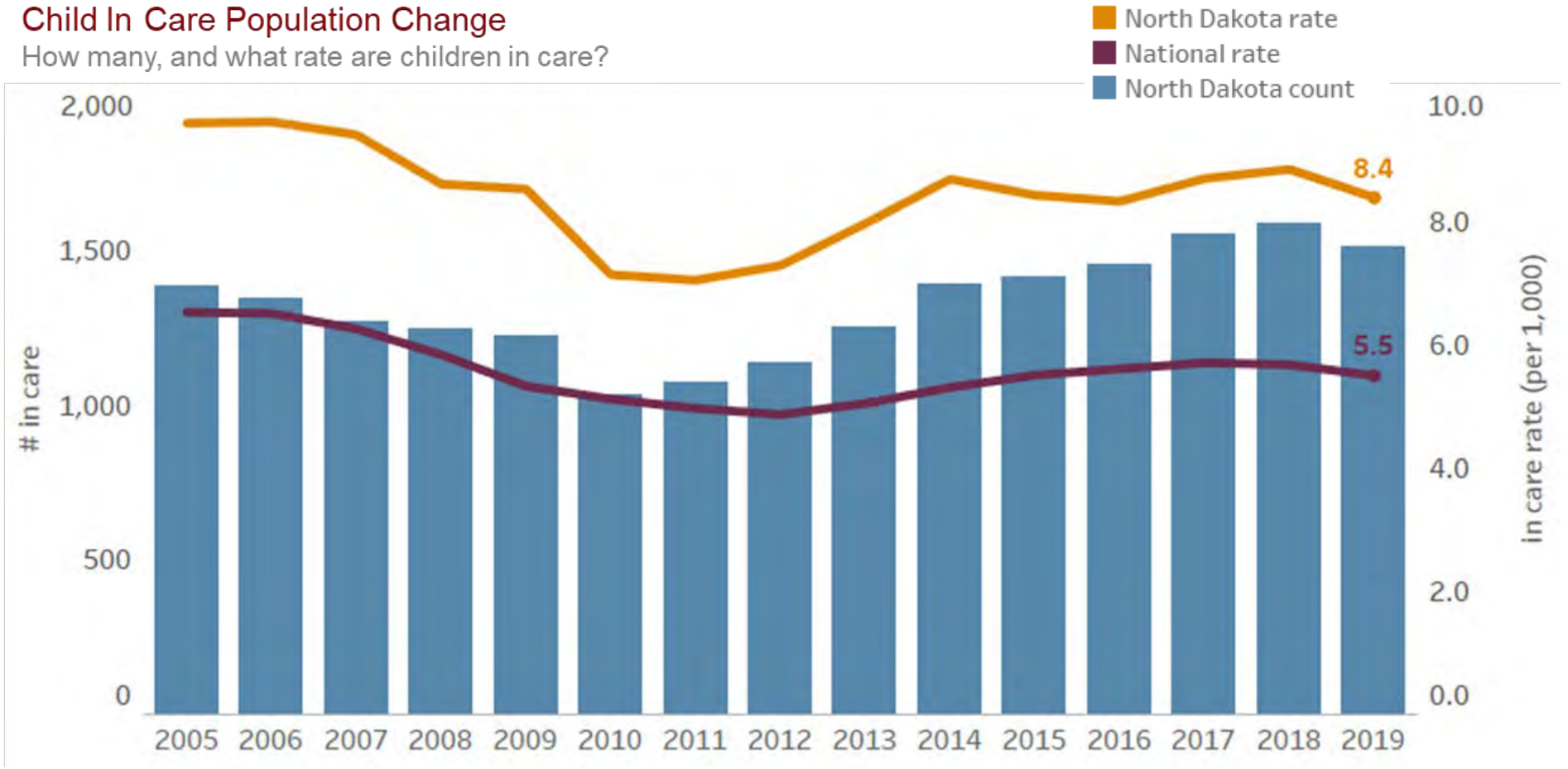


Rethink child welfare

People who call to report a suspicion of abuse or neglect are seeing something that causes them to be concerned about a child's (and their family's) well-being.

We need a different response for those often valid concerns.

The rates at which children are placed in foster care is 52 percent higher in North Dakota than in the U.S. overall



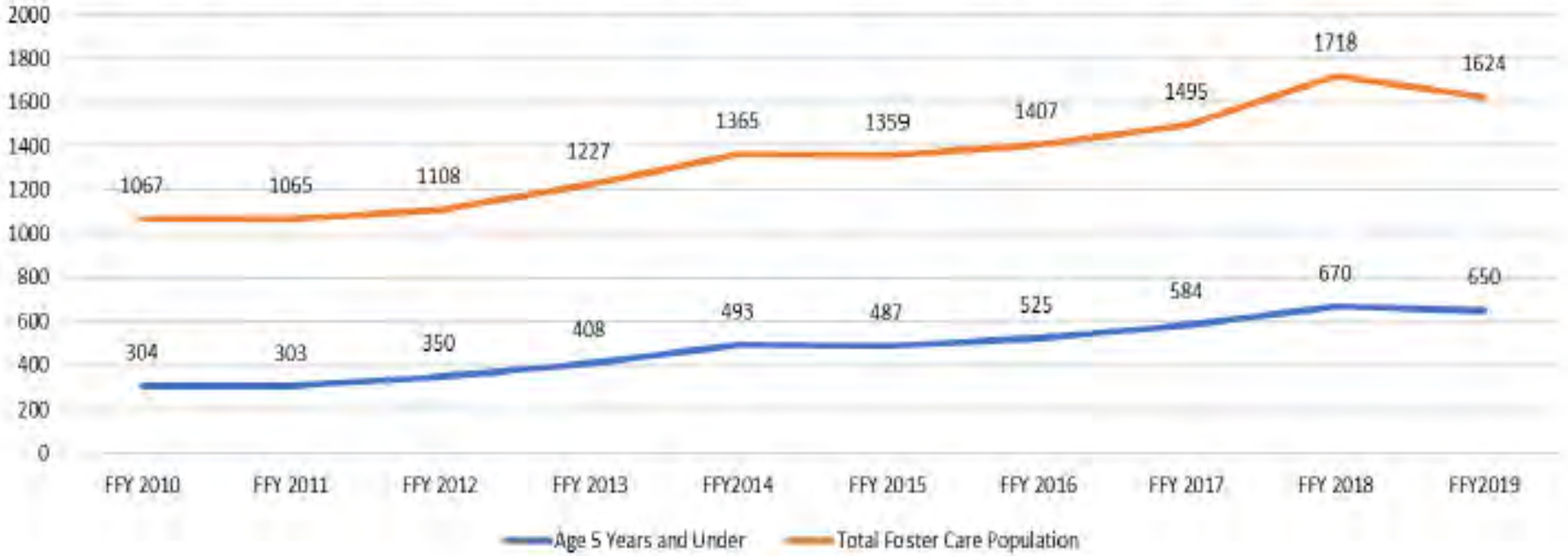
Rethink child welfare

We need to shift resources from removal to family strengthening and preservation.

The percentage of children in foster care under age 5 has risen steadily from 28% to 40% since 2010

The number of children in foster care in ND has risen by 52% over the last 10 years

ND Foster Care census and those age 54 years and under, FFY 2010-2019

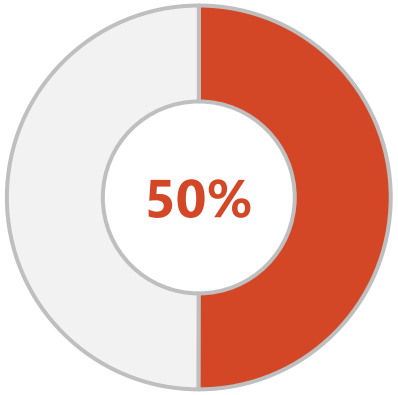


Rethink child welfare

Early interventions with young families are they key to reducing foster care placement for the youngest children.

CHILDREN & FAMILY SERVICES
Foster Care in ND – 2020 Snapshot

796



1 in 2 age 0-7

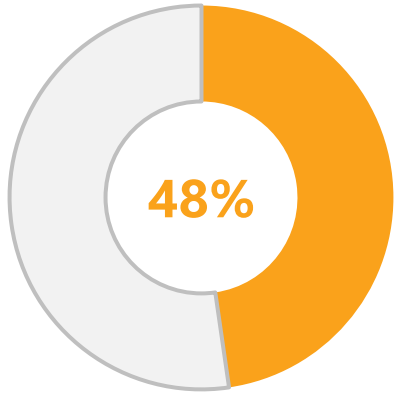
Half of the 1,591 children in foster care in North Dakota are age 7 or younger. (2020)

34%

Intense level of care

Of the 189 kids receiving therapeutic foster care in 2020, 65 (34%) were younger than 7 years old.

759



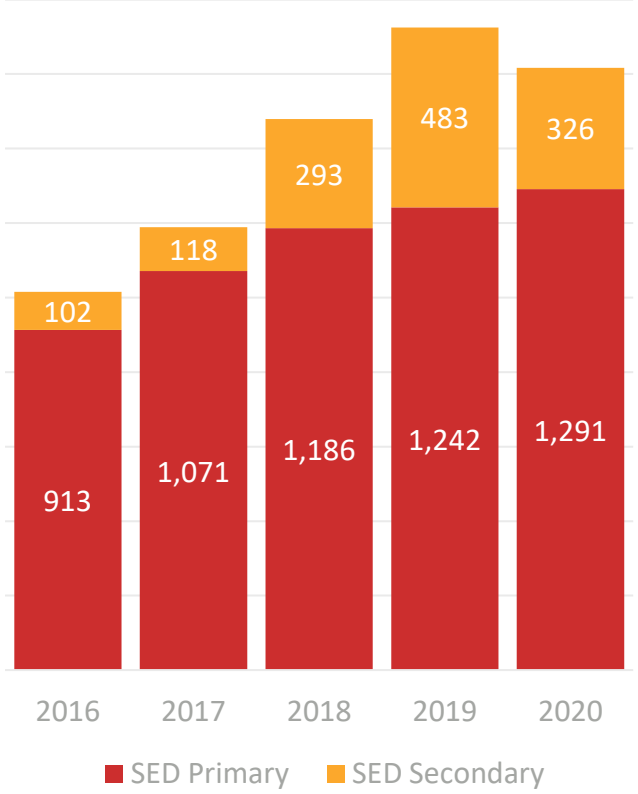
5x more likely

Native American children make up 48% of the total number of children in foster care in ND (759 of 1,591).

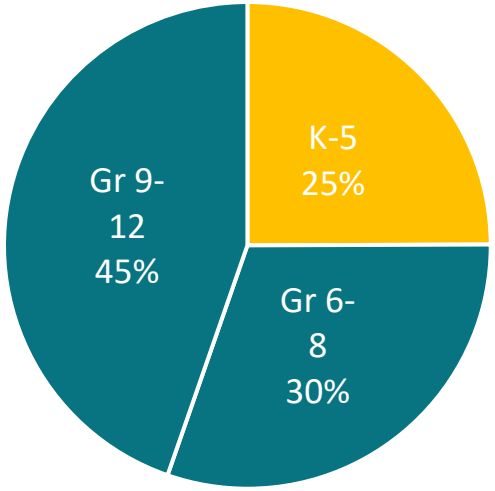
Native American children make up 8.7% of kids under age 18 in ND.

Trends in services for emotional disturbance, age of incidents and rates of chronic absence point to increasing behavioral health needs for kids and families

Students receiving services for "emotional disturbance" in Grades K-12



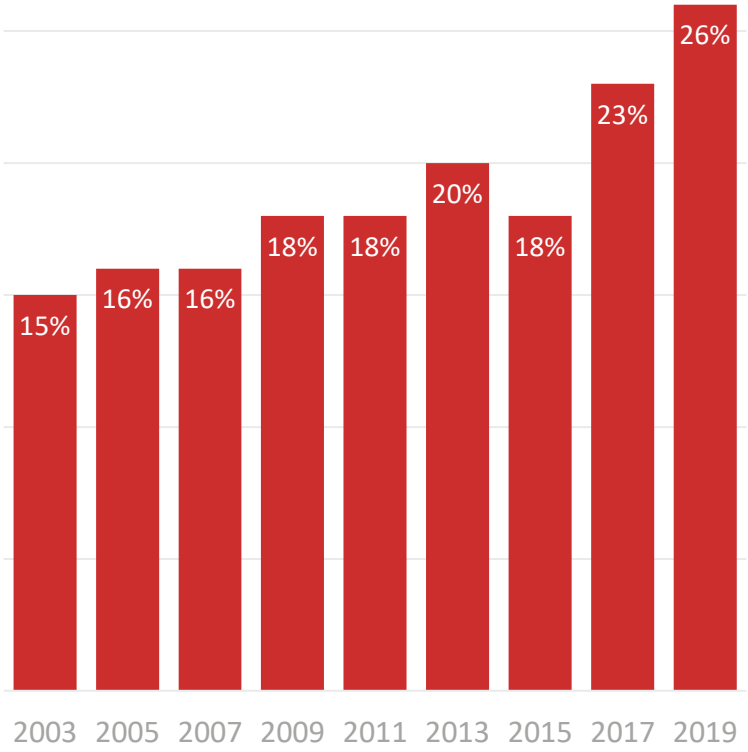
"Incidents" in school setting by grade level (2019-20 school year)



Rethink child welfare

Supporting behavioral health needs in families can prevent disruptions at home and in school.

4th graders counted as chronically absent by academic year





"Everyone would agree that children should not be exposed to abuse or neglect.

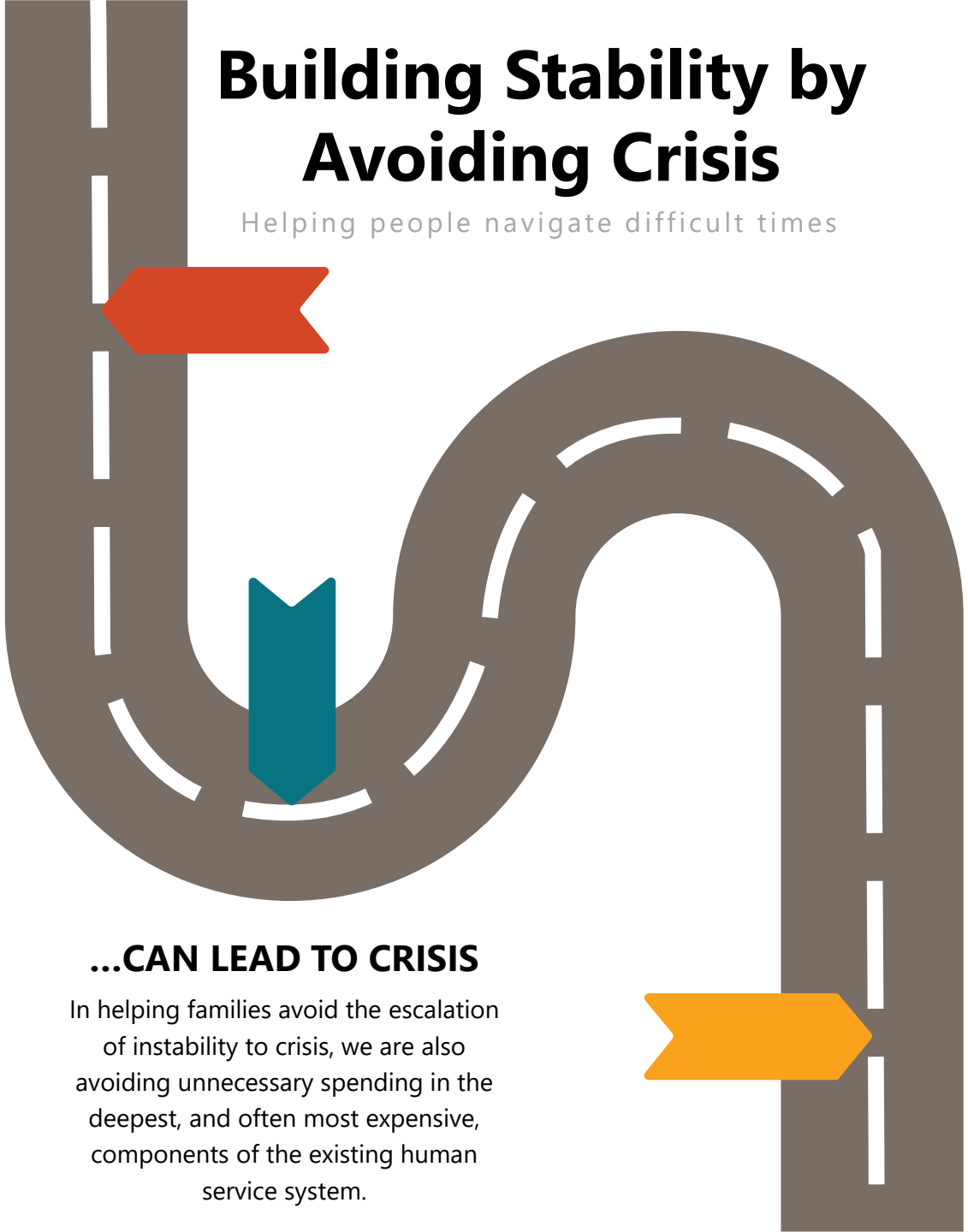
"The process of being removed from one's home and placed in foster care has consequences as well and can have negative effects that last a lifetime."

Building Stability by Avoiding Crisis

Helping people navigate difficult times

DISRUPTION

When families experience disruption, their ability to be a fully engaged, productive member of the community and the workforce is compromised.



...CAN LEAD TO CRISIS

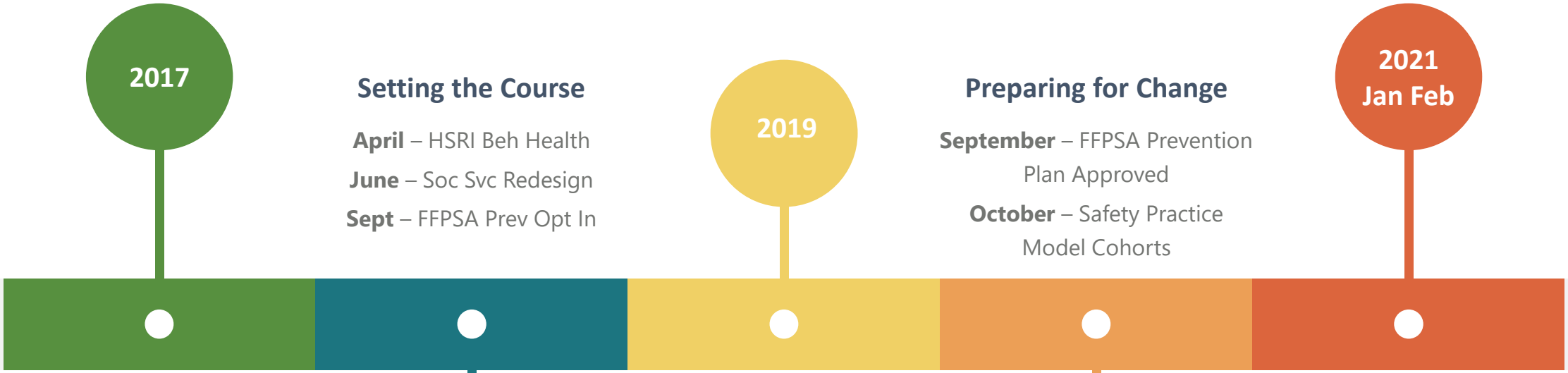
In helping families avoid the escalation of instability to crisis, we are also avoiding unnecessary spending in the deepest, and often most expensive, components of the existing human service system.

SERVICES SUPPORT STABILITY

Intervening early will both save money and strengthen families. It will allow us to reserve deep end services for the times when they are truly needed, and help people avoid deepening their journey into crisis by diverting from institutions, keeping families together, and helping and sure that people have a place to call home.

Our Journey Toward Building Stronger Families

Redefining Child Safety and Wellbeing through a Two-Gen Lens



2017-19 Session

April - Free Through Recovery

May - Dual Status Youth Kickoff

Setting the Course

April – HSRI Beh Health

June – Soc Svc Redesign

Sept – FFPSA Prev Opt In

2019-21 Session

January – DSY Collab implem

April Approve -

1915i | Soc Svc Redesign | Mobile Crisis Svc | School BH

September – FFPSA QRTP Rules

Tribal IV-E Agreements

Preparing for Change

September – FFPSA Prevention Plan Approved

October – Safety Practice Model Cohorts

Putting into Practice

January – Provider Portals 1915i and FFPSA

Community Connect / Extended FTR | Safety Practice Model | Centralized Abuse/Neglect Intake



"North Dakota's Child Welfare System is focusing on efforts to **ensure availability and access** to a broad, flexible array of **effective community-based services and supports**

for children and their families

that address their emotional, social, educational and physical needs,

including traditional and nontraditional services as well as natural and informal supports."

ND 2020-2024 Title IV-E Prevention Services and Programs Plan

Children considered a "Candidate for Foster Care"

Have access to →

Under 18 years of age	Significant interference or limitations of the child's functioning in home, school or community	Child is pregnant or parenting a child(ren)	Siblings in foster care
Inadequate supervision based on family and youth circumstances	Currently involved in 2 or more community services or agencies	DSM diagnosis for emotional, behavioral, or mental health disorder	Child whose adoption or guardianship arrangement is at risk of disruption
Prior out of home placement	Reunification has occurred	Difficulties are interfering or limiting achievement or maintenance in 1 or more developmentally appropriate skills	Parent/custodian/guardian has limited capacity to meet educational, medical, safety or basic needs of child due to parental need*

*Parental inability to meet needs of child could be due to parent(s)' behavioral health, incarceration, physical or intellectual disability, debilitating or life-threatening medical needs, homelessness or substandard living conditions, verbalization of no longer wanting their child, or substance exposed newborns.

Evidence-based Prevention Services

In home parent skill-based programs

Mental health programs

Substance abuse prevention and treatment

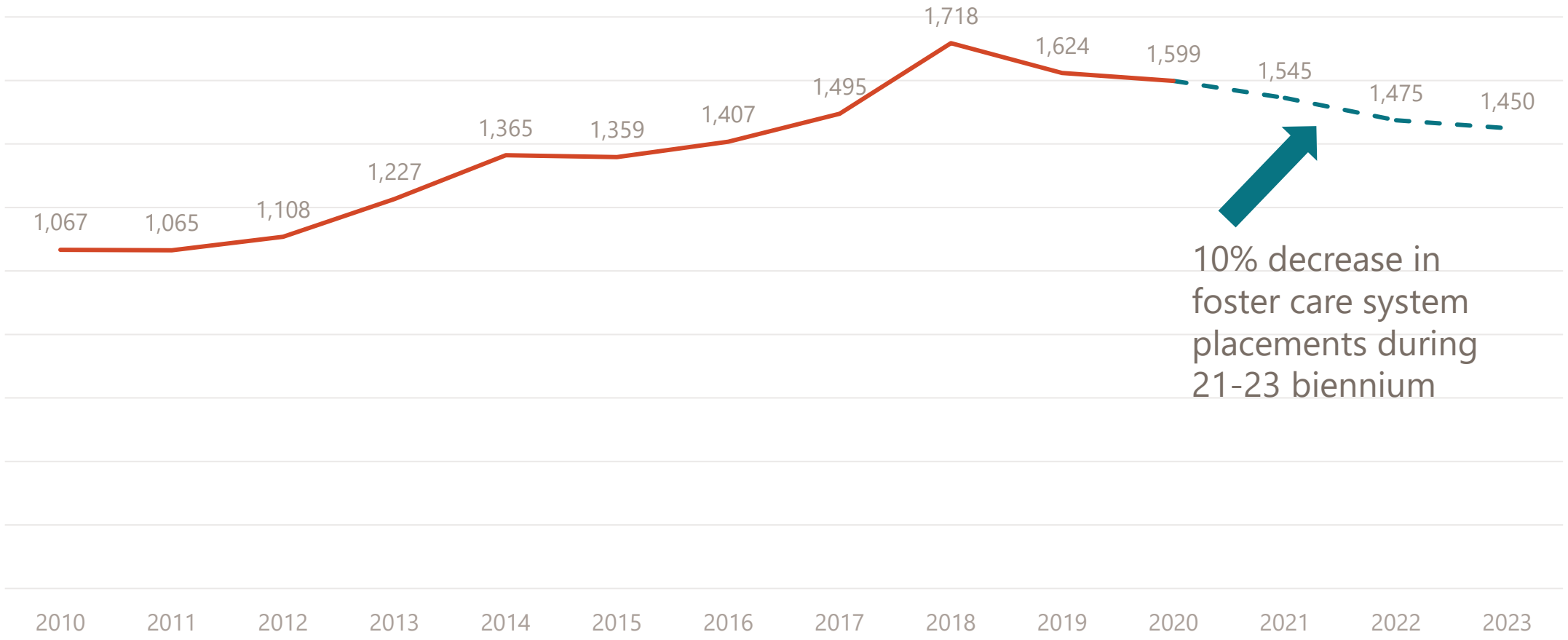


Our goals

- Reduce Foster Care Numbers
- Reduce Institutional Placements
- Reduce Out of State Placements
- Reduce Substance Abuse as Abuse/Neglect factor
- Increase Kids receiving evidence-based supports
- Reduce severity of school-based behaviors

CHILDREN AND FAMILY SERVICES

The 21-23 budget anticipates a modest but steady reduction in foster care and residential placements



SHIFTING RESOURCES TO SUPPORT WHAT RESEARCH INDICATES WILL WORK FOR CHILDREN AND FAMILIES

De-scale investment in **approaches** that are **not proven effective**



Invest in approaches with **proven results** for the populations being served



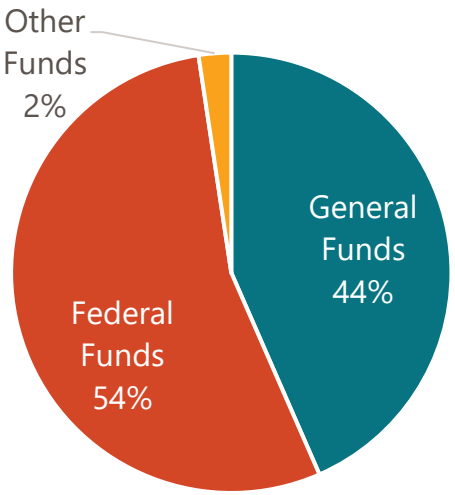
Children & Family Services Budget Summary

19-21 Budget	**$181,171,041**	**41.6 FTE**
21-23 Budget (exec)	**$165,637,720**	**41.6 FTE**
21-23 Budget (House)	**$171,815,985**	**48.3 FTE**

+6.7 FTE and $6.2 million related to early childhood policy bills (HB1416 and HB1466)

21-23 EBR proposed $15.5 million decrease in total budget (7% of reduction is from federal funds)

- Reduce foster care and residential placements, accomplished in part by investing in evidence-based parent skill building and mental health services to families
- Implement equity in payments for services to families (QRTP, subsidized adoption, targeted case mgmt)
- Technology infrastructure investments in early childhood integrated data system and replacement of child welfare technology platform



DEVELOPMENTAL DISABILITIES
Program Purpose

Maximize community inclusion, independence and self-sufficiency to prevent institutionalization, and to enable individuals to transition from institutions to community living.



DEVELOPMENTAL DISABILITIES
What we do

Case Management

- Case management provided by DD Program Managers to individuals and families
- Eligibility review
- Person centered planning
- Service authorization

Administration

- Provider licensing
- Training & TA
- Policy Development
- Contract Management
- Provider Enrollment
- Part C and Infant Development

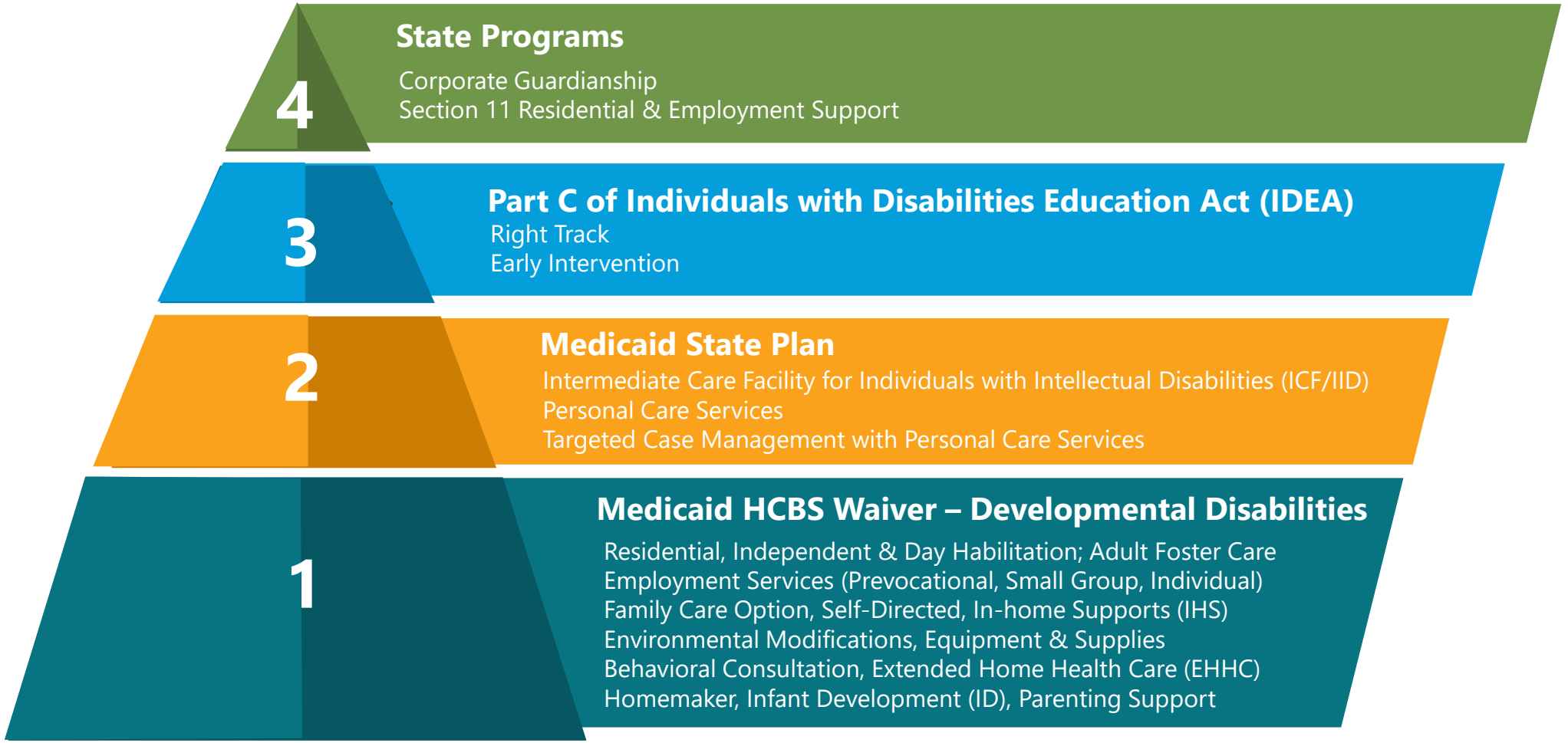
Program Integrity

- Regulatory compliance
- Provider Audits
- Case Reviews
- Federal & State Audits
- Quality Assurance

Partnerships

- North Dakota Interagency Coordinating Council
- State Rehabilitation Council
- Transition Task Force
- Money Follows the Person

DEVELOPMENTAL DISABILITIES
Service Array by Funding Authority



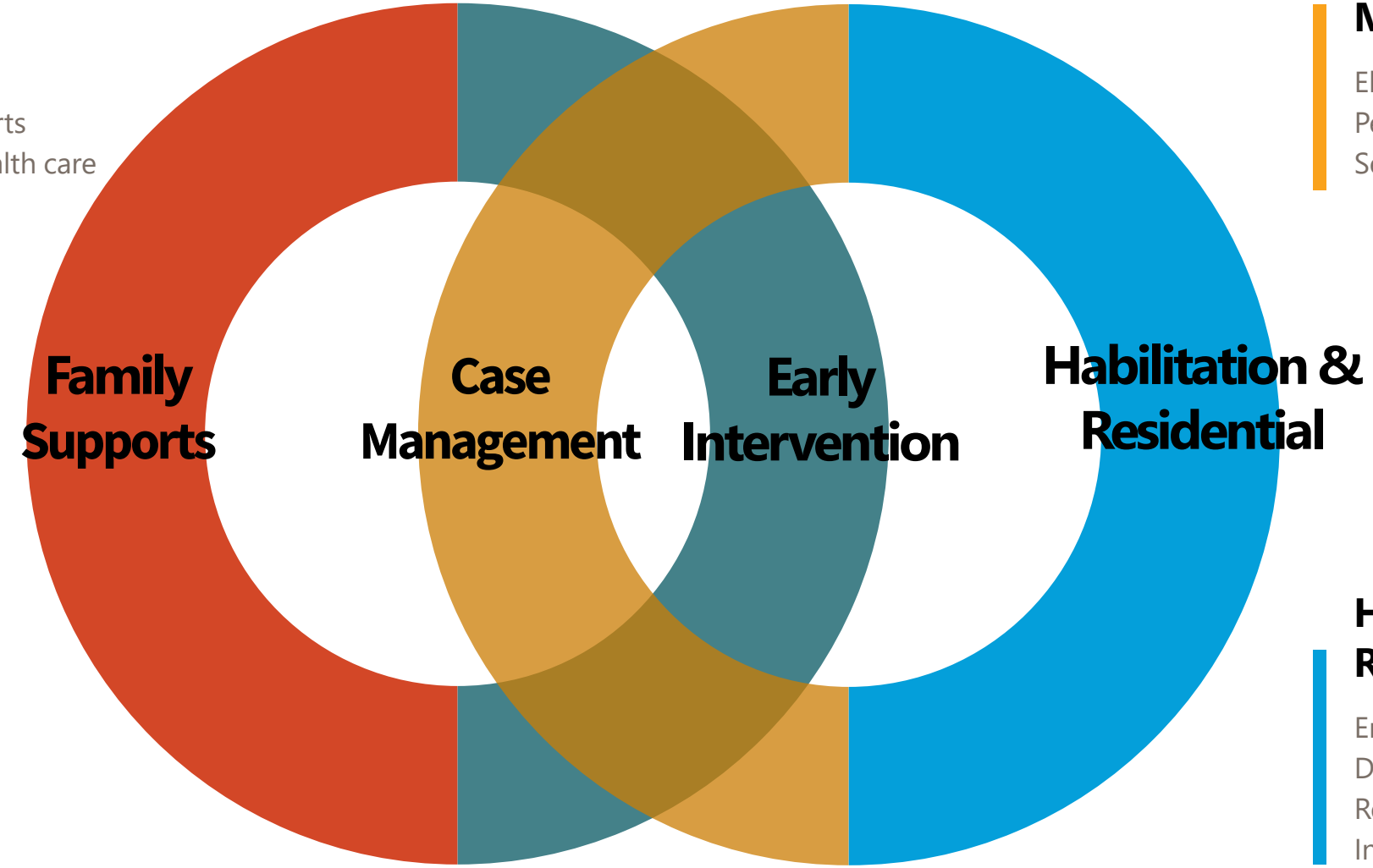
Case management and early intervention are a key intersection within the continuum of services available to people with Developmental Disabilities

Family Supports

In-home supports
Self-Directed supports
Extended Home Health care

Case Management

Eligibility
Person Centered Planning
Service Authorization



Early Intervention

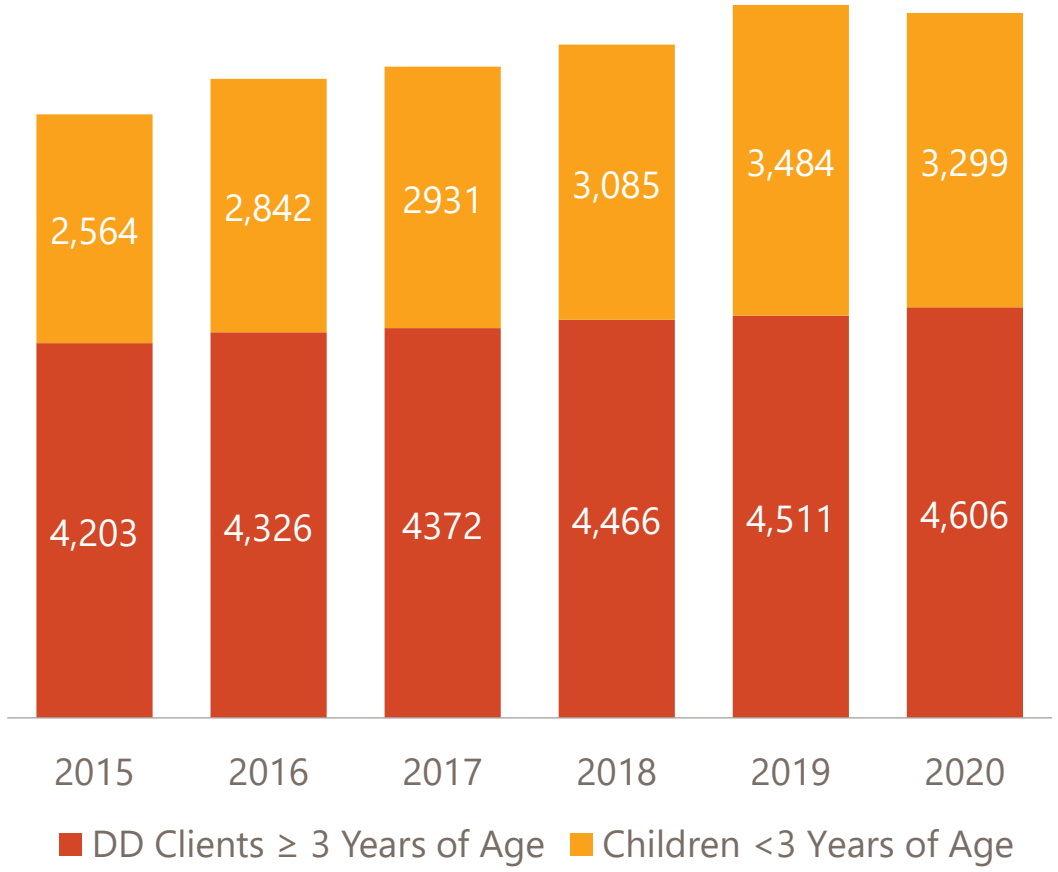
Birth review
Right Track
Infant Development

Habilitation & Residential

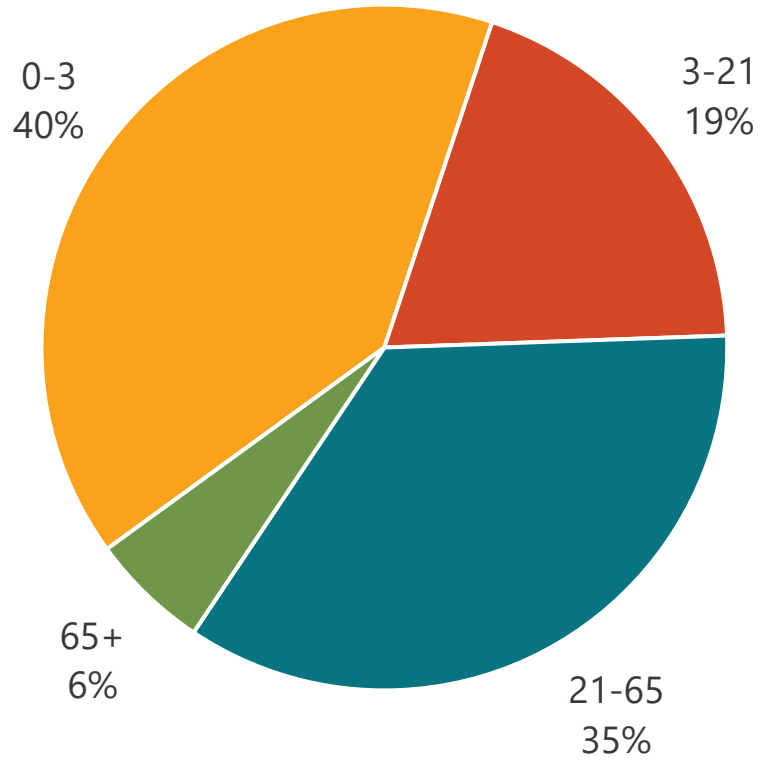
Employment
Day Services
Residential
Intermediate Care Facility

DEVELOPMENTAL DISABILITIES

The majority of individuals receiving case management services are under age 21

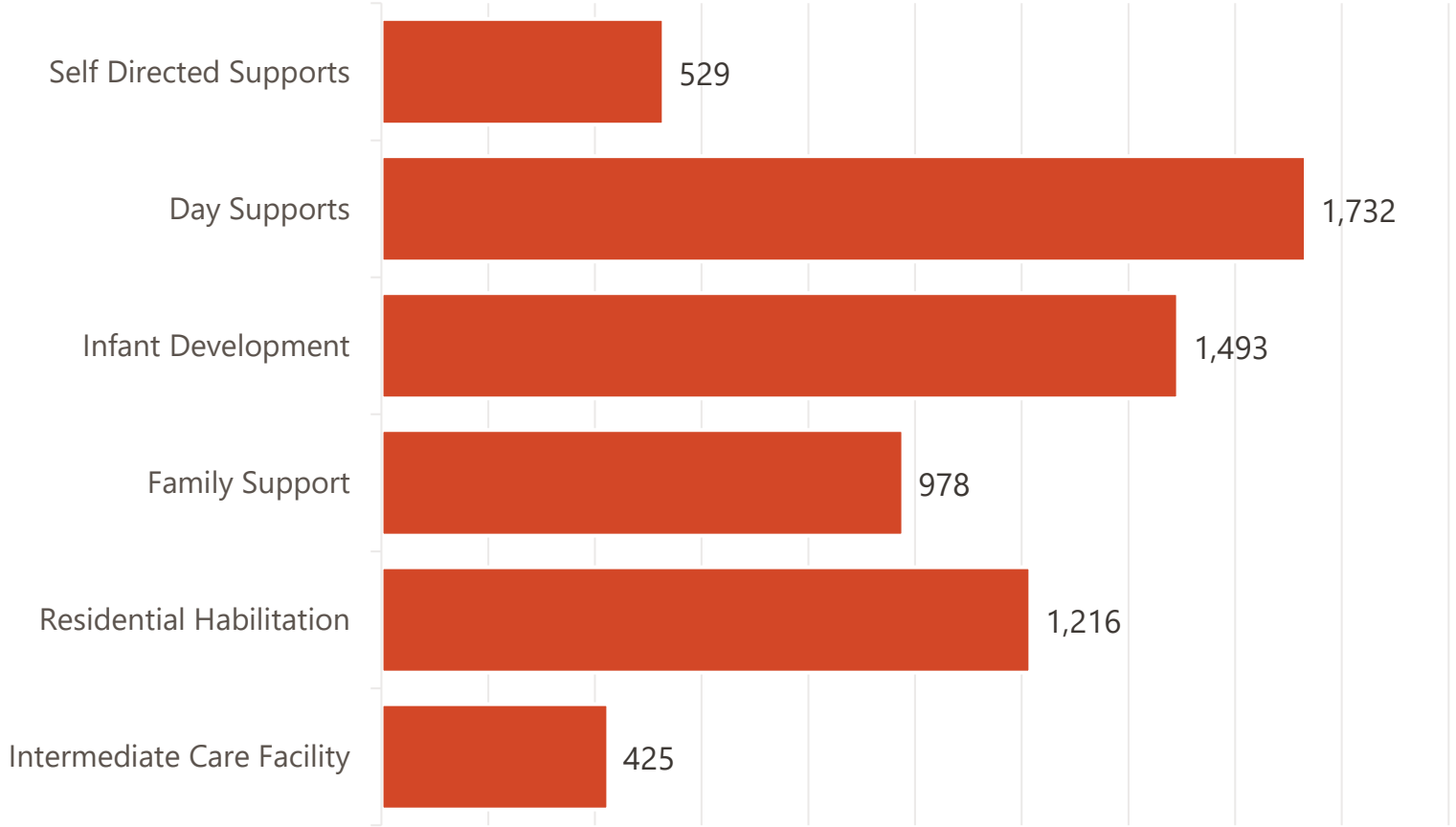


Age of DD clients receiving program management SFY20



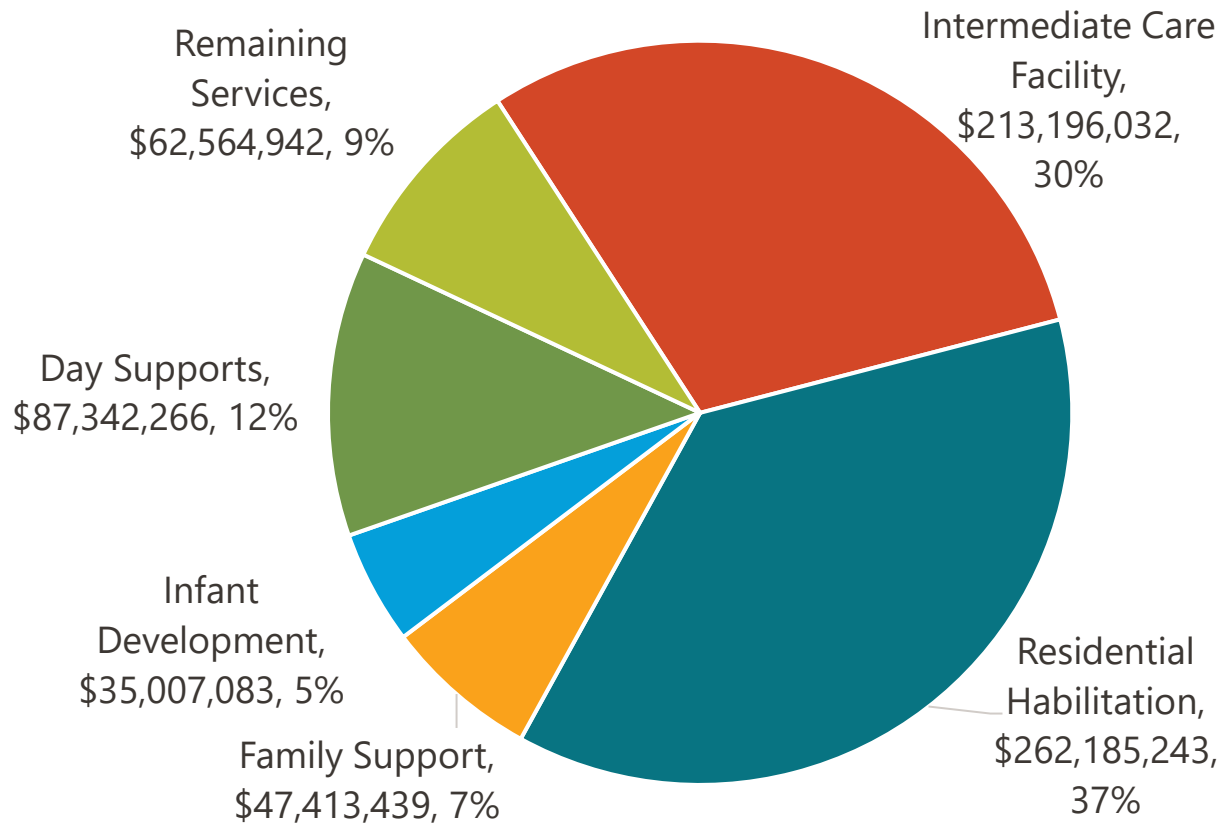
DEVELOPMENTAL DISABILITIES
Individuals receiving 1915(c) waivered services

ND's 1915(c) waivered services for people with a range of developmental disabilities are coordinated by 120 DD program managers and delivered by 38 licensed providers who served 7,900 people ages 0-90+ in 2020



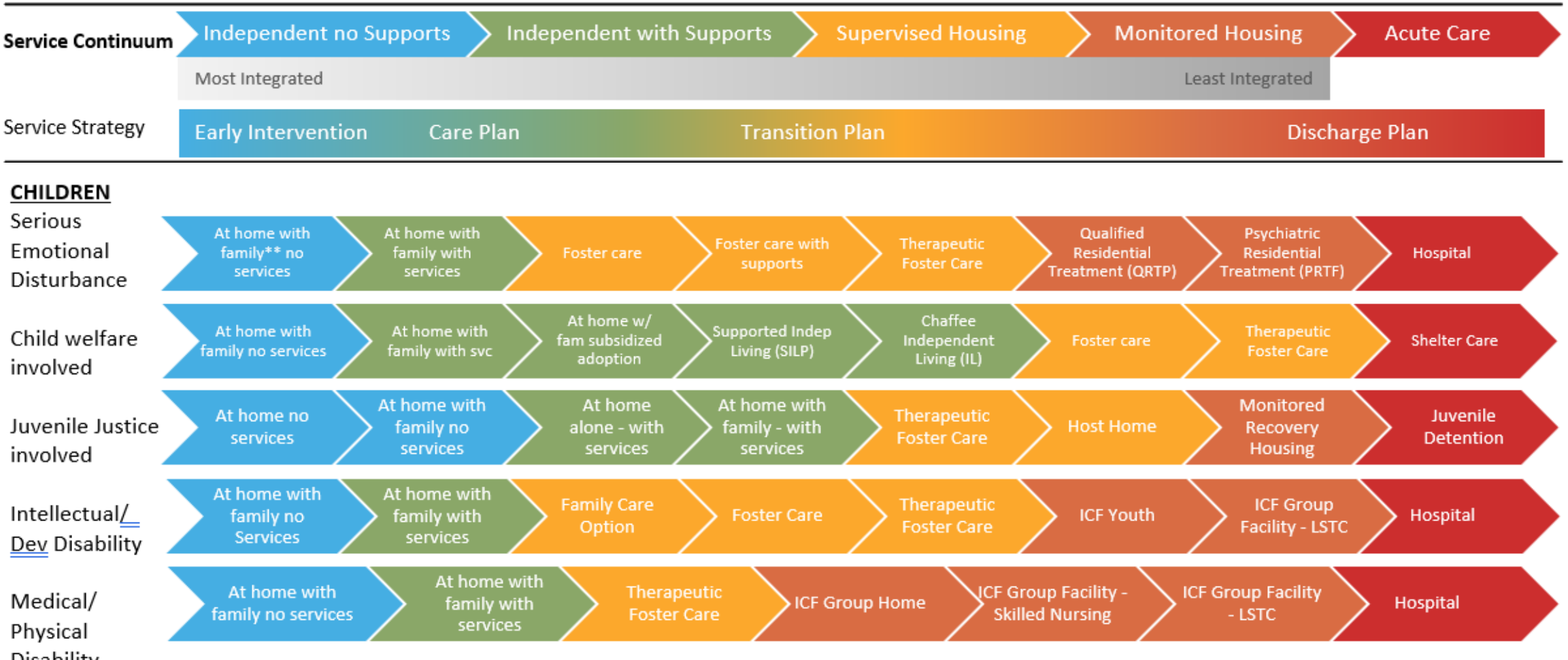
DEVELOPMENTAL DISABILITIES
Proposed 21-23 budget by type of service

67% of the total proposed 21/23 budget for DD services will support residential care for people with developmental disabilities



The Service Continuum - Children

Illustrating the work of transition and diversion

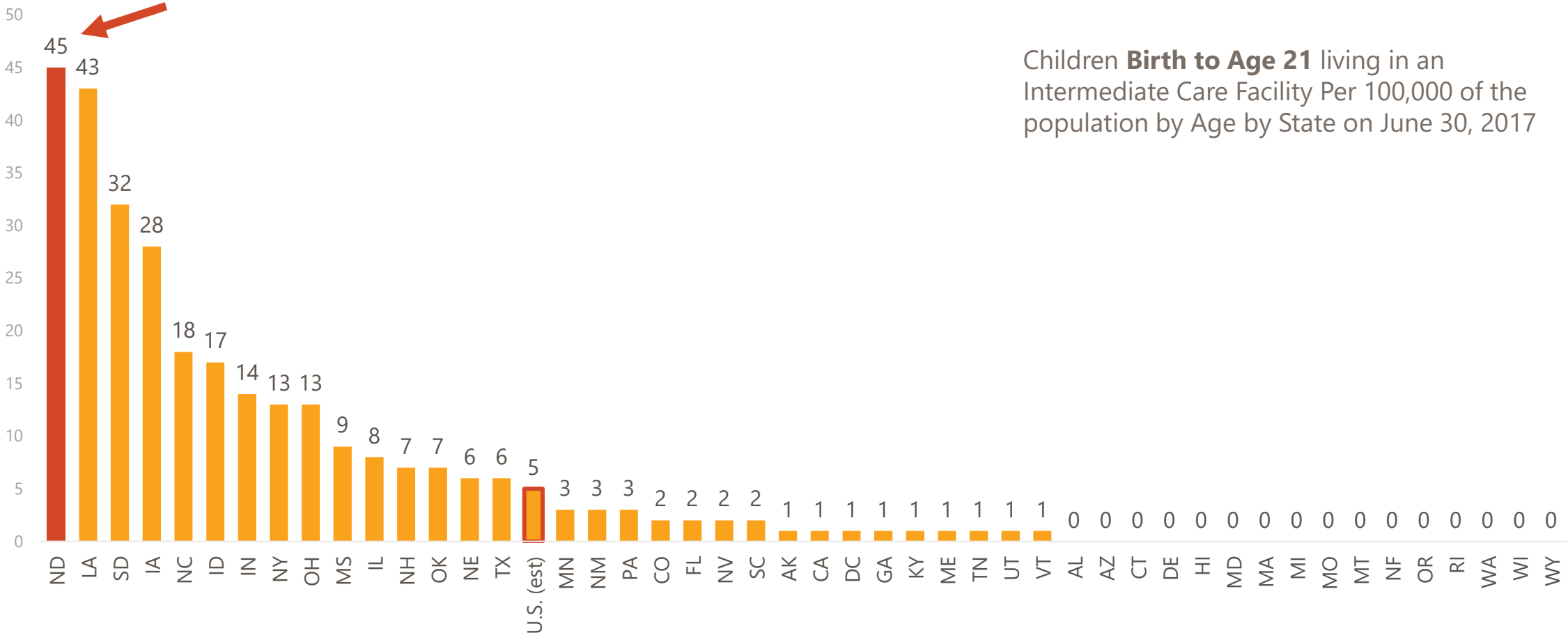


**Home = includes any type of home setting that is the responsibility of the individual (single family home, condo, apartment, mobile home)*

***Family = includes birth family, kin-caregiver, adopted family*

****ICF = Intermediate Care Facility. ICF Group Home (less than 8 people); ICF Group Facility (8 or more people); ICF LSTC (Life Skills Transition Center)*

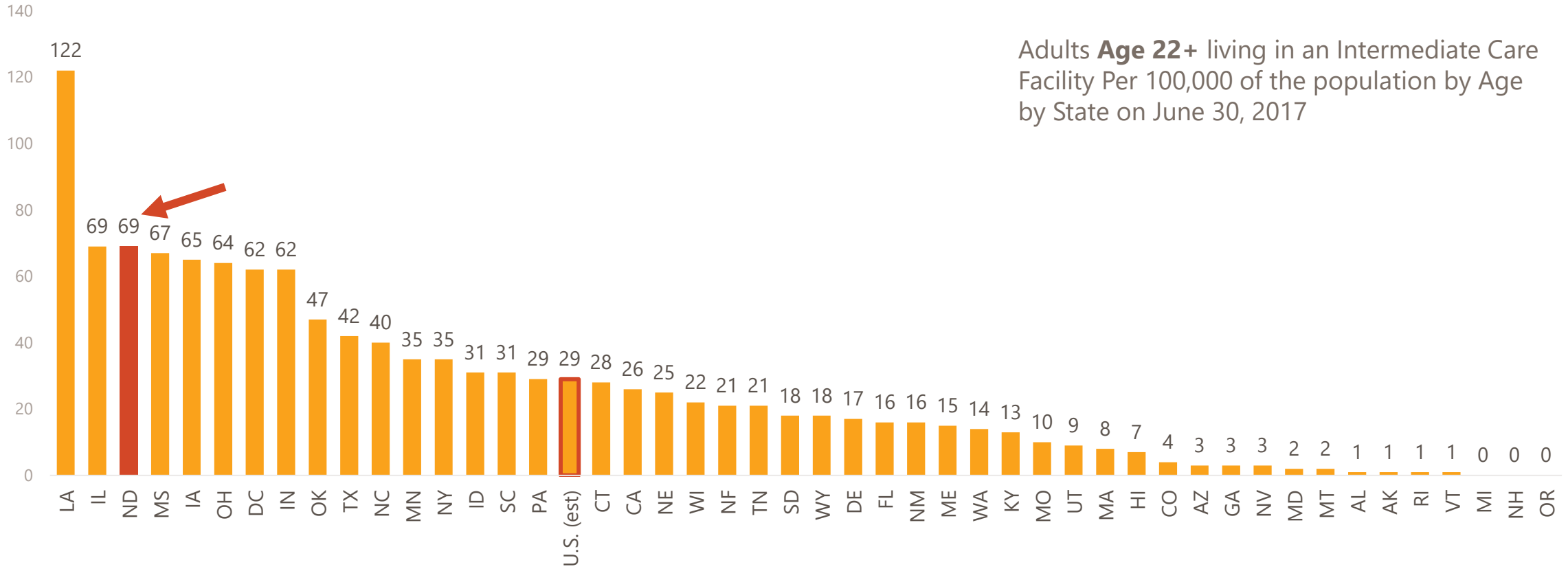
ND HAS THE HIGHEST RATE OF CHILDREN LIVING IN AN INTERMEDIATE CARE FACILITY (ICF)



Children **Birth to Age 21** living in an Intermediate Care Facility Per 100,000 of the population by Age by State on June 30, 2017

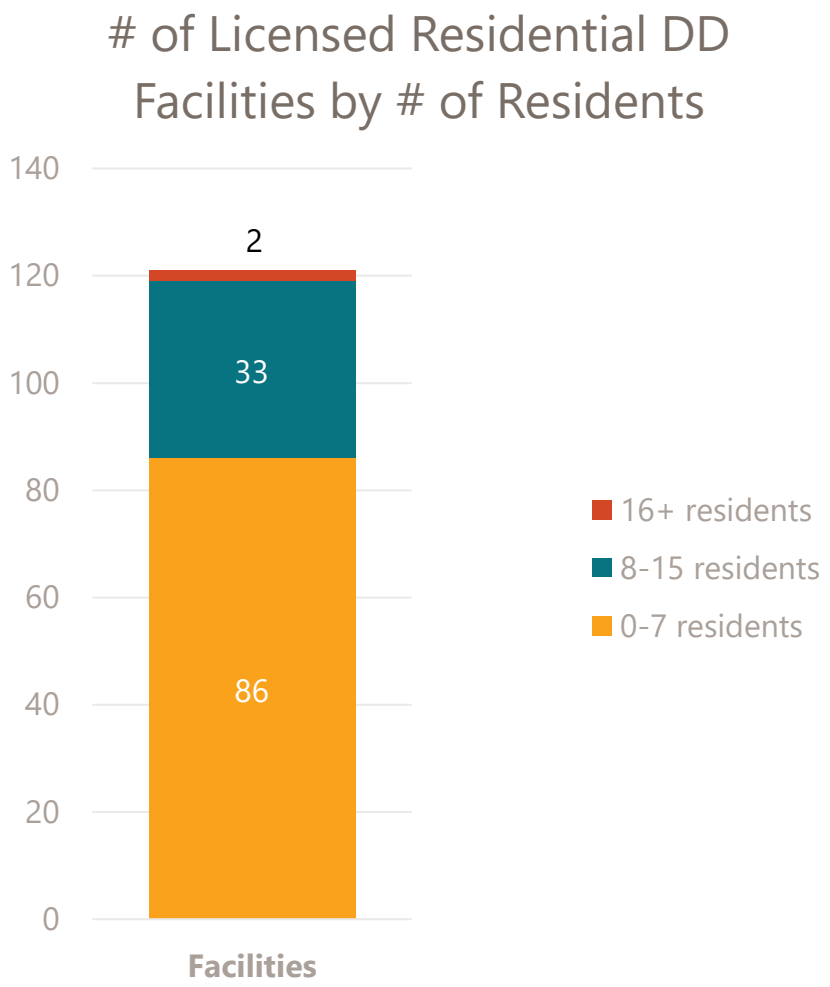
Source: Residential Information Systems Project. In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends 2017. NOTE: Virginia, Kansas, Arkansas and West Virginia not reporting.

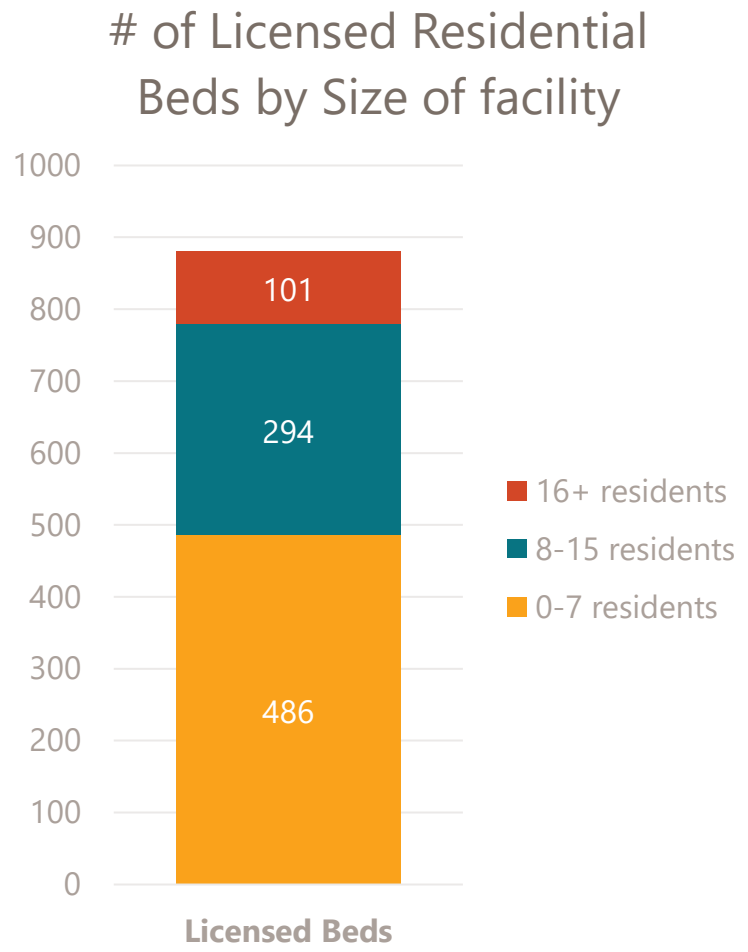
ND HAS THE 3RD HIGHEST RATE OF ADULTS LIVING IN AN INTERMEDIATE CARE FACILITY (ICF)



Source: Residential Information Systems Project. In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and Trends 2017. NOTE: Virginia, Kansas, Arkansas and West Virginia not reporting.

45% OF ND LICENSED DD RESIDENTIAL BEDS ARE IN FACILITIES THAT SERVE 8 OR MORE PEOPLE







What's Driving Us?

In North Dakota, people have the opportunity to learn about their options and make an informed choice about the most integrated setting that is right for them.

Our system partners work together to create robust options for non-institutional living, optimizing autonomy, choice, self-direction and community integration.

A young girl is struggling. So is her family. What do we do?

Understanding how systems can help families find stability amidst crisis

Service Continuum

Independent no Supports | Independent with Supports | Supervised Housing | Monitored Housing | Acute Care

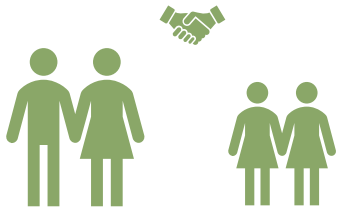
Most Integrated — Least Integrated

Service Strategy

Early Intervention | Care Plan | Transition Plan | Discharge Plan

Intellectual/ Dev Disability

At home with family no Services | At home with family with services | Family Care Option | Foster Care | Therapeutic Foster Care | ICF Youth | ICF Group Facility - LSTC | Hospital



Crisis

Team looks for solutions

In home supports

Respite

Diversion coordination

Crisis

Crisis placement at LSTC

Stabilization (8 mo)

Structure & Routine

Educational supports

Svc during transition





Placement at Youth ICF



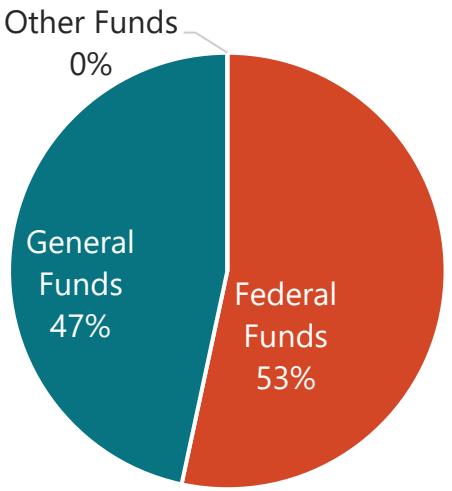


Developmental Disabilities Budget Summary

19-21 Budget	**$689,016,522**	**125.87 FTE**
21-23 Budget (exec)	**$739,269,819**	**125.87 FTE**
21-23 Budget (House)	**$739,217,501**	**125.87 FTE**

21-23 EBR proposed $50.3 million increase in total budget

- Cost to continue services
- Diversion/Transition initiative with LSTC
- Provider inflation
- Payment system adjustments for ICF and Residential Group Homes
- Elimination of supplemental recreational and Section 11 grants
- Transitioning accreditation to provider program cost
- Operating efficiencies related to travel and occupancy



AGING & ADULT SERVICES
Program Purpose

Help older adults and individuals with physical disabilities to remain in their own homes and communities.

Protect the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community.



AGING & ADULT SERVICES
What we do

Aging & Disability Resource Link (ADRL)

- Toll free resource line for people with questions about how to access services
- Centralized intake for HCBS services
- Proactive in-reach and out-reach to build awareness of HCBS options

HCBS Case Management

- HCBS case management provided to consumers
- Eligibility review
- Care Team planning
- Service authorization

Protective Services

- Vulnerable Adult Protective Services delivered statewide
- Ombudsman services for long term care residents

Senior Nutrition & Community Supports

- Administration of Older Americans Act
- Senior nutrition program
- Support for Family Caregivers
- Lifespan Respite grant

Administration HCBS and Partnerships

- HCBS 1915(c) Medicaid waiver
- Medicaid State Plan – Personal Care
- SPED / Expanded SPED
- Money Follows the Person

AGING & ADULT SERVICES
Aging & Disability Resource Link (ADRL)

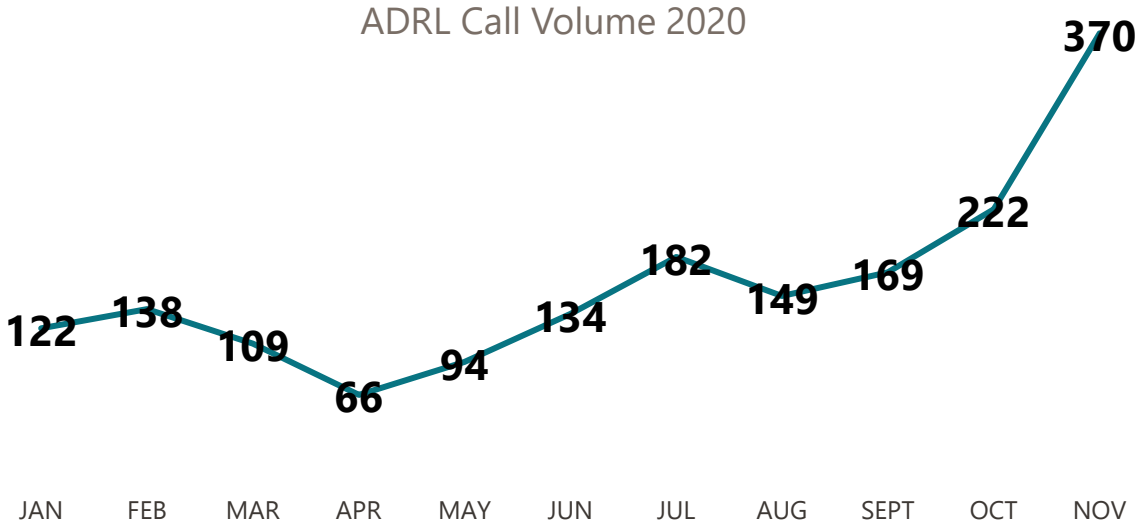
Top 5 Information Requests

- In-home assistance
- Adult protective services
- Medicaid information
- Family caregiver support program (FCSP)
- Older adults/aging Issues



AGING & ADULT SERVICES
ADRL Centralized Intake

- Process to receive HCBS referrals
- Based on no wrong door (NWD) approach
- Network built to support individuals needing LTC services by simplifying and streamlining access to information and services
- 6 FTE dedicated to centralized intake
- Fully implemented January 2021



7 in 10

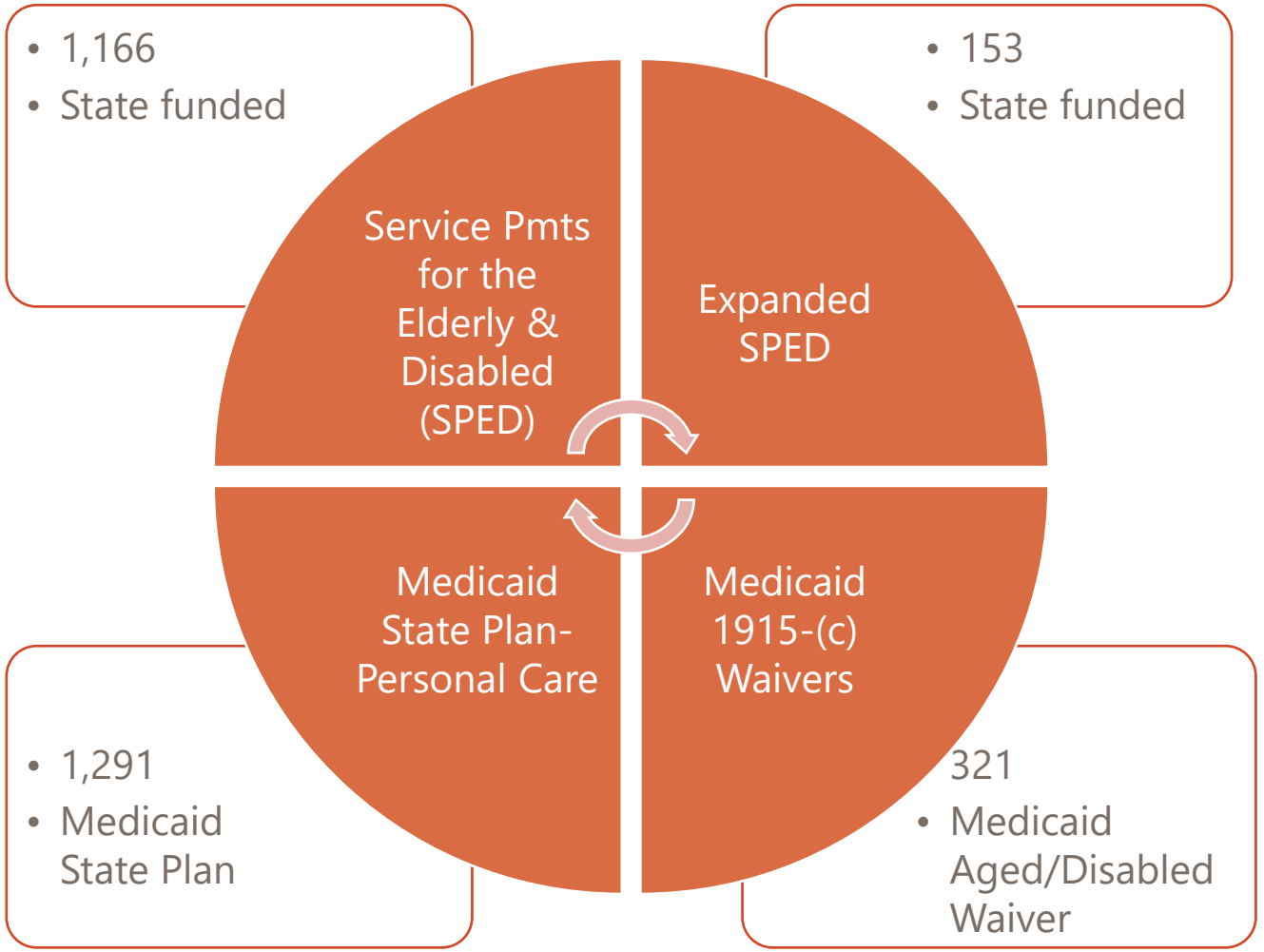
Americans 65+ will need LTC services for an average of 3 years

AGING & ADULT SERVICES
Home and Community Based Services

2,300

HCBS supported 2,300 unduplicated recipients

- Primarily serves older adults and individuals with physical disabilities
- Recipients must be both functionally and financially eligible
- May have client cost share based on income
- Federal and state funds

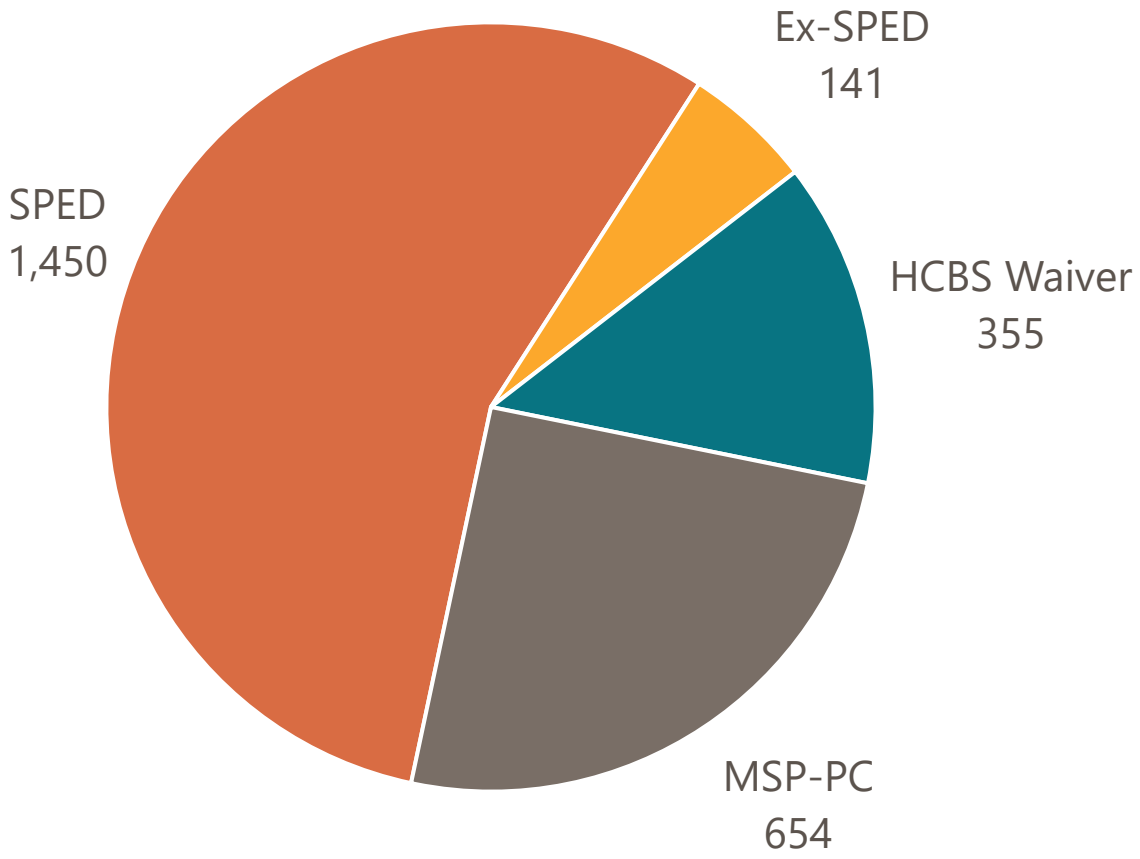


AGING & ADULT SERVICES
Types of *Support Services* available via HCBS

- Adult Day Care
- Adult Foster Care
- Adult Residential Care
- Attendant Care
- Case Management
- Chore Service
- Community Support Services / Residential Habilitation
- Community Transition Services
- Companionship
- Emergency Response System
- Environmental Modification
- Extended Personal Care
- Emergency Response System
- Environmental Modification
- Family Home Care & Family Personal Care
- Home Delivered Meals
- Homemaker Services
- Non-Medical Transportation
- Personal Care Services
- Respite Care
- Specialized Equipment
- Supervision
- Supported Employment
- Transitional Care

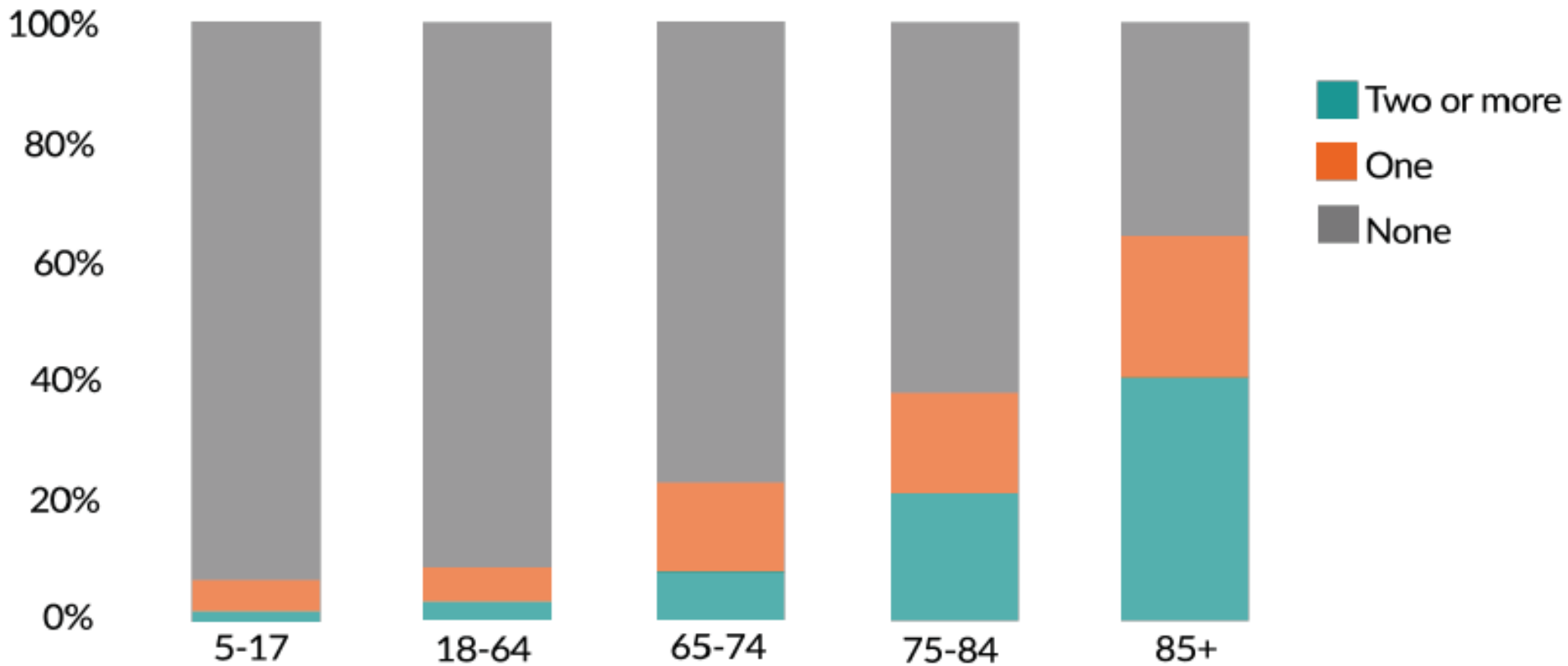
AGING & ADULT SERVICES
Individuals receiving HCBS services (Nov 2020)

ND's HCBS for older adults and people with physical disabilities are coordinated by 64 HCBS case managers and delivered by 1,149 Qualified Service Providers (QSPs) who served 2,300 people ages 18-104 in 2020



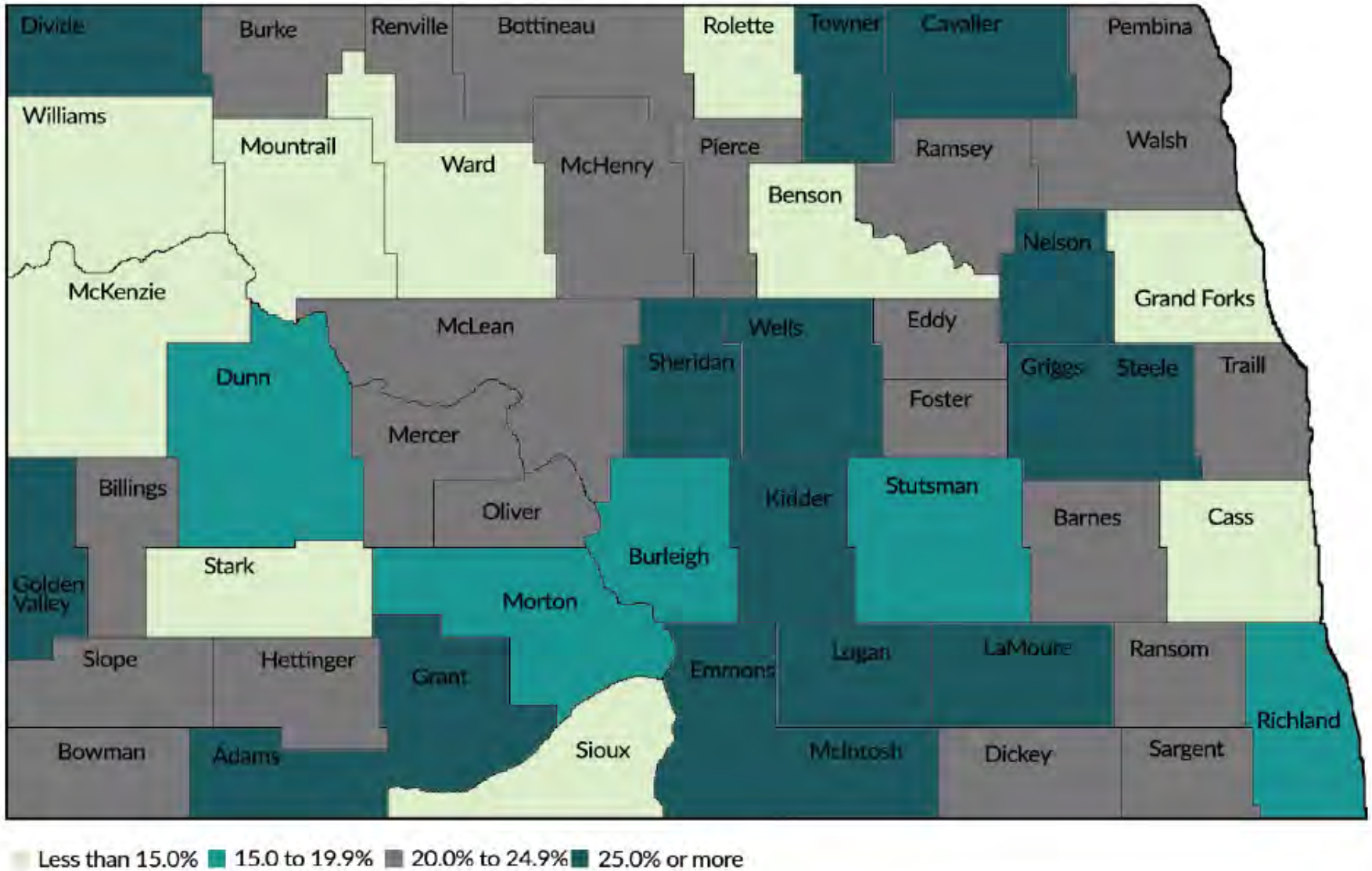
Source: DHS HCBS Caseload Data Nov 2020

Individuals by Detailed Age and Number of Disabilities [18]



Source: "The Current State of Housing in North Dakota", 2020, p.18

Percent of Population Age 65+ [19]



Source: "The Current State of Housing in North Dakota", 2020, p.18

AGING & ADULT SERVICES
HCBS Case Managers

64

HCBS case managers who work in 19 Human Service Zones across ND

3,057

Individuals served by HCBS case managers (Nov 2020)

283 & 54

On average, 283 new referrals and 54 new cases opened for HCBS each month



AGING & ADULT SERVICES
Vulnerable Adult Protective Service (VAPS)

The program addresses the safety of vulnerable adults who are at-risk of harm due to the presence or threat of abuse, neglect, or exploitation.



AGING & ADULT SERVICES
Vulnerable Adult Protective Service (VAPS)

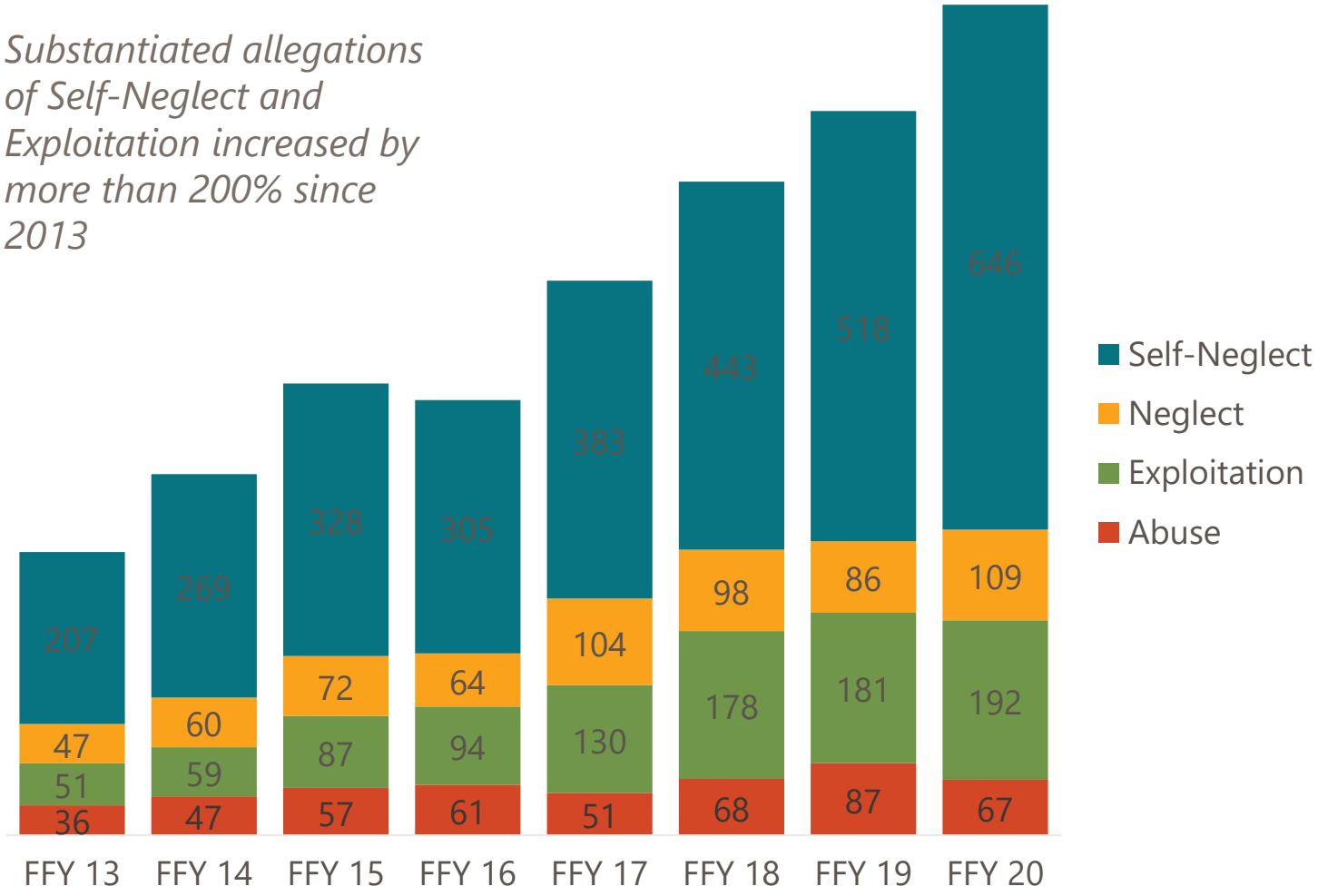
1,695 allegations

1,418 investigations

1,014 substantiated

Most common allegation:
Self Neglect

Substantiated allegations of Self-Neglect and Exploitation increased by more than 200% since 2013



AGING & ADULT SERVICES
Long Term Care Ombudsman

Long-Term Care Ombudsmen are advocates for resident rights. They help protect the quality of life and quality of care of anybody who lives in a nursing home, basic care or an assisted living facility.



AGING & ADULT SERVICES
Long Term Care Ombudsman

ND Long Term Care System

5,635 Nursing Facility Beds*
676 Swing Beds
2,054 Basic Care Beds
3,066 Assisted Living Units

**In 252 facilities located in 79 communities*

Most Common Complaints

Nursing Homes/Swing Bed

- Autonomy, Choice, Preference, Exercise of Rights, Privacy
- Care
- Systems/Others

Basic Care & Assisted Living

- Autonomy, Choice, Preference, Exercise of Rights, Privacy
- Admission, Transfer, Discharge, Eviction
- Financial, Property (Not due to Financial Exploitation)

1,267
Information and Consultations

448
Complaints Received

305
Cases opened

AGING & ADULT SERVICES
Older Americans Act (OAA)

24,600

Older adults served in FFY2019

Serves people age 60+

No income limits

Voluntary contribution

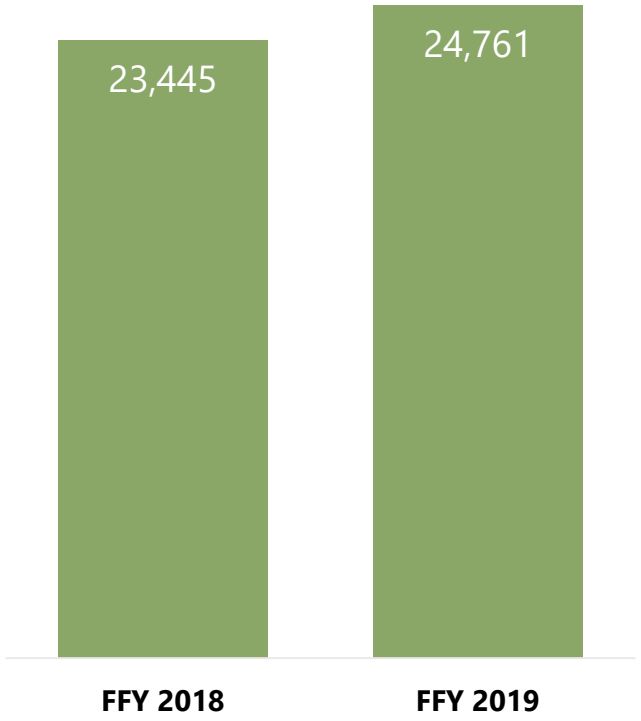
Cannot deny service due to unwillingness or inability to contribute

Federal, state, and local funds



AGING & ADULT SERVICES
Older Adults served with Older American Act Funds

Clients Served with OAA Funds increased by 6%



3,919
Clients with household income at or below **poverty** level (increase of 5% over FFY2018)

4,457
Clients **over age 85** (increase of 2% over FFY2018)

11,882
Clients who lived in **rural** areas (increase of 2% over FFY2018)

AGING & ADULT SERVICES
Senior Nutrition Services

Nutrition services **reduce** hunger, **food insecurity**, malnutrition, and **promote socialization** of older adults.

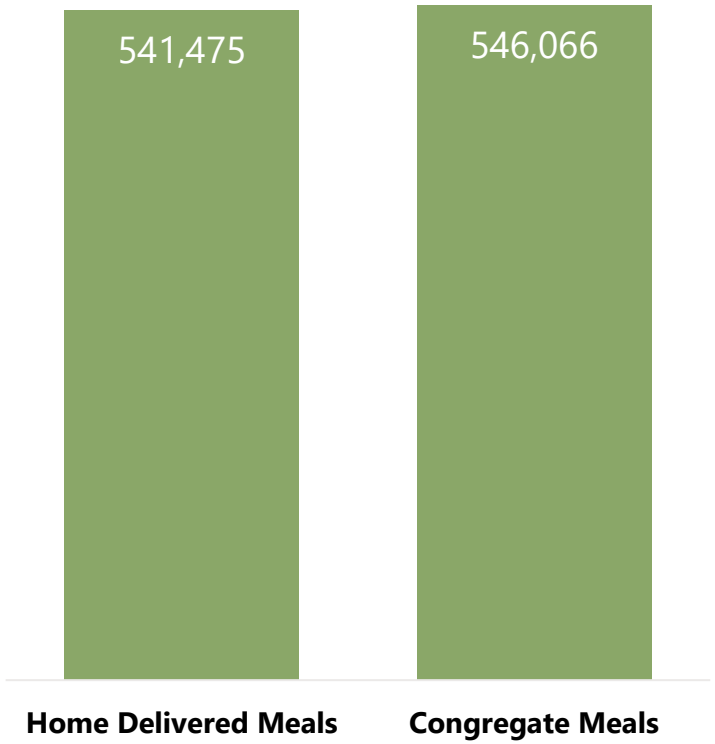
Seniors with food insecurity can have many negative health consequences:

- Prolonged hospital stays
- Unintentional weight loss that can increase need for physical assistance



AGING & ADULT SERVICES
Older American Act Funds Nutrition Services

In 2019 people utilized home delivered and congregate meals in roughly equal rates



23%

Seniors receiving home delivered meals who are "high nutrition risk"
(1,113 of 4,801 individuals served)

9.5% of the 14,311 individuals who received congregate meals in 2019 were "high nutrition risk"

23%

of Seniors receiving home-delivered meals have 2 or more ADL limitations
(1,124 of 4,801 individuals served)



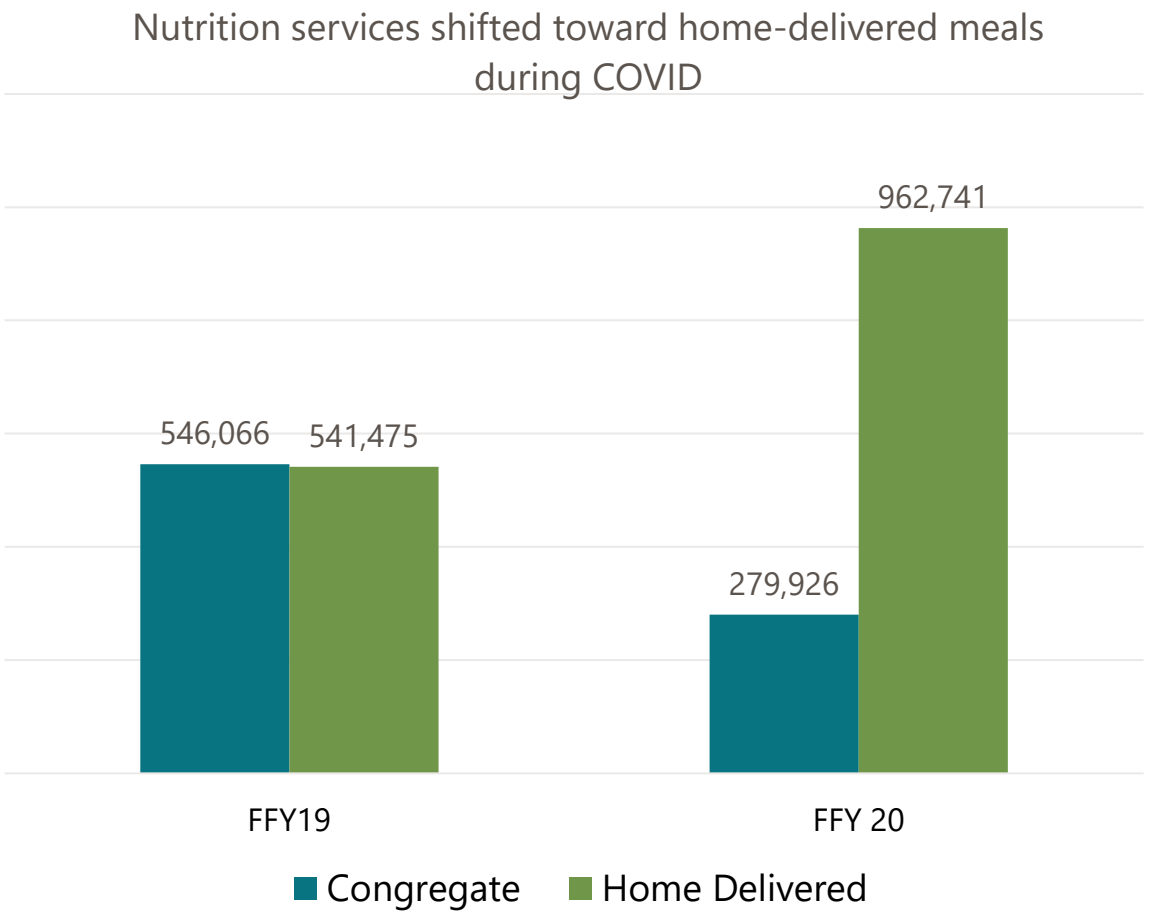
AGING & ADULT SERVICES
Key Changes due to COVID: Nutrition Services

The pandemic changed the way meals are delivered to older adults.

Meals options:
- Home delivered
- Pre-packaged grab-and-go
- Curbside pickup
- Frozen meal options

1,242,667
Meals served FFY2020 increased by 14% over FFY2019

9,362
Consumers served



AGING & ADULT SERVICES
Key Changes due to COVID: Nutrition Services

Home-Delivered Meals

Increased per meal rate from $4.60 to $7.00 to account for increased administrative costs

Funding

FFCRA	$1.2 M
CARES	$2.4 M
ND CARES	$1.1 M



NORTH DAKOTA OLDER AMERICANS ACT NUTRITION SITES

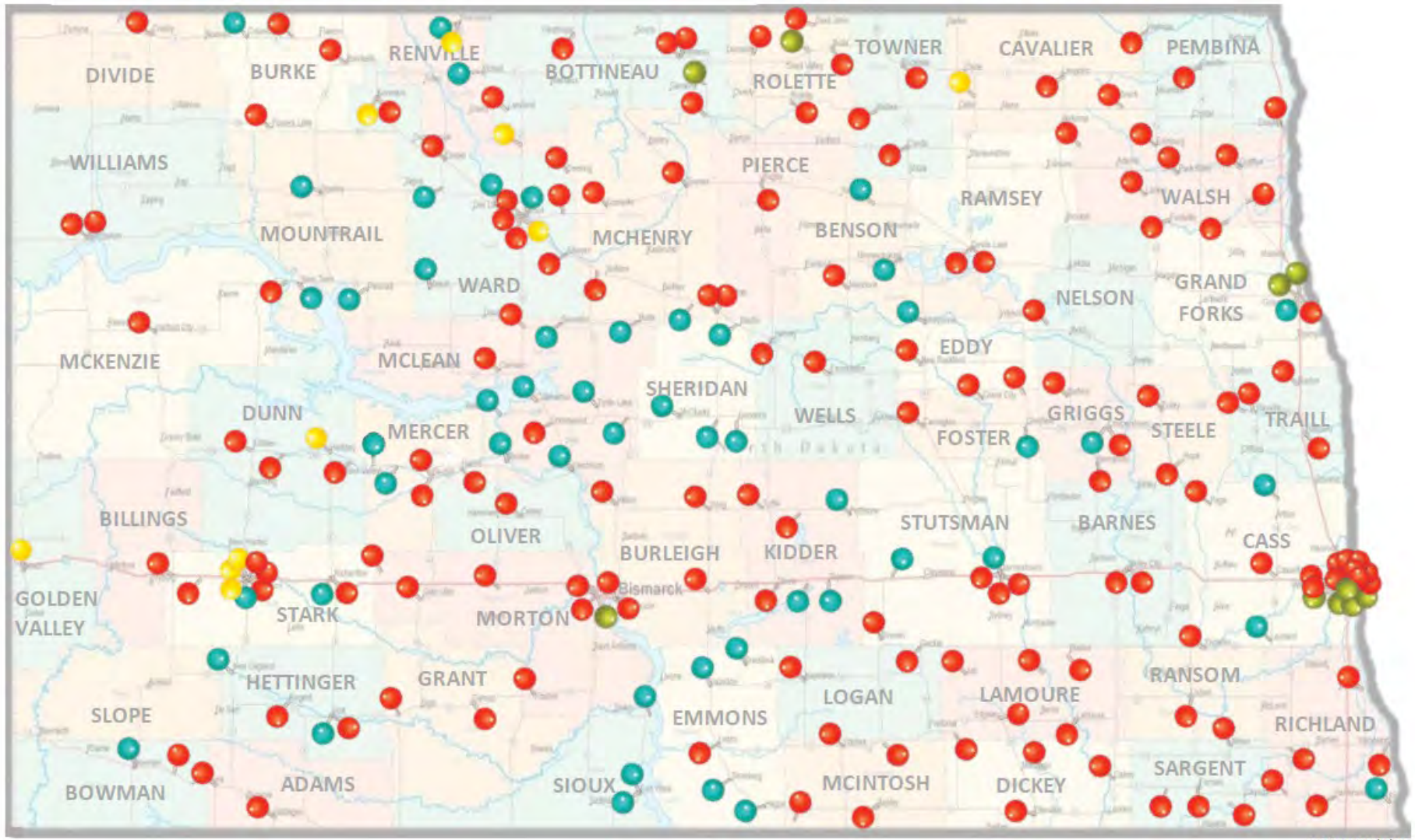
MAP LEGEND:

- Congregate Nutrition Sites Only
- Home Delivered Meals (HDM) Only
- Both Congregate and HDM Options
- Café 60 Nutrition Sites

STATE TOTAL:

219

- 09 Congregate Nutrition Sites Only
- 51 Home Delivered Meals (HDM) Only
- 149 Both Congregate and HDM Options
- 10 Café 60 Nutrition Sites



Last Updated 12/08/2020

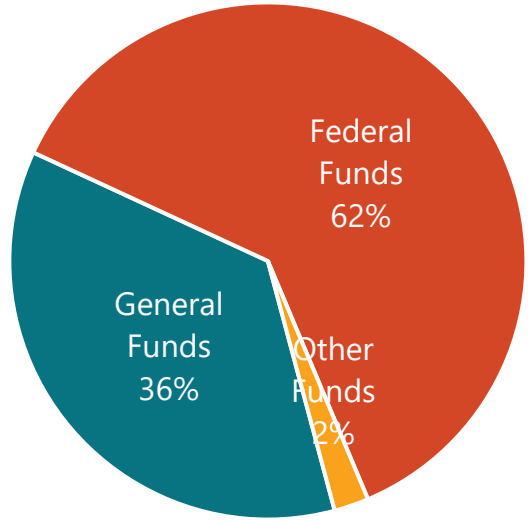


Aging & Adult Services Budget Summary

19-21 Budget	**$31,214,295**	**44.0 FTE**
21-23 Budget (exec)	**$34,452,766**	**44.0 FTE**
21-23 Budget (House)	**$35,738,774**	**45.0 FTE**

+1 FTE for DOJ data/reporting support plus funds for DOJ-related rental assistance and senior employment innovation grant

- Implementation of in-reach and out-reach and centralized intake for home and community-based services
- Continuation of Money Follows the Person
- Various programmatic and operating efficiencies



ND STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Purpose / Mission

The Council advocates for policy changes that promote choice, independence, productivity and inclusion for all North Dakotans with developmental disabilities. The Council provides funding for and supports projects and activities that maximize opportunities in these areas for consumers and families.

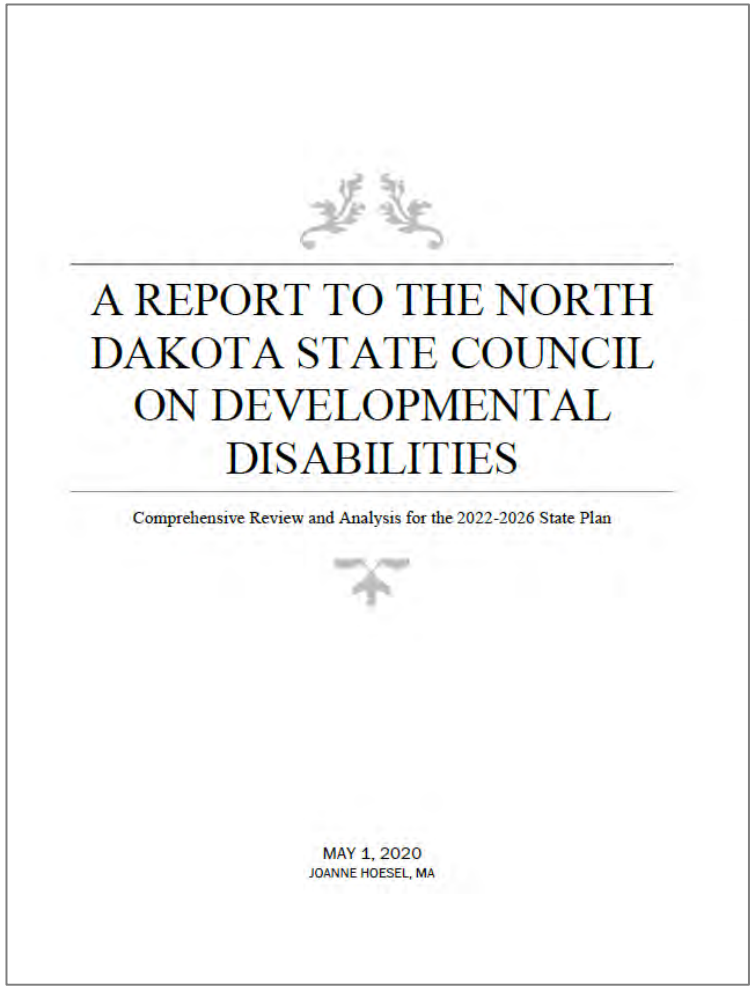


ND STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Key Findings: 2022-26 State Plan Comprehensive Review and Analysis

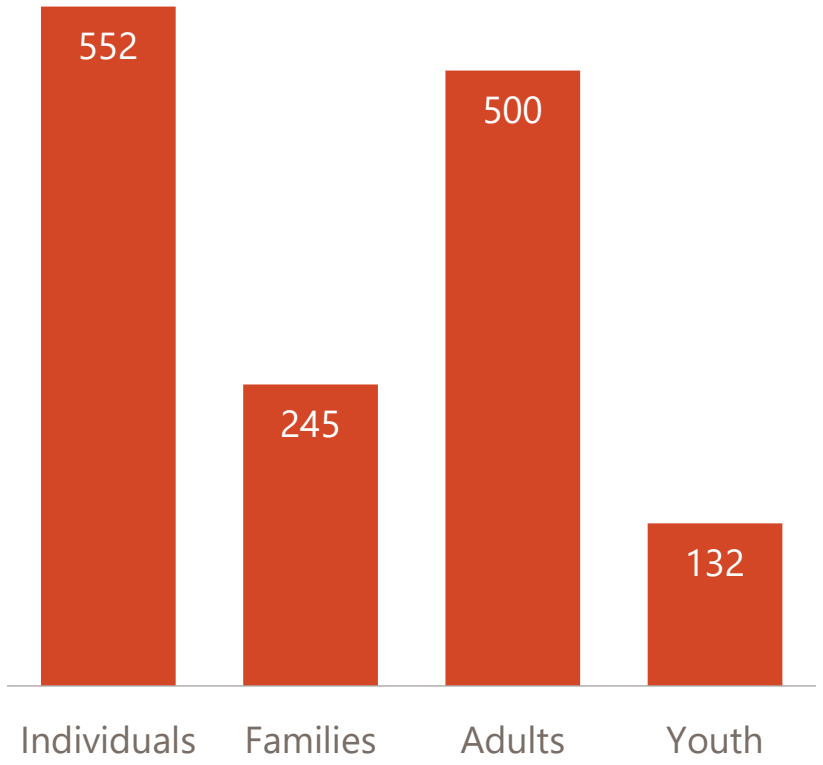
The following recommendations are offered as a roadmap for system improvement and present a range of possible options for consideration.

1. Fetal Alcohol Syndrome
2. Immunizations
3. Telehealth for IDD
4. Money Follows the Person
5. Culturally appropriate services
6. Infant Development services
7. Rental Assistance
8. Supported Decision-Making
9. Special Needs child care

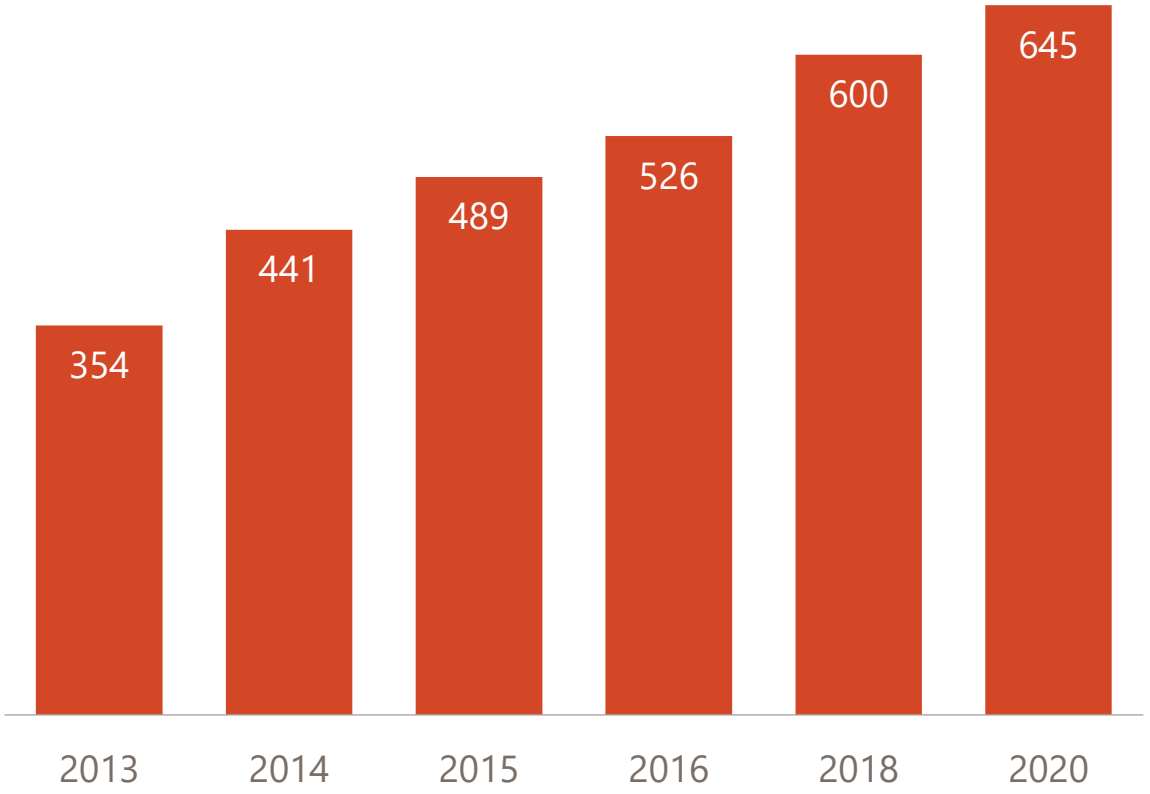


DEVELOPMENTAL DISABILITIES COUNCIL
Individuals Engaged in Training and Advocacy

People Trained Through 5-Year Plan Goals



People Active in System Advocacy



DISABILITY DETERMINATION SERVICES

Purpose / Mission

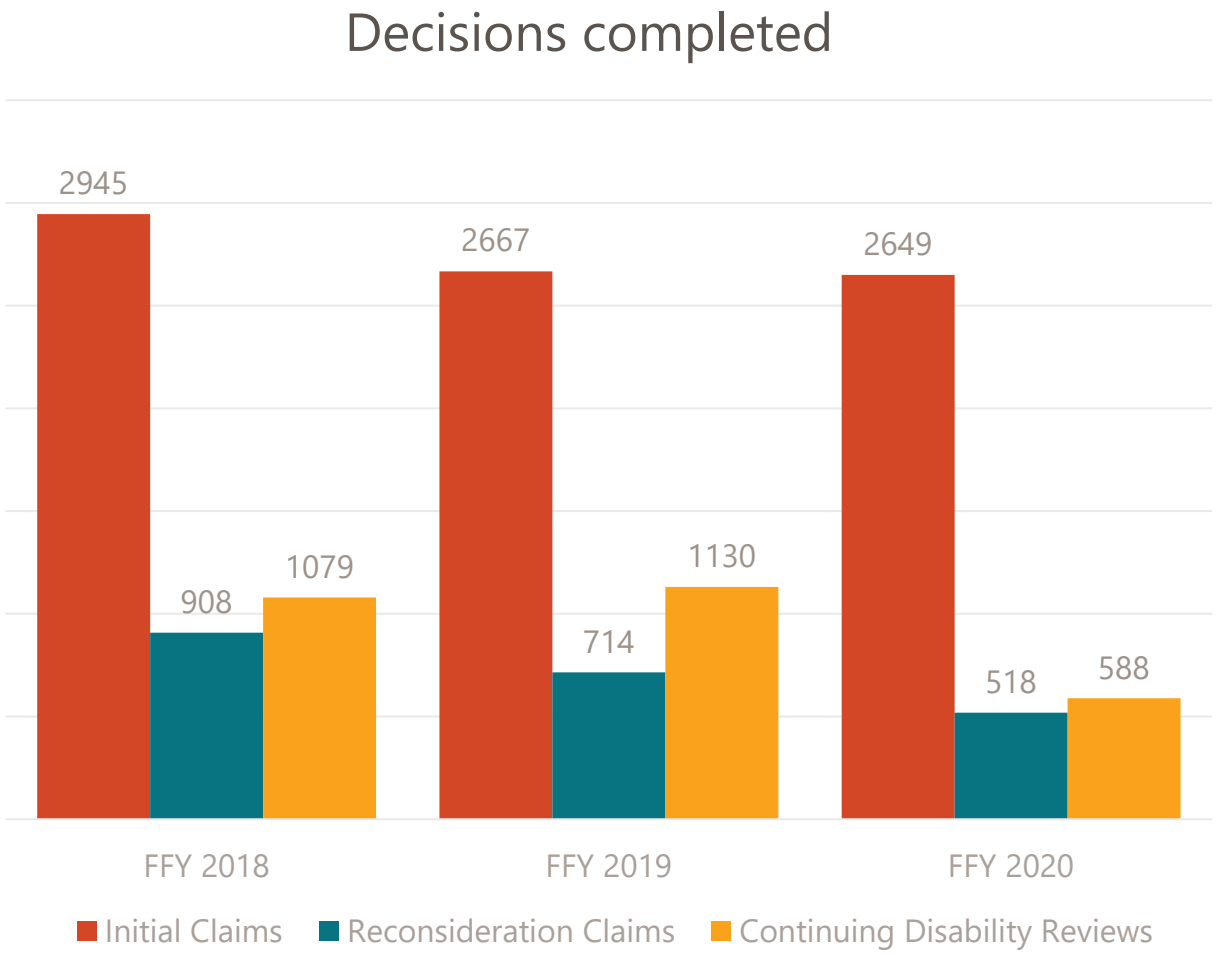
The Council advocates for policy changes that promote choice, independence, productivity and inclusion for all North Dakotans with developmental disabilities. The Council provides funding for and supports projects and activities that maximize opportunities in these areas for consumers and families.



SSDI DETERMINATIONS AND PAYMENTS
Disability Determination Services

$17.5 million
monthly SSDI payments
(Sept 2020)
Social Security Disability Payments

$4.1 million
Monthly SSI payments to
blind/disabled residents
(Sept 2020)
Supplemental Security Income



VOCATIONAL REHABILITATION DIVISION
Program Purpose

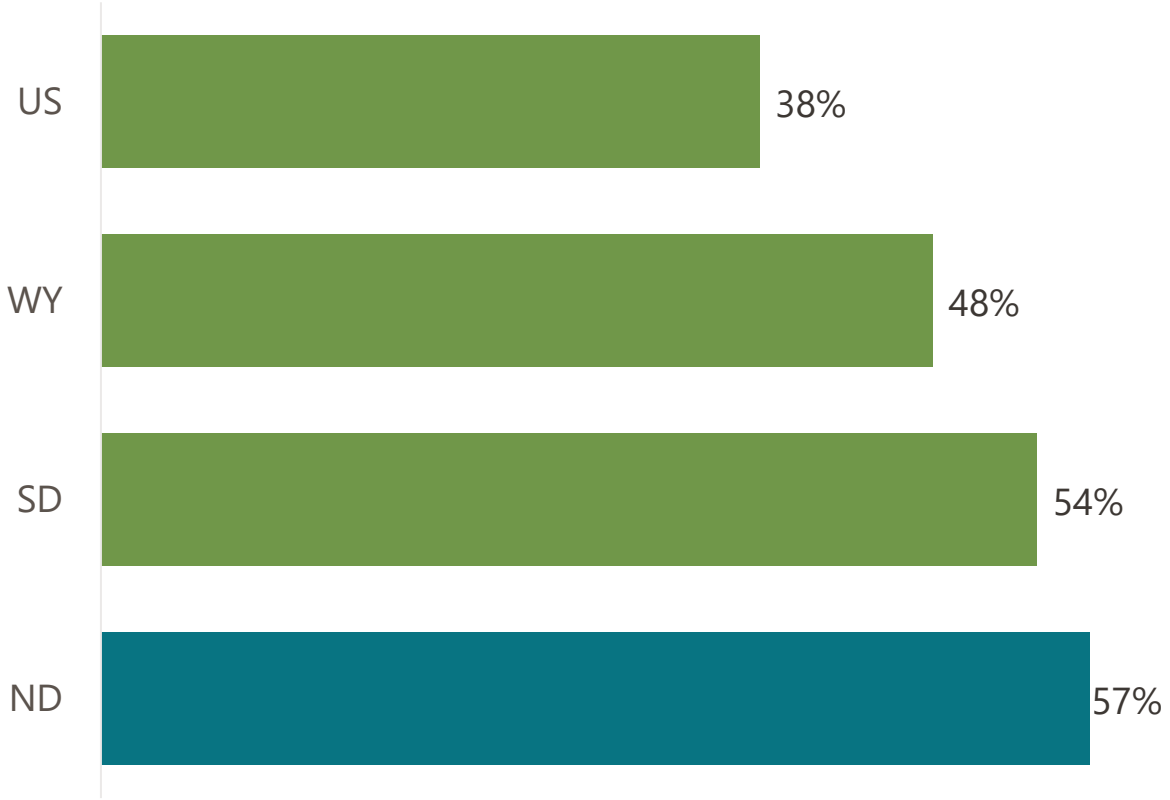
Assists North Dakotans with disabilities to enter or re-enter the workforce through individualized services

- Assess skills and abilities
- Identify a vocational goal
- Develop an individualized plan to achieve employment
- Provide services that result in competitive integrated employment

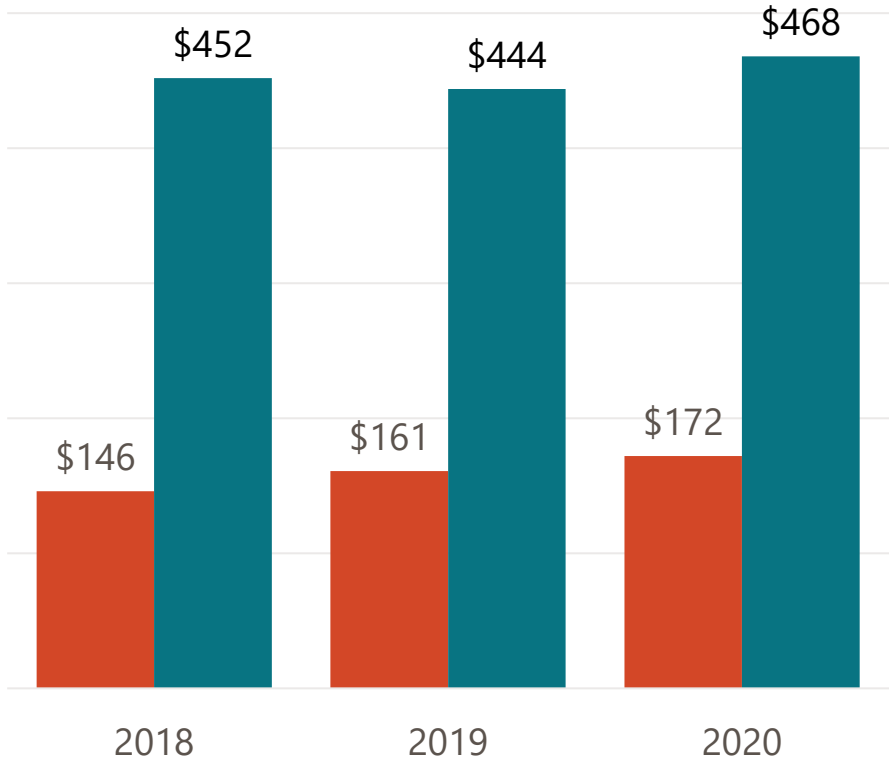


VOCATIONAL REHABILITATION DIVISION
What's driving us

ND is 1st in the US in terms of % of people with disabilities who are employed



Average Weekly Wage of VR Clients at Application vs. Placement

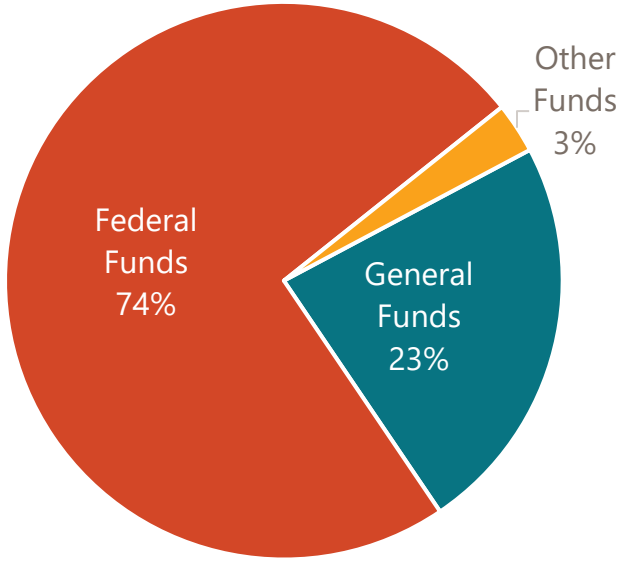




Vocational Rehab Budget Summary

19-21 Budget	**$31,853,039**	**85.0 FTE**
21-23 Budget (exec)	**$30,528,323**	**85.0 FTE**
21-23 Budget (House)	**$32,420,755**	**85.0 FTE**

- Restoration of grant to recreational facility and to Centers for Independent Living
- Operating efficiencies related to travel and occupancy



CHILD SUPPORT
Program Purpose

The purpose of the Child Support program is to help parents meet the needs of their children by securing appropriate and sustainable child support.



CHILD SUPPORT
Return on Investment

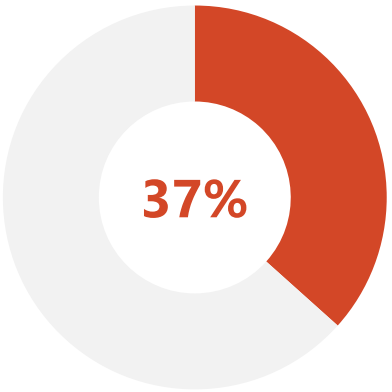
Every **$1.00 spent** on Child Support generated **$6.58 for family recipients**

Every **$1.00 in state General Funds spent** on Child Support generates **$20.00 in support for family** recipients



CHILD SUPPORT
Who we serve

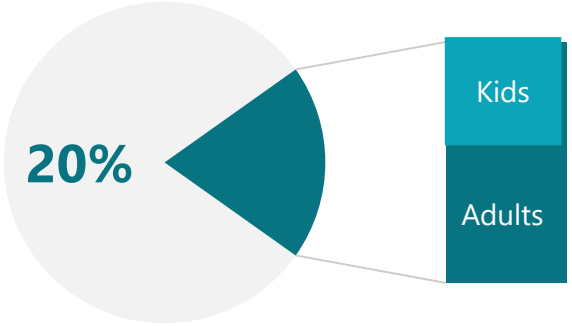
65,999



1 in 3 ND kids

In 2020, 65,999 children received child support services. That is more than 1 of every 3 children under age 18 in the state.

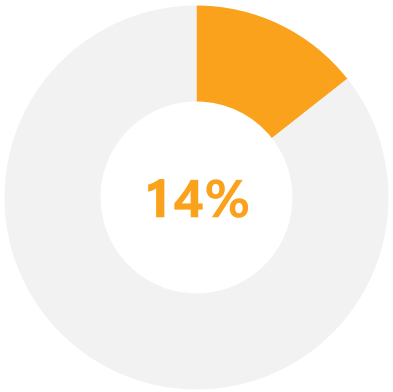
149,720



1 in 5 North Dakotans

149,720 people received child support services in North Dakota in 2020.

83,721



1 in 7 ND adults

In 2020, 83,721 parents received child support services. That means 1 of every 7 adults (age 18+) in the state has a connection to the child support division.

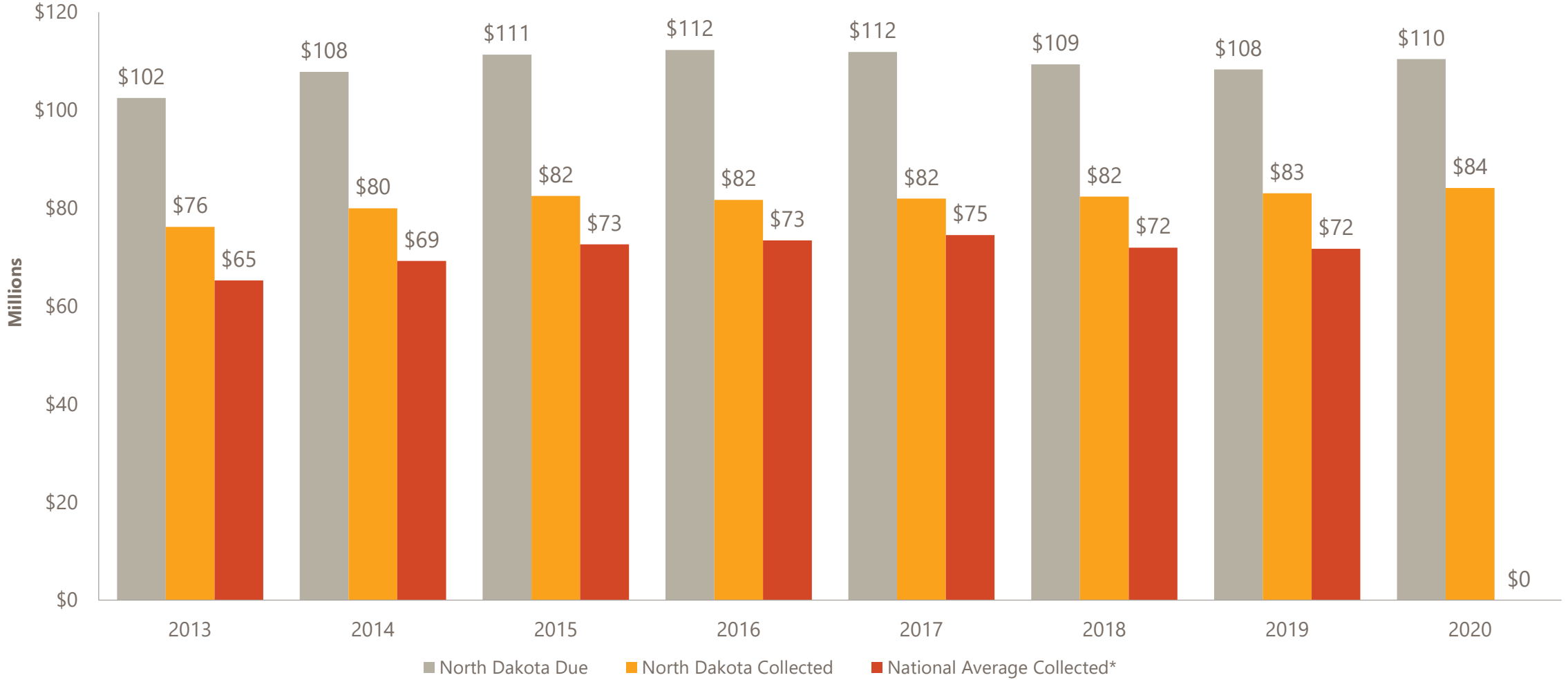
CHILD SUPPORT DIVISION

Supporting Family Stability & Economic Health

When child support is received, a child is able to grow up in a more secure and stable environment.



ND CHILD SUPPORT COLLECTIONS TYPICALLY EXCEED NATIONAL AVERAGES BY ABOUT 10%



	2013	2014	2015	2016	2017	2018	2019	2020
North Dakota	74.3%	74.2%	74.1%	72.8%	73.2%	75.3%	76.7%	76.2%
National Average	63.7%	64.2%	65.2%	65.4%	66.6%	65.8%	66.2%	N/A

**National average performance applied to North Dakota's current support due.*

CHILD SUPPORT
Supporting Family Stability & Economic Health

18,000

More than 18,000 families who are owed child support are not receiving the program's services

$25 million

More than $25 million in child support per year is not received in the month when it is due

$250 million

More than $250 million is owed in past-due support in full-service cases and nearly $400 million total in all cases



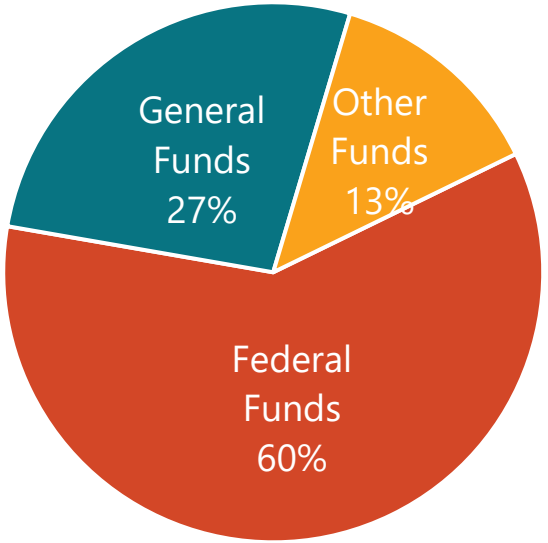
Child Support Budget Summary

19-21 Budget	**$29,805,507**	**157.7 FTE**
21-23 Budget (exec)	**$30,539,102**	**157.7 FTE**
21-23 Budget (House)	**$30,477,361**	**157.7 FTE**

- Operating efficiencies related to travel and occupancy

NOTE:

SB2002 includes shift in responsibility for entry of various child support information into the shared computer system from Clerks of Court to Child Support. Requesting consideration of DHS need for resources to accept responsibility for the work.



ECONOMIC ASSISTANCE

Program Purpose

The Economic Assistance team **helps** lower income **North Dakotans when they are struggling to make ends meet** by **connecting** them **to resources** that can **help meet** their **basic needs**, **preventing** greater and more damaging **crises.**



ECONOMIC ASSISTANCE
Federal Programs



Child Care Assistance Program (CCAP)



Low-Income Home Energy Assistance Program (LIHEAP)



Supplemental Nutrition Assistance Program (SNAP)



Temporary Assistance for Needy Families (TANF) Program

ECONOMIC ASSISTANCE
What We Do

Program Administration

- Federal Compliance
- State Plan
- State Law & Administrative Rules
- Federal Reporting
- Federal & State Agreements

Eligibility System Support

- Program and Policy Support
- Training
- Benefit Issuance
- Integrated Eligibility System Development and Maintenance

Program Integrity and Performance

- Program Monitoring
- Federal and State Quality Reviews
- Federal and State Audits
- Performance Improvement

Connecting North Dakotans to economic assistance is a partnership

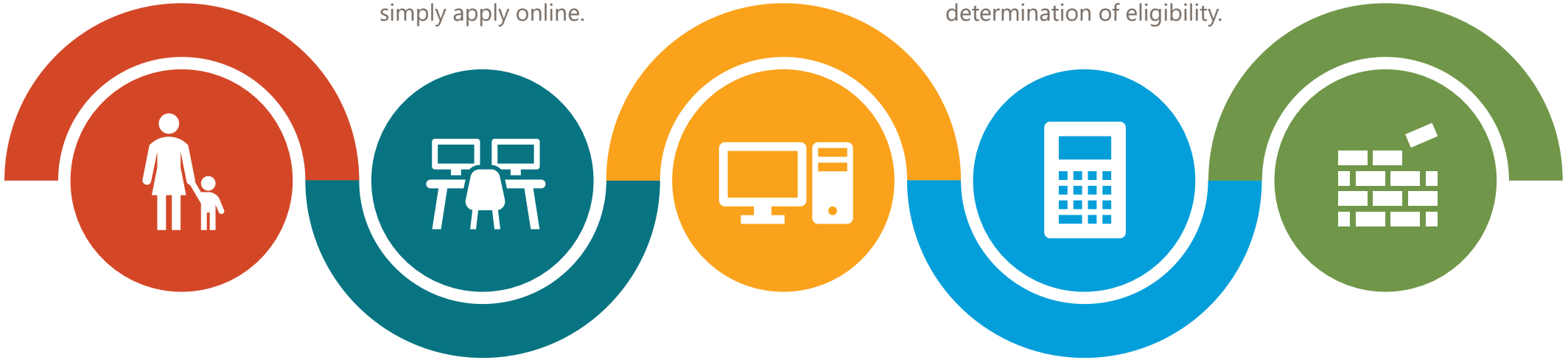
The state and Human Service Zones work together to deliver help to low and moderate-income families

Contact Human Service Zone

The local applicant can contact their human service zone directly or they can simply apply online.

Determine eligibility

An eligibility worker will review the information, reach out if needed, and make a determination of eligibility.



Person decides to apply

Making ends meet is getting more difficult every month so the applicant makes the decision to reach out for help.

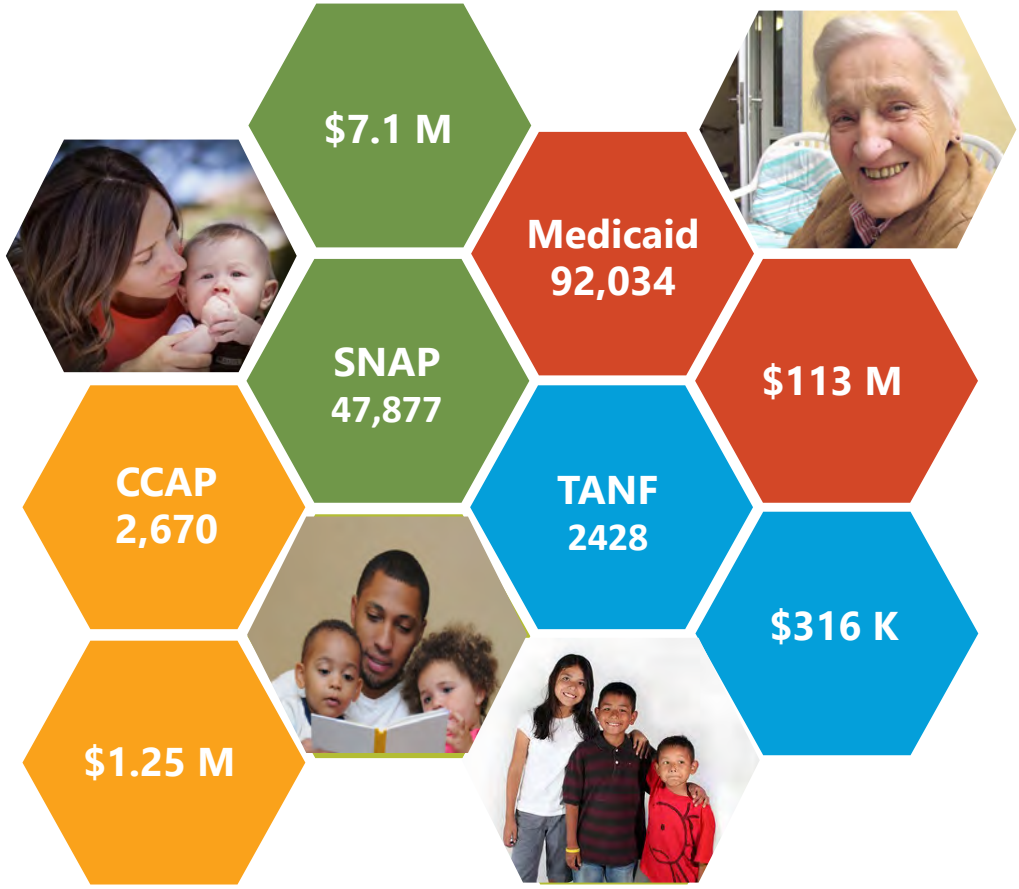
Gather information

The applicant can enter as much info as they can in the SPACES self-service portal.

Issue benefits

If the applicant is eligible to receive assistance, the state will issue the benefit in the appropriate manner.

140,000 - 150,000 North Dakotans utilize SPACES to access economic assistance in North Dakota each year



Average Monthly Individuals/Benefits (FY20)

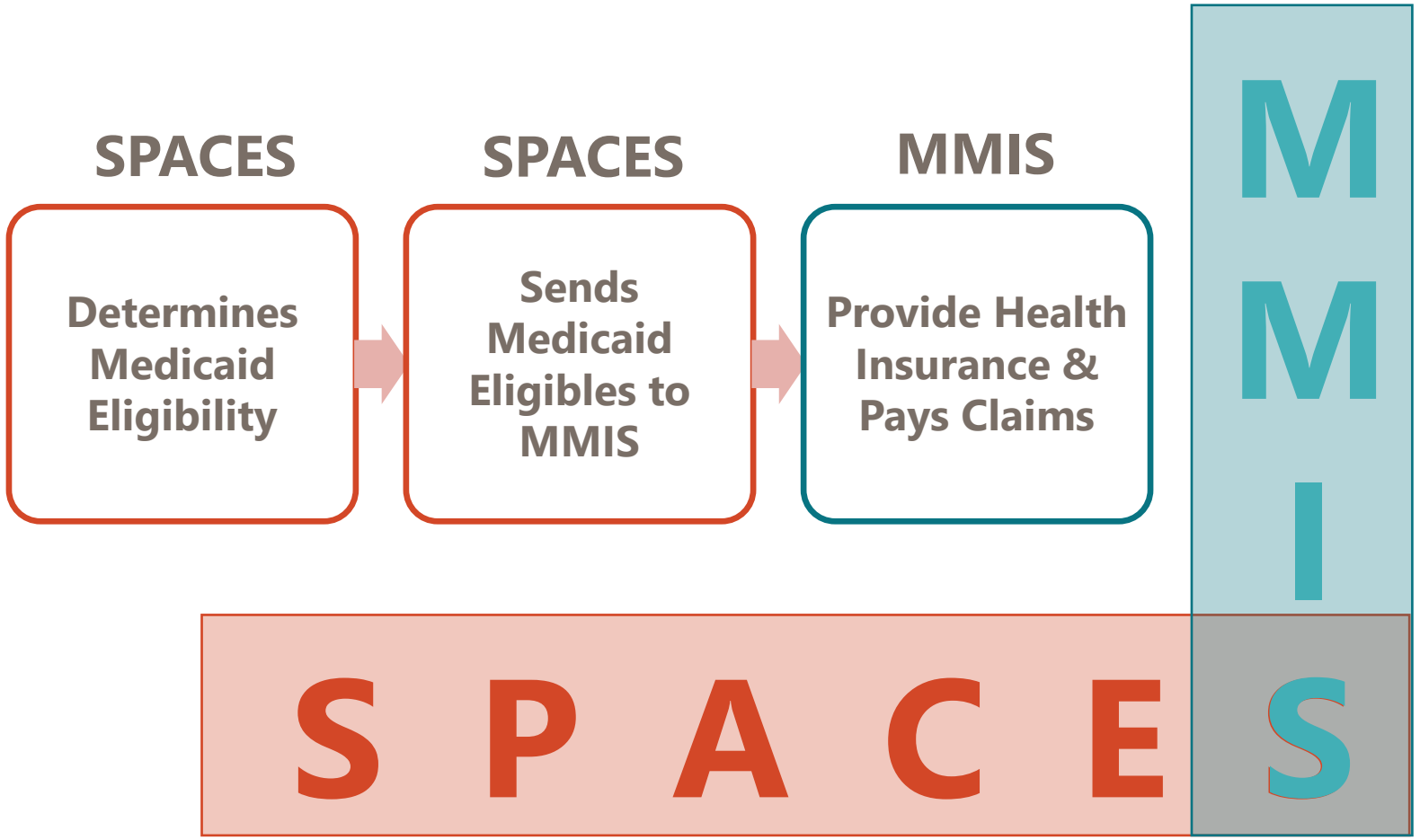
M 119,763 people in 68,287 households have a Medicaid record in SPACES

S 73,262 people in 34,795 households have a SNAP record in SPACES

T 5,124 people in 1,981 households have a TANF record in SPACES

C 4,946 people in 2,960 households have a CCAP record in SPACES

Two major technology platforms work together to connect low-income North Dakotans to resources



SPACES **interfaces with more than 50 systems**, including:

- Child Support
- Social Security
- Vital Records
- IRS
- EBT & EPC Systems
- ND PeopleSoft

145,000

North Dakotans

$1,472,000,000

Economic Assistance

ECONOMIC ASSISTANCE

State Median Income for ND households 2020

Many federal assistance programs are designed to help individuals and families who earn less than 60% of State median income (SMI).

60% SMI is roughly equivalent to 200% of the federal poverty level.

	30% SMI		60% SMI		100% SMI	
Household Size	Annual Income	Hourly Wage	Annual Income	Hourly Wage	Annual Income	Hourly Wage
1	$ 15,720	$ 7.56	$ 31,440	$ 15.12	$ 52,400	$ 25.19
2	$ 20,562	$ 9.89	$ 41,124	$ 19.77	$ 68,540	$ 32.95
3	$ 25,398	$ 12.21	$ 50,796	$ 24.42	$ 84,660	$ 40.70
4	$ 30,234	$ 14.54	$ 60,468	$ 29.07	$ 100,780	$ 48.45
5	$ 35,070	$ 16.86	$ 70,140	$ 33.72	$ 116,900	$ 56.20
6	$ 39,912	$ 19.19	$ 79,824	$ 38.38	$ 133,040	$ 63.96
7	$ 40,818	$ 19.62	$ 81,636	$ 39.25	$ 136,060	$ 65.41
8	$ 41,724	$ 20.06	$ 83,448	$ 40.12	$ 139,080	$ 66.87

Hourly wage based on assumption of 2,080 hours of work / year (full time equivalent)

EVERY OCCUPATION HAS A DIFFERENT EARNING PROFILE, WHICH HELPS US UNDERSTAND WHO MAY BE ELIGIBLE FOR ASSISTANCE

Sampling of occupations by average wage (2019)







Less than $12 / hr	$12 - $20 / hour	$20 - $28 / hour	$28 - $35 / hour
Waiter/Waitress	Pharmacy tech	Carpenter	School counselor
Child care worker	Home health	Loan processor	Rotary drill oper
Dishwasher	PT assistant	Legal secretary	HR specialist
Bartender	Hair stylist	Correctional officers	Accountant
Cafeteria worker	Retail	Auto service tech	Real Estate Sales
Short order cook	Farmworker	Surgical tech	PR specialist
Cashiers	Restaurant cook	Roofer	Counselor
Clerical assistant	Data entry	Lic Practical Nurse	Registered Nurse
Personal care aide	EMTs & paramedics	Dental assistant	Computer network specialist
	Carpet installers	Firefighter	Construction supervisor
	Maintenance workers	Surgical assistant	Dental hygienist
	Nursing assistant	Clergy	Architecture occ
	Laborer	Social worker	Speech pathologist
	Substitute teacher	Police	
	Office/accounting clerk	Hotel manager	
	Light truck driver	Roustabout	
	Extraction helper	Heavy truck driver	

ECONOMIC ASSISTANCE

Child Care Assistance Program (CCAP)

CCAP helps pay a portion of the **cost of childcare** for working families or families in training or education programs.

Families can earn up to **60% of state median income** and be eligible for assistance.



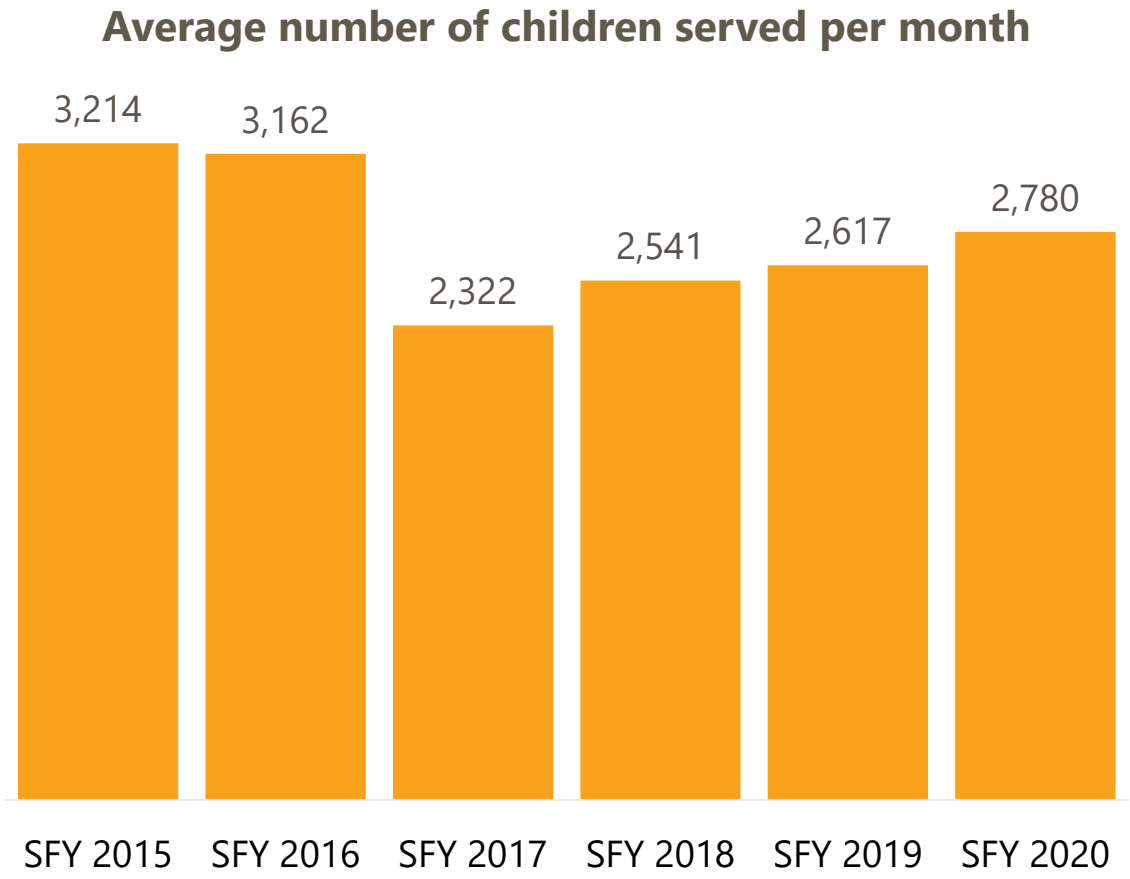
ECONOMIC ASSISTANCE
Child Care Assistance Program (CCAP)

2,780
Average number of children served per month

$1.3 million
Support to families

$466
Average payment per child per month

SFY2020

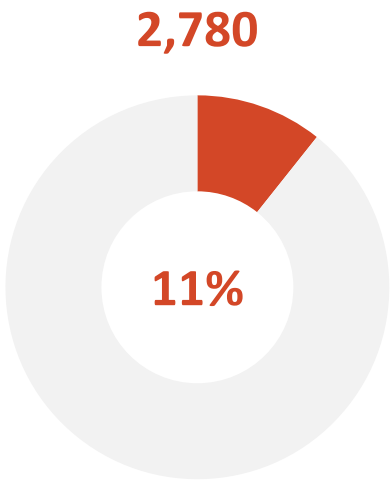


ECONOMIC ASSISTANCE
Child Care Assistance

73%

Parents in workforce

73% of the 44,237 North Dakota households who have children younger than age 5 likely have at least some need for child care as all available parents are in the workforce



1 in 10 eligible children

26,000 ND children age 13 or younger live in households where parent earnings are less than 200% of the federal poverty level. 2,780 children (**11% of** potentially **eligible**) are **currently served** by CCAP in our state.

40,769

7% receive CCAP

1,500+ approved child care providers are licensed to serve 40,769 children each year. In 2020, an average of 2,780 of those licensed slots served children who received assistance

ECONOMIC ASSISTANCE

Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP helps households with **home heating costs** by paying a portion of their heating bills, **and** with **improving** their home's overall **energy efficiency**.

Families can earn up to **60% of state median income** and be eligible for assistance.



ECONOMIC ASSISTANCE

Low Income Home Energy Assistance Program (LIHEAP)

12,785

Households served last heating season

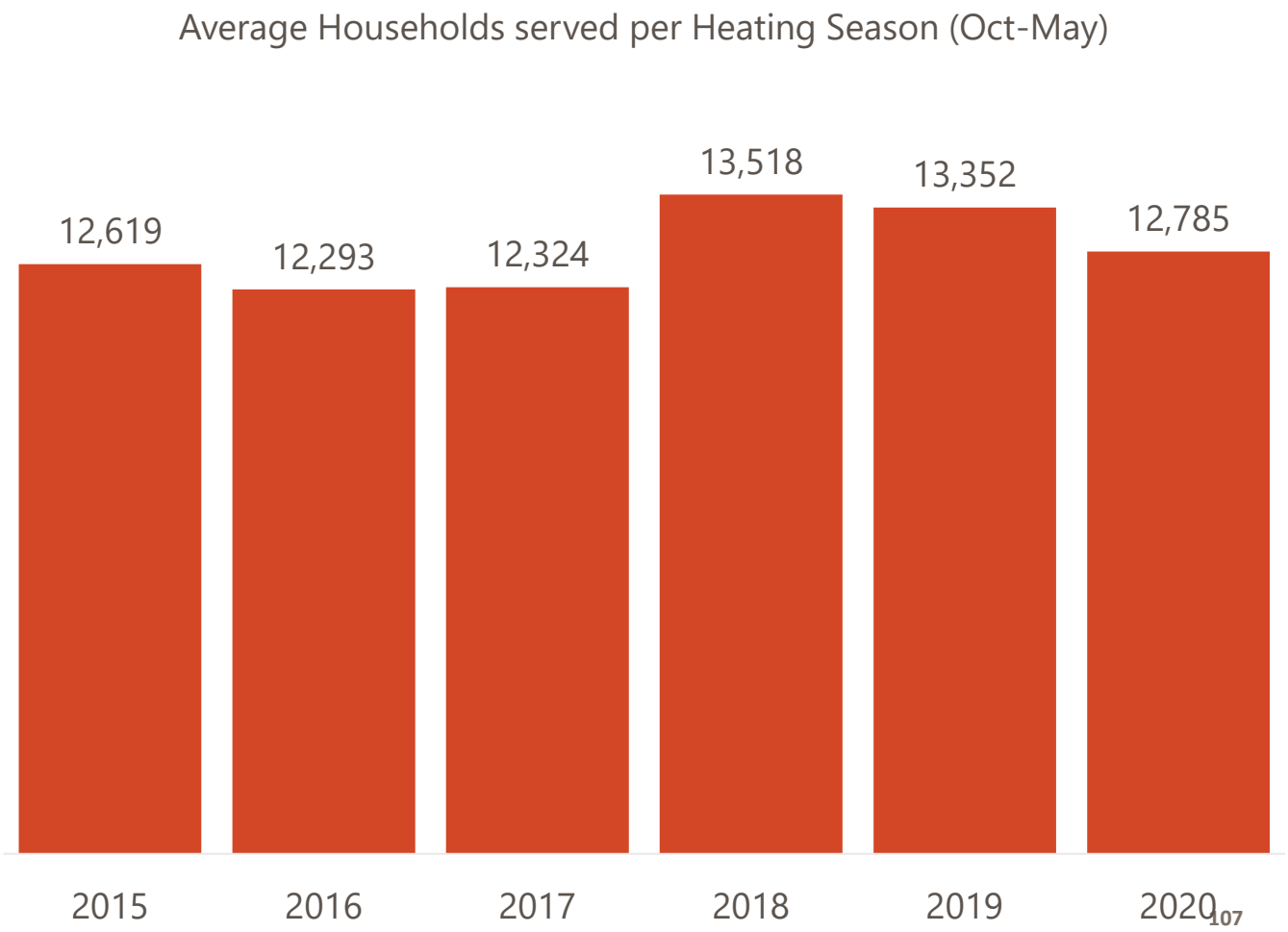
$12 million

Support to households

$930

Average payment per household per heating season

SFY2020



ECONOMIC ASSISTANCE

Supplemental Nutrition Assistance Program (SNAP)

Provides nutrition benefits to supplement the food budget of lower income families so they can purchase healthy food and move towards self-sufficiency

Families can earn up to **60% of state median income** and be eligible for assistance.



ECONOMIC ASSISTANCE

Supplemental Nutrition Assistance Program (SNAP)

520

SNAP is a partnership

520 retailers in North Dakota are authorized to accept SNAP payments from eligible households

$1.00→$1.54

Local economies benefit

Beyond helping families gain access to nutritious food, SNAP offers local economic benefits as well. Each $1.00 in SNAP generates $1.54 in local economic activity.

1/3

Boosting family food budgets

SNAP provides nutrition assistance to people of all ages and circumstances.

36% - children under 18

35% - aged or disabled

35% - have earned income

ECONOMIC ASSISTANCE

Supplemental Nutrition Assistance Program (SNAP)

48,323

Average number of individuals in served in 23,178 households

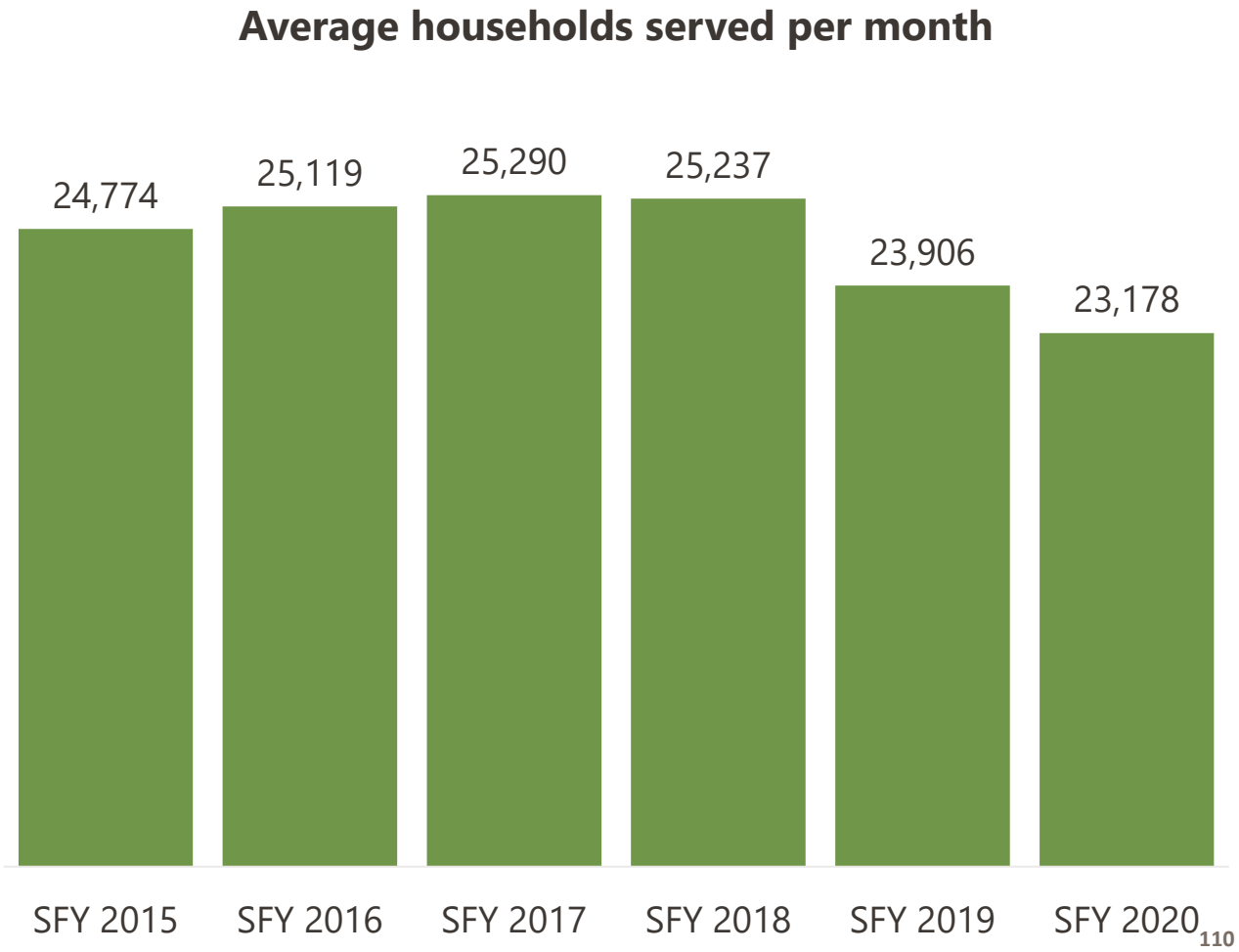
$6.5 million

Support to households

$280

Average payment per household per month

SFY2020



ECONOMIC ASSISTANCE

Temporary Assistance to Needy Families (TANF)

TANF provides assistance to needy families with children who are deprived of parental support or care.

Which means that a parent is absent due to divorce, separation, death or one or both parents are aged or disabled.



ECONOMIC ASSISTANCE
Temporary Assistance to Needy Families (TANF)

945

Average number of families served per month

81%

Of beneficiaries are children

52%

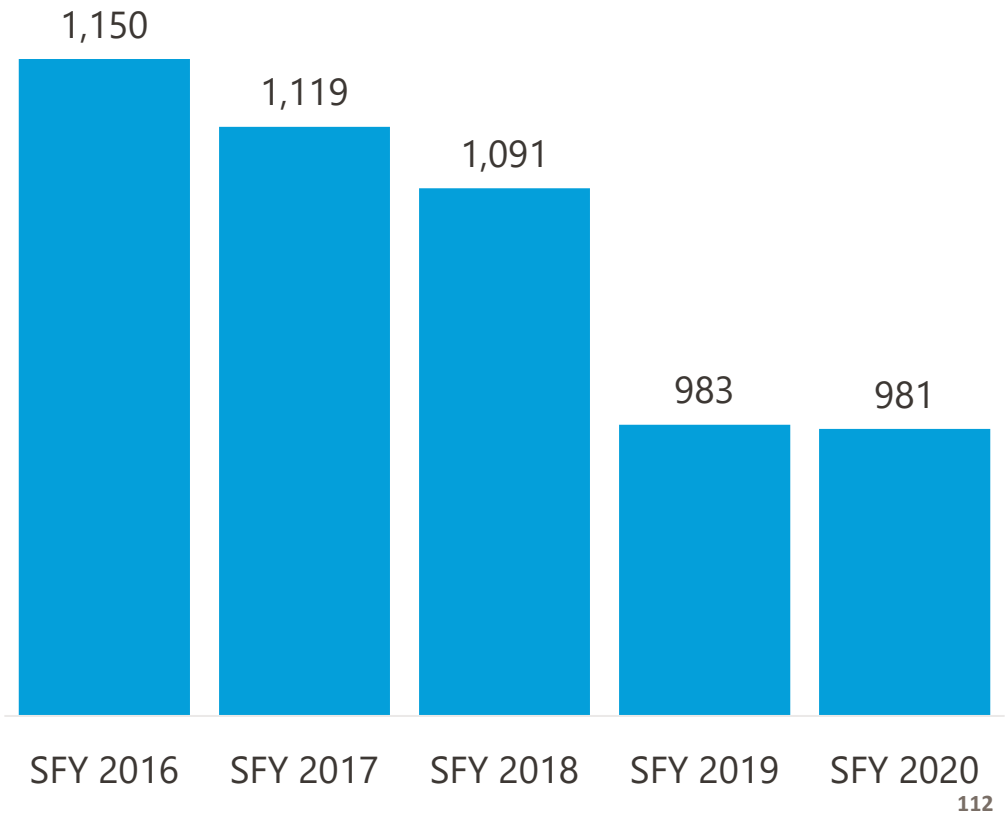
Of ND TANF cases are child only cases (children in the care of a non legally responsible caretaker)

$297

Average benefit per family per month

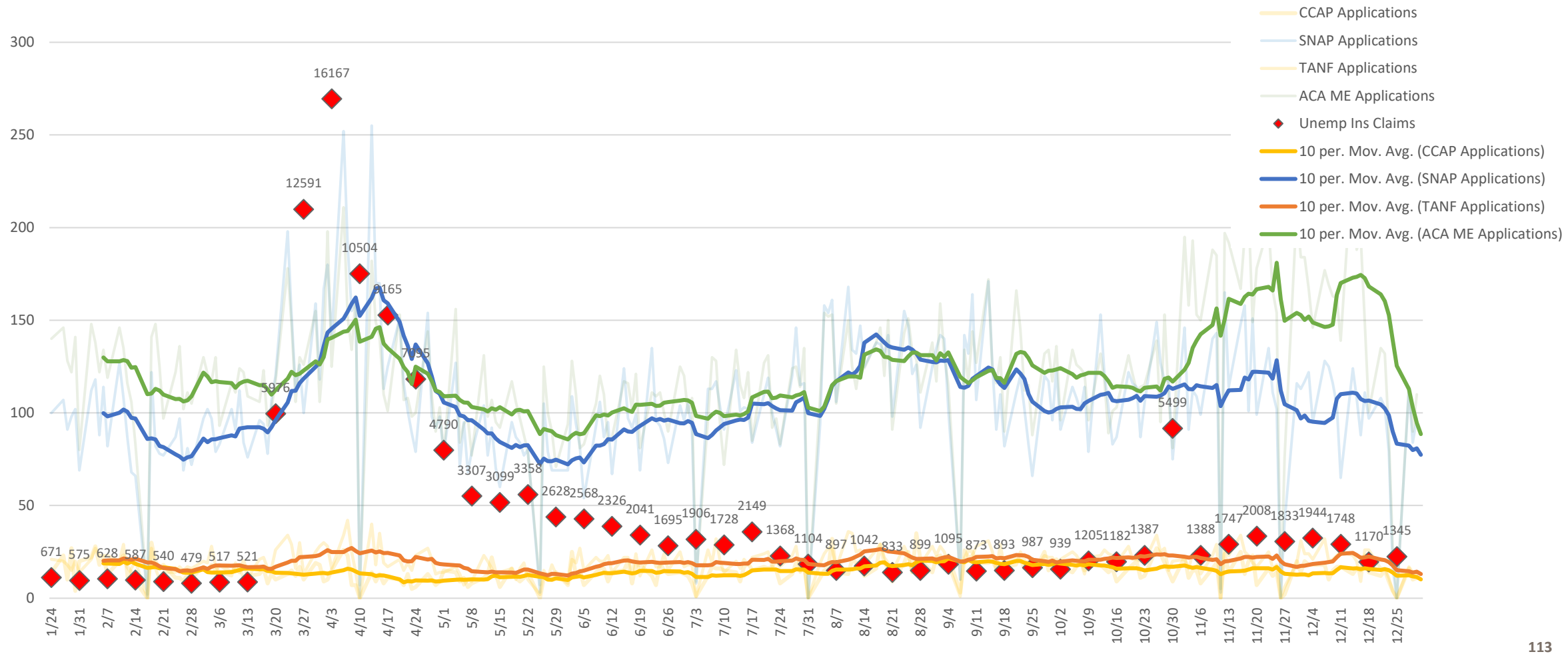
SFY2020

Average households served per month



ECONOMIC ASSISTANCE APPLICATIONS DURING 2020

Daily applications remained above pre-COVID levels throughout 2020 with peaks in April, August and November/December



ECONOMIC ASSISTANCE

COVID 19 - Emergency Food and Energy Assistance

Pandemic EBT (P-EBT)

- Issued SNAP benefits to children eligible for free or reduced-price school meals who did not receive those meals due to school closure.
- Delivered info to families in partnership with DPI.
- Approximately 36,750 children received $9.5 million in SNAP benefits due to COVID school closure March-May 2020.

$9.5 million

SNAP Emergency Assistance

- Provides the maximum SNAP benefit to all SNAP eligible household starting in March 2020.
- An average of 15,000 households receive $2.6 million in additional benefits per month.
- Optional program benefit is authorized each month by USDA FNS.

$26 million

Pandemic LIHEAP (P-LIHEAP)

- Provided one-time help with the cost of electric utility bills for qualifying households.
- Payments were issued directly to participants' electric utility providers.
- Assistance available to households eligible in 2019-20 heating season
- Assisted 6,500 households as of 12-31-20

$3 million

ECONOMIC ASSISTANCE

COVID 19 - Child Care Assistance Program (CCAP)

- Allowed for more than 40 absence hours per month due to illness, quarantine and provider closures
- Allowed families to maintain eligibility as they were seeking employment (both at application and re-review)
- Extended payment request deadlines and aligned with Child Care Emergency Operating Grant (CEOG)



ECONOMIC ASSISTANCE

COVID 19 - SNAP Enhancement Grants

Grant program to help ND grocers update their point-of-sale systems and websites to enable online and by-phone ordering and delivery, improving access to food for both SNAP beneficiaries and community residents

Through Dec 2020 assisted grocery stores with system upgrades in:

- Minot
- Ruthville
- Mohall
- Newtown
- Michigan
- Scranton



ECONOMIC ASSISTANCE

COVID 19 - Emergency Rent Bridge (ERB)

1,410

Rental assistance to 1,500 households in 33 counties

$520

Average amount of rental assistance per household per month

$2.9 million

Total CRF funds distributed through 12-31 for ERB, paid to 486 housing providers



FEDERAL **CARES ACT** FUNDS AVAILABLE THROUGH DHS FOR COVID RESPONSE

Topical summary of emergency assistance to support basic needs (thru 12/21/20)

Child Care

Child Care Em Op Grnt	$48.9 MM (CRF)
Child Care Assistance	$6 MM (CCDBG-CV)

Behavioral Health

Mental Health Grant	$2 MM (SAMHSA)
Crisis Counseling	$1.1MM (SAMHSA)
Community BH	$1.7 MM (CRF)
HSC/Rural	$3.5 MM

Food Assistance

P-EBT	$10 MM (USDA-CV)
P-SNAP	$25.7 MM (USDA FNS)
Sr Meals	$3.6 MM (OAA-CV)
Sr Meals	$1.1 MM (CRF)
Food Bank	$430k (FEMA)

Housing

ERB	$2.9 MM (CRF)
Homeless Coord	$
Rent Assistance	$6.5 MM (CDBG-CV)

Energy Assistance

P-LIHEAP	$5.2 MM (ACF)

Child Welfare

IV-E FMAP	$2.5 MM (ACF)
Violence Prev	$80k
CW Svcs	$76k

Medical Services

FMAP	$85 MM (CMS)
Family caregiver	$500k

Aging Services

Fam Caregiver	$500k
ADRL ACL	$305k
Supportive svc	$1 MM
Ombudsman	$100k
Sr Employ	$889k (SECEP)
SNF Air Pur	$2.6 MM (CRF)

Ops & PPE

Connect Karts	$100k (CRF)
QSP PPE	$50k (CRF)
SNAP Access	$250k (CRF)
Data tools/Ops	$3.5 MM (CRF)

Total Available	**$215,678,868**
Total Spent	**$142,181,611**
(thru 12/21/20)	

FEDERAL **CRRSA** FUNDS TO BECOME AVAILABLE FOR COVID -19 RESPONSE VIA HB1394

Federal Pandemic Relief Bill (CRRSA) signed 12-27-20

Child Care

- Child Care Assistance Program through (CCDBG via ACF/HHS) - $19,448,230

Housing

- Rental Assistance (US Treasury) - $200,000,000
- Low Income Household Water Assistance (OCS/ACF/HHS) - $

Food Assistance

- P-EBT (for families eligible for free or reduced lunch in school) (SNAP via FNS/USDA) - $32,500,000
- Enhanced SNAP benefit eligibility (SNAP via FNS/USDA) - $33,600,000
- P-SNAP Increased benefit (SNAP via FNS/USDA) - $14,400,000

Aging Services

- Supportive services (OAA via ACL/HHS) - $840,000
- Long term care Ombudsman (ACL/HHS) - $20,000
- Adult Protective Services (ACL/HHS) - $704,100

Child Welfare

- Chafee Foster Care / Successful Transitions to Adulthood (ACF/HHS) - $1,391,000
- Safe Stable Families (ACF/HHS) - $90,000

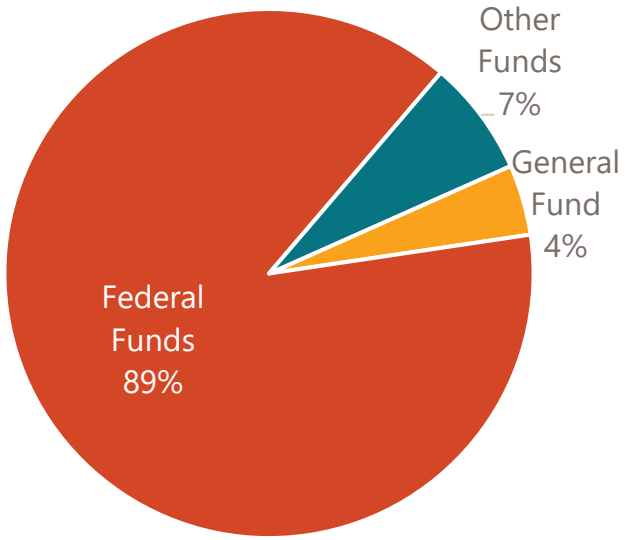
+ Behavioral Health
+ FMAP



Economic Assistance Budget Summary

19-21 Budget	**$259,846,264**	**39.80 FTE**
21-23 Budget (exec)	**$274,998,084**	**39.80 FTE**
21-23 Budget (House)	**$274,960,587**	**39.80 FTE**

- Administer federal COVID relief funds for low and moderate-income households
- Integrate department's housing assistance initiatives into the administration of economic assistance resources

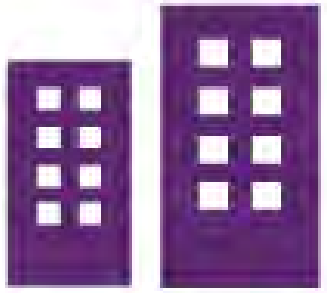


SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.



Childhood experiences



Housing



Education



Social support



Family income



Employment



Our communities



Access to health services

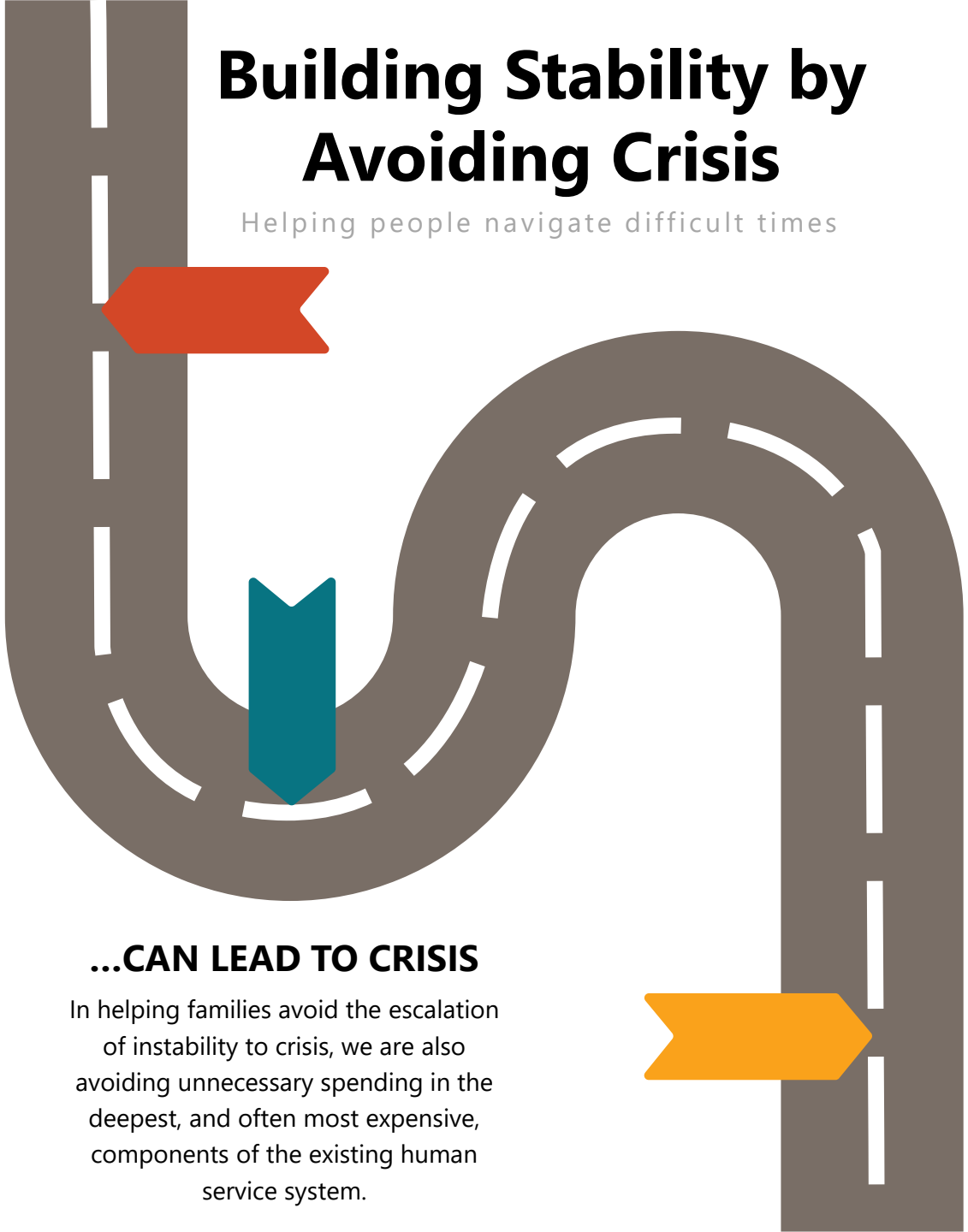
Source: NHS Health Scotland

Building Stability by Avoiding Crisis

Helping people navigate difficult times

DISRUPTION

When families experience disruption, their ability to be a fully engaged, productive member of the community and the workforce is compromised.



...CAN LEAD TO CRISIS

In helping families avoid the escalation of instability to crisis, we are also avoiding unnecessary spending in the deepest, and often most expensive, components of the existing human service system.

SERVICES SUPPORT STABILITY

Intervening early will both save money and strengthen families. It will allow us to reserve deep end services for the times when they are truly needed, and help people avoid deepening their journey into crisis by diverting from institutions, keeping families together, and helping and sure that people have a place to call home.

Return
On
Investment





Contact Information

Cory Pedersen, Children & Family Services

Tina Bay, Developmental Disabilities Division

Nancy Nikolas-Maier, Aging & Adult Services

Julie Horntvedt, Developmental Disabilities Council

Sheri Seil, Disability Determination Services

Damian Schlinger, Vocational Rehabilitation

Jim Fleming, Child Support Division

Michele Gee, Economic Assistance



2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/11/2021 PM
Senate Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the hearing at 1:53 PM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern. Senators Poolman and Heckaman were absent.**

Discussion Topics:

- Cost of inflation consequences
- Guardianship services

Amber Moen, Devils Lake, ND (mother has Alzheimer's) – testified in favor and submitted testimony #8670.

Brian Arett, Executive Director, Valley Senior Services, Inc. Fargo, ND – testified in favor and submitted testimony #8608 and #8609.

Christine Webster, Bismarck, ND – testified in favor and submitted testimony #8453.

Nikki Wegner, Manager, Alzheimer's Association, Mandan, ND – testified in favor and submitted testimony #8699, #8698, and #8690.

Tom Newberger, CEO, Red River Human Services Foundation, Fargo, West Fargo and Wahpeton, ND – testified in favor and submitted testimony #8753.

Scott Anderson, Program Service Director, Development Homes, Inc., Grand Forks – testified in favor and submitted testimony #8819.

Lorena Poppe, CEO, Poppy's Promise, Bismarck, ND – testified in favor and submitted testimony #8752.

Jon Larson, CEO, Enable, Inc. Bismarck, ND – testified in favor and submitted testimony #8749.

Pam Mack, Director of Program Services, Protection and Advocacy Project – testified in favor and submitted testimony #8653.

Josh Askvig, State Director, AARP ND – testified in favor and submitted testimony #8808 and #8809.

Roxane Romanick, Executive Director, Designer Genes of ND, **Inc.** – testified in favor and submitted testimony #8723.

Kirsten Dvorak, Executive Director, The Arc of ND – testified in favor and submitted testimony #8729.

Scott Burlingame, Executive Director, Independence, Inc. – testified in favor and submitted testimony #8852.

Bruce Murry, Exec Director, ND Association of Community Providers – provided testimony #8748.

Donene Feist, Director, Family Voices of ND, Edgeley, ND – testified in favor and submitted testimony #8523, #8524, #8525.

Jackie Long, Community Living resident, Fargo, ND – testified in favor and submitted testimony #8410.

Jackie Krei, Community Living resident, Fargo, ND - testified in favor and submitted testimony # 8414

Brooke Austin, CEO, Community Living Services, Fargo, ND – testified in favor and submitted testimony #8674.

Donna Byzewski, Guardianship Division, Catholic Charities – testified in favor and submitted testimony #8697.

Allan Peterson, testified in favor and submitted testimony #8877

Additional written testimony: #7751, #7752, #7753, #7754, #7847, #7864, #8228, #8263, #8375, #8423, #8425, #8567, #8621, #8680, #8693, #8731, #8735, #8751, #8782, #8835, #8836, #8837, #8838, #8851.

Senator Holmberg closed the hearing at 4:08 PM.

Rose Laning, Committee Clerk

Testimony
House Bill 1012 – Amber Moen, Devils Lake, North Dakota
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 11, 2021



Mister Chair and members of the committee, my name is Amber Moen, and I am from Devils Lake, North Dakota. I was a caregiver for 7 years for my mother who had Early Onset Alzheimer's.

My mother's name is Susan. Growing up, she was just your average mom. She somehow found the perfect balance of parent and friend, being just strict enough but always there for you if you needed someone. She ran an in-home daycare for 17 years while also raising my younger sister and myself. She was creative and artistic, often working on beautiful cross stitching's that she would donate and were always a high-priced item at our Catholic School fundraisers. She had so many wonderful qualities about her, her laugh was infectious, and her strong Catholic faith guided her through the most difficult times in her life.

In 2008, we celebrated her 50th birthday, I had turned 21 and my sister graduated from high school. It was also that year that she confided in me that something wasn't quite right. She was losing her speech. It started gradually but was getting noticeably worse. Her handwriting and the ability to do simple math was also declining. As a business owner and caregiver for small children she was genuinely concerned. It was this phone call that would begin our 2-year journey of trying to figure out what was going on.

By the time 2010 came, she could hardly speak. We had tried everything. We were referred to Mayo Clinic in Rochester. After 2 weeklong stays and 1 follow up visit, we received the diagnosis of Early Onset Alzheimer's Disease. She was 52 years old.

After that, we went home. We didn't know what to do next. My parents were divorced and with my sister and I both trying to find our own paths in life, my mother was living alone trying to process this unbelievable information. She started on medication that would help to slow the progression, but she would never get any of her speech back eventually losing it completely.

In 2011, her disease progressed to the point where she had to close her daycare and stop driving. Realizing she needed more help I decided to move back to Devils Lake to become her primary caregiver. Even though it had been a year since we received her diagnosis, we were still in a sort of limbo. I was trying to figure everything out basically on my own and had no idea where to start. Then one day I heard of an education series being held at the college by the Dementia Care Services Program. It was at this time that I met my care consultant, Ashley who would change things for our family tremendously.

It was Ashley who was finally able to give me some sort of direction. She provided resources on everything from general information about the disease to certain programs that she knew my mom could qualify for. More importantly, she was the support that I needed as a caregiver. She did not live in Devils Lake but was always willing to find time to meet. Through the Dementia Care Services Program, I was able to become a better caregiver which in turn gave my mother a better quality of life.

This is why the Alzheimer's Association is asking you to increase funding, so that more families like mine can receive these critical services. So, we are asking today to increase funding for the Dementia Care Services Program to $1,332,000.

As for my mother, it was decided in 2017 that it would be best to move her into a Memory Care Unit. On January 11, 2018, my mother passed away, 3 days later, I gave birth to my daughter, Finley Sue, who would have been my mother's first grandchild. It is now for my children that I continue to advocate and fight to end this terrible disease.

Thank you so much for taking the time to hear my story today. Please let me know if you have any questions.

Testimony
House Bill 1012 – Department of Human Services
Aging Services Budget
Senate Appropriations
March 11, 2021

Chairman Holmberg and members of the committee, my name is Brian Arett. I am the executive director of Valley Senior Services providing services for senior citizens in the six counties of southeastern North Dakota. I am also a member of the North Dakota Senior Service Providers, an association of agencies that provide Older Americans Act Services to the senior population of this state.

Attached to my testimony is a copy of a booklet entitled Feeding Grandma 2021. This is the fifth booklet in a series that we have provided during the legislative session. Each session we have updated it to provide the most current and in-depth data on senior hunger, how our programs help prevent this from happening in North Dakota and why it is one of the most cost-effective methods for keeping seniors in their homes.

The basic premise behind this booklet is that providing a stable source of healthy, nutrient dense meals is a key factor in successful aging. And because this service is very cost effective - the cost of providing senior

meals for a year equals two days in the hospital or five days in a nursing home - it makes good fiscal sense for our state and for the people we serve.

But the Senior Nutrition Program is so much more than just a meal. At senior centers, it is a chance for our seniors to engage and socialize with other seniors. And our “Meals on Wheels” programs provide meals to our most vulnerable seniors, those that are unable to leave their homes. Home delivered meals also provide our homebound seniors with a daily well-ness check. Many times, this might be the only human contact our seniors have throughout their day. This happens every day in our most rural communities and in our largest cities.

In the state of North Dakota 49% of our seniors live alone, 67% live in rural areas, 61% are women and 20% live in poverty. Inadequate nutrition and /or limited social contact has direct health consequences that affect the healthcare system and the economy.

The agency I work for – Valley Senior Services – provides about 1,400 Meals a day to the seniors of southeastern North Dakota. The average age

of the people we serve is just over 82. For many of the people that we deliver meals to, their only contact with another person during the day is the volunteer making that delivery. We feel that this connection combined with an incredibly healthy meal provides invaluable support that allows many of these people to continue living independently much later in life than they otherwise would. And the partnership that we have with the state of North Dakota through funding provided by the Department of Human Services Aging Services Division is critical in making this happen.

Over the past few sessions, our senior meal programs have had great support from legislators in adding state dollars to the Aging Services budget to work toward our Associations' goal - to have enough combined Federal Title III and State Funds so that ALL senior meals provided by Title III agencies receive the unit rate reimbursement. The $4.60 unit rate reimbursement is NOT intended to cover the full cost of the meal. The total cost, estimated to be $11.02/meal, are covered with participants' program income contributions, required local match, NSIP (Nutrition Services Incentive Program) dollars and additional funds raised locally.

In testimony provided by Nancy Nikolas-Maier, Division Director for the Aging Services Division, she presented a proposed budget for the biennium for Senior Nutrition Services of $12,036,132. A portion of these funds, the NSIP dollars of $1,693,820, are distributed to providers separate from the $4.60/meal reimbursement we receive for the meals we provide to seniors. This leaves a balance of $10,342,312 in funds designed for reimbursement to providers. Her testimony also noted that meal counts increased dramatically during the pandemic and that we served 103,672 meals in the month of November 2020. If we continue to serve that number of meals it would require funding of $11,445,389 to provide reimbursement for every meal served – an increase of $1,103,079 over the budgeted amount. Our first request of this committee is to add this amount to the budget to reimburse providers for every meal served through this program.

It is also important to point out that the unit reimbursement rate of $4.60/meal has not been increased since July of 2015 – a period of six years at the conclusion of the current biennium. At the same time, costs connected to providing this service have grown by 28.3% (from $8.59/meal to $11.02/meal). With that in mind, our second request of this committee is to increase the per meal unit rate to $5.60/meal. This request would

recognize the impact that inflation has on the cost of maintaining this service and would add an additional $2,448,128 for the 2021-23 biennium.

These additional funds will help us to continue to keep up with the growth in demand for our services brought on by the ever-growing senior population. It will also assist us to keep up with rising food costs, and the costs associated with attracting, and retaining the employees required for providing our services.

North Dakota Senior Service Provider agencies are dedicated to making our state the best place possible to grow old. We feel that the State of North Dakota is a natural partner in helping us to accomplish this goal and ask that you add $3,551,207 in state funds to the 2021-23 biennium budget.

Thank you for your time in consideration of this testimony. I would be happy to answer any questions you might have.

8609

Feeding Grandma 2021



A 2021 Legislative Document

Provided by North Dakota
Senior Service Providers (NDSSP)
www.ndseniorservices.org

We Feed Seniors So They Can Remain Healthy and Independent

North Dakota Senior Service Providers (NDSSP) is a group of agencies that provides services to older adults across the entire state of North Dakota. Older Americans Act Title III Nutrition Programs are some of the services we provide. Funding for this program flows to the state from the federal Administration for Community Living and consists of two primary components:

- **Congregate Nutrition Services** - providing nutritious meals for seniors in a social, group setting
- **Home Delivered Nutrition Services** - providing meals for homebound seniors, also known as Home Delivered Meals and Meals on Wheels

This document provides the highlights and updated usage and cost information for Federal Fiscal Year 2019. Research citations for this "Feeding Grandma 2021" document can be found in the "2015 Feeding Grandpa" document available at www.ndseniorservices.org.

Congregate & Home Delivered Meals Are Cost Effective

Many of the chronic health conditions that result in frailty and disability, loss of independence, and reduced quality of life in older adults are preventable through low-cost lifestyle interventions, incorporating proper nutrition and physical activity. Clearly these meals save valuable health and long-term care dollars.



Source: Meals on Wheels America, 2019.

Congregate & Home Delivered Meals Promote Good Health

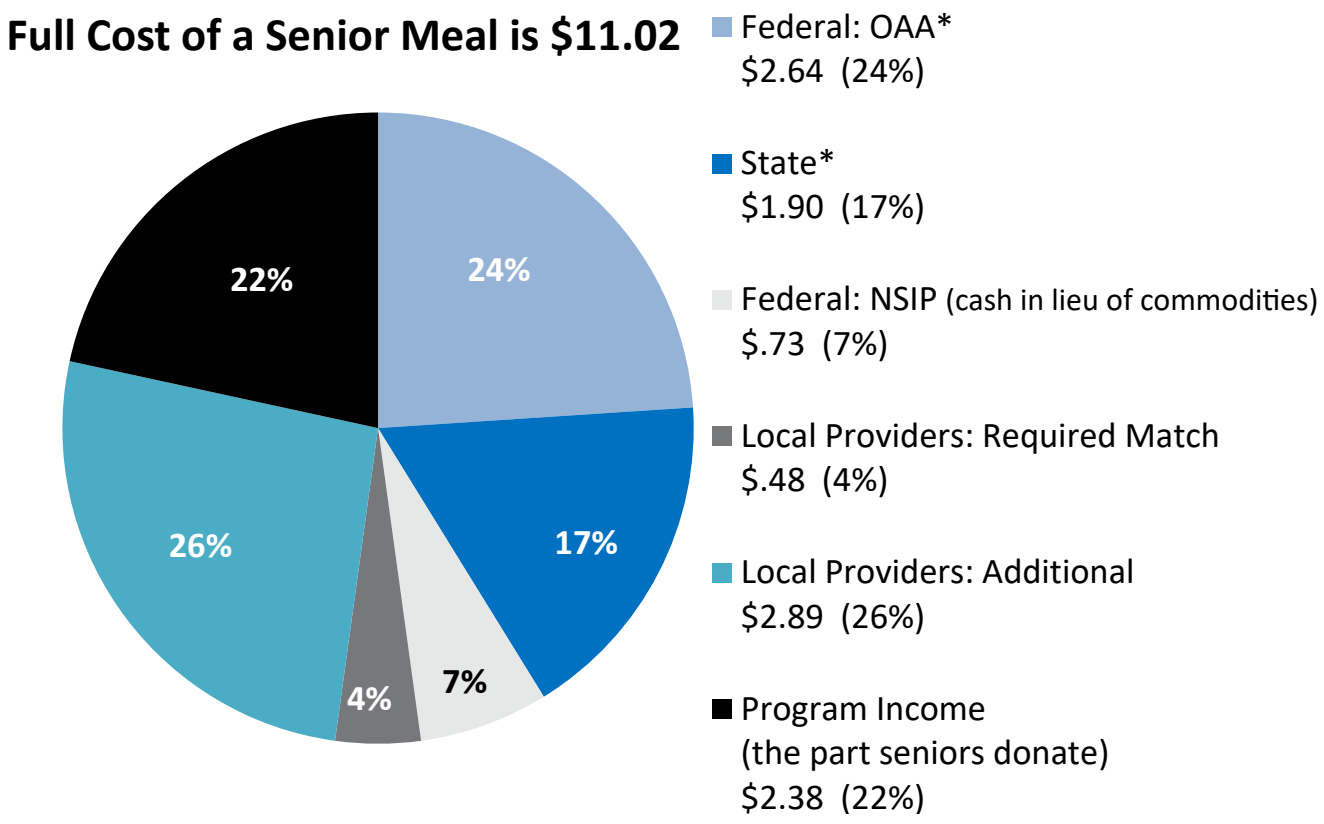
Nutritional status is closely associated with an older person's ability to function and remain independent. Hospitalized older adults suffer from many adverse effects when malnourished. Nutritious meals, tailored to older adults, reduce the risk of chronic diseases and related disabilities, prevent nutritional deficiency, and improve health over the long term.

Congregate & Home Delivered Meals Save the State Medicaid Money

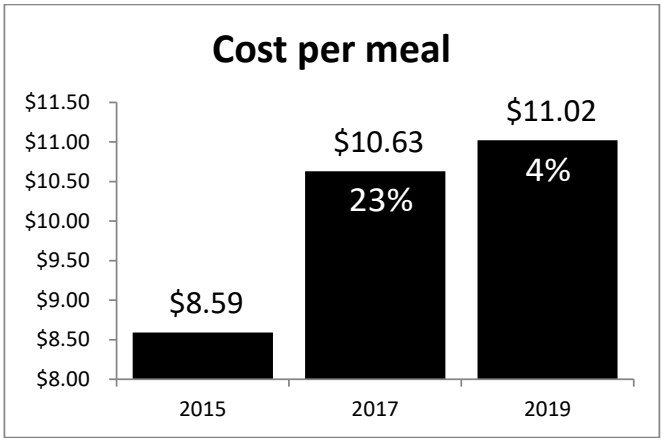
These older adults who participate in our nutrition programs have many of the characteristics that make them nursing home-eligible. In federal fiscal year 2019, 172 of the 4,801 home-delivered meal clients scored with 3+ ADL (Activities of Daily Living) limitations AND were Medicaid eligible. This is a conservative estimate of the nursing home-eligible clients receiving home delivered meals. According to the 2019 Genworth Financial cost of care survey, the average annual cost in a North Dakota nursing home is $132,324. **This means the Medicaid cost to the state for nursing home care for these 172 people would have been over $22.76 million in 2019 alone.**

Congregate & Home Delivered Meals Funding is Lagging Behind Ever-increasing Costs and the Long-term Aging of the Population

In federal fiscal year 2019, the average full cost to provide a senior meal was $11.02. Below is a chart identifying where the money came from in FFY 2019 for these senior meals.



IMPORTANT NOTE: The Federal OAA and State monies are the funds that reimburse agencies the unit rate for the meal.* ***These two categories sum to only $4.54 a meal and not the unit rate of $4.60 per meal because there was not enough funding for all of the meals to be reimbursed* *at the unit rate in 2019. If 100% of the meals were reimbursed at the unit rate, these two figures would add up to $4.60.*



The average cost of a senior meal continues to increase. While the state has provided additional funding in past sessions, it has not been enough to keep up with inflation. In federal fiscal year 2019, a total of 1,087,541 meals (546,066 congregate and 541,475 home-delivered meals) were provided across the state.

COVID-19 Response

Mid-March 2020, the COVID-19 pandemic shut down ALL congregate meal sites in North Dakota, per ND Aging Services mandate. Providers were deemed "essential" and stepped up to provide grab-n-go meals, take-out meals, and drive-thru meals, as well as adding many people to the Home Delivered Meals programs. Meals during the COVID-19 pandemic have increased over 40% over pre-pandemic times in some areas. While federal COVID-19 stimulus funds were allocated to help pay for these meals, the funding did not cover the full cost of the meal and will be spent out by 12/31/2020. Until there is an effective vaccine and all have been vaccinated, many of the state's older adults will continue to utilize these safe methods of getting food. **The average cost of a senior meal continues to increase. 2020 has seen food shortages, increased costs for both food and supplies, and the need for Personal Protective Equipment for staff and meal volunteers. All of these things have caused a spike in meal costs across the state; however these costs are not reflected in the graphs, which only show data through June 30, 2019.**

The basic unit rate of $4.60/meal has not changed since 2015. We are asking to be included with other Department of Human Services programs, which receive annual cost of living increases. Additionally, agencies are only allocated federal and state funding for a portion of the meals they provide. NDSSP is asking to be treated the same as other Department of Human Services providers. We request that we be paid a basic unit rate, with annual cost of living increases, for ALL of the Title III meals provided across the state - not just a portion of them.

Meal providers need to be able to depend on stable, basic rate funding for food, supply, and staffing costs. We try to utilize volunteers as best as we can for our meal programs, but we still have staffing costs. As our senior population continues to grow, we need to work collaboratively in a proactive way so essential services, such as senior meals, will not suffer as the state budget fluctuates. **These meals help seniors remain in their homes and out of costly nursing homes.**

Take action to save Medicaid dollars and support an increased basic unit rate for ALL Title III senior meals. Thank you!

Written by Colette Iseminger, MS, RD, LRD of the Grand Forks Senior Center for North Dakota Senior Service Providers, 620 4th Ave South, Grand Forks, ND 58201 c/o Brian Barrett, APT Solutions brian@aptnd.com Cell: 701-471-5104

HB 1012

House Judiciary Committee

Testimony of Christine Webster, Junior Undergraduate Student, Social Work, University of Mary Social Work program in support

January 25, 2021

Mr. Chairman and Members of the Committee:

My name is Christine Webster, I am a student at the University of Mary in Bismarck, North Dakota and I am testifying in support of House Bill 1012. My family have been the caregivers in the last 8 months for my grandmother, Barbara, who is living with dementia. She is a dear soul who is both spunky and cute. Even when she is in a bad mood you can't help but giggle. She is about 5 foot 5 inches, 85 years old and still walking outside to feed our goats in the morning. Our family has definitely experienced the highs and lows of caring for a person living with dementia. Dementia has always seemed like a distant issue to me—like a disease that only happened to people once in a blue moon. Unfortunately, it's more common than I thought. I started working as a caregiver at an assisted living facility where several of the residents were suffering from dementia. It was difficult for me to understand at first, but then I began to sympathize with their situation and I enjoyed working with those particular residents.

My family is caring for my grandmother in a beautiful way, but there are hard times when I have encouraged my mother to hire a direct care service provider to come a few times a week. The provider would maybe make breakfast for my grandma and do activities with her so that not all of the pressure would be on my mother and two highschool brothers. It is difficult for my mom to finish raising kids while also caring for her mother in this way. Among Alzheimer's and

dementia caregivers in North Dakota, *more than half* provide care to their parent or their parent-in-law. My mom's experience as a caregiver is shared with many other families. There are, of course, online groups and activities for elderly with dementia through the Alzheimer's Association, but my grandmother has a hard time understanding technology and doing activities over a computer would be too confusing for her. I think it is really important that we keep funds enabling caregivers to provide care at home, including the services that the Alzheimer's Association is providing through the Dementia Care Services Program. They are experts that meet with families to help guide and support them through this journey, educate them about the type of dementia they are dealing with and help connect them with available resources.

Thank you for your time and attention, I would be happy to answer any questions that you may have at this time.

alzheimer's association®

8699

North Dakota Dementia Care Services Program

Our state's residents affected by Alzheimer's and other dementia can receive support through the North Dakota Dementia Care Services Program (DCSP), a contract program through the Department of Human Services, Aging Services Division. For many families, the DCSP services are a lifeline when they need it most.





Since 2015, Lisa Millsap of Minot has been living with Alzheimer's disease. Her husband, Mel, has been caring for her in their home. Before the pandemic, Lisa was able to go to adult day care while Mel worked. Now, Mel is a 24/7 caregiver. Lisa and Mel have benefited from the support of the Alzheimer's Association through the DCSP, including care consultations with an on-staff dementia care expert. "Lisa was not properly diagnosed when she first developed early-onset," Mel says. "I'm grateful for the programs and support Lisa and I have received from the Alzheimer's Association and their staff through the state-funded Dementia Care Services Program.

Mel is one of the estimated 30,000 unpaid Alzheimer's caregivers in North Dakota. He wants people to understand that his wife Lisa "is still Lisa."

Alzheimer's Association Minnesota-North Dakota Chapter
2631 12th Ave. S, Ste. A, Fargo, ND 58103
24/7 Helpline 800.272.3900 | **alz.org/mnnd**

North Dakota Dementia Care Services Program

The Alzheimer's Association has served North Dakota residents through the Dementia Care Services Program (DCSP) since 2010 to improve disease management and increase family support to people living with dementia and their caregivers. Services include:







Care Consultation

Individuals with memory loss, family members, or concerned professionals meet with Alzheimer's Association Care Consultants. Consultants provide a customized road map including information about the diseases, care plans, resources for housing, financial and legal planning, referrals to community resources and support for caregivers. Meetings generally take place via phone, at the individual's home or at their preferred location.

Physician Outreach

Health care setting outreach informs medical staff in clinics, hospitals and public health agencies about the importance of Alzheimer's early detection and diagnosis, as well as how to make referrals for family education and support.

Education - General Public & Professional Development

Community outreach offers education on dementia-related topics, such as understanding memory loss, brain health, partnering with one's doctor, and understanding communication. Classes are available for the general public, professionals, care partners, medical professionals, and law enforcement.

COVID-19 Update

Fortunately, COVID-19 has not disrupted the services provided by the DCSP. Without any delay and with the support of staff across the country, the Association has found innovative and creative ways to continue to reach constituents virtually. Depending on the client's preference, care consultations have been conducted via video conference or phone.

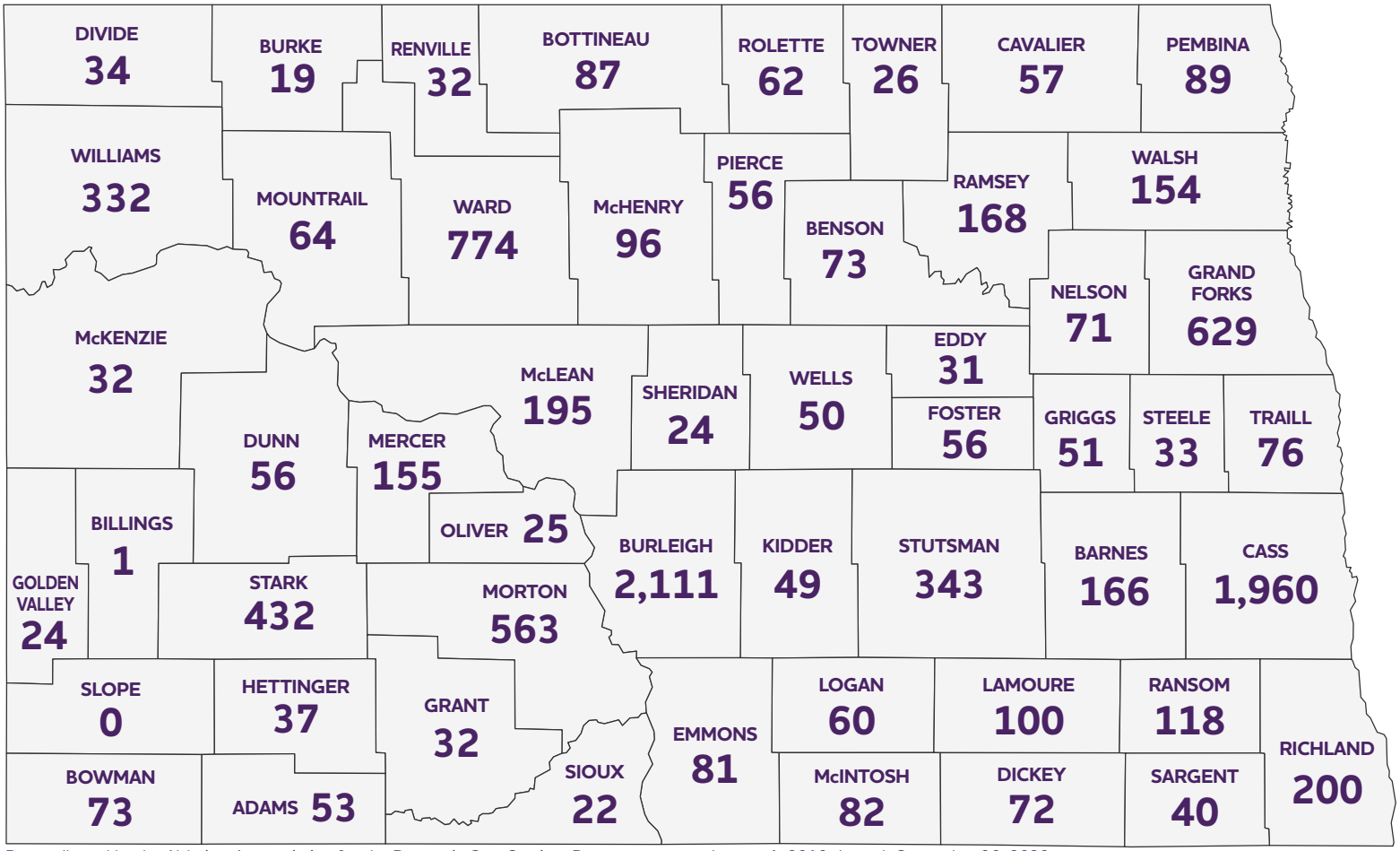
We have seen an increase in interest for professional dementia training, both from organizations as well as individuals. Our North Dakota long-term care and community-based providers that previously have not participated are now joining. Also, individual direct care workers, who previously would travel to receive training are now able to participate from their workplace or home. Although we still believe in-person training is the most effective way to improve quality care, interactive training from virtual locations has proven useful during the pandemic.

alzheimer's association®

North Dakota Dementia Care Services Program

The Alzheimer's Association has supported the families of 3,328 people living with dementia, including providing 11,896 care consultations for 6,898 caregivers.

Individuals Served by County[1] January 1, 2010 - September 30, 2020



Data collected by the Alzheimer's association for the Dementia Care Services Program contract January 1, 2010 through September 30, 2020.

We have also educated **44,018** people across the state, to increase awareness of community resources, to understand the disease process, and to improve the quality of care of people living with dementia in North Dakota.

Alzheimer's Association Minnesota-North Dakota Chapter

2631 12th Ave. S, Ste. A, Fargo, ND 58103

24/7 Helpline 800.272.3900 | **alz.org/mnnd**

alzheimer's association®

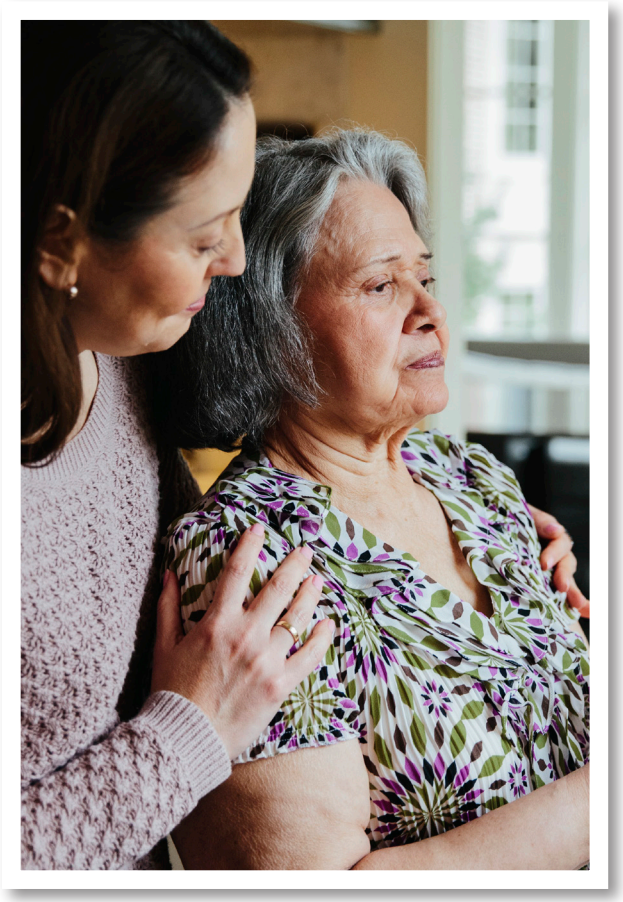
North Dakota Dementia Care Services Program

What is the value of the Dementia Care Services Program?

Recent research has demonstrated that two types of programs have potential for reducing avoidable health care and premature nursing home placement. One is the DCSP's caregiver support programs, and the other focuses on the care delivery team. Studies indicate that resources assisting caregivers have promise for reducing unnecessary emergency department visits and hospitalizations, and reducing transitions to residential care for individuals with Alzheimer's disease and other dementias.

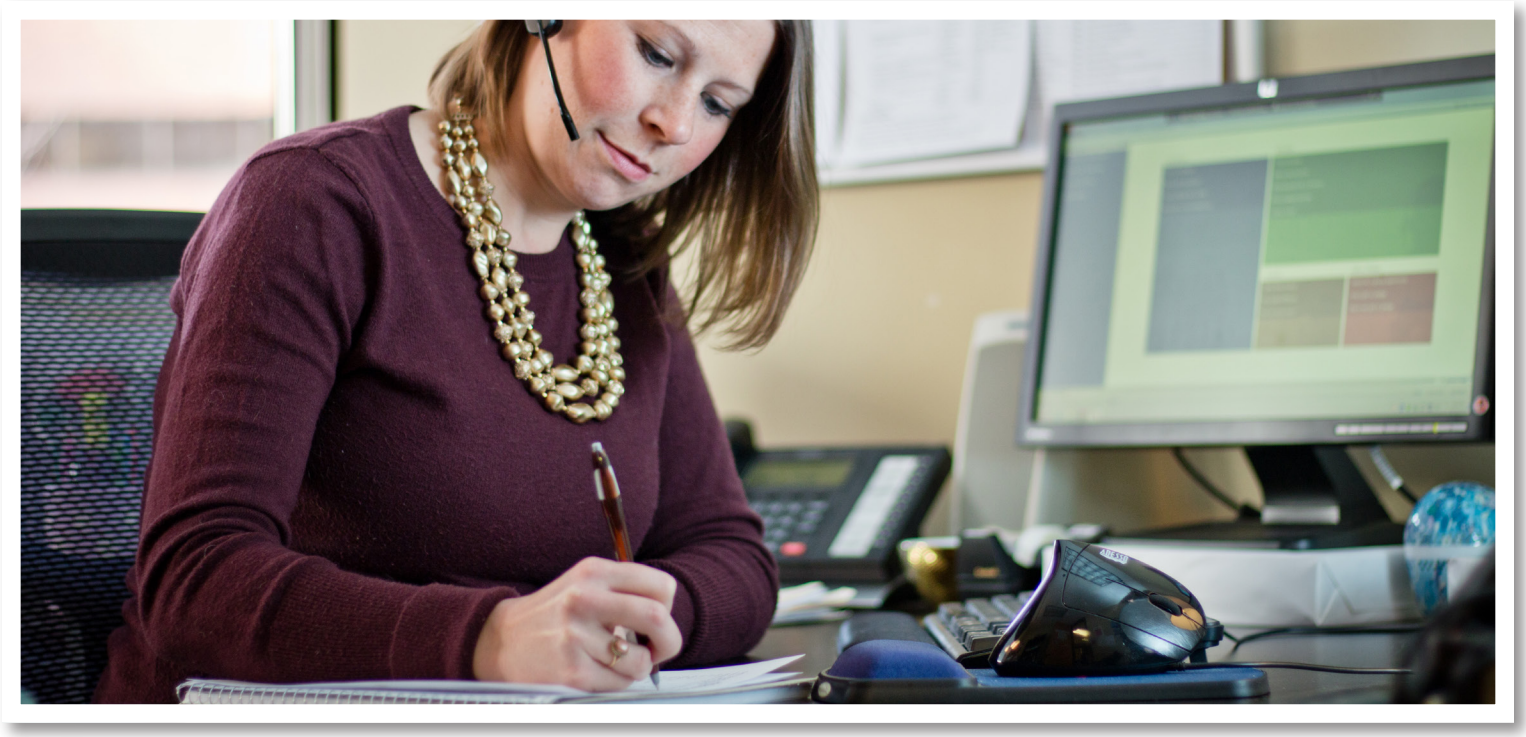


An evaluation from the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences found:



- Over a 42-month program period, the legislature appropriated an investment of $2.2 million for the contract and has estimated results of long-term care cost saving of $39.2 million, such as those incurred through hospital or emergency related services and delays in placing a person with dementia in long-term care facilities.
- Caregivers who were more engaged in DCSP activities had greater hospital and rural ambulance cost savings compared to caregivers who were not.
- Caregivers who participated were more likely to complete important dementia care-related tasks like establishing a power of attorney and instituting health care directives.
- Caregivers who received DCSP services were twice as likely to either delay nursing home placement or decrease their likelihood of placement. The total cost avoided was $3,007,147 (based on 46 people who indicated an increase in the amount of time to place a person with the disease in an institution).

Additional Services Provided Outside of the North Dakota Care Services Program



24/7 Helpline (800.272.3900)

Staffed in 200 languages, this resource serves people with memory loss, their caregivers, healthcare professionals and the public by providing information and referrals to local community programs and services; dementia-related education; crisis assistance; and emotional support.

Support Groups

More than thirty support groups are held each month in various North Dakota locations and are led by trained volunteer facilitators to provide support, assistance, and encouragement to individuals and their care partners impacted by dementia.

facebook.com/alzmnnd

twitter.com/alzmnnd

youtube.com/user/alzmnnd

instagram.com/alzmnnd

linkedin.com/company/alzheimer's-association-minnesota-north-dakota

Testimony
House Bill 1012 – Nikki Wegner, Alzheimer's Association, ND/MN Chapter
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 11, 2021

Chairman Holmberg and members of the committee, my name is Nikki Wegner and I am the Western North Dakota Program Manager for the Alzheimer's Association. I am one of six staff who provide programs and supports to North Dakota residents impacted by Alzheimer's and other dementia.

Thank you for the opportunity to speak with you today on House Bill 1012.

We appreciate the continued funding included in this bill for the Dementia Care Services Program (DCSP), however we are opposed to the cut of $168,000 that was passed by the House. In fact, we are asking the committee to consider an increase of $132,000. I will explain why we believe this funding increase is necessary to meet the growing needs of North Dakota residents.

This longstanding partnership between the State and the Alzheimer's Association has provided a life-line for thousands of North Dakota families when they need it most, when they are faced with a dementia diagnosis and growing care needs for their family member. This program has also provided dementia education for tens of thousands of community members and professionals across the state.

I encourage you to read the written testimony from Denise Fettig-Loftesnes. Her family was shocked by back-to-back dementia diagnoses of her father and mother. Denise and her siblings have received critical assistance through our program. And you will hear from Amber Moen today as well, who also received support that allowed her and a network of caregivers to provide care for her mother at home for years before making the hard decision to place her mother in a long term care facility.

With the recent Olmstead Settlement Agreement, we understand that the legislature and the administration are looking carefully at how North Dakota can transform its long-term care system, so that people can remain at home with access to the care that they need. The DCSP supports and encourages access to available home and community-based services.

The UND Center for Rural Health studied the first few years of the DCSP at the request of the legislature. **Over a 42-month period, with an investment of $2 million, the state saved an**

estimated $39 million in long-term care costs from reduced hospital and emergency related services and *delays in placing a person with dementia in long-term care facilities*.[1] You can see more details on that study in the document submitted with my written testimony. This document also includes a full overview of the DCSP, has a more in-depth explanation of our services, the total numbers of people-served, as well as a map of North Dakota showing our service numbers by county.

The goals of the DCSP are 1) to improve care, quality of life, and health outcomes, and 2) to reduce total cost of care associated with the disease for individuals, families and ultimately the state budget.

In the current contract for the DCSP[2], the Alzheimer's Association has:

- Delivered 1,744 Care Consultations – for 1,229 caregivers on behalf of 640 people living with dementia.
- Educated 2,054 community members across the state.
- Trained 135 law enforcement and 1,198 health care professionals.
- Referred 120 people to Family Care Services Program.

While professional training across the state is a valuable asset, it does not represent the largest impact of this program.

The greatest value of the DCSP remains supporting people directly impacted by dementia. We educate, support and provide resources to individuals living with dementia, their caregivers and families. The innovative services provided promote early detection and diagnosis, care coordination, effective caregiver training, support groups, and planning for the future.

Dementia that is unmanaged negatively impacts the individual diagnosed, their caregivers and ultimately creates a costly toll for communities and on the economy. Consider a few facts from our research:

State Costs

North Dakota's 2020 Medicaid costs for people living with dementia were $190 million – and that cost is expected to rise 13.2% by 2025.[3]

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[1] Center for Rural Health Assessment of North Dakota Dementia Care Services Program July 2013, p. 6

[2] Data collected by the Alzheimer's Association for the Dementia Care Services Program contract July 1, 2019 through November 30, 2020

[3] 2020 North Dakota Alzheimer's Statistics

The average annual per person Medicaid cost for someone without dementia is $374, versus $8,779 for someone with dementia – that means that a person with dementia costs Medicaid ***23 times more*** than a person without dementia.[4]

Family Costs

Out of pocket costs for an individual with dementia are 3.5 times greater than for those without. [5]

We estimate that the value of care provided by North Dakota's 30,000 unpaid dementia caregivers is $454 million.[6]

Why are these costs so high?

1. Dementia complicates the management of other conditions,
2. People with dementia have more hospitalizations, in fact, twice as many as other older adults,[7]
3. And people with dementia have more emergency room visits.

The DCSP can help reduce these high costs. For example, studies have consistently shown that active management of dementia can improve the quality of life of affected individuals and their caregivers.[8] And that is where the Dementia Care Services Program enters the equation for North Dakota.

Growing Need

The need for care and support across North Dakota is growing. One in 10 people age 65 and older are living with Alzheimer's.[9] In 2017, we estimated there were 14,000 North Dakotans living with Alzheimer's. Today, we estimate that number to be 15,000. We expect those numbers to rise to 16,000 by 2025, an increase of 14% in just 8 years.[10]

Additionally, the Department of Human Services has indicated a need for a self-paced, online professional dementia education program to train Qualified Service Providers (QSPs). We support this because we know that staff training is an important determinant of quality

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[4] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 46
[5] *Ibid, p. 47*
[6] 2020 North Dakota Alzheimer's Statistics
[7] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 48
[8] Alzheimer's Association 2020 Alzheimer's Disease Facts and Figures, p. 12
[9] *ibid*, p. 18
[10] 2020 North Dakota Alzheimer's Statistics

dementia care across the long-term care spectrum.[11] The Alzheimer's Association has developed a program to deliver evidence-based online dementia training based on our nationally recognized Dementia Care Practice Recommendations.

Request for Funding Increase

To respond to this growing need, we are seeking an 11% increase in funding from $1,200,000 to $1,332,000. Please note that this program has never received a funding increase since it began in 2010.

Without these dollars, we will be unable to meet the increased demand for care consultation, professional training and community education, leaving residents with less access to these vital services that help to keep those living with dementia at home in the community.

We look forward to the continued partnership with the State to better support North Dakota residents and reduce long-term costs to the State. With the State's continued support, the Alzheimer's Association aims to ensure that everyone in North Dakota has access to the services proven to improve disease management and increase family support. We ask this committee to support the funding necessary to continue these vital services and expand our ability to serve the growing need.

Thank you for your consideration. I would be happy to answer any questions you may have.

[11] *The Gerontologist*, Volume 58, Issue suppl_1, February 2018, p. S103–S113

Testimony
House Bill 1012 – Denise Fettig-Loftesnes, Bismarck, North Dakota
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 11, 2021



Mister Chair and members of the committee, my name is Denise Fettig-Loftesnes and I am from Bismarck, North Dakota. Thank you for this opportunity to testify. I am a caregiver for my parents, who were both recently diagnosed with Alzheimer's. I have a sister who also lives in Bismarck and serves as a caregiver, and we have seven other siblings living around the country who do everything they can to help. Here is a picture of my mom and dad, Agnes and Matt, and all of their children and grandchildren.

Three months ago, we learned that our father has dementia, and soon after that we received a similar diagnosis for our mother. We were devastated. With all of our life experience, me and my eight siblings knew almost nothing about Alzheimer's. Our parents live together independently in a wonderful community here in Bismarck, Marillac Manor, and we were desperate to ensure that they could stay there and live safely for as long as possible with their many friends. But what could we do? How do we help our parents? Who do we turn to?

Beginning with helpful guidance from staff at Marillac, and continuing through a number of phone calls, we were directed to Nikki Wegner at the Western North Dakota Alzheimer's Association. That is when our lives, and the lives of our parents, changed forever—and for the better. Nikki immediately put us in touch with health care providers, including an occupational therapist, Megan Dooley of Bismarck, who transformed our parents' apartment into a safe and comfortable home. Nikki also connected us with local experts who recommended and provided important products—such as door alarms and identification bracelets—to enhance our parents' safety.

Most importantly, though, Nikki became a guiding light for our family, holding multiple zoom meetings to answer questions, providing detailed emails, and just generally providing

invaluable counsel. From our first meeting with Nikki we knew that there was hope for our parents. She not only provided the information that we needed to address our parents' needs, but she delivered it in a helpful and caring way that put all of us at ease.

Time and time again my siblings—who live in states from coast to coast—have marveled at the assistance that North Dakota's Dementia Care Services Program provides its elderly citizens. We feel so lucky and so blessed that our parents are growing old in this great state. And we are not alone. My parents' generation—that Great Generation to whom we all owe so much—is getting older, and there are families from Williston to Wahpeton, and from Bowman to Bathgate, that need your help.

My parents are proud, but they want you to know their story. They were both raised on North Dakota farms and educated in rural schoolhouses and worked hard—together—to raise a family and to give their children a chance to live an even better life than they had. They never asked for anything, from anyone. But they need your help now. After giving so much, they—and so many other elderly North Dakotans—need the crucial support that the DCSP provides.

And that is why I am here today—to ask you to please support the services provided by the North Dakota Alzheimer's Association and to increase funding for the Dementia Care Services Program to $1,332,000. Alzheimer's is a cruel fate, and families are desperate for help. Your support of this bill is a small return for all that my parents, and your parents, and all of our elderly friends and neighbors, have done for North Dakota. Please vote Yes.

Thank you. I would be happy to answer any questions.

Denise Fettig-Loftesnes

Testimony
House Bill 1012 – Funding DD Recreational & Social Centers
Senate Appropriations
Senator Ray Holmberg, Chairman
March 11, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, for the record, my name is Tom Newberger. I am the Chief Executive Officer for Red River Human Services Foundation. We provide services to people with Intellectual and Developmental Disabilities (IDD) in Fargo, West Fargo and Wahpeton, North Dakota. I am here today to ask you to restore the $150,000 that was removed from the Governor's budget in the "Budget Account Code 712000" for the 2021-2023 budget. These funds are for Recreational and Social activities for people with IDD in Fargo, Wahpeton and Grand Forks.

I will now explain why these funds are so critical and needed. First, our agency is a licensed and accredited provider for services. One of our programs is the Activity Center that has existed since 1972 and has 425 members. During this time period, the Activity Center has provided Recreational and Social services to people not only from our agency, but from the community and other IDD service providers. We provide services in the afternoons, evenings and on week-ends so people with disabilities can live better lives. Examples of what our Activity Center offers for people with disabilities is hosting dances, playing pool, darts and air hockey, ceramics, safety training classes, such as how to stay safe while walking or riding bikes, providing food for those who cannot afford it, going to people's homes or apartments if they are sick and buying them medications if they cannot afford it. We also support camping during the summer which they really enjoy. These are just a few examples of what we do to give people with disabilities better lives.

A question I received during the 2017-2019 legislative session from the Appropriations Committee was "Do other licensed residential providers do these services too?" This was a great question and really helped all the legislators at that hearing understand our critical services. My response to the question was yes, the residential providers do their best to give people in their programs options, but it is generally very difficult to do based on the limited number of FTEs they

have. For example, if everyone on this committee lived in the same group home and I am the only staff working with you in the late afternoon and evening, and one of you wants to stay home and watch television, another one of you wants to go out and get an ice cream cone, another one of you wants to go the park and another one of you wants to go bowling while someone else wants to play pool and the last one of you wants to do ceramics. The question is how can I as your only staff keep you all happy when everyone wants to do something different? The way to keep you all happy is to bring you to the Activity Center which our non-profit operates and our staff will meet your dreams and desires. The Activity Center promotes social connections and helps prevent mental health issues and reduces anxiety and possible physical aggression. So briefly, this is what our services do.

From a financial perspective, our annual budget for the Activity Center is $221,000 and the State has supported our services with $37,500 per year or seventeen percent (17%) of our budget. From an Activity Center member's perspective, the $37,500 from the State equates to just below twenty-five cents per member per day. This is a very low cost. We previously implemented membership dues of $8.00 per month and then reduced it to $6.00 per month to make it more affordable. Most of the members could not afford it, so now have no membership dues.

I kindly and strongly recommend that this committee re-instate the funding for the two Recreational and Social Centers in our State and consider increasing it to fifty-cents per day per member or a total of $300,000 per Biennium as a good portion of our other funding has been lost.

Thank you and I will be happy to answer any questions you may have.

Testimony
House Bill 1012
Development Homes, Inc. by Scott Anderson
Senate Appropriations – Hon. Ray Holmberg, Chairman
March 11, 2021

Good afternoon Chairman Holmberg and other distinguished Committee members;

My name is Scott Anderson, Program Service Director for Development Homes, Inc. (DHI) from Grand Forks, ND. I am honored and grateful to have his opportunity to speak with you on behalf of DHI, other ND Community Providers, and all the people we serve and support. The focus of my testimony will be to speak to the importance of the quality support and services we as Community Providers do each and every day, seven days a week and 365 days a year. We are fortunate to have the opportunity to serve and support others in the great state of ND.

Development Homes, Inc.(DHI) was established in 1974 supporting children and 46 years later we continue to serve children, along with adults and families as well. Our mission: "Development Homes, Inc. is committed to the provision of quality community based support services to person with disabilities, enabling them to maximize their individual potential, and fulfill their personal dreams.". DHI provides a variety of services to about 170 unique individuals and we employ about 500 staff. DHI is currently the 8th largest employer in our Grand Forks community. The people we support, our organization and our staff, have a significant financial impact on our community. With the continued support from this legislature, DHI and every other provider will continue to provide opportunities for people to have the quality lives that we all aspire to have.

In March of 2020, the impact COVID-19 In ND reached a level that impacted each and every community across the state. Our schools were closed to all in-school education and the all too familiar term of "distance learning" was established and implemented. For all parents and those providers who support children, of which DHI is one, the impact was immediate and without precedent. The announcement was made on March 15, 2020 that kids would not be going to their school building for education starting the very next day, March 16, 2020. The determination and dedication of parents and providers to forge ahead with providing immediate educational support to our children was remarkable. At DHI, we were supporting 12 kids in placements living outside the family home. Most of the kids we support in that environment are in need of significant staff support, with most receiving a staff designated to support each child individually. The needed support, just within DHI, would be 10-12 staff working an additional eight(8) hours per day, five(5) days per week for the next 11 weeks. This totals approximately 4,000 to 5000 hours of unscheduled staffing time and the task of providing that support started the very next day. Several other providers across the state were also thrust into "stepping up" immediately to support many children during daytime, school hours. With the very common and prevalent "can-do" attitude, providers across the state were able to meet this challenge and provide the needed support for our kids. This event truly exemplifies the caring and quality of the organizations ND has providing services to people with disabilities. And one more lingering issue, not one provider has been given a dime of reimbursement for providing this support to our kids over these 11 weeks from March 16, 2020 through May 28, 2020. For providers in the state of ND, it is about the quality of services and being there

when we are needed, no matter the circumstances. We believe that efficiency is important but quality is essential. We need to be good stewards of the resources we have, but above all else, when needed, we need to be prepared to the best we can be, and deliver each and every time. But now that we have spent our hard won reserves to provide these services, our providers are less able to face the next crisis.

In November 2019, DHI opened a new Children's ICF-IDD in Grand Forks. This was a special project in collaboration with the DD Division, Life Skills and Training Center (LSTC) and DHI for the purpose of residential services for four children that were currently at LSTC. This ICF-IDD (5509) became fully operational on 2/24/2020 when the fourth of four boys moved in. This endeavor was certainly going to be challenging enough without COVID-19 but COVID-19 and school closings happened just three weeks later. Each of the four boys DHI was serving at 5509 had behavioral and mental health concerns. As was stated earlier, DHI has been around 46 years and has always served children. The difficulties we encountered and still encounter today are the lack of community resources to help support people, especially children, with higher behavioral needs when they present these difficulties. Sue Forester and the LSTC staff have been excellent to work with and been extremely supportive. The most significant issue with LSTC is logistics. Grafton is an hour away from Grand Forks. When behavioral issues arise, they can escalate very quickly, and any support LSTC can offer will not be timely enough to assist with resolving the event.

DHI has its' own "crisis team", made up of mostly administrative professionals with years of experience and all are Therapeutic Response trainers. DHI has this team so that we can respond with in-person support quickly during our most difficult behavioral events. Even with this timely support, sometimes events reach the intensity that mental health professionals are needed to assess the person having difficulty, for safety for themselves and others. When these calls are made, the first responders are the Grand Forks Police officers. Most times, the police officers arrive and just their presence will de-escalate the event, but not always. We have had events involving both children and adults we serve that have involved the need for physical, chemical, as well as mechanical(handcuffs) restraints with police officers and our staff intervening to try and keep everyone safe. In cases such as these, the paramedics arrive and we ask that the person be transported to the hospital for a psychiatric evaluation. The Grand Forks Police Department has been very professional, responsive and supportive during each of these intense events. The police are sometimes unsure of what their role is at times, as we are not looking for criminal charges against those struggling. Because of this, they can be frustrated with us and ask why did we call them. To be clear, when we make a call for emergency services, we are really looking for a safe transport to the hospital so that person struggling can be assessed.

Once at the hospital, it may take 30 minutes to several hours for psychiatric services to get involved and the assessment completed. Often there is lab work to insure medication levels are within therapeutic range. To be clear, the individuals having difficult have most times presented physical aggression toward others, including staff, others we support and even police officers. Property damage such as making holes in walls, throwing objects, slamming doors with enough force to dislodge the door or the door frame, and breaking windows are common during these intense events. The people are also most times, self-injurious and an elopement risks as well. The hospital in Grand Forks has been very unwilling to admit people presenting these types of difficulties. In my conversations with the on-call psychiatrists assessing, especially when assessing children, they will not admit. I have been told that "We(the

hospital) cannot admit this person as we are not equipped to handle them as they are just too violent." In an ironic twist, soon after they say that, they discharge the person and say that they are calm enough to return to their home. This is not just a DHI or Grand Forks issue. Providers across our state can tell you very similar stories about the frustration of taking on people with significant challenges, without adequate community support from others to assist the person in being successful in their community. As you are all well aware the behavioral and mental health support systems in ND, as well as in our country, are overwhelmed and under-staffed. There are more people in need of this type of support than there is support available. If providers are going to be successful with reducing the number of people at LSTC. We are going to need to be fully-funded to provide the support needed, creative with our approaches (like our own response teams), collaborative with LSTC and our home regions, and have adequate and responsive community support and services that will be of assistance when that assistance is needed most. The net result of not having the supports and resources needed, is a failed placement. When we are working to help those who pose the greatest need, efficient is important but quality is essential. Success means allowing people to thrive in an environment where we learn and grow every day. When people are able to maximize their full potential and live the life they dream of, that is definitely success!

I want to thank each of you for your time and attention today. It has been an honor and privilege to have this opportunity to share on behalf of Development Homes, Inc. as well as the many wonderful and dedicated providers in the great state of North Dakota.

Respectfully,

Scott Anderson, Program Services Director
Development Homes, Inc.

Testimony
House Bill 1012 – Department of Human Services Budget
Senate Appropriations Committee
Senator Ray Holmberg, Chairman

March 11, 2021

Chairman Holmberg and Members of the Senate Appropriations – Committee:

My name is Lorena Poppe. I am the owner and executive director of Poppy's Promise, a Bismarck-based provider of In-Home Support services through the Developmental Disabilities traditional Home and Community Based Waiver. The focus of my testimony today is the impact the Department of Human Services budget, particularly that of the Developmental Disabilities Division, will have on new and small providers of services.

I started Poppy's Promise in the Fall of 2017 in response to families of kids with disabilities expressing there was a shortage of providers to be available to meet the needs of their children and families. My goals were to 1) be another option as families seek out services that will best meet the needs of their children, and 2) meet kids and families where they are at on their unique journeys to full inclusion and participation in home and community life. We believe strongly in designing supports that will help to keep kids in their family homes and communities and minimize the need for institutionalization in a place that is unfamiliar to the child. In our short existence, we have seen the difference a small provider organization can make and are proud that we have been part of keeping families together in their home communities.

I am the sole owner of Poppy's Promise. I started my business by getting a Small Business Administration loan and taking a leap of faith. I knew there was a need, but understand now more than ever, 3 ½ years later, how critical it is that DD providers be supported to do the important work of helping people with disabilities achieve maximum health, happiness and freedom of choice across their lifetimes. At Poppy's Promise, we operate on a month-to-month basis without having a large financial reserve to fall back on. Since opening the doors at Poppy's Promise, I have been excited to see other new provider organizations popping up across the state. This is an exciting thing for North Dakota and I believe there is definitely a place for new organizations that can work together with longstanding providers to assure gaps in services are filled and people can receive supports and services in the least restrictive setting.

I am concerned that new providers and those that are smaller and more specialized are not being fully considered by the Developmental Disabilities Division. Specifically regarding In-Home Supports, that program had the largest drop in utilization over the course of the Covid-19 pandemic (27%). And yet, In-Home Supports was left out of the Appendix K option to receive retainer payments to help providers stay in business during the pandemic. For providers of services that were eligible to receive retainer payments, those payments were an important part of keeping the doors of those businesses open. With the current extension of the Appendix K, there is an opportunity for the Department to extend the retainer payment option to those providers most in need and help to assure the services families rely upon don't disappear.

Another area of concern for all providers of DD services, but especially small providers, is the intention of the Department of Human Services to require providers to absorb the cost of accreditation necessary to maintain DD licensure. Because DHS contracts with one organization for accreditation, the Council on Quality and Leadership (CQL), providers would be forced to pay several thousands of dollars toward the accreditation process. This includes travel and lodging expenses of CQL reviewers coming to North Dakota from across the country. There is no reimbursement for accreditation built into the DHS budget. Poppy's Promise does not have the ability to cover that cost. I believe strongly in review processes being in place to assure quality of services, but also know the reality of trying to maintain a business that does not have the ability to set aside thousands of dollars for unreimbursed licensure requirements.

I come before you today to ask that you consider the current state of services for people with disabilities during an ongoing pandemic, the financial vulnerability of new and small providers, and the addition or preservation of funds to assure all providers who are relied on heavily by the citizens of North Dakota are able to survive and stand strong in continuing to provide supports and services.

Thank you for your time today, and I would be happy to answer any questions you may have.

Testimony on HB 1012
Jon Larson, Enable, Inc.
Senate Appropriations Committee
Hon. Ray Holmberg, Chairman
January 25, 2021

Chairman Holmberg and members of the committee, my name is Jon Larson and I am the executive director of Enable Inc., a licensed developmental disabilities provider here in Bismarck. I also currently serve as the president of our provider association, NDACP.org.

On April 01, 2018 North Dakota implemented a long-awaited new payment system for developmental disability providers. This new payment system was developed by consultants who worked in close consultation with a steering committee that consisted of personnel from the Department of Human Services and DD providers. That steering committee began in the Spring of 2011 and continues to work on issues that arise with this still new system. I have been a member of this steering committee since its implementation.

Although not perfect, the new payment system has done a good job of achieving its objective of fairly allocating resources based on individual needs as measured by a nationally recognized assessment tool and utilizing the existing allocation of resources. This new process involves the use of scores from the Supports Intensity Scale (SIS), a mathematical multiplier to connect the scores to authorized support hours, and a unit rate matrix with standardized rates for defined services, which result in a unique annual Individual Budget Allocation for every client. This new system took years to develop and prior to implementation there were fears expressed by some providers, advocates, and consumers about the viability of continued provision of the same quality services that everyone has come to expect. Upon implementation on April 01, 2018 services continued as expected without drastic alterations to service delivery and providers have adapted to the changes created by the new system. The steering committee continues to meet on a regular basis to address issues that have arisen since the implementation of this new system.

A central component of the new system is the Supports Intensity Scale or SIS. The SIS is a nationally normed tool that is used to identify the unique needs of the individual we support in our programs. North Dakota contracts with an independent organization, The Rushmore Group, to administer these assessments. Each individual supported is to have a new assessment every three years unless there is a significant life changing event that would require a new assessment. The Department hired a consultant in the fall of 2019 who found a trend of rising SIS scores from the assessments that occurred three years previously. A rise in

the SIS score results in a higher payment to the provider. There are many reasons a SIS score would change including a deteriorating health or behavioral condition or an inaccurate score in the initial assessment or subsequent one. The information Optimus used in that conclusion is now nearly one and a half years old. They also noted at the time that they were seeing a leveling off of the increasing scores and it may indicate a stabilization of scores or even a U-shaped curve in the data that would result in a return to scores more closely related to the original.

NDACP has collected data from our members that compares the SIS score resulting from an assessment done in 2020 to the previous score and this data indicates that in aggregate the new scores are slightly lower than the previous scores resulting in lower payments to providers. The executive budget proposes a reduction in rates to residential providers based on the trends they saw prior to 2020. This new payment system is still very new and 2020 interrupted everything making data analysis difficult. The House of Representatives accommodated the position of our association that the rates in this new system not be reduced at this time to allow for the system to have time to stabilize. Adjustments to rates may be necessary but should be done in consultation with the steering committee and should be done in a manner that is cost neutral to the appropriation.

Accreditation by the Council on Quality and Leadership, CQL, has been required for licensure since the days we were operating under a lawsuit. This cost has been paid by the Department either through rate setting and cost settlement prior to the new system or directly after the new payment system. This cost is proposed to go back to providers in the executive budget. CQL accreditation is quite expensive, especially for smaller providers. This was not a cost recognized when developing rates in the new payment system and we feel that this required cost should continue to be paid by the Department.

The last area I want to address is the loss of funding for service under section 11. You have testimony from Brooke Austin, from Community Living Services in Fargo, and two people they serve, that explains it in more detail than I will at this time. Section 11 uses state dollars at a very reasonable cost to provide a much-needed service to people who otherwise fall through the cracks. Providers receive a payment of $7.00 a day for people in this program, far less than it actually costs to provide the service. Without this service, the people in this program will likely struggle and require more urgent services that will cost more and be less appropriate to meet their needs.

In summary, I am requesting that the rates in the new payment system not be reduced as proposed in the executive budget, that accreditation costs continue to be paid by the Department and that section 11 funding be restored. In addition I recommend inflationary increases of 3% and 3% for state fiscal years 2022 and 2023. Thank-you for your consideration and I would be happy to answer any questions you may have.

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Senate Appropriations

Sixty-seventh Legislative Assembly of North Dakota

House Bill No. 1012

March 11, 2021

Good afternoon, Chairman Holmberg, and Members of Senate Appropriations. I am Pam Mack, Director of Program Services for the Protection & Advocacy Project (P&A).

P&A is an independent state agency. Its mission is to advocate for the human, civil, and legal rights of individuals with disabilities. P&A strives to ensure that every individual with a disability is treated with the same dignity and respect as all other ND citizens.

P&A is here today to support HB 1012 and the funding for services for individuals with developmental disabilities. P&A concurs with the long-range goal of the Department of Human Services to purposefully focus on the need for crisis services at the Life Skills & Transition Center (LSTC). At the same time, DHS is working on transitioning many of the current residents to the community, ultimately operating with a lower census. This is consistent with the Transition to the Community Task Force goals that have been established and the state's requirement to ensure that individuals with disabilities are able to live and work in the least restrictive environment. P&A encourages the Committee to thoroughly examine the transfer of funds

through this process to ensure that adequate funding is provided to community providers in this process.

P&A has been involved in the steering committee to collaboratively implement the reimbursement system for DD providers. The current budget, as presented by the DD Division, includes a decrease in reimbursement rates for providers relative to the array of residential services. P&A recommends that the DD Division further determine whether the recommended residential reimbursement rates in the DD budget are adequate to provide for the level of acuity and support needs of the individuals who are transitioning out of the LSTC. This may require a need to compare the daily rate at the LSTC with current rates within community providers, the outlier process, and perhaps the establishment of tiers of service. For example, the per diem at LSTC is $1,200. The average daily reimbursement for community ICF's/IDD is just over half that amount. We cannot set up the community providers to fail by not giving them sufficient resources to serve the same client. The Committee may also need to examine the intent to create a cost-neutral budget a number of years ago when this process started and whether the level of acuity and whether the needs of the current clients served in the community have changed. The rate adjustments that are proposed as part of the current budget may not be appropriate if the acuity needs are creating increasing costs versus a reimbursement rate that needs to be adjusted.

The current budget proposal eliminates the Section 11 grant funds from the DHS budget. These monies provide program management services, and in some cases limited services, for individuals with developmental disabilities who are not eligible for other DD services. This is concerning as this helps to ensure all individuals with developmental disabilities receive appropriate treatment, services, and habilitation consistent with NDCC 25-01.2-02[1]. P&A does recommend that these funds be reinstated fully in the Department's budget to ensure that we do not have people with developmental disabilities that are falling through the cracks.

P&A is aware that the proposed budget for the DD Division shifts the cost for Accreditation with The Council on Quality Leadership, which is required for all DD providers, to the providers. This is a valuable mechanism to ensure that quality services are provided and is not a duplication of other quality assurance efforts. The cost associated with this may be difficult for providers that are smaller and do not have the array of revenue options to cover this cost with CQL Accreditation.

P&A is also concerned with the intended cuts in funding for early intervention supports through the Experienced Parent and Family Support programs. These early intervention supports provide valuable services to parents and families who are beginning to navigate the complex system within our state. P&A would recommend that the $260,000 be restored to the Department's budget to continue these early intervention services.

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[1] **https://www.legis.nd.gov/cencode/t25c01-2.pdf**

Lastly, P&A would encourage the Committee to consider increasing the funding for corporate guardianship for individuals with disabilities. Currently, the contract with Catholic Charities of ND (CCND) provides for valuable services for individuals who do not have other supports available and require a guardian to assist with personal decision making. P&A is concerned about the waiting list for these services and encourages increased funding to CCND to address this need.

Thank you for your consideration. I'm happy to answer questions. You are also welcome to contact me at **pmack@nd.gov** or by phone at (701) 328-3975.

Senate Appropriations Committee
IN SUPPORT – HB 1012 – DHS Budget – Aging Services
March 11, 2021
Josh Askvig, AARP North Dakota
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(701) 355-3642

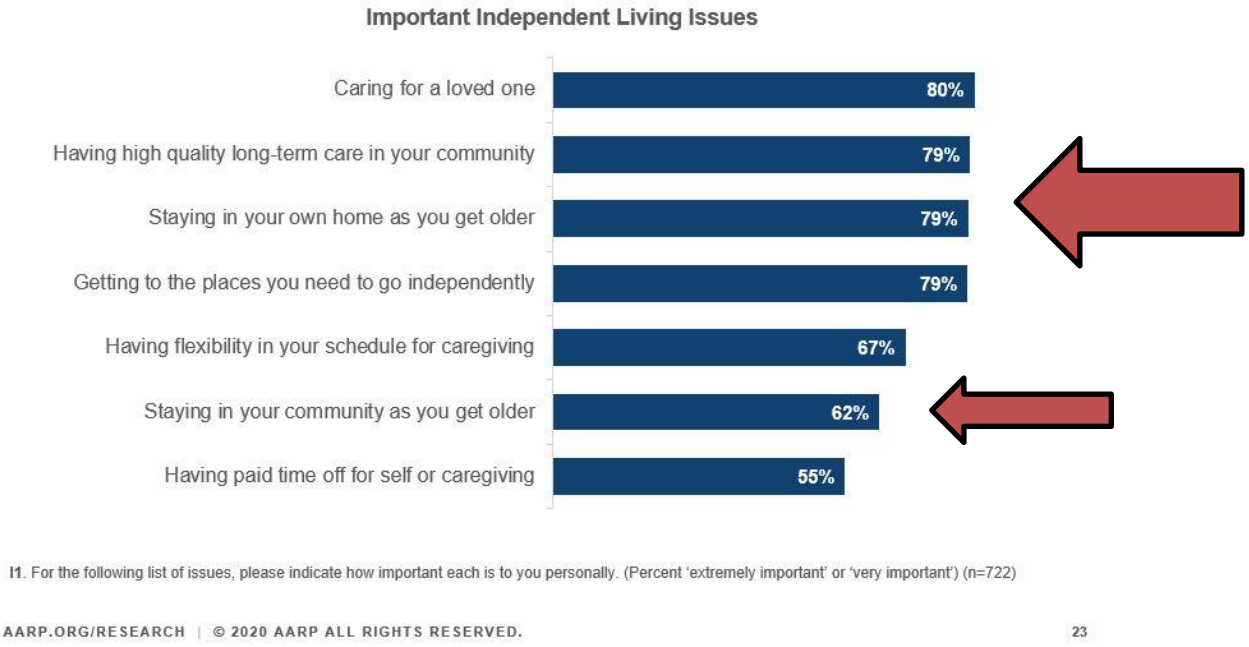
Chairman Holmberg and members of the Senate Appropriations Committee, I am Josh Askvig, State Director at AARP North Dakota.

AARP is a non-profit, non-partisan membership organization with more than 84,000 members in North Dakota. Our mission is to empower people to choose how they live as they age.

Our story began when our founder, Dr. Ethel Percy Andrus discovered a former colleague of hers living in a chicken coop. She had run out of money and couldn't find anywhere to get the help she needed. Dr. Andrus decided she would make it her life's work to ensure older adults were given the opportunity to have dignity and purpose and founded what today is AARP.

We appreciate this committee's work to dig into issue important to older North Dakotans and this need will continue to grow. Today our population age 50+ is almost 256,000 and 50% of those households are age 65 or older. Today in North Dakota over 9 counties have a mean age of over 50 and a number of others are right on their heels.

AARP North Dakota supports the intent that DHS Director Chris Jones stated in his budget overview that the Department's effort is to provide services and care as close to home as possible. Below is a chart from our 2020 North Dakota Vital Voices Survey, a state specific survey of issues that impact North Dakotan's 45+ conducted every three years. In our survey last year, 79% indicated that staying in their own home as they got older, getting to the places they need to go and having access to quality long term care in their community was extremely or very important. Also, 62% said staying in their community as they got older was extremely or very important. It was no surprise to us and I am sure it doesn't surprise you.



I1. For the following list of issues, please indicate how important each is to you personally. (Percent 'extremely important' or 'very important') (n=722)

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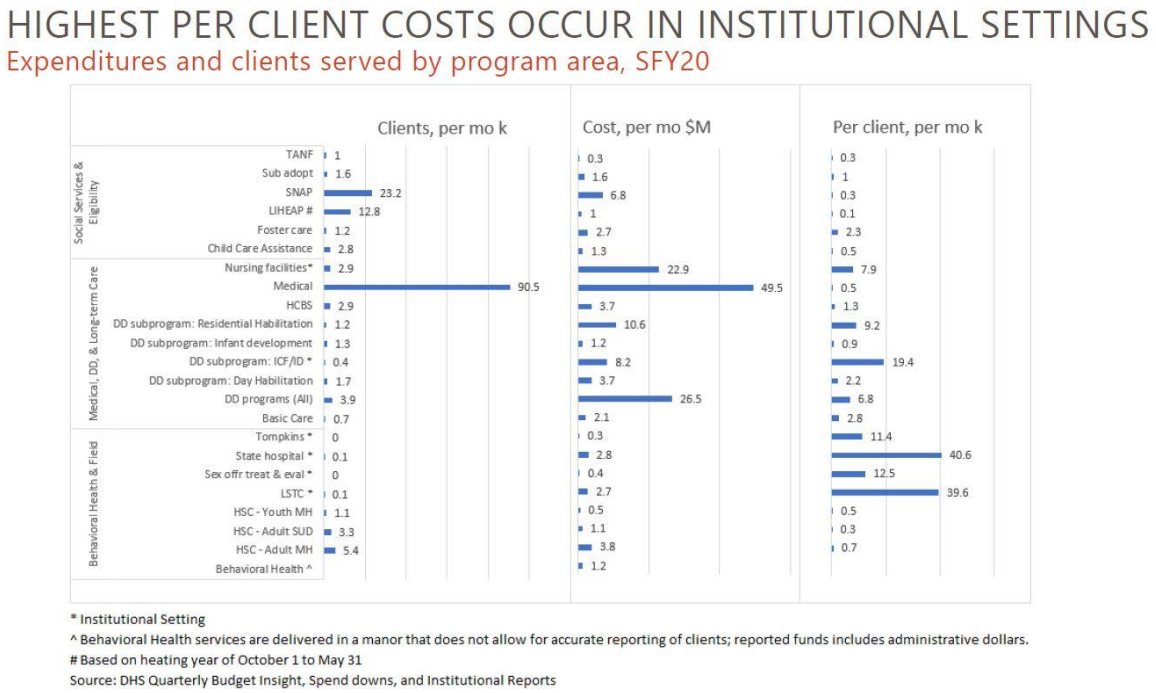
Knowing this the work to continue to move resources, supports and efforts into delivering services through an HCBS model is commonsense. It also makes dollars and cents. If you look at the chart that was shared during the House overview of HB 1012 it is very clear that serving individuals in home and community based settings is not only preferred it is cost effective. The chart appears to show about 1/7th of the cost ($7.9k per client per month for Nursing facilities vs $1.3k per client per month for HCBS).



* Institutional Setting
^ Behavioral Health services are delivered in a manor that does not allow for accurate reporting of clients; reported funds includes administrative dollars.
# Based on heating year of October 1 to May 31
Source: DHS Quarterly Budget Insight, Spend downs, and Institutional Reports

Additionally, in line with the efforts to intervene early to stave off long term costs, the changes made last session to access the state funded Service Payments for the Elderly and Disabled (SPED), adding Expanded SPED and centralizing ADRL intake are already paying dividends.

Attached you will find the *North Dakota: 2020 Long-Term Services and Supports (LTSS) State Scorecard*. This is the 4th time the Commonwealth Fund, The Scan Foundation and AARP have teamed up to provide a state LTSS assessment with apples to apples comparisons. If you look at the card you will see North Dakota made substantial improvement in 7 of the 21 indicators. And two of those were in the area of Choice of Setting and Provider dimension. In fact, North Dakota was recognized nationally during the roll out of the 2020 Scorecard for the work it has done to make improvements.

But let's be clear, while we have done good work, we still have plenty of work to do. Specifically, look at the indicators on the back related to Nursing Home Cost, Medicaid LTSS Balance: Spending and Medicaid LTSS Balance: Users, and Successful Discharge to Community where we continue to rank low. Investments in HCBS like those in the Aging and Adults Services area including the additional FTE to administer the DOJ settlement, increasing QSP rates, and capacity for awareness and education of HCBS services only aid in moving those measures. Again, for AARP and the thousands of North Dakotans we represent, it's about choice. Older North Dakotans deserve to know they have options for care as they age. Overwhelmingly they prefer to stay in their homes and communities and the budget should continue the state moving in a direction that prioritizes Home and Community Based care.

A couple of other notes related to the Aging and Adults Services portion of the DHS budget. The importance of the Long Term Care Ombudsman should be highlighted. During the pandemic, Karla Backman and her team were a critical component to ensuring that the rights of residents and their families were respected and honored. The Ombudsman program was an often needed referral for our team at AARP as the pandemic unfolded.

Finally, we would be remiss not to mention Senior Nutrition funding. The meals programs funded through the Aging and Adults services budget are a critical life line for older adults. They promote good health and as evidenced during the pandemic a critical component to keeping individuals at home and in their communities. The North Dakota Senior Service Providers put together a document every legislative session about their meals funding. I was reading through the 2021 document and understand that it is estimated that 1 year of meals funding is equal to 5 days in a nursing home. And in too many instances malnourishment leads to hospitalization and increased LTC needs. It should also be noted that meals programs also help to combat isolation and loneliness.

Combine these factors with the idea that it appears many of these senior providers will be losing some additional federal supports they received during the pandemic and knowing they have seen a significant shift in their costs as they have moved to almost exclusively pick up or to go meals, and there is a need for a funding increase. We would encourage you to increase the meals funding to ensure that this critical service can meet the needs.

Again, we appreciate the time to raise issues important to North Dakotans 50+ and would be happy to answer any questions. Thank you.

North Dakota: 2020 Long-Term Services and Supports (LTSS) State Scorecard

The fourth edition of the *LTSS State Scorecard*, released in fall 2020, takes a multi-dimensional approach to measure state-level performance of LTSS systems that assist older adults, people with physical disabilities, and family caregivers. Unlike many other rankings that focus on a particular aspect of LTSS system performance, the *Scorecard* compares state LTSS systems across multiple dimensions, reflecting the importance and interconnectedness each has on the overall LTSS system. The full report is available at www.longtermscorecard.org

Data used for this *Scorecard* was analyzed in 2019, prior to the COVID-19 outbreak. Therefore, performance on this *Scorecard* does not include the impact of the pandemic on the LTSS system, which is considerable. Nevertheless, the *Scorecard* indicators continue to be highly relevant, both in the current environment and in a future post-COVID world.

Purpose: The *Scorecard* aims to empower state and federal policy makers and consumers with information they need to effectively assess their state's performance across multiple dimensions and indicators, learn from other states, and improve the lives of older adults, people with physical disabilities, and their families.

Results: The *Scorecard* examines state performance, both overall and along five key dimensions. Each dimension comprises 4 to 7 data indicators, for a total of 26 indicators. The *Scorecard* also measures changes in performance over the previous three years wherever possible (reference data available for 21 of the 26 indicators). The table below summarizes current performance and change in performance at the dimension level. Indicator data appear on the next page.

Dimension	Rank	Number of indicators with trend*	Number of indicators showing:		
			Substantial improvement	Little or no change	Substantial decline
OVERALL	**28**	**21**	**7**	**13**	**1**
Affordability & Access	**30**	6	1	4	1
Choice of Setting & Provider	**25**	6	2	4	0
Quality of Life & Quality of Care	**20**	2	1	1	0
Support for Family Caregivers**	**34**	4	2	2	0
Effective Transitions	**22**	3	1	2	0

* Trend cannot be shown if data are missing for either the current or baseline data year.
** The support for family caregivers dimension comprises 12 policy areas, organized into four broad categories. Change is shown at the category level in the table above. Policy data are shown on the next page.

North Dakota: 2020 Long-Term Services and Supports State Scorecard Data

Dimension and Indicator (Current Data Year)	Current Rate	Baseline Rate	Rank	Change	National Average	Top State Rate
OVERALL RANK			**28**			
Affordability and Access			**30**			
Nursing Home Cost (2018-19)	**328%**	333%	**48**	▬	245%	168%
Home Care Cost (2018-19)	**99%**	97%	**46**	▬	80%	51%
Long-Term Care Insurance (2018)	**106**	119	**4**	✗	43	138
Low-Income PWD with Medicaid (2016-18)	**59.1%**	51.8%	**12**	✓	56.7%	79.2%
PWD with Medicaid LTSS (2017)	**41**	43	**24**	▬	46	100
ADRC/NWD Functions (2019)	**54%**	52%	**37**	▬	66%	96%
Choice of Setting and Provider			**25**			
Medicaid LTSS Balance: Spending (2016)	**17.3%**	17.1%	**48**	▬	45.1%	73.5%
Medicaid LTSS Balance: Users (2017)	**27.7%**	29.1%	**51**	▬	64.2%	83.9%
Self-Direction (2019)	**5.6**	*	**35**	*	30.4	149.1
Home Health Aide Supply (2016-18)	**25**	16	**12**	✓	22	47
Assisted Living Supply (2016)	**102**	105	**1**	▬	49	102
Adult Day Services Supply (2016)	**48**	10	**17**	✓	61	171
Subsidized Housing Opportunities (2017-18)	**6.1%**	6.2%	**21**	▬	6.2%	18.6%
Quality of Life and Quality of Care			**20**			
PWD Rate of Employment (2016-18)	**38.1%**	25.3%	**1**	✓	21.4%	38.1%
Nursing Home Residents with Pressure Sores (2018)	**4.8%**	*	**1**	*	7.3%	4.8%
Nursing Home Antipsychotic Use (2018)	**17.8%**	18.5%	**44**	▬	14.6%	7.8%
HCBS Quality Benchmarking (2015-19)	**0**	*	**38**	*	1.30	3.60
Support for Family Caregivers			**34**			
Supporting Working Family Caregivers (6 policies)	**0**	0	**38**	▬	3.17	13.50
Family Responsibility Protected Classification (2019)	**0**	0			0.29	2.00
Exceeds Federal FMLA (2019)	**0**	0			0.29	3.00
Paid Family Leave (2019)	**0**	0			0.50	3.50
Mandatory Paid Sick Days (2019)	**0**	0			0.85	3.00
Flexible Sick Days (2019)	**0**	0			0.75	3.00
Unemployment Insurance for Family Caregivers (2019)	**0**	0			0.49	1.00
Person- and Family-Centered Care (3 policies)	**3.00**	1.28	**28**	✓	3.04	5.50
Spousal Impoverishment Protections (2019)	**1.00**	0.28			0.90	2.00
Having Caregiver Assessment (2019)	**1.00**	1.00			1.34	2.50
CARE Act Legislation (2019)	**1.00**	0			0.80	1.00
Nurse Delegation and Scope of Practice (2 policies)	**4.50**	4.00	**13**	✓	3.30	5.00
Nursing Tasks Able to be Delegated (2019)	**3.50**	3.50			2.69	4.00
Nurse Practitioner Scope of Practice (2019)	**1.00**	0.50			0.61	1.00
Transportation Policies (1 policy)	**0**	0	**8**	▬	0.14	1.00
Volunteer Driver Protection (2019)	**0**	0			0.14	1.00
Effective Transitions			**22**			
Nursing Home Residents with Low Care Needs (2017)	**13.1%**	*	**41**	*	8.9%	2.1%
Home Health Hospital Admissions (2017)	**14.7%**	17.6%	**7**	✓	15.8%	13.8%
Nursing Home Hospital Admissions (2016)	**14.4%**	13.8%	**22**	▬	16.8%	4.7%
Burdensome Transitions (2016)	**20.1%**	19.2%	**5**	▬	28.6%	16.2%
Successful Discharge to Community (2017-18)	**49.9%**	*	**48**	*	53.9%	68.5%

* Comparable data not available for baseline and/or current year. Rank cannot be calculated without current data. Change in performance cannot be calculated without both baseline and current data.
ADRC/NWD = Aging and Disability Resource Center/No Wrong Door
CARE Act = Caregiver Advise, Record, Enable Act
FMLA = Family and Medical Leave Act
HCBS = Home- and Community-Based Services
LTSS = Long-Term Services and Supports
PWD = People with Disabilities

Key for Change:

✓	Performance improvement
▬	Little or no change in performance
✗	Performance decline
*	No trend available

DESIGNER GENES
A·DOWN·SYNDROME·SUPPORT·NETWORK

HB 1012
Senate Appropriations
Thursday, March 11, 2021
Senator Ray Holmberg - Chairman

Chairman Holmberg and Members of the Senate Appropriations:

My name is Roxane Romanick and I'm representing Designer Genes of ND, Inc., as their Executive Director. Designer Genes' membership represents 260 individuals with Down syndrome that either live in our state or are represented by family members in North Dakota. Designer Genes' mission is to strengthen opportunities for individuals with Down syndrome and those who support them to earn, learn, and belong.

Individuals with Down syndrome have made many strides in living in their homes, schools, and communities because of educational and medical advances, public policy, and advocacy efforts. Public investments in early intervention, family support, public schools and special education, post-secondary school options, and home and community-based services do make a real difference for people with Down syndrome. The vast majority of our membership are living in home and community-based settings. Thank you for your important part in opening up these opportunities.

My daughter, Elizabeth, and our family are an example of the positive outcomes of this investment. Elizabeth has been a consumer of services from the first day of her life when her Early Intervention staff visited her in the hospital until the present with support from Vocational Rehabilitation and the Minot State Access Disability Services and the ASTEP program. Her education was supported by special education and general education from 2002 to 2018. A number of her job experiences have been supported by Vocational Rehabilitation. As a family, we have been supported by Family Voices of ND as well as the connections we've made through Designer Genes and the rest of the Down syndrome community across a wide arena of areas. All of these services and supports poured into a reservoir that she is depending on as she works on an Early Childhood Paraprofessional Associates from Dakota College of Bottineau. Who would have thought?

Our organization has interest in a number of areas of HB 1012 and this single piece of testimony is presented to draw your attention to those areas:

1. **Developmental Disabilities Division**
    a. **Restore the Experienced Parent Program Funding**
    The Experienced Parent Program has been a part of the North Dakota Part C Early Intervention system for close to 25 years. The program provides funding to hire parents who had children in Early Intervention to support and mentor other parents in

the Early Intervention system. Originally, the funding was contracted out through our Human Service Centers.

In the current baseline budget, the program was been funded with $100,000 of state general funds and $160,000 of the federal Part C grant through the Department of Education. This funding was secured in the 65th session. This past December, Tina Bay, Director of the Developmental Disabilities Division, informed the North Dakota Interagency Coordinating Council that the $100,000 of state general funds would be cut. This was understood to be part of the Department's savings plan. In addition, it became known that the $80,000 was no longer included in the budget for the federal Part C grant, nor is it in the one for FFY '21. This leaves the program unfunded and thus eliminated. **I am asking that this loss of $260,000 for family support in our state be restored**.

Family-to-family support, parent support, peer support – call it what you want - is a critical element in sustaining the confidence and competence for families who have children with special health care needs. While we don't receive any state and/or federal funds, to offer an example, Designer Genes is designed expressly with that purpose in mind. In a 2005 research study of postnatal support of mothers of children with Down syndrome (mere_43_304.196_212.tp (brianskotko.com), the vast majority of mothers reported a desire to be connected to their local down syndrome organization "which can provide practical knowledge in addition to establishing the beginnings of a long term support relationship."

Our families who are raising children with special health care needs depend on connecting with peers who have lived experience either through their own experiences or through helping other families. We need structured approaches to matching families with other families like Family Voices of North Dakota does through their Parent-to- Parent program.

In this same spirit, we are asking for a full restoration of funding for family support that are in Children and Families as well as Behavioral Health. A total of $30,000 is being cut from agreements with Family Voices of North Dakota and Federation of Families. In total, this would be a loss of almost $300,000 for the very programs that keep many of our families on requiring deeper end services.

b. **Payments for Developmental Disability Services** – We stand in support with other advocacy efforts and the DD provider system to ensure that HB 1012 has the necessary funding for Developmental Disability Services. Our individuals across the life span from infants and toddlers in our Early Intervention (Infant Development) to our oldest individuals with Down syndrome rely on this system. We agree that a 3%/3% provider

increase is needed to address wage pressures and workforce shortage. Every dollar makes a difference in our communities, so we also ask that the Department continues to pay the accreditation costs.

2. **Vocational Rehabilitation**
    a. **Restore state general funds for the Centers for Independent Living –** If anyone should be testifying on this section, it's my daughter, Elizabeth. Through Dakota Center for Independent Living (DCIL), she was able to get her driver's permit. DCIL's active engagement on the Bismarck-Mandan Mayor's Committee on People with Disabilities helped her to know about their scholarship program, of which she's been awarded funding the last 3 years. Probably what she would tell you about the most though is their Youth Empowering Social Status (YESS) movement and the opportunities that she's had to develop leadership, speak publicly, and connect to other youth and young adults with disabilities and without. Sustaining our four Centers for Independent Living is another piece if assuring individuals with disabilities in our state live quality lives.

Thank you for your time and I will take any questions that you may have.

Roxane Romanick
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The Arc
North Dakota

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Testimony House Bill 1012
Senate Appropriation
March 11, 2021

Chairman Holmberg and members of the Committee, my name is Kirsten Dvorak. I am the executive director of The Arc of North Dakota, which includes all six Arc chapters in North Dakota: Bismarck, Bowman, Dickinson, Fargo, Grand Forks, and Valley City. Our mission is to improve people's quality of life with intellectual and developmental disabilities and actively support their full inclusion and community participation.

According to the Developmental Disabilities Assistance and Bill of Rights Act (DD Act) and other federal legislation, "disability is a natural part of the human experience…". Prevention activities do not diminish the value of individuals with intellectual and/or other developmental disabilities (I/DD) but instead strive to maximize independence and enhance people's quality of life with I/DD.

Individuals with intellectual and/or other developmental disabilities deserve the opportunity for a full life in their community where they can live, learn, work, and socialize. To achieve this goal, they need a comprehensive, person-centered and directed, system of appropriate high-quality long-term supports and services (LTSS), a well-trained, fairly compensated workforce of providers, and direct support professionals.

The quality and effectiveness of LTSS for people with I/DD depends upon qualified providers of supports and services with adequate skills and training. Inadequate compensation hampers both recruitment and retention of direct support professionals (DSP). Insufficient funding would negatively impact the quality of support available to people with I/DD and the success that individuals have in living the life they choose in the community.

The Arc
North Dakota

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It has been over 40 years since The Arc of North Dakota began the task of eliminating the state institution at Grafton. In 1980, The Arc was called the ARC, and the Life Skills and Transition Center (LSTC) was named the Grafton State School. When the lawsuit to close San Haven and the Grafton State School was dismissed in 1995, it was with the understanding that the state would continue to work to keep our citizens in their homes and communities. The Arc of North Dakotas' vision of closing LSTC has not changed. The Arc of North Dakota supports the census reduction and is a provider that specializes in crisis and stabilization services. We also support the need for a new state hospital for specialized care, as they cared for 18 clients diagnosed with I/DD in 2020.

However, we have concerns about the decrease in the disability services budget. The reduction would jeopardize the promise of keeping our citizens in the programs to participate fully in their communities, where they experience personal independence. We ask that you reinstate the 11 million dollars of funding. Funding is used for person-centered home and community supports delivered in natural community environments for individuals that don't qualify for waiver services.

I urge you to help us look for answers to a problem that has troubled us well over the 40 years.

Kirsten Dvorak
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701-989-4934

North Dakota Centers for Independent Living

To: North Dakota Senate Appropriations
From: North Dakota's Four Centers for Independent Living
Subject: Funding for Independent Living Programing in HB 1012
Date: 3/11/21

Chairmen Holmberg and Members of the Committee,

My name is Scott Burlingame, I am the Executive Director of Independence, Inc. a Resource Center for Independent Living located in Minot. I am here today to speak in support of the full funding for Independent Living Programing in HB 1012.

The funding for independent living services in the last biennium was $73,756 towards a federal match, and $1,675,406 in general funds for a total of $1,749,163.

In your handout (see figure 4) you can see a map of the four Centers for Independent living in our state, and the area they serve. As you can see, Dakota Center for Independent Living serves the southwestern part of the state, Freedom Resource Center serves the southeastern area, Options Interstate Center serves the northeastern part, and at Independence, Inc., we serve the northwestern quadrant.

All Centers for Independent Living are required to provide five core services, which are: **Independent Living Skills Training, Individual and Systems Advocacy, Peer Counseling, Information and Referral, and Transition from institutional settings to community living, as well as for youth who are out of school**. We also provide community services such as **systems advocacy, community education, accessibility consultations and outreach.**

One of the most important things to understand about the value of Independent Living is we are, at our core, people with disabilities serving other people with disabilities. Over half of our staff are persons with disabilities. We are people who have faced obstacles and barriers, fought back, overcame them, and have now dedicated our lives to doing our part to help others achieve their dreams.

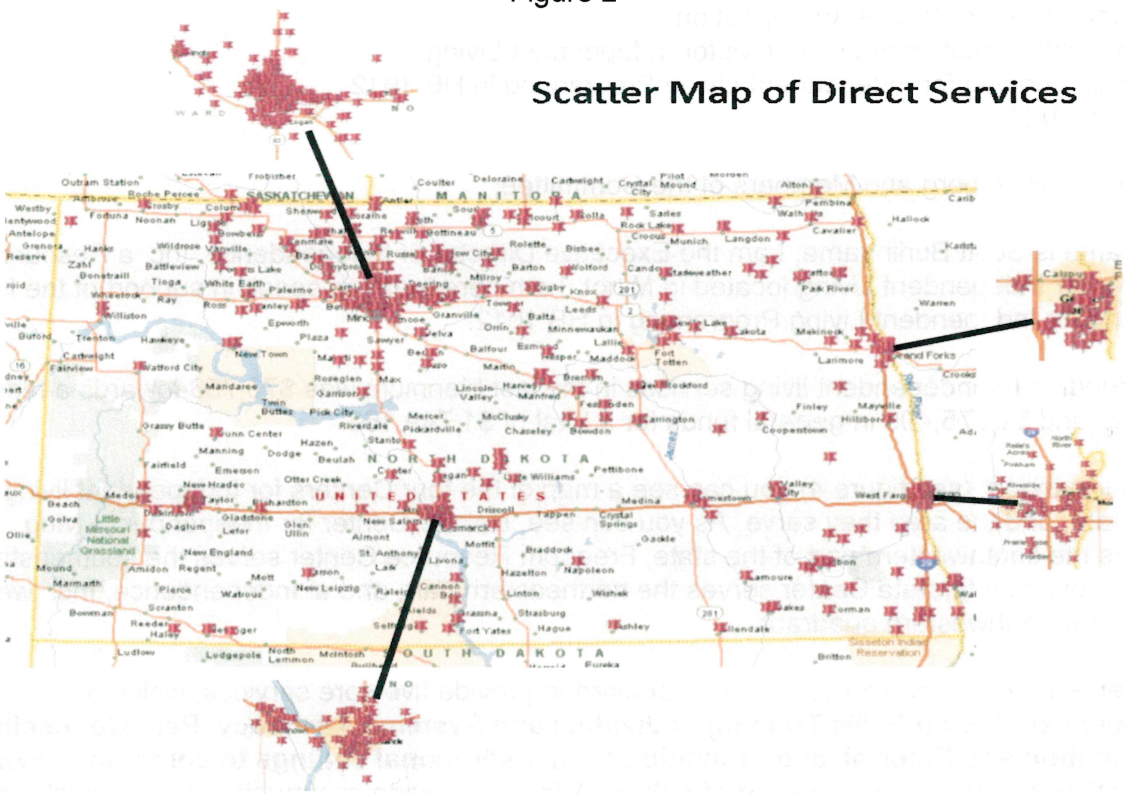
Centers for Independent Living are peer driven and peer led. In addition to our staff, over half of our management and board of directors are also persons with disabilities. Our disabilities are as varied as those of the people we serve, but make no mistake, our staff are also trained and capable professionals. The average Independent Living staff in North Dakota has 11 years of experience. Our staff have college degrees in areas like Social Work, Education, Rehabilitation Counseling, Vocational Evaluation, Developmental Disabilities, Psychology, Communication and more.

As we talk about our need for funding, please remember our network has never been fully funded. According to a study we commissioned back in 2015, it would take over $8,000,000 to fully fund our network and meet the needs of every person with a disability in our state. The fact that we are so far from that number means each of our local Centers must make decision on how best to spend our limited resources and to provide the best impact for our investment in our individual communities.

The funding provided by the state of North Dakota has been a game changer in our ability to serve North Dakotans with disabilities. We have presented you with a map with a pin showing the address of each of the people served by a Center in the past two years (see figure 1). As you can see, despite our limited funding, we have been able to provide a variety of services across the state.

Without the state funding, most of those pins will disappear.

Figure 2



Our local Centers have the ability to respond to our unique community needs. This means we can help a senior in High School with a learning disability in Crosby to pass his driver's test, or we can help a Senior Citizen from Grand Forks County who wants a ramp for their church. We can help a woman with a new physical disability in Wahpeton to find accessible housing or we can help a 40-year-old with a brain injury in Bismarck to learn to pay his bills,

Our local controls mean we can be partners in building local communities as well. A few of the many things we have done is helped the Grand Forks and Jamestown Airports to accommodate people with disabilities in their emergency preparedness, provided trainings to landlords on accessible housing, taught disability awareness to elementary age students, and held a public forum on overcoming the stigma around mental health and addiction.

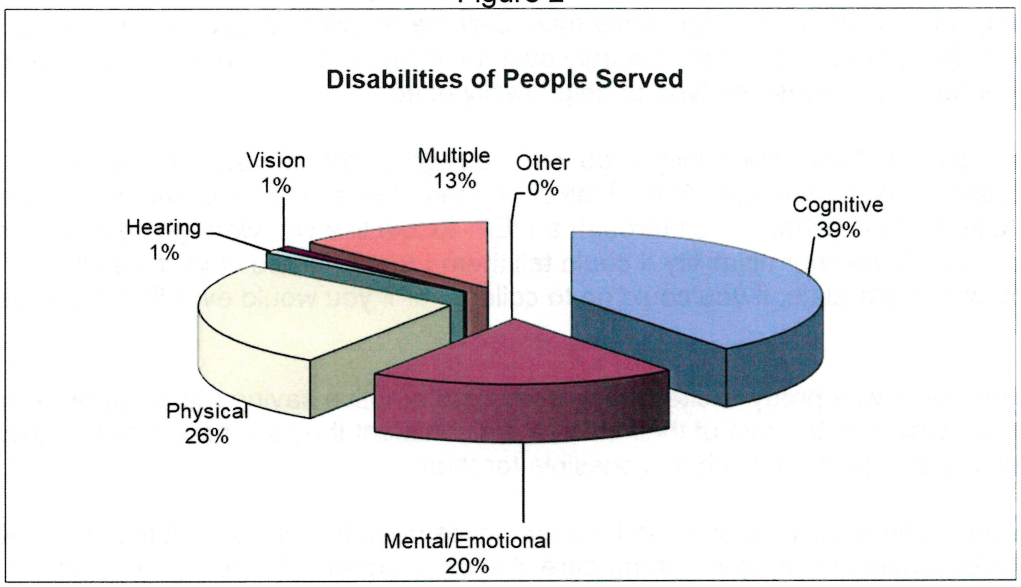
In the past two federal fiscal years, our CIL's have prevented 41 persons from entering nursing homes or other institutions and assisted in relocating 54 people from institutional care. According to our estimates (see figure 5), this outcome has the potential to save the state $6,239,505.00, and even more the longer people are able to stay in their own home.

As you listen to the testimony on all the programing in HB 1012 it has to seem overwhelming and at times be difficult to understand all the programs and services available to North Dakotans. As I am sure you have discovered, the services and supports available to people with disabilities vary greatly depending on age and medical diagnosis.

That is not true at Centers for Independent Living.

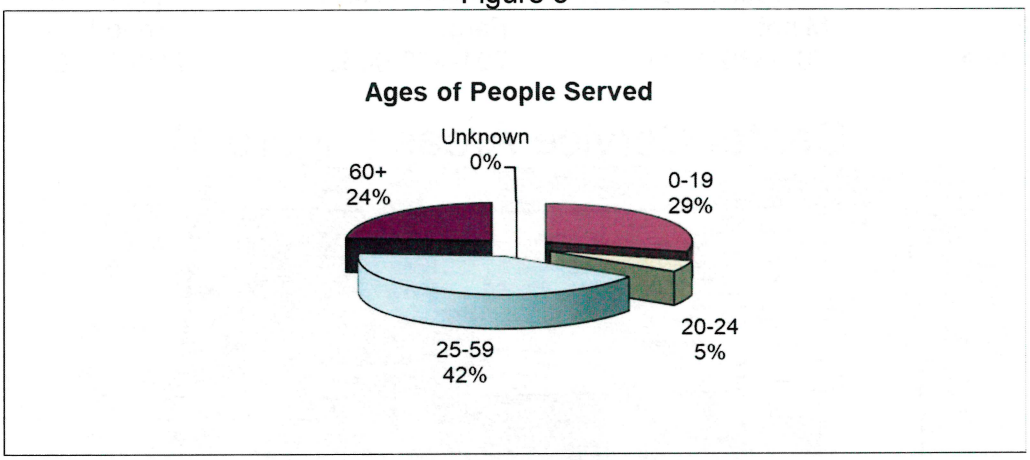
At Centers, we serve and all types of disabilities (see figure 2). In the past two years, 39% of the people we serve have cognitive disabilities, such a learning disabilities or autism, 26% people are people with physical disabilities, such as spinal cord injury, arthritis, or cerebral palsy, 20% are people with mental health type disabilities, like depression, substance abuse disorder, or bipolar disorder, and about 1% each are who are Deaf/hard of hearing or Blind/visually impaired. Around 13% of the people we served reported multiple disabilities.

Figure 2



We also serve all ages (see figure 3). This includes 29% under the age of 19, 5% age 20-24, 42% between the ages of 25-59, and 24% age 60 or over.

Figure 3



Eligibly for Independent Living is not based on disability type or age. It is based on very simple criteria:

- Are you a person with a disability?
- Does that disability affect one or more of your major life areas?
- Do you want Independent Living Services?
- Are you willing to set a goal and do your part to achieve that goal?

It is the self-determination that is inherent in how we do things that makes our programing so successful. There is much focus on Person Centered planning as a best practice in today's service delivery model, however, without solid self-determination, Person Centered planning will never succeed.

Here is an example, a long time ago, I was a student on an Individualized Education Plan (IEP). I went to meetings at my school, with my parents, teachers, special education teachers, school counselors, and other professionals. As a student who was struggling with how to write, that was a pretty intimidating room. You could have built the programing around my needs, and it may have helped, but I was not able to truly overcome my disability until I accepted it and was confident enough to request the type of help I really need.

Two years ago, I had the opportunity to go into the High School in Velva and work with kids who were a lot like I was at their age. When I talked to them, I was able to tell them I knew what it was like to struggle in school, to sit through an IEP, to feel like you were going to be defined for the rest of your life by your disability. I could tell them I remembered what it was like to not be sure if you would graduate, if you could go to college, or if you would ever find a successful career.

I have to tell you; I was pretty excited when I received a notice saying these students had graduated on time with the rest of their class. I am confident they are now entering adulthood with a better understanding of what is possible for them.

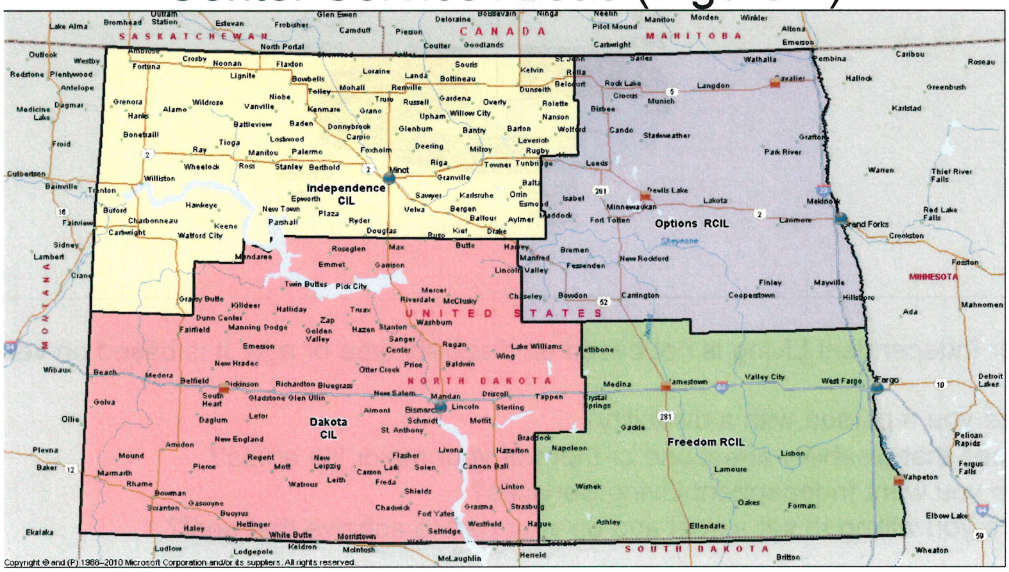
Independent Living is cost effective and a smart investment for the state. It is part of the solution to the ever-increasing costs of long-term care, it is an alternative to the high cost of dependency, and it is the right thing to do. People who live independently live longer, they are happier, and it saves the taxpayer money.

I would gladly answer any questions you may have.

Center for Independent Living Executive Directors

Royce Schultze	Scott Burlingame	Angie Bosch	Randy Sorensen
Dakota CIL	Independence, Inc.	Freedom RCIL	Options RCIL
Bismarck	Minot	Fargo	Grand Forks
701-222-3636	701-839-4724	701-478-0459	218-773-6100

Center Service Areas (Figure 4)



(Figure 5)

POTENTIAL INSTITUTIONAL CARE COSTS SAVED BY NORTH DAKOTA CENTERS FOR INDEPENDENT LIVING

Part of the Core Services of Independent Living Centers is to assist persons with disabilities in either leaving or preventing their placement in institutions. This effort by the four Centers for Independent Living in North Dakota has the potential to save the state $6,239,505.00. This potential savings is the difference between what it costs for individuals to live independently using the average monthly cost rate compared to institutional care average rates. Nursing Home cost rates were reported by CMS, for Older Adults and people with disabilities, (CMS Data by State & Waiver Program Page 1 table 43, 2015) compared to the average nursing home cost, (personal communication ND DHS, Aging Division, Money Follows the Person Program) The institutional care rate was adjusted for room and board. The information is for the time period FYs 19 and FY 20.

$	**9,523.00**	**AVERAGE NURSING HOME COST PER MONTH**
	x 70%	**ADJUSTMENT FOR ROOM AND BOARD @ 20%**
$	**6,666.00**	**ADJUSTED COST PER DAY FOR NURSING HOME CARE**
$	**6,666.00**	**ADJUSTED NURSING HOME RATE**
	x 12	**DAYS OF THE YEAR**
	$ 79,992.00	**COST PER YEAR FOR NURSING HOME CARE**

$ 79,992.00	**COST PER YEAR FOR NURSING HOME CARE**
14,313.00	**AVERAGE COST PER YEAR** (waiver Program Expenditures OlderAdults & PD, CMS data 2015
$ 65,679.00	**COST SAVINGS**
x 95	**PEOPLE WITH DISABILITIES**

$ 6,239,505.00 TOTAL POTENTIAL SAVINGS

Note: Centers for Independent Living reported Independent Living Services prevented 41 persons from entering nursing homes or other institutions during the last budget period and assisted in relocating 54 people from institutional care.

Testimony Regarding House Bill 1012
Scott Burtsfield, The Vocational Training Center
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
March 11, 2021

Good Afternoon. My name is Scott Burtsfield, and I am extremely honored and privileged to serve as the Executive Director for the Vocational Training Center (VTC), a licensed service provider for people with intellectual and developmental disabilities, located in Fargo, North Dakota. I want to first thank you for the opportunity to speak to you about House Bill 1012.

As most of you are aware, in 2018 a new payment system was implemented that forever changed the landscape regarding how North Dakota pays for services to those providing care and support for individuals with Intellectual and Developmental Disabilities. Now, a couple of years into the new system, we realize our task is not quite completed.

We still have work to do - and we are doing it. Community providers, working diligently and collaboratively with Developmental Disabilities Division leadership, have recently rebalanced deficiencies pertaining to inadequate reimbursement rates for day-time services. Essentially, whether supported individuals attend their Day programs or not, providers of those Day Services remain responsible for providing 100 percent of the staffing, resources, etc. without compensation for the services and expenses they incur based on the expected attendance. Though the issue was evident at the onset of our payment system over two years ago, it has only worsened over time.

These issues compounded with increasing regulatory requirements, escalating operational costs, and rising employment related expenses have forced many provider organizations to be looking at ways of doing much more with much less.

As you can see, in our industry, there is no shortage of trials, tribulations, transformations and reforms. However, through it all, there has been one fundamental element to the success of the individuals we support. This has always been our Direct Support Professionals (DSPs).

For most of the state's providers of I/DD programs, well over 80% of budgets go directly to the salaries and benefits of Direct Service Professionals, and rightfully so. They are undeniably invaluable as the core personnel providing direct care services for North Dakota's most vulnerable citizens.

The incredible Direct Support Professionals in our state literally give their blood, sweat and tears to provide support and care for the state's most vulnerable population. Their jobs are often demanding, stressful, and physically and emotionally exhausting. At times, their work is even dangerous or harmful. But they also form bonds of trust and companionship that transcends stereotypical "worker/client" relationships, often becoming like family members.

However, our DSPs are increasingly held to much higher standards in terms of what is expected of them in their day-to-day work. In the last nearly three years there has been heightened standards, training requirements, data collection and entry…the list goes on. These expectations have been imposed upon them with implementation of many of the new rules, policies, and mandates since the implementation of the new payment system.

As a show of appreciation for DSPs increasing roles, responsibilities, expectations, and hazardous job duties, the Governor is recommending our DSPs and our services for individuals with disabilities be treated as "less than." "Less than" his recommendations for increases in other industries, "less than" his support for other professionals, and "less than" state employees who do not face being hit, bit, kicked, covered in human excrement daily.

The Governor's recommendation of a 1% living adjustment comes at a time when it is increasingly difficult to retain current employees and attract potential candidates, a time when our DSPs keep seeing the cost of living continues to rise while their spending power decreases, a time in which it much easier and tempting to find employment outside of our field, and a time when most major retailers and other local industries such as service jobs, warehouse and fast-food positions are offering better pay with much less pressure, responsibility and regulatory requirements. For example:

- A local manufacturing company's starting pay is $2.00 per hour more for an entry level position.
- Average Administrative assistant salaries statewide are over $1 per hour more than our DSP's and don't even come with the added benefit of the potential for bodily harm our DSPs face every day!

- Recently, our organization actually placed 2 individuals in entry level jobs making more than the DSPs that are supporting them in that job!!

- McDonald's, Walmart, COSTCO and many others have starting wages greater than the DSPs in those communities.

I've spent over well over 25 years working in the nonprofit world. I believe I speak for many when I proclaim that we're used to making do and having to just get by. We're used to

balancing priorities based on budget restrictions. We're used to stretching the dollar as much as we can. It's truly a shame the things you get used to. But the supported individuals and DSPs in our state deserve better.

Therefore, I am asking you to not compromise services to the state's most vulnerable adults or jeopardize the workforce that supports them. Please cast aside the Governor's recommendation and support NDACP's request to leave provider services rates unscathed and support a 3% increase for each year of the biennium for service providers and the Direct Support Professionals we employ.

Again, I wish to thank you for the opportunity to speak to you about House Bill 1012.

Scott Burtsfield, Executive Director
The Vocational Training Center

scott@fargovtc.org (701) 551-3149

Testimony on HB 1012
2021 Legislative Session
March 11, 2021
Sen Holmberg Senate Appropriations Chairperson

Senator Holmberg and Members of the Committee

My name is Donene Feist, I am the Director for Family Voices of North Dakota. I come before you today regarding HB 1012.

Family Voices of North Dakota is statewide family to family health information and education center who serves families of children with special health care needs in ND. Each state in the country and our territories has one family organization that has been designated as a family to family health information and education center by HRSA federally. We are that entity for ND. We provide emotional and informational support to many families across North Dakota who have a child who has a chronic health condition and/or disability. In addition to the support and 1:1 assistance we provide to families, we also provide various trainings and workshops, which help families understand how systems work so that they can also be good stewards of state dollars and the programs of which their children are enrolled. Our staff, who all are parents to children with special health care needs, provides assistance to families by helping them access and navigate services; explaining what the services mean, how systems work, and where the funding comes from; by providing emotional support to assist with their unique and individual needs.

FVND follows the Maternal and Child Health definition of children with special health care needs, which is those children and youth who have a chronic condition of at least one year, a physical disability or mental health/behavior health diagnosis. Additionally, there are many children and youth who may have a physical disability and a chronic health illness but also may have a co-occurring mental health diagnosis. Because of many families have a co-occurring condition, it often leaves families having to understand and navigate many systems and complicated silos. We receive our referrals through agencies, physician offices, out of state hospitals where a child/youth may be receiving services.

All of our services under the auspices of the statewide health information and education center are performed through parent-to-parent mechanisms through our staff. In addition, we run a parent-to-parent matching program called North Dakota Parent-to-Parent which provides connection of one parent to another as a mentor for emotional support. This program mirrors the "peer support" program that you may be familiar with in the behavioral health system; of which the Federation of Families provides to families. However funding for peer support outside of the behavioral health system has not been prioritized.

In partnership with Designer Genes since 2012, we provide support through a project called Project Carson. Project Carson provides emotional and informational support to families who may receive a ***prenatal diagnosis or an at birth diagnosis***.

We continue to experience an increase in the number of calls and requests for assistance from families and providers. On the last few pages of my testimony I have included the data we collect on the calls we receive and the help that is provided.

We are requesting that the dollars described be fully funded and placed back into HB 1012. The need for family support is not going away. Dollars for family support sadly have been reduced for the Federation of Families for Children's Mental Health and Family Voices of ND. Sadly, dollars for family support through the Experienced Parent program have been eliminated in the 1012 budget.

Families desperately need a place to go to get the help that they need. Through funds appropriated in the 2015 session and 2017 session, we have been able to increase staff time. We often encounter families who are in crisis and experiencing difficulty accessing services because of denials and ineligibilities. Current staff are assisting families across ND. Funds allocated, not only help meet increase in demands for assistance to families and professionals 1:1, but also for ongoing training, and development of educational materials. Our mailing list has steadily increased to nearly 7394 across the state.

FVND does have concerns regarding the 1915i, and how many children will be screened eligible. We are also very concerned about the Department eliminating the autism voucher and moving those funds to the autism waiver. Some of the children and youth that were served through the voucher will not be transferred to the waiver

which will again cause a gap for those with an autism diagnosis. This would be a travesty for some families. There continues to be a wait list for the autism waiver, in my opinion, this would not be eliminated by moving voucher funds to the waiver and again, what happens to those children and youth who are already being served.

In addition to the proposed change to the autism voucher, I do want to mention in SB2256, Senator Dever a sponsor, would approve a study to be done on children and youth with a developmental disability, identifying the gaps in services and how they are being served. Many children do not qualify for the DD waiver, unless they have an ID diagnosis which leaves many children behind. Diagnosis such as Down syndrome, Spina Bifida, cerebral palsy, muscular dystrophy and autism etc. to name a few. While we have done well in trying to gap fill with the medically fragile waiver, hospice waiver and autism waiver, we have not gotten to the meat and potatoes to look at the system as a whole and how to best serve all children and youth with a developmental delay. This has been a vital need for a long time as many families continue to not receive any services.

What we know through prevalence data for ND from the Data Resource Center 2018-2019 is there are approx. 30,244 children and youth who have a special health care need in ND. One in five families in North Dakota has a child with special health care needs.

That data also indicates that:

32.4% of this population utilize public insurance (this may include income eligible Medicaid and waivered Medicaid
12.6% use only private insurance
52.4% of this population use both private and public
21.7% of this population were currently at the time of the survey uninsured.
For those who may use the 1915i state plan amendment would fall into a very narrow category.

In previous years ND Kids Count Data indicates that 86% of parents with children eligible to receive services are not aware of available programs. We feel that this is still an issue five years later. ***People cannot access what they do not know exists*.** In essence, we do the work to help families, one of our most vulnerable population the how to access the provider networks they will need in raising their child with a chronic illness and disability. Who then would provide this service to families?

Most recently, through focus groups to identify family's needs through the Money Follows the Person initiative, we learned families needed assistance in navigating and understanding the various systems and silos, a streamlined approach, need to connect with others, application assistance and help coordinating services. We also know through a survey that we completed with DD Program Managers which revealed many of them do not know local resources and this is where FVND plays a very valuable part to systems of care.

Our data collected below and on the final sheets of this testimony, is information that all staff collect and is aggregated. I share the information to help you understand the magnitude of information that we collect daily.

The included table identifies the ongoing increase in the number of calls that are received by our office. We are on our 20th anniversary as a nonprofit. Eighteen years ago, our total contacts were 518 families and 427 providers. As you can see we have had a steady increase in the number of contacts to staff from families and professionals. Our federal fiscal year is July 1 through June 30 of which this data is reflective.

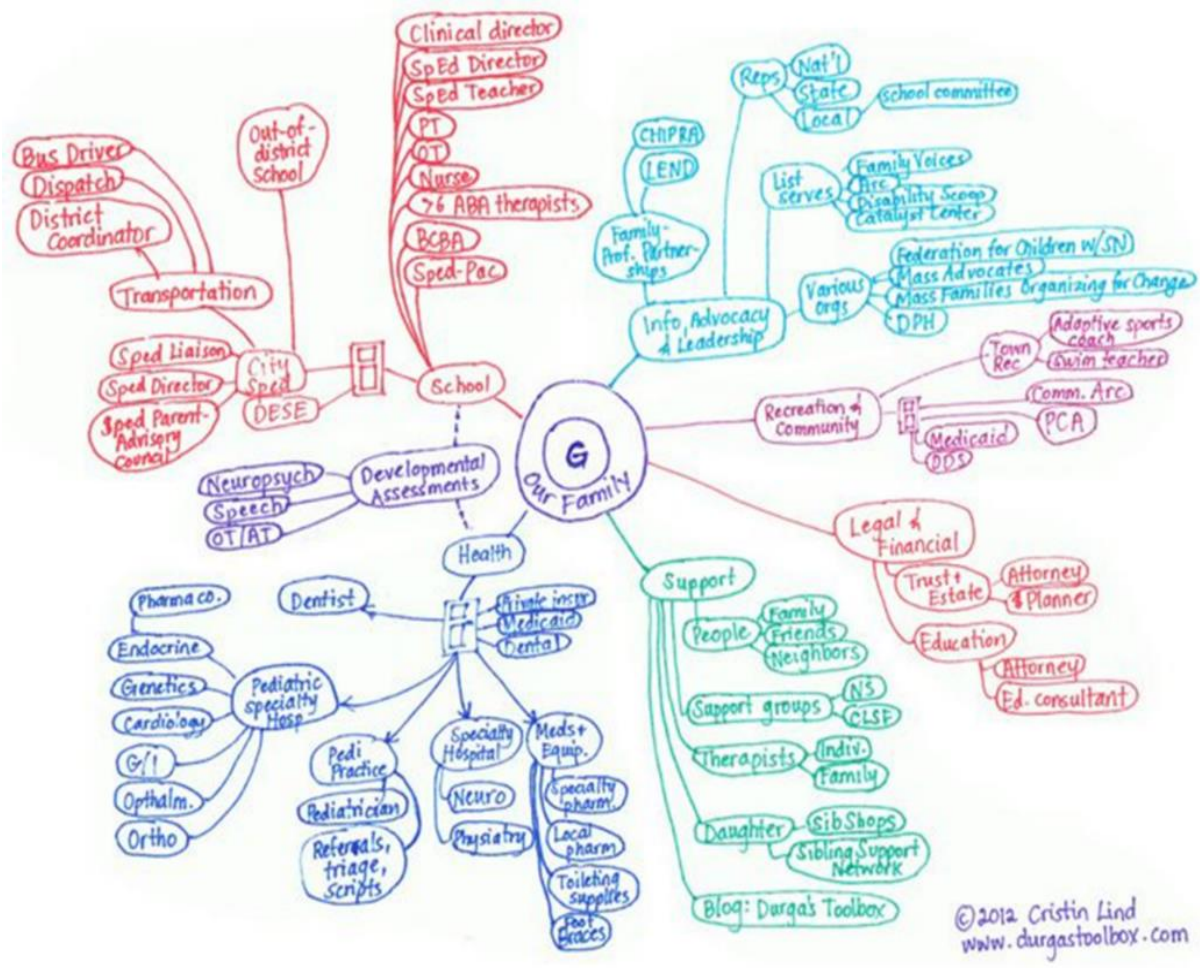
Total Encounters of all calls	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**June 1, to Dec 31, 2020**
Families	**2865**	**3260**	**3712**	**4026**	**4172**	**4233**	**2296**
Professionals	**2339**	**2499**	**2893**	**3076**	**3158**	**3273**	**2173**
Totals	**5204**	**6059**	**6605**	**7102**	**7330**	**7506**	**4469**

As stated earlier, many times, our encounters with families are heightened because the family is in crisis. We have noted that the issues being presented by families today are being increasingly complex. This year with the Covid pandemic, many of our families were in crisis.

Our staff work with a large number of families who experience gaps in service, have difficulty understanding the complexities of our Medicaid systems and Medicaid

waivers, and their private insurance who have children with very complex medical issues. Many providers contact us to make a referral or to assist them in locating resources for families they are working with. Families often do not know where to begin. We will partner with them in making those connections to community resources, possible eligibility criteria and programs, assist them with the application process, follow up with them to assure their family needs are being met, and provide ongoing emotional and informational support.

In the diagram below you will see children with a chronic condition or disability utilize many services. Most services that families encounter are in silos.



We know and can identify as best practice that families thrive when supported by others with lived experience. We also know that families build capacity, strength and confidence through support and coaching from another parent. Active engagement with families through responsive listening from others who have walked

in the same shoes assists families in a manner that allows them to receive services necessary to meet their family and child's needs.

Families across North Dakota have repeatedly shared the difficulty in locating and accessing services when they call our offices. Raising a child or youth with special health care needs, accessing quality services and paying for them while still meeting the needs of the entire family and maintain employment is stressful.

Senator Holmberg and members of the committee, I have stood before you all for many years. The needs for families to live, thrive and survive in their community has also increased. We often **hope for the best, but don't know what the future holds in a world and system that wasn't built for our children.** There is no handbook or parenting book about raising a child with special health care needs and disabilities.

Most of our children don't fit a mold. All are uniquely their own, and many have multiple diseases or disorders so rare that often doctors have never seen. Early on families realize with a heavy heart, the world we live in isn't built for our children. Each and every day families are fighting someone about some aspect of their care. It could be a doctor, nurse, therapist, educator, or an insurance company. Every day families launch battles for what we know our children need to thrive, and sometimes our fight ends in defeat.

Every day many families are fighting a battle against a disability, disease or chronic illness that we will never beat. Most of families know the very real implications of what can happen to our children at any given time.

Our role is not only to provide support, assistance in navigating and connecting to services to families, but through or various trainings and workshops, help families understand how systems work so that they can also be good stewards of state dollars and the programs of which their children are enrolled. A valued provider has stated "It is important to ensure that there are adequate supports for families, as these strengthen the family unit as a whole. This results in a decreased demand for providers as you are creating lasting change within the family unit."

Again, we are requesting that the dollars described and removed above be placed back into the budget for HB 1012. The need for family support is not going away. Do the most vulnerable families in the state not deserve assistance?

In closing, let us remember as each of us makes decisions that will affect children—whether we are parents, educators, health professionals, or government officials—it is our duty to consider if that decision either affirms or denies a child's most basic human rights. **Families are not looking for handouts, but they do often need a rope to hang on to, to keep from drowning in an every changing system. Family support is vital, to help them live, thrive and survive in an every changing world.**

The data shared on the last few pages are from federal fiscal year July 2019-June 2020 is to illustrate not only the number of calls but the type of information families and providers call us about. Additionally, several families we have assisted have shared information with you. I have also included a document that was done by the Federation of Families, Designer Genes, Protection and Advocacy, Family Voices regarding the importance of family support.
We thank you for your consideration.

Donene Feist
FVND Director
701-493-2634; fvnd@drtel.net

FAMILY VOICES OF NORTH DAKOTA®
Navigating Crossroads to Hope

Family Voices of North Dakota

Family Voices Data Report

From 7/1/2019 Through 6/30/2020

The following data has been tracked and summarized from contacts and activities recorded in FV Solutions. Please print this report and input these totals, matching the questions, along with your other information into the online Data Report Form.

SECTION A.UNDUPLICATED COUNTS

OVERALL # of Families and Professionals Served

Families	Professionals
1116	560

of Families and Professionals Served by Type of Assistance

Families	Professionals	
1074	534	through 1-1 assistance
272	134	through training (identified individuals)

SECTION B. DUPLICATED COUNTS

of Families and Professionals Served by Type of Assistance

Famlies	Professionals	
4233	3273	through 1-1 assistance
640	247	through training (identified individuals)

O1 THRU O6. # of Families and Professionals Served by Outcome

Community-Based Svcs	Families	4186
Community-Based Svcs	Professionals	3362
Financing	Families	717
Financing	Professionals	388
Medical Home	Families	718
Medical Home	Professionals	302
Partnering	Families	1513
Partnering	Professionals	4071
Screening	Families	189
Screening	Professionals	211
Transition	Families	391
Transition	Professionals	263

Duplicated Totals of Health Care Financing Issues Reported through 1-1 Assistance

Financing Issue: Denial of Coverage

Professionals	1	Medicaid
Families	16	Medicaid
Families	1	Private Healthcare
Families	1	Other Financing Pgm

Financing Issue: Denial of Service/Other

Professionals	2	Medicaid
Families	33	Medicaid
Families	1	CHIPRA
Families	1	State Public Pgm
Families	1	Other
Professionals	1	Private Healthcare

Families 3 Private Healthcare

of Families and Professionals Served by Outcome Sub Category

	# of Families/Profs Assisted 1-1:	# of Families/Profs Trained (Tracked Individually)	# of Families/Profs Trained (Estimated)
Community-Based Services			
Basic Needs (food, clothing, etc)	89		
Bullying/Violence	5		
Child Care	17		
Comm Relationships-Resources	4699	621	946
Cultural Brokering	2	1	
Disability Awareness	19	5	
Disability-Specific Info	849	112	204
Emergency/Disaster Planning	107	26	
Family Support	3507	512	963
Home Care	2		
Home/Vehicle Modification	2		
Hospitals/Clinics	39	3	41
Housing	33		
Immigration/Citizenship		1	
Legal Services	102		
Other	46		
Parenting/Foster Care/Adoption	32		
Pet Therapy/Service Dogs	1		
Recreation	916	10	
Respite	209	23	
Safety/Injury Prevention	15		
Schools	696	65	
Social Determinants of Health	182		43
Special Needs Planning	15	71	
Substance Abuse	1		
Transportation	47		
Unspecified	49		
Utilities	2		
Financing			
CHIPRA	23	69	104
Donations/Grants	3	8	
Health Exchange	22	83	
Medicaid	436	109	207
Other	65	4	37
Other ACA	14		
Other Public	206	26	29
Prescription Assistance	1		
Private	267	4	29
Public Assistance (SSI/TANF)	113	128	
School-based	3		
State-funded	12		
Tri-CARE/Military	1		

Medical Home

Assistive Technology	27	14	
Care Coordination	330	22	64
Child Development	45	62	
Cultural Competence	24	7	
DME	25		
Healthy Weight	1		
Immunizations/Vaccines	1		
Interpreters/ASL	2		
Life Course		3	
Medical Home (model/concept)	1	25	18
Medications	35		
Mental/Behavioral Health	429	10	
Nutrition	12		
Oral Health	8		
Other	6		
Physical Activity	1		
Primary Care	6		
Record Keeping/Care Notebooks	1	13	
Sexuality	3		
Specialty Care	54	6	
Supplies (diapers, Formula, etc)	5		
Testing	12		
Therapies	83	26	
Unspecified	12		

Partnering

Advancing Knowledge	435	244	946
Advocacy	749	102	139
Communicating w/ Providers	2780	262	584
Cultural Competence	54	88	315
F2F Collaboration w/ Professional	1651	174	238
Family Collaboration w/ Protessional	24	27	
Family-Centered Care	66	95	202
Involvement w/ Title V	494	47	610
Mentoring	98	126	120
Other	10	1	37
Parent Leadership Development	7	87	8
Systems Involvement	1113	227	1063
Unspecified	2		

Screening

Autism Spectrum Screening	42		
Developmental Screening	64		79
Diagnostic Testing	22		
EI / IEP Screening	49		29
Genetic Testing	71	30	100
Mental Health/Behavioral Screening	17		
Neuropsych Evaluation	4		
Newborn Hearing	121		66
Other	14		
Speech/Language Screening	1		
Unspecified	1		

Transition			
Adult Provider	20	3	
Community Involvement	2		
Driving/Transportation	1		
Guardianship Alternatives	10	80	
Health Skills Training	20	63	15
Higher Education	15		
Independent Living/Housing	5	2	
Navigating Adult Services	142	100	95
Other	14		
Person-Centered Planning	4		
Relationships/Socialization	1	13	
School Transitions	45	18	95
Self-Determination/Self-Advocacy	9		80
Sexuality/Sexual Safety	28	15	
Special Needs Trusts	3	68	
Suicide Prevention	12		
Teen Councils / Leadership	12		
Unspecified	137		
Vocational / Employment	23	16	80

Total # of Hardcopy Materials Disseminated

Total Materials Disseminated Through 1-1 Assistance: 1718

Total Materials Disseminated Through Activities: 55262

Total: 56980

Total # of Trainings: 144

Total # of Meetings (not including Trainings): 518

To the Members of the Senate Appropriations,

Three years ago, my six year old daughter, Addilynn, was fighting for her life in PICU in Minnesota after seizures nearly took her from us.

Four years ago, I attended the Parent Leadership Institute through Family Voices of North Dakota. I have also reached out to their staff on numerous occasions for guidance and support.

Both of these moments have changed my life and my daughter's. Addilynn has a very rare genetic disorder that causes developmental delays and difficult to treat epilepsy. My ability to advocate for her changed dramatically after attending the Parent Leadership Institute. It has helped Addilynn get the medical treatment, equipment and therapies she needs to thrive. It has helped me insure that she has qualified and competent individuals caring for her when her family cannot. Without the services that Family Voices of North Dakota provides, I would not be able to advocate for her in the manner in which I do now…which would have a great effect on her quality of life.

I urge you to reconsider the budget cuts made to the Family Voices of North Dakota programs. Family of children with special health care needs NEED agencies like Family Voices to help them navigate a confusing and sometimes scary system for their children.

I know that my daughter would not be thriving today without the advocacy skills and support that I have received from Family Voices of North Dakota.

toby.jean.carlson@gmail.com

To the Members of the Senate Appropriations,

I would just like to give due praise to Family Voices of North Dakota. This particular program has been so helpful to my family on many levels.

I have a son who is now 18 his name is Kaden and he has a rare disease called leukodystrophy. He is totally dependant on us for all his care. Being a parent of a child with special healthcare needs can be very overwhelming, which is why programs like Family Voices are absolutely vital to families in ND.

I have many stories I could share of the help they have delivered, but I will tell the one that really introduced us to them and what they stand for. In 2010 my son Kaden suffered a brain hemorrhage and needed brain surgery along with months of recovery. It was the most afraid and overwhelmed I ever have been. In that moment I called Family Voices for guidance and support and they were there for my family.

They went above and beyond in support and pointing me in the direction I needed to go. They were amazing in their ability to jump in and really be there. I have used their services for many things from emotional support, help in guidance through the medical system, training me to be a better parent to my son, and help in general questions.

I have worked with many non-profit organizations, and Family Voices has been the most efficient and caring. I can't express enough how much FVND has meant to our family. I know if I call them tomorrow with a question it will be answered. In a world with a lot of runaround that means so much. They are worth every bit of funding and need to stay as a big presence in our state. As a parent I am so grateful for them!!

Amanda Burner

Minot ND

amanda.burner@outlook.com

To the Members of the Senate Appropriations,

We are so thankful for Heather Wheeler staff of Family Voices of ND in Williston.

Our family has been blessed with a beautiful little boy who is now 6 years old who faces many challenges due to his disabilities, including Fetal Alcohol Syndrome, Autism Spectrum Level 2, ADHD and anxiety.

As we embrace these challenges along side him we have often felt lost, afraid and very alone. This path will never be easy, but after my first phone call with Heather, I realized that we will never be alone. There will always be someone there to help us navigate through this uncharted path and help us get back up if we fall.

In the world of FAS they say that if you know one child with FAS, you only know one which with FAS. This is because FAS is so different due to the brain damage to each child.

Heather and Family Voices of North Dakota, although she may only know Jaxson; Jaxson is who she knows well. Jaxson needs her and so do we. Thank you so much for putting this support in our lives

The Kostad family

Williston ND

kostadcrew@hotmail.com

To Members of the Senate Appropriations Committee,
HB 1012

I would just like to speak for a few moments regarding Family Voices of North Dakota. This particular program has been so helpful to my family on many levels. My son was diagnosed at 3 with Autism, he will be 13 yrs old by the time you read/hear this.

Being a parent of a child with special needs can be very overwhelming, which is why programs like Family Voices are absolutely vital to families in ND. They have been there for us guiding us thru process's and listening to frantic calls on how to deal with behaviors, schools, and helping guide us into therapies for our son. Even though he is almost 13 now and we are in a groove they are still there for us. They went above and beyond in support and pointing me in the direction I needed to go. They were amazing in their ability to jump in and really be there. I have used their services for many things from emotional support, help in guidance through the medical system, training me to be a better parent to my son, and help in general questions.

They aren't just there for the family member with a disability, they are there for the whole family. Specifically, recently my husband ended up in the hospital on a ventilator for 45 days with Covid. They were there thru my tears and my heartache and my joys. They listen and guide without judgement. Without them we would have been lost in the shuffle of the system. We need them so more families do not get lost in the system. They aren't just a vital part of my family; they are my family.

Family Voices is the most efficient and caring for the whole family. I could go on and on but there are truly a million reasons why need them. Please restore their funding because without them the state would feel a great loss. As a parent I am so grateful for them!!

Toby Cherney
Jamestown ND
chernfamily5@daktel.com

Testimony HB 1012

Mr. Chairman and members of the committee:

My name is Stephanie Orr and I am asking you to please protect the general fund dollars that Family Voices receives in HB1012.

My family is one among many, many families within North Dakota that has been helped by Family Voices of North Dakota. I have a 10-year-old son that was diagnosed with Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) in 2015. I was referred to Family Voices during one of the darkest years of our lives. I felt absolutely alone and unsure about how to move forward with this rare diagnosis. My son had been kicked out of two separate daycares for violent outbursts that he could not control. Family Voices helped me navigate my childcare options and later pointed me in the direction of Bismarck Early Childhood Education Program (BECEP), which I had never heard of before. Vicki Peterson, from Family Voices, came to our meetings with BECEP staff to help support us. We would have been completely lost without her! She ensured that my son was evaluated for services and, once he qualified, she helped make sure that his needs were covered in an IEP.

Before Family Voices stepped in, I was in way over my head. I had no experience whatsoever with disability and special education services. There are services in place to help families, but when a family is facing a new and scary diagnosis, there is no way for families to find out about those services if someone isn't there to guide them. Family Voices is that someone. Not only were they there to fight for us, but they taught me how to advocate for myself and my child. They have helped me grow in ways I could have never imagined.

Family Voices also supports parents thru their Parent Leadership Institute each year. Every parent that has attended will tell you the same thing – it changed their life. Not only have I learned a ton about advocacy and how our government and healthcare systems work, but I have made life-long friends. I now have a whole network of people in my life that are always there to help, support and encourage me.

I don't know where we would be without Family Voices. I have gained more from them than I could ever put into words. When I look back, it is really scary to think what would have happened had we been on our own. We just did not have the tools or knowledge to navigate what we were going thru. I know other families dealing with the same diagnosis across the nation that have not been so lucky and have had to institutionalize their children because they didn't know there was any other option. Family Voices has played a huge part in getting us where we are today – happy, healthy, together.

I am asking you to please help protect the funding for Family Voices in HB1012 so that more families have a success story like ours!

Thank you for your time and consideration.

Steph Orr, Bismarck stephanie_orr@hotmail.com

Testimony on HB 1012
2021 Legislative Session
January 26, 2021
Sen Holmberg Appropriations Chairperson

Chairman Holmberg and members of the Committee

Hello, my name is Beth Larson-Steckler and I am writing in opposition to HB1012 specifically the cut to Family Voices. I am writing as a health advocate, as an individual that worked in mental health and as well as a parent whose children have complex chronic conditions. I submit this letter with the permission of our two children: Ellyse Steckler and Josh Steckler.

My husband had a genetic condition, PRSSI, or hereditary pancreatitis. We were unaware that he carried this gene or the high rate of transmission to our children. His disease advanced and he died of pancreas cancer. Unfortunately, the gene was passed to our two children. This disease is extremely painful. There is no cure, only treatment for symptoms. Our children's health deteriorated to the point where they were constantly in the hospital. We were provided one option. The treatment was a radical treatment called Auto Islet Transplant, pancreatomy with splenectomy.

Navigating the systems of care when you have a child with any health conditions much less complex chronic health condition is overwhelming and quite honestly brutal. The number of children with chronic health conditions has been rising nationally. Internationally and nationally, it has been recognized that organizations such as Family Voices are vital to families whose children have chronic and or complex health conditions for multiple reasons.

When a child is diagnosed with a chronic or complex condition it is overwhelming, frightening, and often isolating for parents. The medical system as well as other systems that one becomes involved in when a child receives a diagnosis can be very dismissive of families. Professionally, I worked at navigating systems of care for families whose children experienced significant mental health challenges. I saw firsthand the barriers they faced. Those barriers were often erected by those working in the mental health system, as well as systematic barriers. Many in the field had no idea what these families were dealing with. They were provided categorical services that were available, not that met their needs. Their concerns often dismissed. When I met families, they often were overwhelmed, and felt they had no voice and that their concerns did not matter. I always provided information on entities such as Family Voices that could provide support and navigation as well as connection to other parents that had similar life experiences. Family Voices advocated for these families, attended meetings with them. Educated them on their rights and made them aware of supports that those in the system had not made them aware of. With the support of Family Voices, parents found their voice; they felt empowered, they felt supported. They were assisted in navigation of a complex system. They were provided educational opportunities to learn to advocate for their child and other children. This is critical. This is NOT a 'fluff' service. What Family Voices provide is necessary and should be accessible to all families. I believe to this day, that entities are

still not providing this information to family consistently and families often must find out about this through other channels.

When our children started becoming sicker, I thought that because of my previous professional positions and knowledge I would be able to successfully navigate the health care system as well as other systems that my children needed. The sicker they became the harder it became. When my husband passed, I had no support. My children both underwent multiple transplants. The outcomes were poor. My daughter has chronic pain, brittle diabetes, malabsorption issues, gastroparesis, dysautonomia, eating issues as she was starved (per her specialists' recommendation) severe medical trauma, depression, and anxiety among other health issues. My son had chronic pain, battled C-diff for three years, tachycardia, dysautonomia, asthma, medical trauma (PTSD), malabsorption. Neither has a spleen, pancreas and they only have half a stomach. I was overwhelmed. There are only seven places that does this transplant and often those that have complications are on their own to find answers. While prior to their transplant I had support of this medical team, after with their complications, they were unsure what to do. I was on my own. Multiple specialists provided conflicting recommendations, my concerns as well as my children often were dismissed, and their education was suffering. Their mental health issues became worse because of medical trauma which impacted their health and behaviors. I continued to reach out to organizations, supports and services that I was aware of and yet no assistance was provided. Our lives became about literally fighting to survive. I was ashamed that I was failing my children.

The school filed an abuse and neglect on me. Obviously, this is not something I like to discuss as it is embarrassing. I worked in the mental health system. Again, I want to reiterate that I have asked my children's permission to share what I am sharing today. My kids missed school and a lot of it. My daughter had chronic pain as well as my son. They also had GI issues. My son fought C-diff for three years. During this period, I would struggle to get him to school. I did call the police on him several times. They would question why I was sending my son to school when he would have constant accidents. I reached out myself to social services. My daughter started not taking care of her health issues. I should have been cognizant that this was a result of medical trauma but at the time I was unaware. Even though I reached out to social services, abuse and neglect reports were filed. I was doing everything in my power to assist my kids. I had reached out to social services and asked for assistance, I had gone to the top specialists, I had accessed treatment for my daughter. Finally, at this point I reached out to Family Voices. I was lost. I was exhausted and felt I was losing my children I was afraid that they would be taken away or that they would die. Family Voices provided me support at my son's school meetings. They encouraged my voice when it was silenced. Family Voices provided me information about supports and services. They provided me training. I believed that with my education, knowledge of the system that I would be able to navigate the care my children needed. I was not. Family Voices provided me the support that many others did not. This is not uncommon. The more I have become involved in advocacy nationally and internationally I have listened to the stories of many families had multiple resources at their fingertips and they often express how marginalized they were when they advocated for their

children's health. It was organizations such as Family Voices that empowers. As parents, we are the main caregivers of our children. We have expertise in our children and our voices should be heard. We are partners.

My kids are young adults now. We still have numerous health and mental health battles, but things are better. I am Co-Founder of National Childhood Pancreatitis Foundation, state chair of North Dakota National Pancreas Foundation, member of other various national and international advocacy groups focused on treatment of chronic pain, medical trauma and other issues related to health care.

The health care and mental health care systems are becoming more and more complex. As stated, before it can be an enormous undertaking for parents to navigate systems to ensure their child is getting the necessary care. It is overwhelming, it is frightening and isolating. Family Voices is staffed with individuals who understand the experience of parents. They can truly empathize and understand the journey of a new diagnosis, navigating the systems. Family Voices has considerable expertise in the system – not as an untouched medical provider or educational provider- but someone who has experienced and knows the barriers that seem invisible to many that work in the health care system. It has been demonstrated that one of the most effective aspects for parents are organizations such as Family Voices. By eliminating funds, you are essentially eliminating the voices of parents whose children have chronic and complex needs. We need Family Voices. As a parent with a Masters in Sociology of health, a BS in psychology and criminal justices and years working to assist other families to navigate care, when I found myself in a similar position, I struggled with that navigation. Not, that I did not have the skills. The system is brutal and complex, I began to not trust myself, I became overwhelmed and depressed. Family Voices honestly, helped me get my voice back. Quite honestly, we need more funds allocated to Family Voices and more staff. As parents, we provide most of the care to our children. We ARE partners and should be treated as such. Cutting Family Voices is not only inconsistent with national and international steps working to increase organizations like Family Voices, it is silencing the voices of North Dakota caregivers, parents, and patients. Cutting allocations is cutting a lifeline of support from parents, children, and youth. This would be extremely detrimental.

If you would like to speak to me more, please do not hesitate to contact me. My phone number is 701-202-1522. You can also e-mail me at socnavigations@yahoo.com

Sincerely,

Beth Larson-Steckler

Supporting Families in North Dakota: Through the Lens of Lived Experience



Family Story

Family Voices of ND has been a valuable resource for me and my family. They have provided me with valuable training and knowledge about resources networking in my community and areas around me. My husband and I now have a better understanding of how "the system" that our child, with special health care needs, is in. Everything can be so confusing, but this knowledge has better equipped us. There have been topical calls to further enhance our learning. This is extremely beneficial to us and other families, so we can understand what everything is all about in this world that we must now live in, that we were so totally unprepared for. Also, a big thing I am so thankful for, about FVND is that their line is always open. Sometimes, I just don't know where to begin. I know I need something for my child, I know something just isn't right, but where do I start, where do I go from here? One call is all it takes. This is immensely valuable. FVND usually doesn't just give me the number and say, "try this." Often, the call is made for me, and things get going. Then, I get a call from someone if I needed a referral to another place. I don't end up spending an hour or more on the phone trying to get to where/who I need to. What a relief.

The Parent to Parent program has been an excellent resource as well. I was matched with another parent when I wanted to talk to another parent close in my area who had a child similar in diagnosis to mine. It was very nice not to be paired with someone in another state away. We could discuss what works, what doesn't, and things like local providers and state resources. I felt reassuring to have someone near by to talk with. Then, I was paired with a parent to who wanted to talk to me about their child and I was going to support them. Interestingly, it worked both ways. We enjoyed talking with each other and were able to learn from each other. What kind of things had worked and providers we had found. We actually both benefited and were able to improve the care for both our children!

Supporting families *involves the connection to another person who has also raised a child/youth with a special health care need and/or disability and who has a shared life experience. This connection assures that families get resources and services in ways that are respectful, relevant, and honor their unique choices and perspectives so that they can make informed decisions to achieve the best possible outcomes for their children and/or youth.*

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members, we nurture, protect, and influence each other. Families are dynamic and are cultures unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations.

Developed and adopted by the New Mexico Legislative Young Children's Continuum and New Mexico Coalition for Children, June 1990.



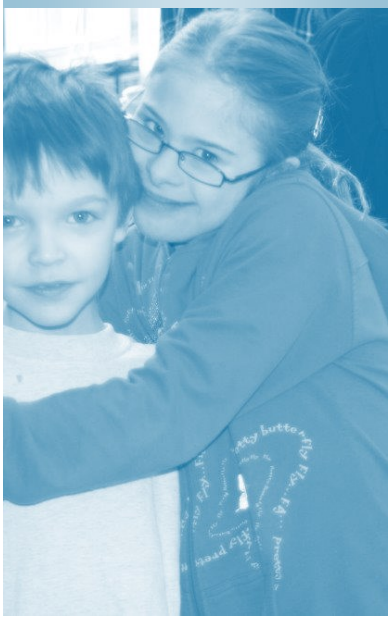
Family Driven

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing supports, services, and providers;
- Setting goals;
- Designing and implementing programs;
- Monitoring outcomes;
- Participating in funding decisions; and
- Determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.

Osher, Osher, & Blau, 2006

Fidelity is trust, accountability, and predictability across the systems of care between all stakeholders within an established and accepted practice. Families of children and youth need fidelity from the people in their lives; teachers, providers, support team, and others. The expectation of fidelity to family driven or centered practices is a fundamental value in family support.



Background

There are an estimated 27,000 children and youth with special health care needs and another 23,000 children and youth with an emotional, behavioral, or mental health condition in ND; 13,000 of these children receive special education.

Research and experience shows that there is much more to meeting the needs of children and youth with special needs than those services offered by providers. Most services are provided according to guidelines that dictate the eligibility, type of service, and access. Because of this, families of children and youth with special needs often serve in a variety of roles to ensure the well-being of their children and youth, such as care management, transportation services, social support, socialization, advocacy, medical treatment, therapies, and other necessary services. And, because family caregivers are generally the primary and/or sole caregivers to their children and youth with special needs, their own physical, mental, and emotional health and wellbeing can impact how they provide that care. As a result, parents of a child or youth with special needs may also experience increased stress, guilt, blame, or reduced self confidence in parenting, which can divert attention from other aspects of family functioning. In turn, this can effect the physical, mental, and emotional health and wellbeing of all of their children and youth.

Children and youth with special health needs include all children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Further...

Researchers and leaders across the nation agree that key to this support is:

-**Connections** to others who have lived experience in successfully navigating the system of care for their own child or youth;

-**Access** to formal and informal information and resources that are family and youth driven/ centered and culturally responsive; and

-Family and youth **choice** based upon their interpretation of that information.

Each component is essential as the foundations of family and youth driven/centered care and support. Family driven/ centered care assures the health and well-being of children and their families through a respectful family professional partnership. Family driven/centered means that families have a primary decision-making role in the care of their children, as well as in the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. Family-driven/centered care is the standard of practice which results in high quality services.



Current State of Supporting Families

Historically, until the past decade, families, youth, and consumers of services had to fight to secure a place at the decision-making table, and typically served in a volunteer advisory capacity. Later, some were paid a "stipend" to cover childcare costs, travel related expenses, and income lost due to missed work. As organizations and individuals became more experienced and skilled, and as programs and service providers saw the value of ongoing support, some agencies contracted with family run organizations and leaders as providers of lived experience, peer to peer support for families of children and youth with special needs. States and their communities have taken the task of developing sustainable support as a critical component to the provision of a continuum of services for families of children and youth with special needs. Many are offering funds and resources for family run organizations to provide support services.

Using representatives from lived experience populations has been on an upward evolutionary process for over three decades. Federal, State, and private funding sources require family, consumer, and youth representatives and a shift towards a more family, consumer, and youth driven approach to serving vulnerable populations. Aside from organizational and funding requirements, the inclusion of a lived experience representative to provide family support has multiple benefits.

Across the Country

In **Arkansas** a community based, family run organization was awarded a contract from the state to provide peer to peer home visiting for targeted families of young children at risk for special needs. The organization was given enough funding to train the trainers of home visitors, hire and supervise home visitations, and to manage the program within nonprofit business practices.

In **North Carolina**, the statewide, family run organization for children and youth with mental health needs received a large, state contract to hire, train, and supervise Family Support Specialists with lived experience across the state to work with providers and ensure a family driven approach to service delivery and evaluation.

Lived Experience

The term "lived experience" has been used to characterize consumer and family members whose experiences are likely to match up to individuals currently receiving services. The term can be used to describe the first-hand accounts and impressions of living as a member of a group, such as those who have used mental health services, families who have been involved in the child welfare system or families who received services through a federal or state program. The core concept of supporting families is based upon an embedded lived experience and a peer to peer approach. One or more of the following might describe an individual with lived experience:

- A parent, family member, caretaker who has raised or is raising a child or youth with special needs;
- Willing to share life experiences in a positive manner;
- Has been involved in and understands multiple service delivery systems;
- Can separate both the good and bad experiences and use them to improve the system response to the families they serve;
- Can use experiences to help other families move beyond perceived limitations;
- Can transfer knowledge to build the capacity of the families served/supported;
- Builds their knowledge of systems through interactions with different families and their needs;
- Has an understanding of where and how to get answers regarding identified needs; and
- Persistence in securing necessary resources and information.

Guiding Principles of Supporting Families

The following Guiding Principles were developed to serve as a foundation for supporting families across the state with special needs.

- **Lived Experience:** Support evolves from lived experience, where families have access to persons familiar with the road who understand the questions, worries, joys, heartache, and celebrations that are a part of the journey;
- **Coactive Navigation:** Families build their capacity, confidence, and strength through support and coaching from another parent who can share their experiences when traveling new paths with their child's or youth's diagnosis.
- **Meaningful Connections**: Families build their capacity, confidence, and strength in navigating systems through active support and coaching from another parent.
- **Active Engagement:** Responsive listening and translation is provided through shared experience and serves as a vital component to assist families in a manner that allows them to receive the services necessary to meet their authentic needs.
- **Critical Partnerships:** The system promotes and models family-professional partnerships as a predictable aspect in establishing family identified needs and services.
- **Unbiased Respect:** ALL support recognizes and builds on the strengths of each family member and respects their choices, culture, and beliefs in an impartial and nonjudgmental manner.
- **Sense of Belonging:** Families have peers with similar experiences standing with them as they identify and use their natural networks to promote a sense of belonging.
- **Ongoing Sustainability:** Adequate efforts and resources are identified and available to ensure the continuity and longevity of supporting families for the duration of need.

Supporting Families: A Sampling of Services

Some of the supporting families services that could be offered to families and the systems that serve them includes:

- Serving on care planning teams with families;
- Building the capacity of families to identify and express their needs;
- Advocating and sharing information on the needs of families;
- Developing or editing material that builds the knowledge, capacity, and skills of families;
- Creating special programs or activities to meet family needs;
- Evaluating the program's response to the principles of family, consumer, and youth driven-centered;
- Creating and collecting satisfaction surveys;
- Discussing with families their specific needs and guiding them to resources;
- Serving as a trainer for in-service trainings;
- Representing the families served on workgroups, taskforces, and/or interagency councils;
- Reviewing program policy to ensure sensitivity to the needs and experiences of families served;
- Creating and facilitating family advisory committees;
- Serving as an family advocate or voice at service planning meetings; and
- Serving as a peer mentor to those served when partnering with professionals or navigating the system of care.

Recommendations

In light of the previous discussion, the following recommendations emerged from the group.

- **Families must have access to organizations that represent the lived experience through:**
    - Referrals to supporting family organizations by all child and youth serving agencies and programs within a specified period of time;
    - Systems that use available evidence based, parent to parent models and family driven principles to connect families; and
    - Family run organizations that provide family support through a memorandum of agreement and within the guiding principles of this paper.
- **Support to families must be accessible on all levels of planning, treatment, and evaluation and feature the following:**
    - Statewide coverage without gaps;
    - Transparency that allows families to make choices on what will work best for them;
    - 24/7 availability;
    - Family driven and centered approaches;
    - Opportunities to access culturally competent support that is respectful and responsive to their own beliefs, values, and customs; and
    - Adequate provisions for urgent and emergency support needs.
- **Families are engaged and have opportunities to build their skills as a parent of a child or youth with special needs through:**
    - Agencies and programs that are committed to assisting family run organizations in identifying families that could benefit from additional training and support;
    - Utilization of family run organizations and their expertise to develop and manage training programs for families that are responsive to their identified needs;
    - Annual trainings within the state to build the leadership capacity of families; and the
    - Availability of a formal career ladder for families with lived experience through a rigorous training and certification program.
- **Family support is viewed as a critical and professional service to the well-being of families of children and youth with special needs and demonstrated through:**
    - An examination of the extent to which current supports are aligned with these principles;
    - Ongoing opportunities for funding and resources to ensure that family run organizations have the capacity to sustain the support they offer;
    - Family leaders have regular opportunities to meet with the Governor, policymakers, and agency management to discuss and review the state of the state in family support;
    - During budget discussions, family support will be considered as a viable alternative to more costly interventions;
    - Regular, consistent, and predictable funding from the state; and the
    - Recognition that program management does not constitute family support in itself.

"Overall, there have been fabulous things going on in the state of North Dakota to support families with children with special health care needs. At the beginning of our diagnosis of our daughter, I felt disconnected, afraid, and outnumbered by children who seemed to live lives as "usual." I have felt quite thankful for the groups that I have been a part of and believe they are a vital part of our system."

A.L. North Dakota

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Next Steps

In an effort to promote the principles and intent of this paper and promote the fidelity of supporting families, we have agreed to the following next steps:

1. Development of a short and long term strategic plan that will outline goals, activities, outcomes, and accountability;
2. Meet with stakeholders and policymakers to establish direction and resource options to finance and sustain family support;
3. Work collaboratively to align our organizations with responsibilities; and
4. Create memorandums of agreement between organizations to minimize competition, repetition, and confusion.



Changing the future,

one family at a time

Contributors

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(701) 258-7412
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Pathfinder Parent Center
Cathy Haarstad, Executive Director
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Executive Summary

North Dakota Family Support;
Sharing Through the Lens of Lived Experience

Research and experience indicates that there is much more to meeting the needs of children and youth with special needs than those services offered by providers. Most services are provided according to strict funding guidelines that dictate the eligibility, type of service, and access; leaving huge gaps to fill in the pursuit of the wellbeing of children and youth with special needs and their families. Meeting the unique and diverse needs of families and their children and youth with special needs can only be accomplished by maximizing contributions of all stakeholders. Family leaders from across North Dakota gathered to discuss how to maximize the capacity of the system and families they serve and their role in targeted support activities that promote the well-being of children and youth with special needs. Through intense strategic planning, the group emerged with a definition, guiding principles, recommendations, and next steps that they feel are critical components of elevating the focus on ensuring and improving the well-being of children and youth with special needs and their families.

Definition of Supporting Families

Supporting families involves the connection to another person who has also raised a child/youth with a special health care need and/or disability and who has a shared life experience. This connection will assure that families get resources and services in ways that are respectful, relevant, and honor their unique choices and perspectives so that they can make informed decisions to achieve the best possible outcomes for their children and/or youth.

Guiding Principles

The following Guiding Principles were developed to serve as a foundation for supporting families across the state with special needs.

- **Lived Experience:** Support evolves from lived experience, where families have access to persons familiar with the road who understand the questions, worries, joys, heartache, and celebrations that are a part of the journey;
- **Coactive Navigation:** Families build their capacity, confidence, and strength through support and coaching from another parent who can share their experiences when traveling new paths with their child's or youth's diagnosis.
- **Meaningful Connections**: Families build their capacity, confidence, and strength in navigating systems through active support and coaching from another parent.
- **Active Engagement:** Responsive listening and translation is provided through shared experience and serves as a vital component to assist families in a manner that allows them to receive the services necessary to meet their authentic needs.
- **Critical Partnerships:** The system promotes and models family-professional partnerships as a predictable aspect in establishing family identified needs and services.
- **Unbiased Respect:** ALL support recognizes and builds on the strengths of each family member and respects their choices, culture, and beliefs in an impartial and nonjudgmental manner.
- **Sense of Belonging:** Families have peers with similar experiences standing with them as they identify and use their natural networks to promote a sense of belonging.
- **Ongoing Sustainability:** Adequate efforts and resources are identified and available to ensure the continuity and longevity of supporting families for the duration of need.



Recommendations

The following recommendations emerged as critical components of advancing family support across the state.

- *Families must have access to necessary connections* though organizations that represent the lived experience, including referrals to supporting family organizations by all child and youth serving agencies and programs within a specified period of time; the use of evidence based, parent to parent models and principles to connect families; and family run organizations will provide family support through a memorandum of agreement and within the guiding principles of this paper.
- *Family support must be made accessible on all levels* of planning, treatment, and evaluation and minimally feature statewide coverage without gaps; transparency that allows families to make choices on what will work best for them; 24/7 availability; family driven and centered approaches; opportunities to access culturally competent support that is respectful and responsive to their own beliefs, values, and customs; and adequate provisions for urgent and emergency support needs.
- *Families are engaged and have opportunities to build their skills* as a parent of a child or youth with special needs through agencies and programs that are committed to assisting family run organizations in identifying families that could benefit from additional training and support; utilization of family run organizations and their expertise to develop and manage training programs for families that are responsive to their identified needs; annual trainings within the state to build the leadership capacity of families; and availability of a formal career ladder for family support providers through a rigorous training and certification program.
- *Family support is viewed as a critical and professional service* to the well-being of families of children and youth with special needs and demonstrated through an examination of the extent to which current supports are aligned with these principles; ongoing opportunities for funding and resources to ensure that family run organizations have the capacity to sustain the support they offer; family leaders have regular opportunities to meet with the Governor, policymakers, and agency management to discuss and review the state of the state in family support; during budget discussions, family support will be considered as a viable alternative to more costly interventions; regular, consistent, and predictable funding from the state; and the recognition that program management does not constitute family support in itself.

Next Steps

In an effort to promote the principles and fidelity of sound family support to ensure the wellness of North Dakota's families of children and youth with special needs, we will develop a short and long term strategic plan that will outline goals, activities, outcomes, and accountability; meet with stakeholders and policymakers to establish direction and resource options to finance and sustain family support; and work collaboratively to align our organizations with responsibilities.

For more information, please contact:

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8410

March 11th, 2021
67th Assembly—Senate Appropriations Committee – HB 1012: Section 11 DD funding

Hello Chairman Holmberg and members of the committee,

My name is Jackie Long and I've been getting Section 11 services from Community Living Services for about 9 years now and they have helped me out a lot. My case manager Janice comes every week and helps me with my pills and helps me with my money. If I have appointments she will help bring me to those too. It is difficult for me to make my own appointments—I need a reminder, and Janice makes sure I make it to my appointments and helps me understand my doctor's orders. I've been working at NDSU since 2014, and Janice also helps me with work and financial stuff, and with my benefits when I need it.

My staff Angie helps me go to Walmart, get groceries, and helps me with keeping up my apartment. It's hard for me to get on my knees and scrub the floors, so this helps me out a lot.

Being involved with CLS has helped me get connected with other activities even though I don't have "Day Hab" hours—For example I go to TNT Fitness every Mondays and Wednesdays to exercise.

In the past when I did not have this support, I had an ex-boyfriend take advantage of me with my credit cards and got me into lots of problems. I went into debt, I lost my job, I lost my home and my housing assistance. My DDPM switched me to CLS and it has helped me so much.

I feel secure and better that I know where my finances are at, and that I have someone to help me make decisions about big purchases when I need them. It's helpful to have someone to help guide me in the right direction, and to help me in making good choices and better decisions, and the Section 11 program has done that for me. It would be too much for me on my own; I don't think I could handle it.

I do hope that CLS can continue this service because the people using Section 11 really do need the help. It would be much harder for us if we were on our own and it would be very difficult to manage things. We do need that support and do need you the keep going with these services. If I did not have this service I would probably be so overwhelmed I might have a nervous breakdown, because it would to so hard for me to manage everything on my own.

Thank you for your time, I appreciate all you do.

Jackie Long
1201 2nd Ave N, Apt 609
Fargo, ND 58102
701-361-1582

8414

March 11th, 2021
67th Assembly – Senate Appropriations Committee -- HB 1012: Section 11 DD funding

Hello Chairman Holmberg and members of the committee,

My name is Jackie Krei and I just started receiving Section 11 services in the last year. Before that, I mostly relied on my family to help me with things. My family likes to help me out when they can, but my mom is now 82 and my dad is in his late seventies so it is not as easy for them to help me out as much these days. I have brothers too, but they have to work, and one has a son with disabilities so it can be tough for him too.

With Section 11, my staff Lashelle helps me with groceries and running errands. She also helps me with coordinating my doctor's appointments and helping me get to them. When things settle down with COVID, she is also going to help me find a job.

In high school I was what some would call a "slow learner" and I was in classes for people with learning disabilities. I also have epilepsy, which can be difficult for me to manage on my own. Sometimes I have trouble explaining things, and sometimes I forget things. When I go to doctor's appointments, and I don't know what to say, Lashelle backs me up, and helps me feel more comfortable and more understood.

I ask you to please continue the Section 11 program to help me better stand up on my own, and to accomplish what needs to be done.

Thank you for your time.

Jackie Krei
436 7th Ave E
Apt 206
West Fargo, ND 58078
701-429-8646

HB 1012 : Developmental Disabilities Section 11 funding

March 11th, 2021

Good afternoon Chairman Holmberg and members of the Committee,

Thank you for the chance to speak with you all today. Upon hearing that the funding for Section 11 is under consideration to be eliminated, I wanted to share with you what I have experienced in my role as Executive Director at Community Living Services about the necessity for Section 11 services, and I wanted to ensure that you had the opportunity to hear from those most impacted by the decision. Of the 77 people in North Dakota that receive services from the Section 11 program, CLS supports 33 of them. These are individuals that have developmental disabilities, but they do not qualify for other DD waiver services.

In most cases, these are people that would otherwise fall through the cracks, and the minimal services that they receive through Section 11 are a lifeline to health, safety, and community integration. The specific needs of Section 11 program participants may not be related to mental health or physical disability, and therefore those currently served in this program, in many cases, would not be eligible for other supports, like QSP or Behavioral Health Supports.

Many of the people we support in Section 11 have been in the program for many years, and the services each person needs vary based on their individual circumstances. For some, the services include assistance with medical appointments and health care supports. For others, it may be money management and budgeting supports. Sometimes it is help accessing grocery stores and pharmacies. In some cases, they need supports to find and maintain employment. Sometimes it is helping with applications for housing and benefits. Additionally, supports have been needed to assist with the impact of the Covid-19 pandemic. In all cases, Section 11 services improve the quality of life for the people receiving it.

Although the current funding for the Section 11 program does not cover the total expense of the providing these supports, we recognize that this program is so significant to its participants, that we are happy to advocate to maintain the current level of funding, so that these individuals are not left without support.

One or two hours of support a week might seem insignificant or dispensable, but to people in the Section 11 program these are crucial. They can protect people with developmental disabilities from unemployment, homelessness, hospitalization, institutionalization, food insecurity, and discrimination.

I urge you to maintain funding for the Section 11 program, so that North Dakotans with disabilities do not lose the supports that mean so much to them.

I greatly appreciate your time and am open to any questions you may have.

Brooke Austin
Executive Director of Community Living Services, Fargo
baustin@clsnd.org

Senate Appropriations Committee

Testimony on House Bill 1012

Senator Ray Holmberg – Chairman

March 11, 2021

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Donna Byzewski and I am the Program Director of the corporate guardianship program at Catholic Charities North Dakota. I am respectfully asking your committee to approve funding as detailed in the Developmental Disabilities Division budget for corporate guardianship services for people with intellectual disabilities. To continue providing quality services to meet the needs of current and future clients, we respectfully ask for a cost of living increase of 3% for the first year of the biennium and 3% for the second year.

The court appoints a guardian when a person's capacity to make decisions is compromised and he or she is at risk of neglect, abuse and exploitation. It is important to note that many adults with intellectual disabilities are their own decision maker. However, there are critical times when the person may need the services of a guardian, and if no one else is available or appropriate, a corporate guardianship is a necessity. Corporate guardianship is the guardian of last resort. Our contract specifies that Catholic Charities ND can only accept referrals from Developmental Disabilities Program Managers from the regional human service centers in North Dakota.

In the past 20 months, we have admitted 71 individuals to our program. We have made great strides reducing our waiting list for services. One year ago, our waiting list was at an all-time high of 126 people and our current list has the names of 92 persons. The reduction is primarily due to the additional legislative funding we received for 20 new slots/openings on 7/1/19. This has had a tremendous impact on the lives of people who were on the waiting list and I sincerely thank you for making this happen!

Our request for the next biennium is as follows:

7/1/21 to 6/30/22	489 wards x $8.37 x 365 days = $1,493,919 489 wards x $0.25 (3% COL) x 365 days = $44,621	$1,538,540
7/1/22 to 6/30/23	489 wards x $8.62 x 365 days = $1,538,540 489 wards x $0.26 (3% COL) x 365 days = $46,406	$1,584,946
7/1/21 to 6/30/23	Petitioning costs	$89,555
	Total for FY 2021 & FY 2022	**$3,213,041**

The request that we are submitting is bare bones, allowing us the capacity to meet the needs of 489 wards during the next biennium. We realize that the Department of Human Services' budget is tight but the requested funding will help assure that we have the staff and resources to meet the complex health and safety needs of the individuals we serve. Thank you for the opportunity to stand before you today and I would be happy to answer any questions you may have.

Testimony for the Older Individuals Who Are Blind (OIB) Program Appropriation within HB1012.

To: Chair Ray Holmberg, and Members of the Senate Appropriations Committee, North Dakota 67th Legislative Assembly.

From: Allan Peterson, Legislative Committee, North Dakota Association of the Blind (NDAB).
Home address: 7009 Horseshoe Bend, Horace, ND 58047.
Home: (701) 282-4644; cell: (701) 429-7209; Email address: allan.c.peterson@gmail.com

Re: Testimony in support of the state Appropriation for the Older Individuals Who Are Blind (OIB) Program within the Division of Vocational Rehabilitation, North Dakota Department of Human Services

Greetings Chairman Holmberg, and members of the Senate Appropriations Committee,

We are testifying on our own behalf, as well as to help represent the advocacy goals of the North Dakota Association of the Blind (NDAB). Our testimony is directed in support of the Appropriation for the Older Individuals Who Are Blind Program within the Division of Vocational Rehabilitation for its operation during the next biennium of 2021 - 2023.

In North Dakota, the Older Individuals Who Are Blind Program is administrated by the Division of Vocational Rehabilitation within the Department of Human Services. Funding for the program is generated through a 90% grant from the federal government which requires a minimum state appropriation of 10%. Federal funding for the program is authorized under the U.S. Rehabilitation Act.

Federal funding for the Older Individuals Who Are Blind program is allocated to the states on the basis of population size. Because North Dakota's population base is small in comparison to other more populated states, it receives what is termed a minimal allocation. Minimal federal funding is a problem for the program here in North Dakota because our state is geographically large in relation to its population size, which necessitates a lot of travel to meet with clients in their homes. Also, our state has a higher proportion of people in the older age ranges, which experience a much higher incidence of sight loss. The Older Individuals Who Are Blind Program is specifically directed to serve individuals who are 55 years of age and older.

Although there have been many significant advances in eye care, sight problems such as macular degeneration, diabetic retinopathy, glaucoma, and cataracts continue to be primary sources of vision impairments and blindness, particularly, for persons who are 55 and older.

The professional staff which are trained to provide the services for the Older Blind Program are classified as vision rehabilitation specialists. In North Dakota there are 6 vision rehabilitation specialists assigned to work in each of the state's 8 defined Human Service regions. Vision specialists, employed in the older blind program, travel to a client's home to do an assessment of needs and provide the services and counseling that is needed in that person's home environment and is individualized to meet client needs. The services of this program have helped thousands of our older citizens who have experienced severe sight impairments to become more independent and enjoy a more productive and fulfilled life in spite of having lost some or all of their eyesight.

The skills and aids that the vision rehabilitation specialists provide to older citizens with sight loss, is often quite an (pardon the pun) "an eye opener" which does much to help them stay in their own homes and postpone or avoid institutionalized nursing home care. The cost savings that are gained by postponing or avoiding institutionalized care and the increased sense of wellbeing and dignity that are realized by being more independent are compelling reasons for the state to provide the appropriation needed for this program in North Dakota. In most instances, the clients served are elderly and live on very fixed incomes so for them to purchase a vision aid that would help them is difficult or impossible.

The rural character of our state and limitations on access to public transportation can mean those who experience severe sight loss are isolated and very dependent on others.

You might ask, among us in ND, **how many today have a loss of eyesight**? The U.S. Senses Bureau estimates that presently there are approximately 762,062 residents in North Dakota. Many credible studies have demonstrated that, conservatively, that **3.3%** among the general population, will have conditions that mildly, moderately, or severely medically compromise their eyesight – this means that more than 20,000 individuals in North Dakota are affected by uncorrectable sight loss - a quarter of whom (5,000) have significant sight loss and/or are "legally blind".

About North Dakota Association of the Blind (**NDAB**): You could say that NDAB is an organization of and for people who are blind or sight impaired. We are a statewide membership organization founded 85 years ago in 1936, a majority of our members are blind or sight impaired.

LEGAL DESCRIPTION

GRAFTON FIRE DEPARTMENT PARCEL

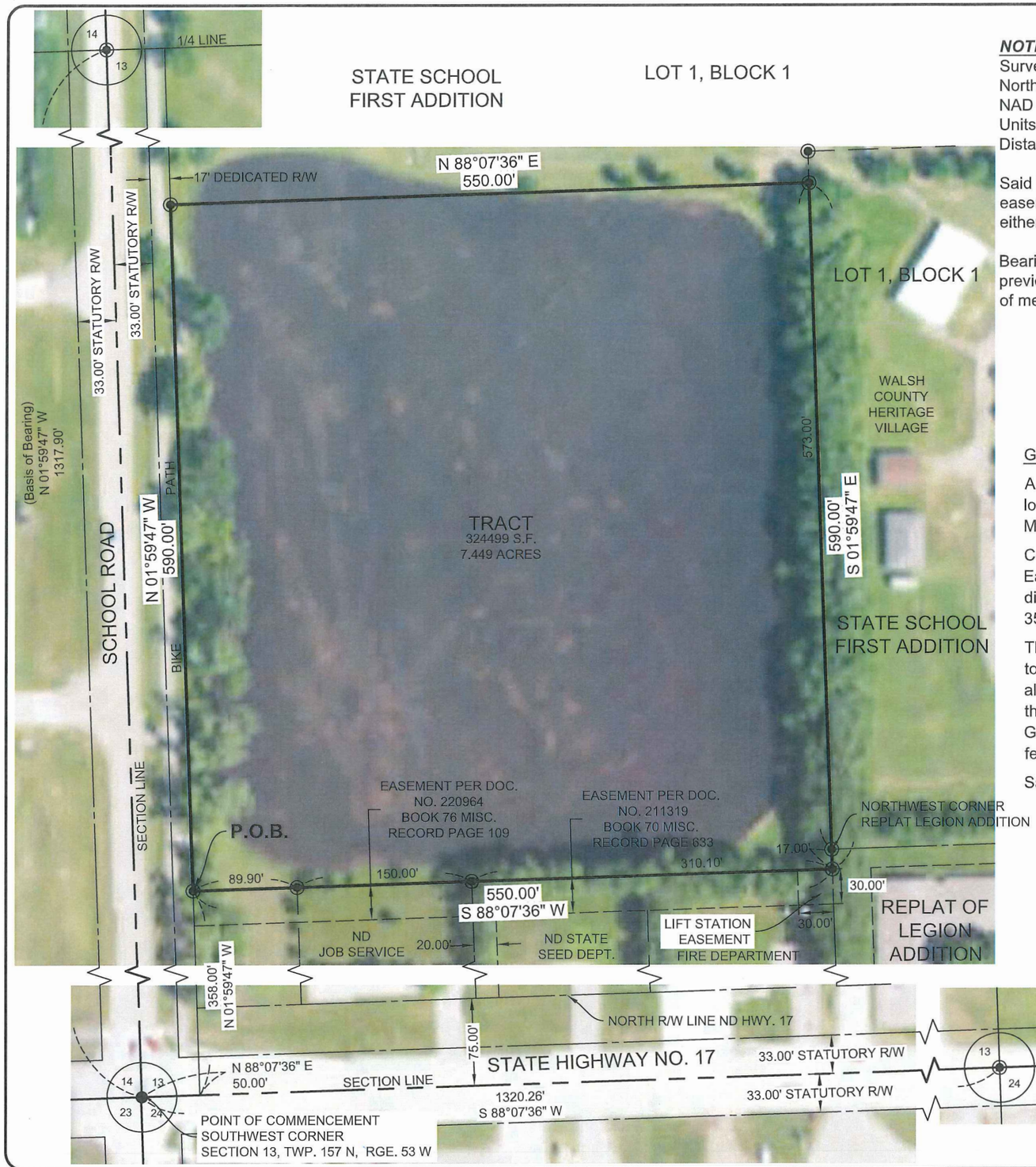
A parcel of land located in part of Lot 1, Block 1, State School First Addition to the City of Grafton, which is located in the SW ¼ of the SW ¼ of Section 13, Township 157 North, Range 53 West, 5th Principal Meridian, more particularly described as follows.

Commencing at the Southwest corner of Section 13, Twp. 157 N., Rge. 53 W., 5th P.M.; thence in an Easterly direction, along the South line of said Section 13, on an assumed bearing of N 88° 07' 36" E, a distance of 50.0 feet; thence N 1° 59' 47" W, and parallel to the West line of said section 13, a distance of 358.0 feet, to the point of beginning [P.O.B.]

Thence continuing N 1° 59' 47" W, a distance of 590.0 feet; thence N 88° 07' 36" E, a distance of 550.0 feet, to a point on the West line of land owned by the Walsh County Heritage Village; thence S 1° 59' 47" E, along said west property line, a distance of 590.0 feet, to a point 17.0 feet south of the Northwest corner of the Replat of Legion Addition to the City of Grafton; thence S 88° 07' 36" W, along the North lines of City of Grafton, North Dakota State Seed Department & North Dakota Job Service properties, a distance of 550.0 feet, to the point of beginning. [P.O.B.]

Said parcel of land contains 7.45 acres, more or less.

7752

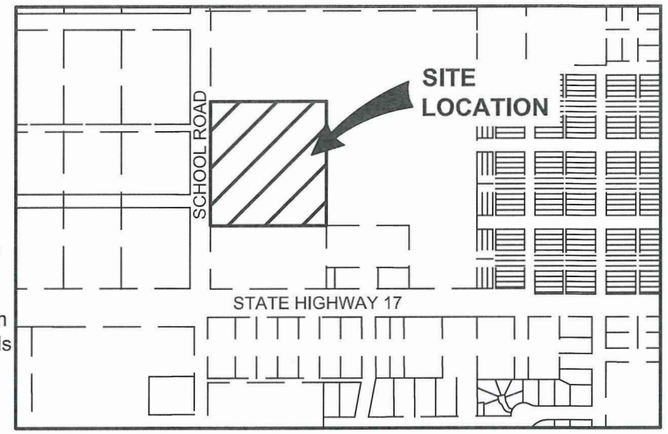


NOTE:

Survey is based on ND State Plane,
North Dakota North Zone
NAD 1983 (Conus)
Units are International Feet.
Distances shown are Grid distances.

Said tract of land is subject to any easement restrictions or reservations, either existing or record.

Bearings and distances may vary from previous plats due to different methods of measurement.



LOCATION MAP

NOT TO SCALE

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I, Dennis Markusen, Professional Land Surveyor, N.D. PLS No. 1194, do hereby certify that the tract survey shown hereon was made by me, or under my direction, from notes made in the field, and the same is true and correct to the best of my knowledge and belief.

Dennis Markusen
N.D. PLS No. 1194

1-9-2015
Date

DENNIS J. MARKUSEN
REGISTERED
LAND
SURVEYOR
LS-1194
NORTH DAKOTA

LEGEND

- Iron Rebar Found
- Calculated PCR

N

SCALE 1" = 100' FEET (50 0 50 100)

Rev'd. Field Book: , Pg. 00-00

BOUNDARY EXHIBIT
GRAFTON FIRE DEPARTMENT
GRAFTON, NORTH DAKOTA

SHEET NO. 1

KLJ

LOT 1, BLOCK 1
STATE SCHOOL ADDITION
GRAFTON, NORTH DAKOTA

DRWN. BY	CHK'D BY	PROJECT NO.	DATE
FJM	JRJ	6615100	01/09/15

© KLJ 2015

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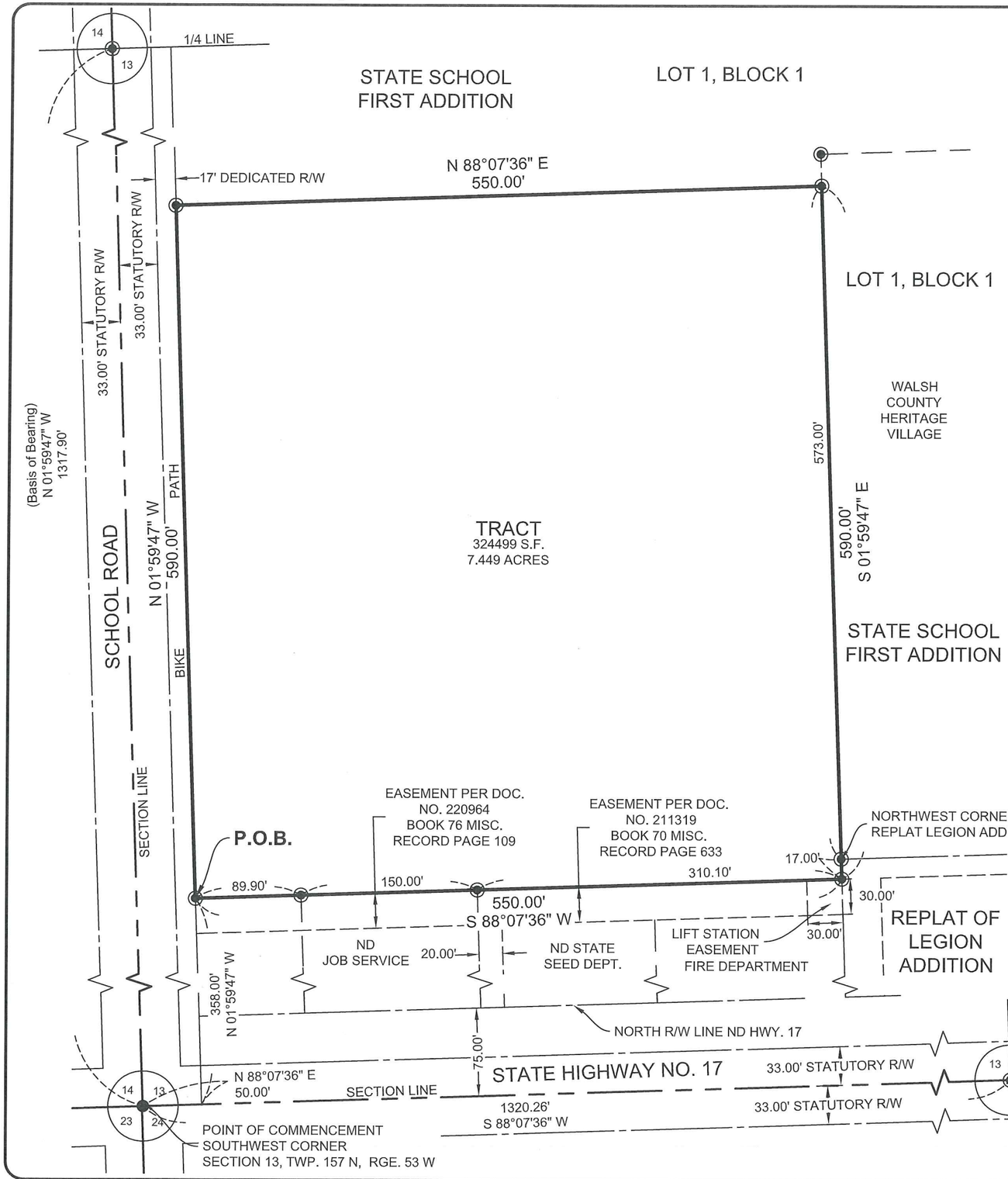

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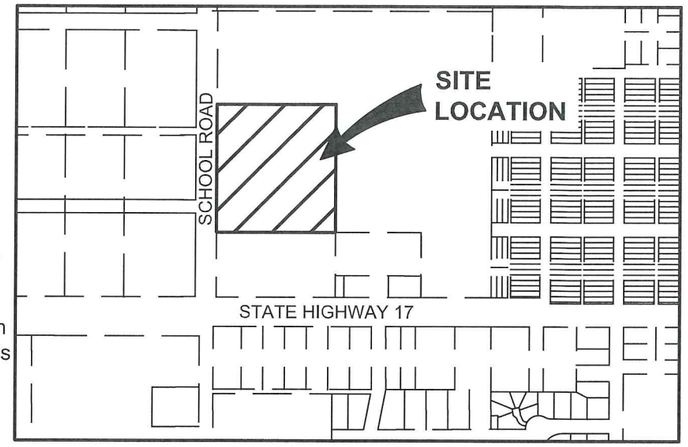

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Dennis Markusen 1-9-2015

Dennis Markusen
N.D. PLS No. 1194

Date

DENNIS J. MARKUSEN
REGISTERED
LAND
SURVEYOR
LS-1194
NORTH DAKOTA

LEGEND

- ● Iron Rebar Found
- ◉ Calculated PCR

N

50 0 50 100
SCALE 1" = 100' FEET

Rev'd. Field Book Pg. 00-00

BOUNDARY EXHIBIT
GRAFTON FIRE DEPARTMENT
GRAFTON, NORTH DAKOTA

SHEET NO. 1

KLJ

LOT 1, BLOCK 1
STATE SCHOOL ADDITION
GRAFTON, NORTH DAKOTA

DRWN. BY	CHK'D BY	PROJECT NO.	DATE
FJM	JRJ	6615100	01/09/15

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BKV
GROUP

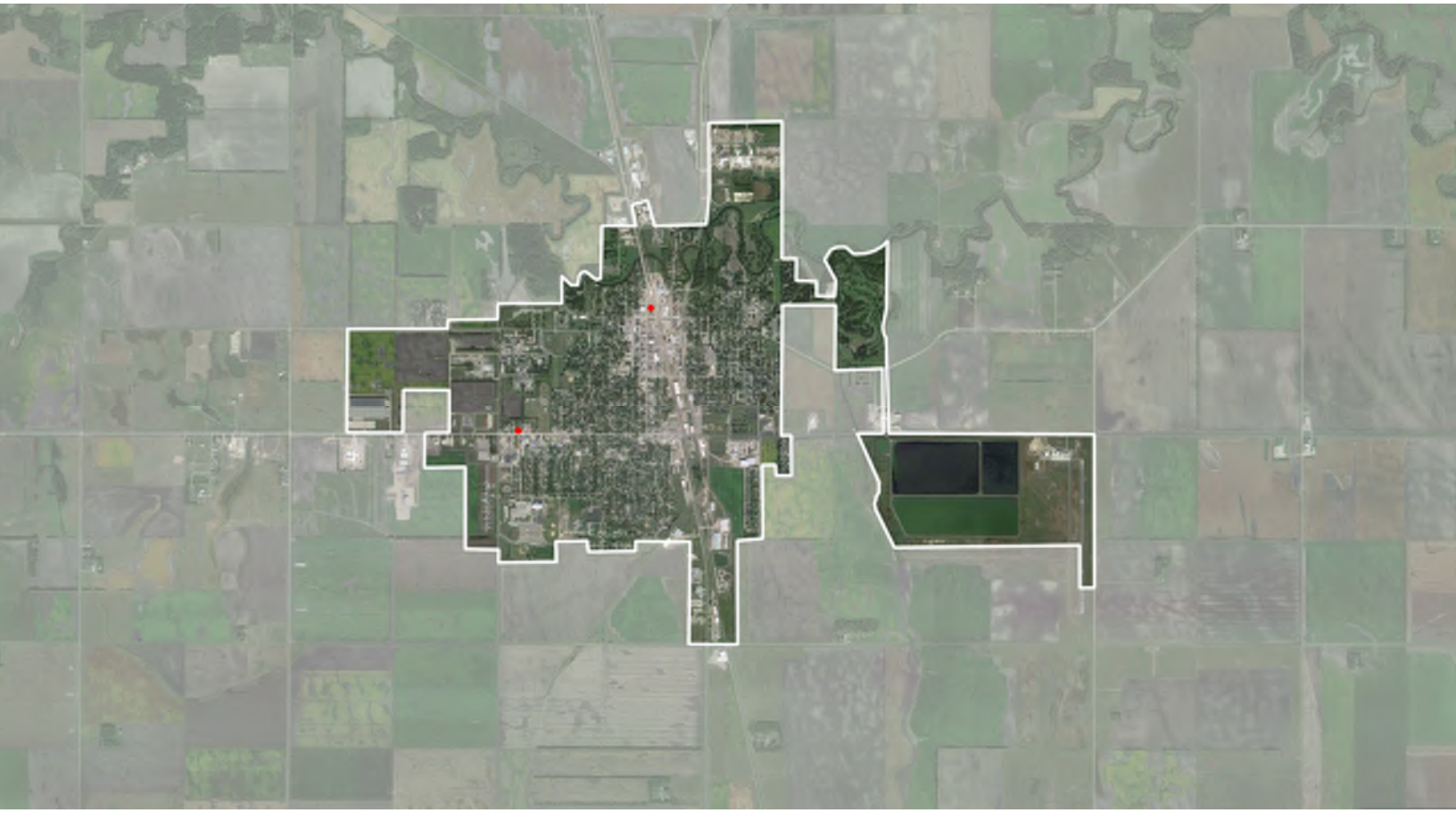
Architecture
Interior Design
Landscape Architecture
Engineering

222 N Second St, Suite 101
Minneapolis, MN 55401
Telephone: 612.339.3752
Facsimilie: 612.339.6212
www.bkvgroup.com
EOE

Grafton Fire Department Study

City of Grafton, North Dakota

August 25, 2016



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Interior Design
Landscape Architecture
Engineering

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Minneapolis, MN 55401
Telephone: 612.339.3752
Facsimilie: 612.339.6212
www.bkvgroup.com
EOE

August 25, 2016

Grafton Fire Department
5 East 4th Street
Grafton, ND 58237



RE: Report for the Grafton Fire Department Study

Dear Chief Popiel, Board Members, and Firefighters:

We enjoyed working with you to evaluate your current fire stations and plan for the long-term needs of your department. The attached report shows our findings. This report should allow the City and Department leadership to make informed decisions about the most appropriate course of action for the community.

The goal of the study was to identify multiple planning options that will support efficient and highly-functional operations for current and future staffing, that compare appropriately to projects that nearby communities have undertaken, that are economically responsible, and that are in-line with the broader planning goals for the City of Grafton.

The process included the following steps:

Existing Conditions Review – We studied the original construction documents and physically toured the existing spaces being utilized by the department and developed a list of physical and functional deficiencies, including deficiencies with regards to NFPA Compliance and a list of functional concerns.

Programming – We met with the department to discuss the rooms and spaces required to function effectively. We looked at demographic trends to understand the impact that future development might have, and we created a program of spaces for the project based on national standards, the stated needs of the Department, and our professional experience..

Potential Site Review – We reviewed the community for potential station locations, including existing locations, new downtown locations, and a parcel north of Station 102.

Masterplanning Concepts – We produced three building program options (a large, a medium, and a small footprint) and examined each to understand impacts of size and functionality on the department and the potential project budget.

Project Implementation Review – We provided conceptual level review of the project schedule and project budget.

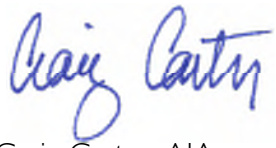
This report lays of the results of each of these steps for public record and provides the basis for informed decision making as the project moves forward. Thank you again for the opportunity to serve the Grafton Fire Department. Please feel free to contact us should you have any questions about this report.

Sincerely,

BKV Group, Inc.



Bruce Schwartzman, AIA
Partner



Craig Carter, AIA
Senior Associate

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Acknowledgements

BKV Group would like to thank Brad Martinson for spearheading this effort and showing us around the existing fire stations.

BKV Group would like to thank the Board of Directors, the Officers, and the Firefighters of Grafton for the opportunity to work with them on this project

Board of Directors:

President	Dean Woinarowicz
Vice President	John Maxwell
Secretary/Treasurer	Shane Mohn
Fire Chief	Ken Popiel
Director at Large	Rick Byer

Fire Department Administration:

Fire Chief	Ken Popiel
Assistant Chief	Jeff Moe
2nd Assistant Chief	Dean Woinarowicz
Captain	Spencer Potts
Caption	vacant

Executive Summary

BKV Group was retained in early 2016 to review the conditions of the Grafton Fire Department facilities, assess the future needs of the Department, and recommend how to move forward.

There is very limited space at both Station 101 and 102 and both buildings are showing their age. Station 101 was built sturdily, but the size and configuration of the spaces are not consistent with a modern fire department and cannot be easily modified. Station 102 has exceeded the expected lifespan of a pre-engineered metal building. Both buildings would require significant investment into physical repairs to remain reliably operational over the next ten years.

There are several operational issues at each location that put firefighters at risk of injury or illness. Most concerning are as follows:

- The lack of proper decontamination/ shower facilities to allow firefighters to remove contaminants before bringing them home to their families.
- The tight physical spaces which, combined with backing into the apparatus bays, poses risk of a firefighter getting pinned by a truck.
- The lack of compartmentalization between apparatus bays and office/ living areas, which allows diesel pollutants to permeate the buildings.
- The location of the man door into Station 101 requires that responding firefighters cross the path of apparatus leaving the station.
- The lack of dedicated space for exterior prop training adjacent to classroom training.
- The lack of a physical conditioning room for cardiovascular and strength training exercise.
- The lack of modern electronic safety sensors for CO monitoring, stopping overhead doors due to obstruction, etc.

In addition to these operational concerns, there are code deficiencies (e.g. lack of separate restroom facilities for women), accessibility issues (e.g. wheelchair clearances, protruding objects), and risk management concerns (e.g. storage in apparatus bays, lack of sprinkler systems).

Finally, there are operational complications associated with the Department operating out of two locations. There are duplicated expenses, duplicated equipment, transfer time back and forth, and concerns about enough staff responding to the station with the appropriate equipment for the emergency in question, delaying response when seconds count.

Based on national standards, interviews with the Fire Department, and our experience, BKV Group assembled three potential building programs for consideration.

- Program A, at 34,379 square feet, represents a 9 bay fire station with training and fitness spaces, amenity spaces for the firefighters to aid recruitment and retention, and a new 800-person community hall facility with associated storage, kitchen, restrooms, and mechanical spaces.
- Program B, at 24,809 square feet, represents an 8 bay fire station with classroom training, physical training, and fitness spaces in line with national standards.
- Program C, at 18, 628 square feet, represents an 8 bay fire station with tighter bays and only the minimal functional elements to support the workflows of the firefighters and to provide for their safety and welfare.

BKV Group looked at potential expansion at each existing station location, but the sites are poorly suited to the size of a combined station. A combined station could be placed downtown if a full city block could be acquired,

but stormwater detention would need to be accommodated underground and some building elements might move to a second floor, which increases project costs significantly. A combined station would easily fit on the State-owned land directly north of Station 102, including space for a future training tower and a Community Hall with associated parking.

A new station would take approximately 9 months to design and another 12 months to bid and construct. Construction costs could vary depending on the materials used. A pre-engineered metal building might cost ~$113 per square foot while brick over CMU with metal roofs and high-performance building systems might cost ~$308 per square foot. Assuming a new station of 25,000 square feet (Program B) that starts construction in 2017 and that the department elects to pursue a middle-of-the-road construction quality, BKV Group recommends planning for a construction cost around $5,400,000. Total project costs would be on the order of $6,500,000 which includes a healthy contingency. Construction costs escalate over time, so we recommend planning for an additional 4% of costs each year.

Until the Department can define a project budget, these numbers remain somewhat arbitrary. Both the size of the station and the quality of construction can be adjusted to accommodate funding realities once those are known. BKV Group recommends working with the City of Grafton, Walsh County, and the State of North Dakota for potential funding assistance. We also recommend investigating low-interest loans through the USDA and any local sources of grant funding. An understanding of the cash flows that can be used to pay down the loan is the first step to understanding the budget capacity of the Department.

A project such as this is dauntingly expensive, but an architect experienced in fire station projects can help limit costs, separate elements for grant funding, plan for phasing the project over time, and provide advice about self-performing some of the work if volunteers want to help construct the facility.

While BKV Group has not met with the Grafton Police Department to perform a study similar to this one, we are aware of space concerns in the building the Police share with the County Sheriff. If the Police were interested in moving into a combined public safety building, we roughly estimate an additional 8,000 square feet of building, which translates into $1,800,000 of additional total project cost. By constructing a combined facility as opposed to two separate buildings, the citizens of Grafton would save ~$750,000 of project costs.

Next steps for the Fire Department should include:

- Meet with the City about the combined public safety concept and any potential City financial contributions to the project.
- Make this report available for the general public and set up times for the public to visit the Stations and observe the conditions firsthand.
- Examine the likelihood of being able to acquire a full city block downtown without displacing residents or businesses and without taking on any environmental contamination liability.
- Meet with the State to determine availability of the land north of Station 102 and the disposition of the Station 102 property once the Department moves out.
- Obtain an architect's sketch of the potential project for use in a public awareness campaign.
- Meet with a financial advisor to determine the ultimate capacity of the Department given all funding sources.

Existing Conditions Assessment

The purpose of this section of the Study is to document the condition of the two Grafton Fire Department buildings. This information provides the necessary data to enable the City to make informed decisions regarding how to best address any repairs, upgrades and/or replacements as part of the City's long range planning. There are two components to the Existing Conditions Assessment:

An on-site *Physical Condition Assessment* of the building was performed to determine maintenance issues, safety and code concerns, remaining useful life for the building systems and finishes, and to review how current conditions affect building system operations and energy costs.

A *Functional Assessment* was performed through observations and discussions with key staff. It determined how existing building conditions are affecting staff operations and the ability to serve the community. The Functional Assessment also examined how present operations and workflows compare to current recommended best practices in the industry.

The assessments are intended to provide an indication of the capital maintenance requirements, potential code and regulatory required upgrades, and other building conditions which should be considered as part of the facility's general upkeep as well as part of any building project. It is beyond the scope of this study to provide detailed cost estimates of these interventions, nor does this study address areas of the building that are concealed behind walls or locked doors.

Fire Station 101 Building Description

Station 101 is located in the City Hall building at 5 East 4th Street. The City Hall was constructed in 1938 as an addition to the existing Fire Hall and Power Plant. The portion of the building currently occupied by the fire department is the pre-1938 portion. The fire department occupies ~4,125 square feet on the ground level and has ~1,400 square feet on the second floor for their "Firemen's Hall." The exterior walls are constructed of brick masonry with plaster on the interior face. Most of the original window and door openings have been bricked up. The roof is wood plank decking over metal joists. The fire station has hydronic unit heaters and an air filtration system for exhaust extraction. The Firemen's Hall has radiator heat.

Fire Station 102 Building Description

Station 102 is located at 845 West 12th Street. It was constructed in 1984 and totals 4,500 square feet on the ground floor with a storage mezzanine of approximately 1,000 square feet. The building is constructed as a typical pre-engineered metal building with girts and purlins spanning between the main steel members. Exterior metal wall panels are fastened over a layer of 4" fiberglass batt insulation with exposed fasteners. The standing seam roof is fastened to the purlins through a layer of 4" fiberglass batt insulation. The building has a 200 amp electrical service and is heated with electric resistance unit heaters and in-floor electric radiant heating installed in the 12" sand base below the slab.



No sprinkler system



Flammable cabinet bent, no longer able to contain fumes



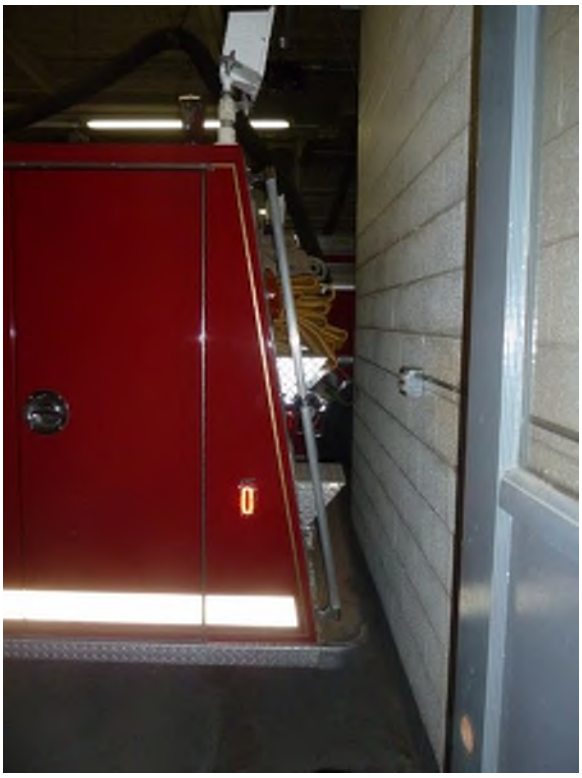
No photo-eyes on bay doors, creating pinning/ crushing hazard



SCBA repair and cleaning area takes place in dirty environment



No exhaust removal system in maintenance bay



Insufficient walking space around apparatus



Insufficient space for maintenance shop, too close to fire apparatus



Insufficient decontamination space for SBCA masks and equipment



Pedestrian entry into station during a call crosses apparatus response path



Only one means of egress from Firemen's Hall



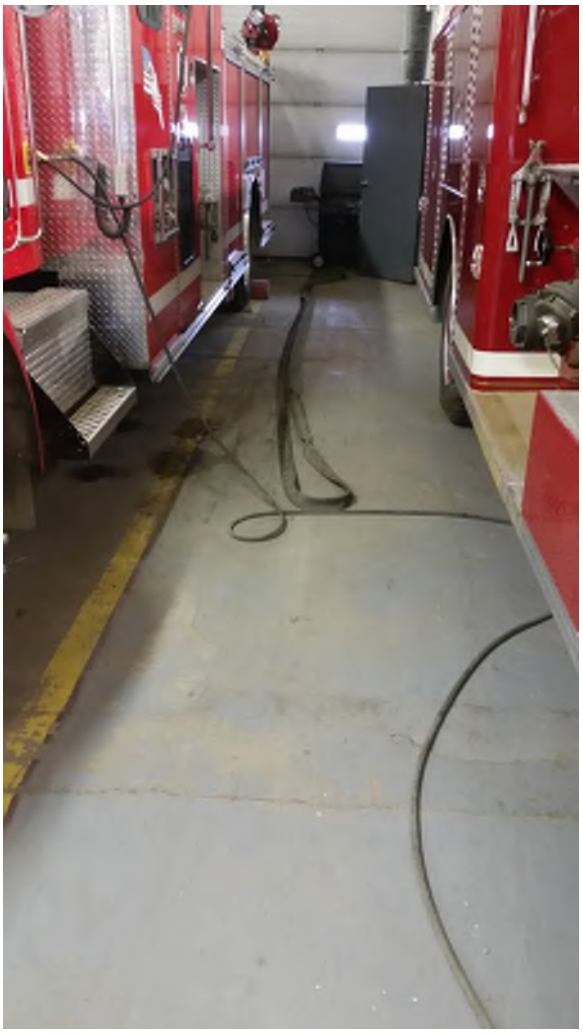
Unseated electrical cover plates



Limited floor drains and insufficient slope results in pooling water and slip hazards



Equipment stored in front of electrical panels



Shore lines laying on floor create tripping hazard



Turnout gear stored on bay walls too close to apparatus. Solid panels at gear lockers restrict evaporative drying of turnout gear



Ladder to hose drying not secured

Station 101 Repair/ Maintenance Issues



Roof due to be replaced next year



Cracks in floor, some down to rebar



Weatherstripping at rear apparatus door needs replacement



Mechanical exhaust system motor needs maintenance



Exterior needs tuck pointing at parapet above the bay doors



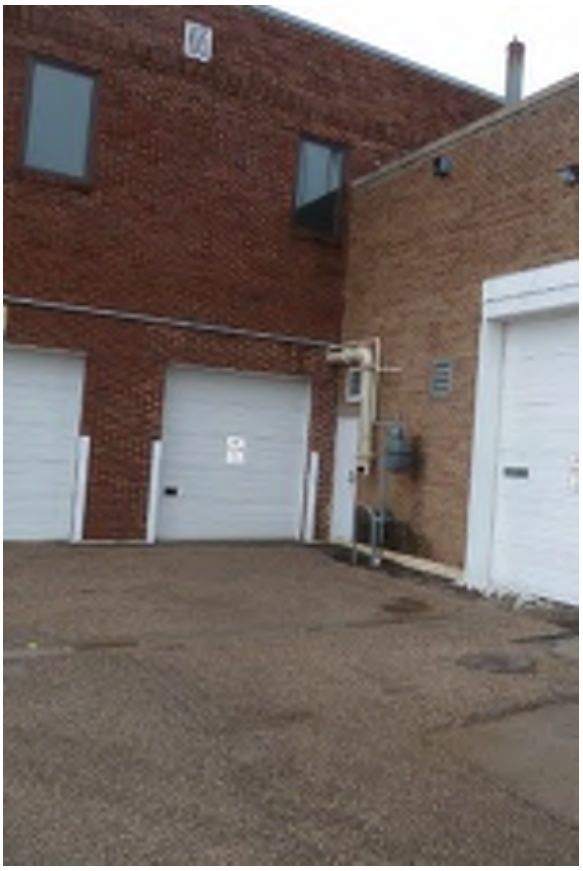
Exterior needs tuck pointing along the north wall



Apparatus door jambs need to be re-caulked



Kitchen casework in Firemen's Hall past the end of its useful service life



Client reported leak under window of Firemen's Hall





Roof drain discharges water at building wall, creating environment for molds and lichen and causing brick to spall and deteriorate



Grading at rear apparatus door slopes towards building



Wood framing below shower pan not protected from moisture and shows evidence of disintegration



Asphalt past the end of its useful service life. Exhibiting potholes, cracks, disintegrating top layer



Fixtures and finishes in toilet room past the end of their useful life



Plaster cracking and falling off interior walls



Ceiling tiles loose at Firemen's Hall



Carpet at Watch Office past the end of its useful service life



Shower area degraded to the point of uselessness

Station 101 Building Code Issues



Fuse box serving Firemen's Hall no longer code compliant



Access to fire boat in basement through door directly onto ramp



No separate restroom facilities for men and women



No evidence of code required sand trap/ oil separator from apparatus bay drains



No code required ventilation in office

Station 101 Accessibility Code Issues



Kitchen appliances, casework, and fixtures not accessible

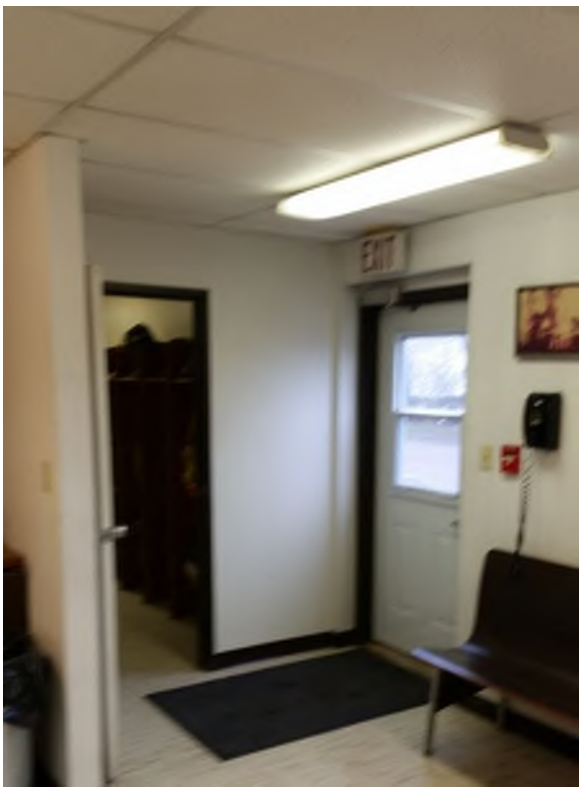


Toilet room not accessible due to step



No wheelchair maneuvering clearance at the doors to/ from corridor

Station 102 Occupant Safety Issues



Exit lights are not operational throughout the facility



No exhaust provided in turnout gear storage room to capture off-gassing toxins



Solid panels at gear lockers restrict evaporative drying of turnout gear



Insufficient space for maintenance shop, too close to fire apparatus



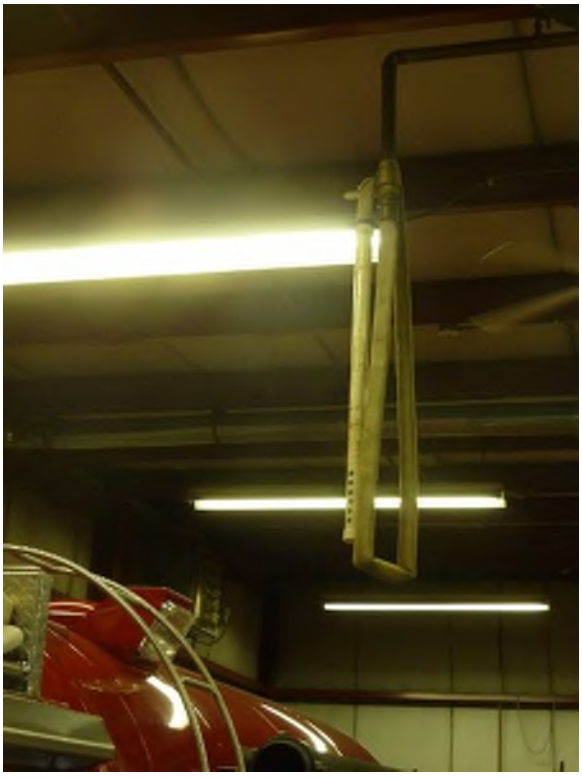
Direct capture tailpipe exhaust requires climbing over apparatus to attach, and lack of seal at attachment point allows some exhaust to escape into the space



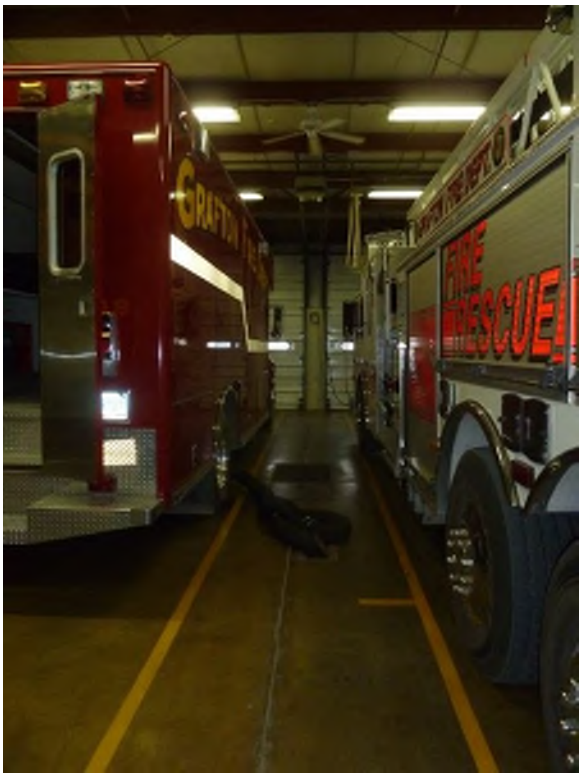
Limited floor drains and insufficient slope results in pooling water and slip hazards



Center column in apparatus bay creates pinning/ crushing hazard by backing apparatus



Overhead truck fill requires climbing on apparatus to operate



Underslab exhaust hose creates a tripping hazard



Oil pit grating not flush with surrounding concrete, creating a trip hazard



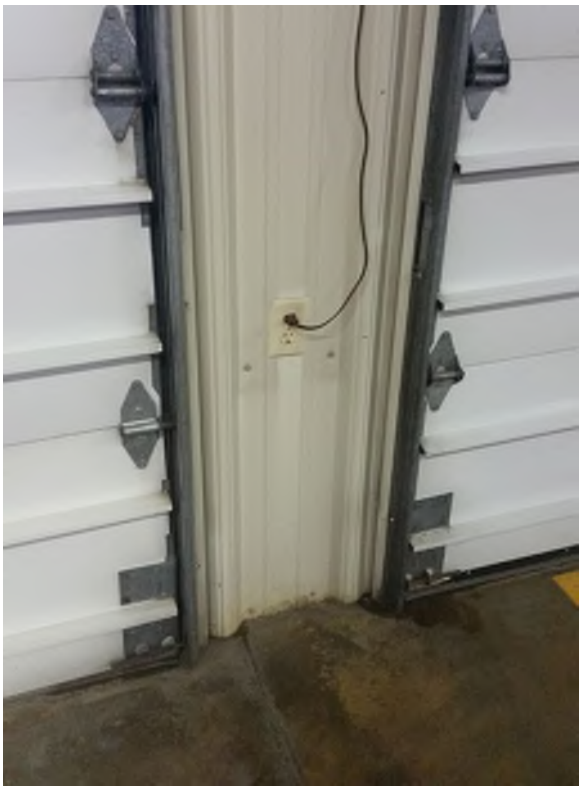
No sprinkler system



Rear door stoop has separated from building



Concrete has cracked and settled in apparatus bays, creating trip hazard at joints



No photo-eyes on bay doors, creating pinning/ crushing hazard



Sidewalks heaving/ settling compared to stoops, creating trip hazard



Southwest downspout discharges across sidewalk, creating potential for ice formation



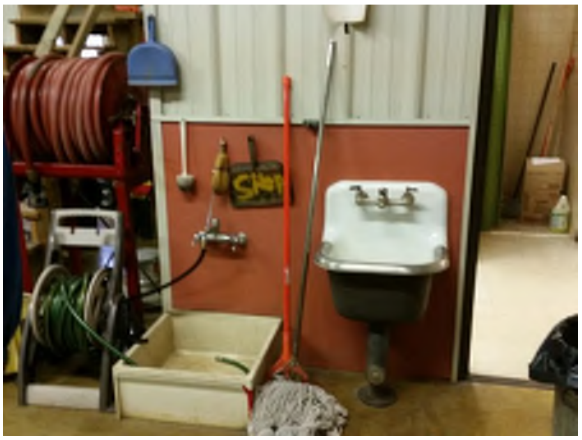
Insufficient walking space around apparatus



Electrical equipment not protected from vehicle traffic by bollards

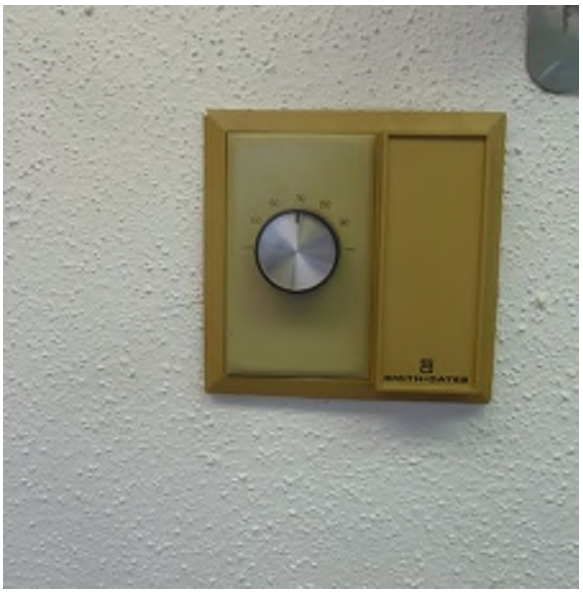


Apparatus apron is too flat, creating water ponding issues that may freeze and create slippery conditions for apparatus exiting



Insufficient decontamination space for SBCA masks and equipment

Station 102 Repair/ Maintenance Issues



Client reports that in-floor radiant heat system broken



Cracked light fixture lens in watch office



Evidence of roof leaks at ceiling tiles. Client reports having repaired roof several times.



VCT showing signs of distress with gapping at joints and crushing at turnout locker partitions, nearing end of useful service life



Exhaust fan needs maintenance, rebalancing



Stove and cabinets at end of useful service life



Ceiling tiles exhibit significant sag and are at end of useful service life



Shower needs re-grouting and new curtain



Water valve broken at street, creates water hammer problems inside building



Concrete floor in apparatus bay showing signs of deterioration



Spray foam insulation exposed on exterior



Grade slopes towards footing at north wall



Southwest downspout damaged and leaking down face of building



Asphalt at parking lot past the end of its useful service life. Exhibiting potholes, cracks, disintegrating top layer



Glazing panels in sectional overhead doors have large gaps at seals



Bottom of metal wall panels beginning to deteriorate



Spalling at concrete footing wall at northeast corner of building



The west side of apparatus door closest to the office is damaged



No visible flashing at base of wall condition - allowing water into wall system



Sealant failing at all locations – needs to be re-caulked



Weatherstripping at overhead doors damaged and needs replacement

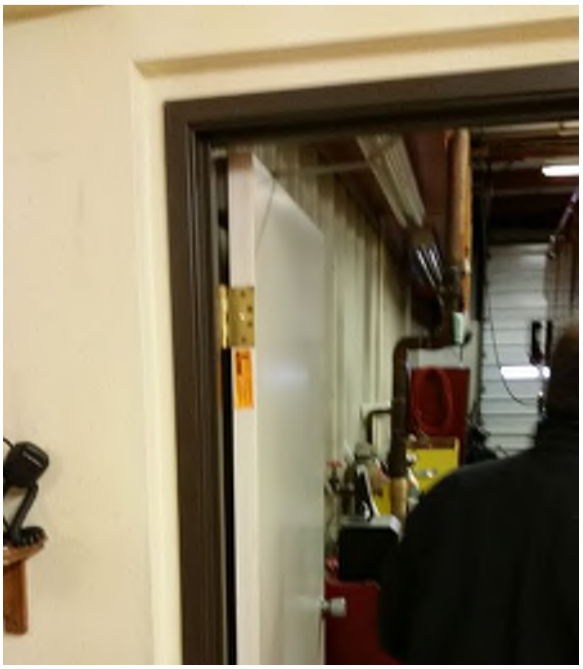
Station 102 Building Code Issues



No separate locker and toilet facilities for females



No code required ventilation in office



Fire rated doors held open by door stops



Staircase has open risers and non-compliant handrails/ guardrails



Exterior stoop at west side not flush with interior floor slab



Exterior electrical outlets do not comply with current Electrical Code



Exterior electrical outlet missing weather protection cover

Station 102 Accessibility Code Issues



Door knobs not ADA accessible



No wheelchair maneuvering clearance at the four doors to/ from corridor



Kitchen appliances, casework, and fixtures not accessible



Fire alarm panel is protruding object



Radio shelf is protruding object



No detectible warning features between sidewalk and parking spaces



Lavatory, shower, urinal, and toilet not accessible



No 5'x5' pad at entry doors

Station 102 Energy Use Issues



T12 fluorescent light fixtures are inefficient compared to T8 fluorescent fixtures or LED fixtures



Roof and wall insulation compressed at each girt and purlin, rendering it less efficient at resisting each transfer



Frequent tears in vapor barrier at ceiling/ walls throughout facility allows moisture into batt insulation, rendering it much less efficient at resisting heat transfer



No make-up-air for exhaust system requires exterior doors to be propped open when exhaust is operating

Functional Issues

Responding to Calls

The flow of responders from the parking lot to the turnout gear storage room is arranged well at Station 102, but the tight spaces and trip hazards within the apparatus bays makes getting to the apparatus difficult and unsafe. At Station101, there is no parking dedicated to firefighters and once parked, they must pass in front of the apparatus doors to access the station, putting them at risk of being hit by a truck hurrying out to a call. Once inside the bays, firefighters have to stand uncomfortably close to the apparatus to don their turnout gear.

Responding to certain calls takes extra time because apparatus are stacked in the bays and the vehicle in front must be moved first. At Station 101, most of the apparatus has to maneuver within the apparatus bay to head out the one overhead door. Once out the door, there is not enough depth to the apron to allow the truck to pull completely out of the building before stopping at the curb to wait for traffic to clear. The fire boat is stored in the basement of City Hall. To retrieve it, a pickup truck must be backed down a steep ramp, connected to the boat trailer, and then driven back up. This adds minutes to response times.

Upon returning from a call, the trucks must be carefully backed into the buildings. This process comes with real danger to the personnel assigned to stand outside the vehicle and guide it into place. In many cases, there are inches between the rigs and the rear walls of the building because there simply isn't enough length. The proximity within which the vehicles are parked to each other, the walls, the center column at Station 102, and other functional spaces creates significant risk to for getting personnel or equipment accidentally pinned by the apparatus. At Station 102, the apparatus doors are only 12' wide, which increases the likelihood that backing apparatus will contact the door jambs. At Station 101, the apparatus are forced to block the street, then back in at an angle before finally cutting the wheels and straightening out. The direct tailpipe exhaust capture systems, which are provided for some but not all parking spaces within the bays, require clambering up the side of the rigs, reaching for the exhaust hose, and manually sleeving it over the hot exhaust pipe. This process creates a risk for falls and burns, and since it cannot be completed until the vehicle is parked, does not prevent the first few minutes of diesel exhaust from flooding the room.

Low apparatus door heights at both stations will prevent the Department from purchasing the next generation of Aerial vehicles without expensive customizations to reduce heights.

Cleaning and Decontamination

There is no dedicated decontamination space for cleaning equipment after a call and there are insufficient facilities for the entire crew to shower within a reasonable time frame. There are no accommodations for female firefighters to use the restroom or shower at Station 102, and the single restroom at Station 101 is in such bad repair that it is seldom used. There are no personal lockers to allow storage of a clean set of clothes at the station, and there are no laundry facilities to wash the clothes worn under the turnout gear.

Washing the fire apparatus is important to extend the lifespan of the vehicles. Unfortunately, it is very difficult to wash when there is little clearance between trucks, and soapy water pooling on the floor due to lack

of drains and proper slopes makes the process risky.

Currently firefighters are putting themselves and their families at risk by bringing contaminants home from the fire scene. There is no separation between "dirty" and "clean" areas at Station 101, and in fact the only spaces that aren't directly open to the exhaust and fire ground toxins of the apparatus bays are the unused restroom and the watch office, which sits inside the apparatus bays, has no separate mechanical system, and has carpet on the floor that absorbs all of those harmful chemicals and transfers them to the shoes of the firefighters. The separation between "dirty" and "clean" at Station 102 has been defeated by door hold-opens, which are used because the doors swing the wrong direction or are in space to narrow to use comfortably.

Storage space at both buildings is insufficient, as evidenced by the amount of equipment on the perimeter of the apparatus bays. This makes cleaning the Apparatus Room very difficult and results in accumulation of harmful diesel particulates on the wall and floor surfaces, as well as on the equipment itself. Some storage rooms require shuffling sideways along the shelves to get access to items at the far end of the room. Maintenance shop spaces are undersized for the types of tasks required to keep the small equipment running smoothly.

Modern turnout gear is extremely effective at protecting firefighters from heat, smoke, and water. However, it must be well-cared for to be effective. This requires storing it apart from diesel exhaust contamination, away from all sources of UV light and especially sunlight, exhausting the space to prevent off-gassing toxins from resettling on the gear, being properly washed and dried, and allowing for final drying with specially designed locker systems.

Gathering and Training

There is an assembly space at Station 102 where firefighters can gather to wait for the next truck to leave or after a call to debrief, but there is no similar space at Station 101. Instead, firefighters gather around the Watch Office, standing in the apparatus bays.

Training space is sufficient at Firemen's Hall, but there is little space for exterior hands-on training after a classroom-style session. When inviting neighboring departments for a joint training session, the Hall is difficult to find, gets crowded quickly, and parking is inconvenient.

The Department runs a very successful Steak and Lobster dinner every year as a fundraiser, but is forced to host this event at the Winter Sports Arena because there is no other space in town large enough. This artificially restricts ticket sales and suggests that there may be a demand in town for a larger community banquet hall.

There is no physical conditioning space at either fire station. The majority of line-of-duty deaths in the fire service are due to heart attacks while on a call or shortly after returning. Preparing for the stress and physical exertion required for the job is critical to the long term health and safety of the firefighters. A dedicated room for fitness equipment is also an excellent amenity to aid recruitment.

Locations

Station 101 is located in close proximity to active railroad tracks. A derailment might seriously damage the building and the apparatus within, preventing the department from effectively responding to the incident. Station 101 is also located within the flood zone and has needed sandbagging to protect it from water damage. This effectively takes

the station out of service until the floodwaters recede. It is recommended that any new facility be located above the flood elevation and a safe distance away from the railroad tracks.

Station 102 was built because the department was out of space at Station 101, not because the community size dictated two stations for response time coverage. That decision bought the department another 30+ years, but now both stations are out of compliance with NFPA and OSHA standards, with building codes, and with fire service industry standards intended to improve firefighter health and safety.

The fact of two stations has created some functional issues for the department. Hose and gear drying can only be accomplished at Station 101, for instance. All hose cleaning occurs at Station 101, and it is transported back to Station 102 later. In some cases, having two stations has necessitated a doubling of equipment – multiple washer/ extractors, workshop tools, office furniture, backup generators, kitchen appliances, traffic control signalization, lawn mowers, snow blowers, etc.

Perhaps most critically for a small volunteer department, there are situations where the minimum number of firefighters to staff a truck might not be met at either station, but if the firefighters were all responding out of the same station, the minimums would be exceeded.

NFPA Compliance

The National Fire Protection Association (NFPA) creates and updates the national standards addressing many aspects of the fire service industry. The standards are developed through an open and consensus based process, and represent the collected knowledge of the nation's firefighters and allied industries. Many of the standards have an impact on the physical space that fire departments occupy. Both Station 101 and Station 102 are non-compliant with several of these national standards.

NFPA 1500 requires that fire stations be in full compliance with all applicable health, safety, building, and fire codes. The stations do not achieve that, as previously discussed.

The stations are non-compliant with NFPA 1500 in several ways. They lack CO monitors in the living areas, they do not prevent exposure to exhaust emissions, they do not have space for effective central record keeping for written policies, standard operating procedures, risk management plans, occupational safety and health plans, incident records, meeting minutes, etc.

The stations lack a fitness room in support of the Health-Related Fitness Program required by NFPA 1583. Access to fitness equipment can be provided out-of-house.

The stations lack in-house training capabilities to address the requirements of NFPA 1500, NFPA 1720, and various other NFPA standards. These can be addressed at fire school or other offsite locations, but annual training of each skill set is required and can be difficult for volunteers to achieve without local training options.

The stations are non-compliant with NFPA 1581. The stations lack facilities for effectively drying PPE, PPE storage areas are not well-ventilated, and Station 101 does not comply with the prohibition of natural light exposure for PPE.

The stations lack adequate space for performing SCBA maintenance and inspections per NFPA 1852. This service can be performed by a third-party if the budget allows.

The stations lack testing assemblies for the required annual checks of various equipment - hose and nozzles per NFPA 1962, ladders per NFPA 1932, power rescue tools per NFPA 1936, apparatus mounted pumps per NFPA 1901, and SCBA fit testing per NFPA 1852 and 29 CFR 1910.134. These services can be performed by a third-party if the budget allows.

The stations are non-compliant with NFPA 1581 in several ways. Both lack appropriate handwashing facilities for decontamination before entering the living areas. The kitchenette in Station 102 does not have functional appliances, a double basin sink, or a sprayer attachment. Neither kitchen area has appropriately non-porous surfaces for storage of kitchenware. The restrooms provided for firefighters at each station do not meet plumbing code standards. There are no dedicated and physically separated decontamination spaces in either station for the cleaning of PPE, portable equipment, and other clothing. Neither station has a PPE dryer to go along with its PPE washer/ extractor.

Space Requirements Study

BKV Group conducted a planning workshop to understand the current policies and procedures of the department and identify the goals a new station should achieve. Based on this information, BKV Group prepared three Program options that show appropriate rooms and spaces based on national standards, current staffing, and current equipment levels.

Goals

Safety around apparatus, whether moving or parked

Turnout gear protected from diesel exhaust, UV light, and weather

Adequate space to change into turnout gear

Safe path of travel from parking into building

Functional kitchen with modern equipment

Sufficient storage for critical supplies and equipment

Physical Conditioning Room to support firefighter health and safety

Safe apparatus doors

Training opportunities designed into facility

Current Staffing

40 maximum volunteers

Current Apparatus

7 pumpers/ tankers

1 aerial platform

1 rescue

1 grass rig

1 pickup

1 van

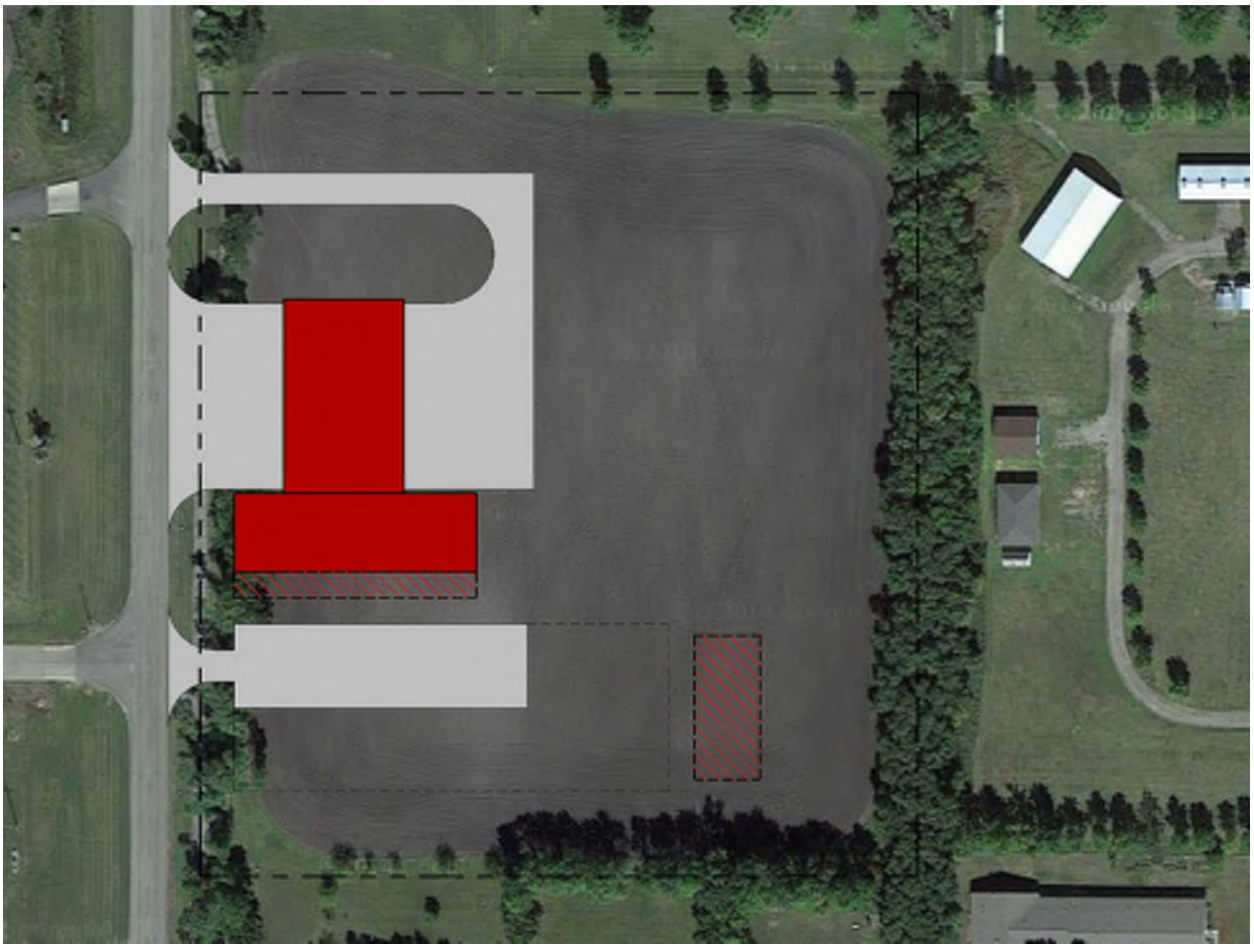
1 16' boat trailer

1 parade truck

	OPTION A			OPTION B			OPTION C		
	count	unit area (sf)	net total (sf)	count	unit area (sf)	net total (sf)	count	unit area (sf)	net total (sf)
Public Areas			5,310			1,621			0
Vestibule	2	70	140	2	50	100	0	0	0
Lobby	1	100	100	1	100	100	0	0	0
Museum	1	300	300	1	300	300	0	0	0
Public Restrooms	2	250	500	1	56	56	0	0	0
Community/ Training Room	1	3500	3500	1	950	950	0	0	0
Community Room Kitchen	1	300	300	0	0	0	0	0	0
Coat Room	1	120	120	1	15	15	0	0	0
Storage Room	1	350	350	1	100	100	0	0	0
Office / Training Areas			920			320			200
Conference Room	1	220	220	0	0	0	0	0	0
Chief's Office	1	140	140	0	0	0	0	0	0
Treasurer's Office	1	120	120	0	0	0	0	0	0
Fire Marshall's Office	0	120	0	0	0	0	0	0	0
Fire Prevention Office	0	120	0	0	0	0	0	0	0
Fire Prevention Storage	1	120	120	0	0	0	0	0	0
Captains Office	0	140	0	0	0	0	0	0	0
Station Watch Office	1	200	200	1	200	200	1	140	140
Copy Room	0	108	0	0	0	0	0	0	0
Storage Room	1	120	120	1	120	120	1	60	60
Living Areas			3,115			2,810			1,210
Male Locker Room	0	500	0	0	0	0	0	0	0
Female Locker Room	0	200	0	0	0	0	0	0	0
Individual Bunk Room	0	85	0	0	0	0	0	0	0
Shared Locker Room	1	400	400	1	400	400	1	400	400
Unisex Shower Rooms	4	80	320	3	80	240	2	80	160
Laundry Room	1	100	100	1	100	100	1	100	100
Storage	1	120	120	1	120	120	0	0	0
Dayroom	1	625	625	1	400	400	1	400	400
Game Room	1	400	400	1	400	400	0	0	0
Dining Room	0	250	0	0	0	0	0	0	0
Kitchen	1	350	350	1	350	350	1	150	150
Physical Conditioning Room	1	800	800	1	800	800	0	0	0

Apparatus Bays			14,580			12,520			12,140
Apparatus Bays (18x90)	8	1620	12960	5	1620	8100	8	1440	11520
Small Vehicle Bays (16x35)	0	0	0	5	560	2800	0	0	0
Wash / Repair Bay	1	1620	1620	1	1620	1620	0	0	0
Apparatus Bay Support			2,470			2,050			1,372
Decontamination	1	120	120	1	120	120	1	120	120
Turnout Gear Storage	1	440	440	1	440	440	1	440	440
Staging & Coats	1	150	150	1	150	150	1	12	12
Compressor and Fill	1	140	140	1	140	140	1	140	140
SCBA Repair Shop	1	140	140	0	0	0	0	0	0
Medical Storage	0	100	0	0	0	0	1	110	110
Hose Tower with Training	1	400	400	1	400	400	0	0	0
General Storage	1	600	600	1	400	400	1	400	400
Hose Storage	0	0	0	0	0	0	0	0	0
Quartermaster Storage	1	100	100	1	100	100	0	0	0
Hazmat Cleanup Storage	1	80	80	0	0	0	0	0	0
Maintenance Shop	1	150	150	1	150	150	1	150	150
Lawncare Storage	1	150	150	1	150	150	0	0	0
Building Support			1,330			686			100
Mechanical	1	300	300	1	120	120	1	50	50
Electrical	1	100	100	1	100	100	1	50	50
Communications	1	80	80	1	16	16	0	0	0
Sprinkler riser	1	50	50	1	50	50	0	0	0
Stairs	0	0	0	0	0	0	0	0	0
Firefighting Training	1	800	800	1	400	400	0	0	0
Exterior Areas									
Patio									
Generator Enclosure									
Mechanical Equipment									
Total Programmed Area (sf)			27,725			20,007			15,022
Circulation Factor (sf)		12%	3,327		12%	2,401		12%	1,803
Envelope Factor (sf)		12%	3,327		12%	2,401		12%	1,803
Building Foot Print (sf)			34,379			24,809			18,628

Site Feasibility Analysis



While it is not within the scope of this study to determine the optimal location of a new fire station, BKV Group did examine some potential options. One potential site that BKV Group has been made aware of is on State-owned property along School Road. The parcel is directly north of Station 102 and backs up to Heritage Village. The site appears to be very near the flood elevation but the building pad could be elevated with material removed for stormwater detention.

This parcel is approximately 7.5 acres, and would be sufficient to contain the entire footprint of the proposed project. The above figure shows the area required for program Option B in red, with the areas necessary for Option A shown dashed. The community room and associated spaces are shown here as a separate building with additional parking area indicated with dashed lines.

The site permits separate traffic movement for apparatus and personal vehicles with comfortable maneuvering clearances while leaving ample space for stormwater detention. The site allows for significant future expansion to both the apparatus bays and support spaces, as well as phased construction for the community room spaces and/or a potential live-burn training tower.

BKV Group also examined locating the new building in the center of Grafton, where the blocks are 300' square and there are few vacant parcels. Drive through apparatus bays with appropriate concrete aprons on each side would occupy half of a block (150'x300'), with the remaining building area and associated

parking filling the remaining portion. Stormwater detention would likely be underground in this scenario, and it is likely that some portions of the facility would end up on a second story, necessitating an elevator and staircases. Assembling land for a full block would likely force at least one existing business and/or multiple single-family homes to relocate.



The existing fire station sites are not large enough to accommodate the proposed facility. At Station 101, the new facility would need to overcome the proximity to the railroad tracks and the floodplain issue, and would require moving the water tower. Drive through apparatus bays would still be impossible to arrange. This figure shows the size of the apparatus bays *only* in comparison with the existing site boundaries.



At Station 102, the site width is not sufficient to accommodate enough bays across the front of the lot, nor is it sufficient to align the bays parallel with the street and provide the minimum apron depth to turn the aerial apparatus out of the station. This figure shows the size of the apparatus bays *only* in comparison with the existing site boundaries. If the adjacent parcel could be acquired, the station could fit, but it would require alternative stormwater accommodations, would be unable to support enough parking for the community room, and would exclude the possibility for future expansion.

Masterplanning Concepts

Early in the conceptualization process, most departments are unsure of their fundraising capabilities and their optimal facility size. To provide an idea of the spectrum of facility sizes found in fire stations across the country, BKV Group is showing three options. The final list of spaces in the facility will likely differ from these.

Option A: New Facility with Community Banquet Hall

Building area: 34,379 sf

Provides space for a fully functional fire station as well as space for a banquet hall to seat 800 people (with all associated restrooms, kitchens, mechanical, and storage elements). Amenities intended to help recruitment of new firefighters include a larger dayroom and a game room.

Option B: New Facility with Training Facility

Building area: 24,809 sf

Provides space for a fully functional fire station with a classroom to accommodate all staff, allowing the department to move out of the City Hall building. Provides space for hands-on training as well as physical fitness.

Option C: New Facility

Building area: 18,628 sf

Provides space for minimum functionality. Apparatus bays would have less maneuvering clearance so future apparatus would not be able to increase in size. Classroom training would still need to occur at City Hall, and there would be no build-in provisions for hands-on training. No fitness space would be provided.

Conceptual Project Schedule

Due to winter conditions, construction projects in North Dakota almost always start as the ground thaws in the spring. The following schedule durations may need to be adjusted depending upon what time of year the design effort gets underway.

Phase	Duration
Schematic Design	3 months
Design Development	2 months
Construction Documents	4 months
Bidding and Permitting	2 months
Construction	10 months

Conceptual Project Budget

Construction costs for fire stations vary regionally and based on construction type. The new fire station in Manvel is a simple metal building with virtually no site work. That station cost $113 per square foot ($950,000; 8,400 sf). Grand Forks Fire Station #5 is brick over concrete masonry and designed to blend with nearby houses. It cost $308 per square foot ($2,800,000; 9,092 sf).

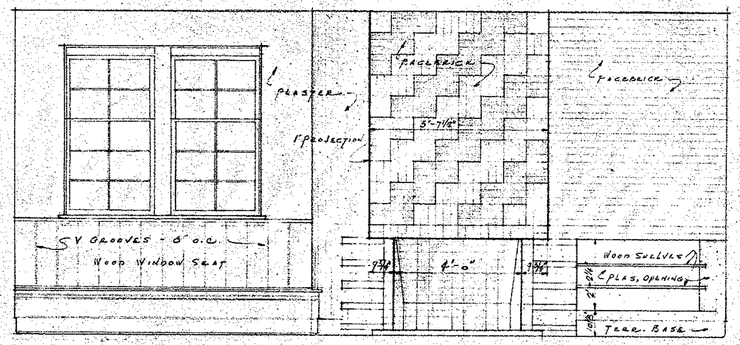
For the purposes of this cost estimate, we have assumed a new station located on the School Road site with a building area accommodating program Option B (24,809 sf) and a construction cost of $200 per square foot. This assumes construction starts in 2017. Escalation of 4% per year should be added if project will commence in later years.

Description of Expense	Estimated Cost
Land Acquisition and Sale (net)	$ 1
Demolition of Existing Structures	$ 0
Building Construction Cost	$ 5,000,000
Site Construction Cost	$ 400,000
Design Fee	$ 432,000
Site Survey	$ 5,000
Environmental Report	$ 2,500
Geotechnical Report	$ 7,500
Utilities Extension	$ 0
Furniture, Fixtures and Equipment	$ 80,000
Materials Testing	$ 18,000
Permitting and Approvals	$ 20,000
Owner's Project Contingency (~9%)	$ 535,000
TOTAL PROJECT	$ 6,500,000

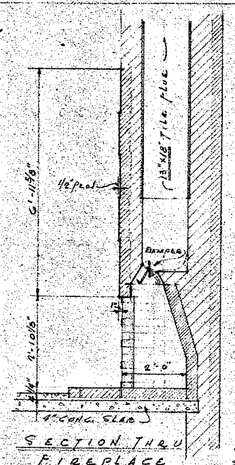
Appendix A – Existing Drawings

BKV Group was provided with existing drawings of Stations 101 and 102. These do not necessarily reflect the current conditions of the facility, but are attached to this report for informational purposes.

Note: Shaded portion shows 1/2" proj. in brick pattern. Entire panel proj. 1"

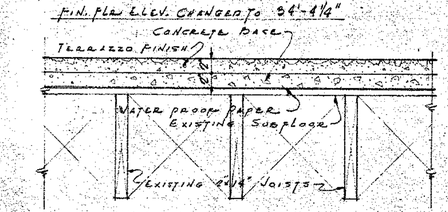


° E L E V A T I O N °
3/8" = 1'-0"

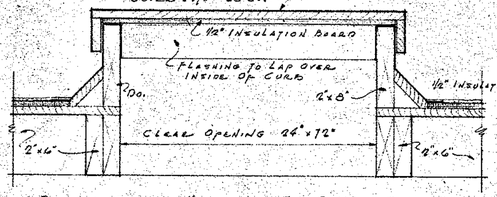


SECTION THRU FIREPLACE
3/8" = 1'-0"

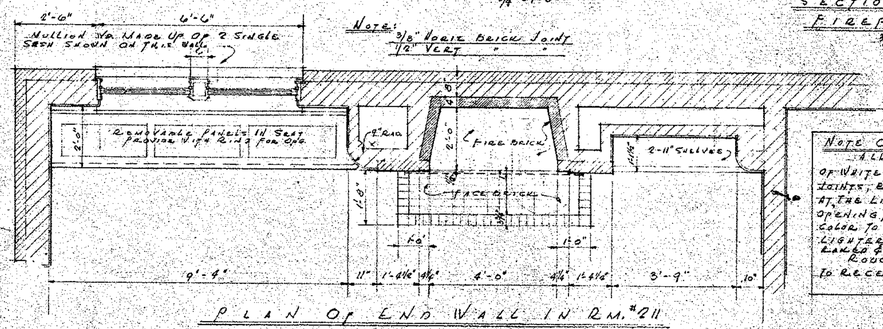
Note:
Fin. flr. elev. changed to 94'-4 1/4"



° ° FLOOR CONST OVER FIREHALL ° °
Scale: 1" = 1'-0"

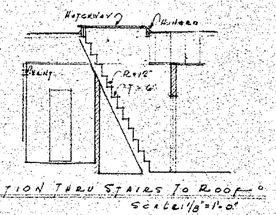


° ° DETAIL OF HATCH TO ROOF ° °
Scale: 1 1/2" = 1'-0"

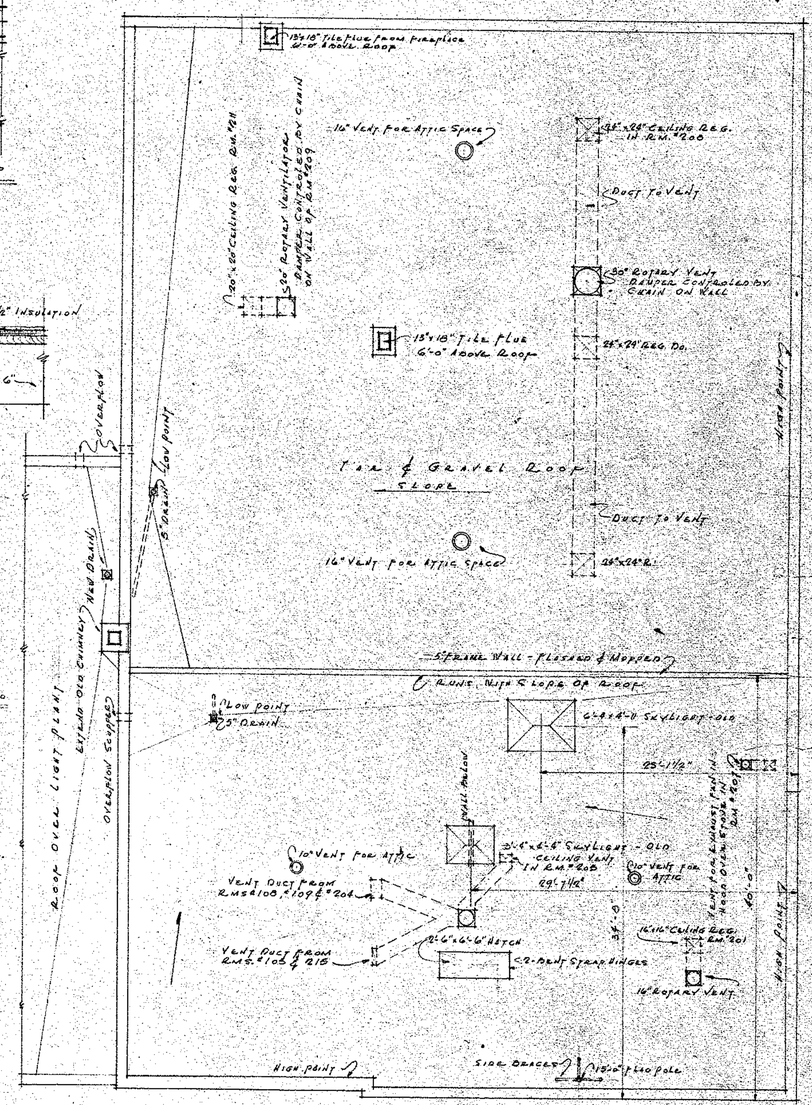


PLAN OF END WALL IN RM. #211
Scale: 3/8" = 1'-0"

Note concerning brick joint:
All horizontal joints to be of white mortar. All vertical joints, except those of rolok cas at the lintel over the fireplace opening, to be of colored mortar, color to match brick but of a lighter cast. Mortar joints to be raked & struck. Rough brickwork to be placed to receive 1/2" plaster coat.

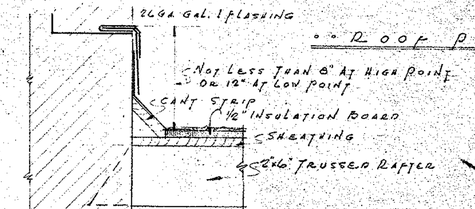


° SECTION THRU STAIRS TO ROOF °
Scale: 1/8" = 1'-0"

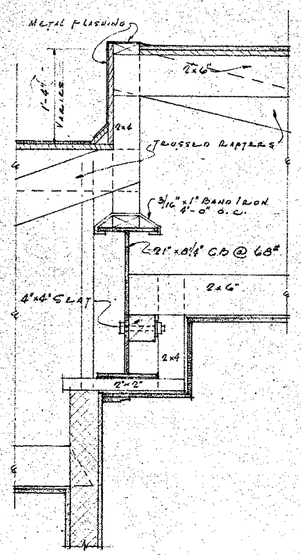


° ° ROOF PLAN ° °

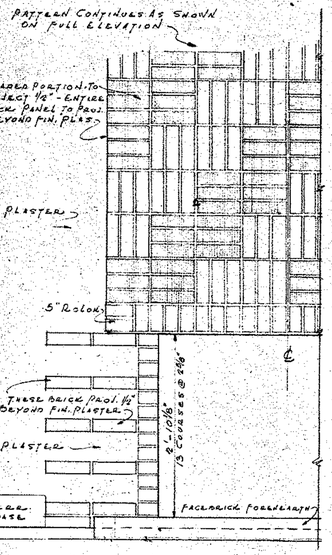
Note:
Skylights to have ceiling sash-glazed with obscure glass.



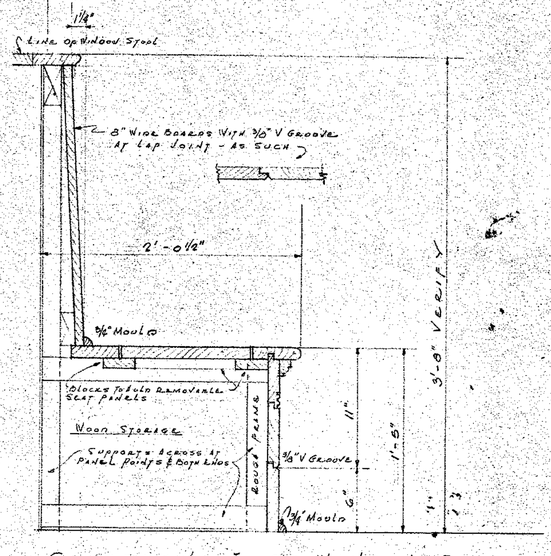
° DETAIL OF PARAPET FLASHING °
Scale: 1 1/2" = 1'-0"



° WALL BETWEEN ROOF LEVELS °
Scale: 1" = 1'-0"



PART DETAIL OF BRICKWORK AROUND HEARTH OPENING
Scale: 3/4" = 1'-0"

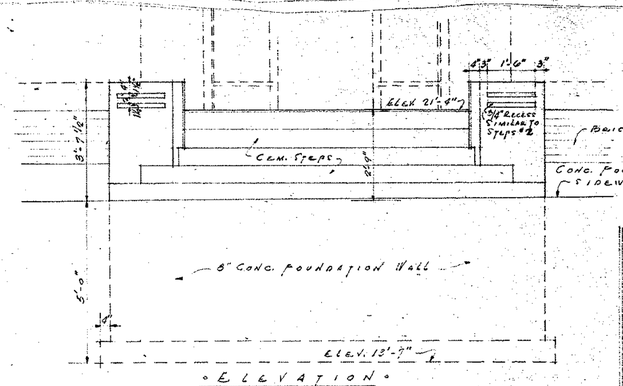


SECTION THRU WINDOW SEAT
Scale: 1 1/2" = 1'-0"

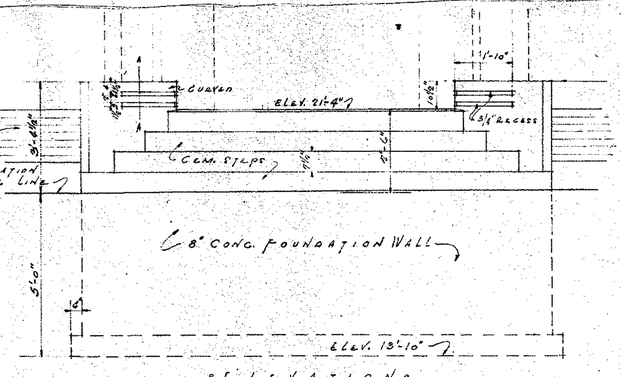
August 2, 1938

A CITY HALL FOR
CITY OF GRAFTON
GRAFTON, NO. DAK.

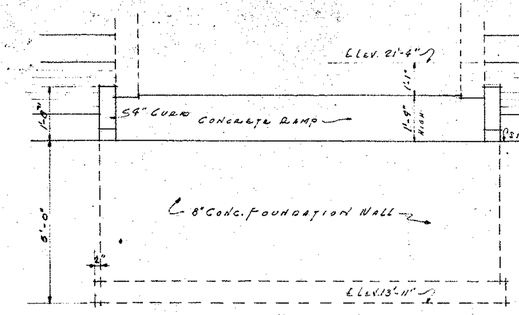
Job No. 3708	Theodore D. Wells	Sheet 5
W.P.R. File 2305	Architect	
	Grand Forks, No. Dak.	



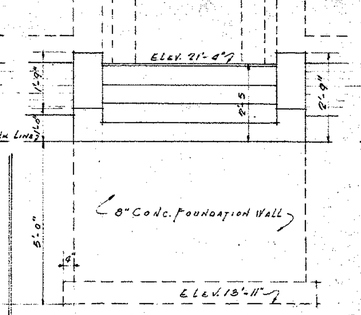
°ELEVATION°



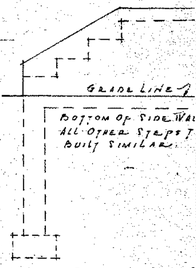
°ELEVATION°



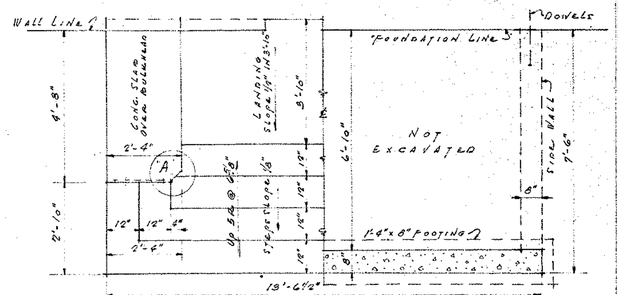
°ELEVATION°



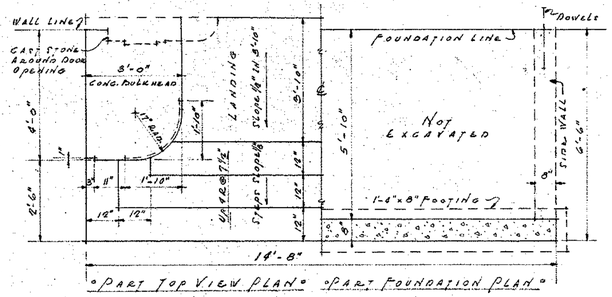
°ELEVATION°



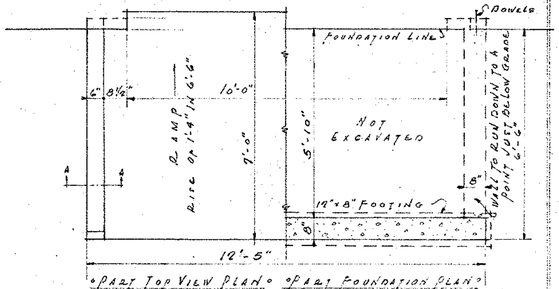
°SIDE ELEV.



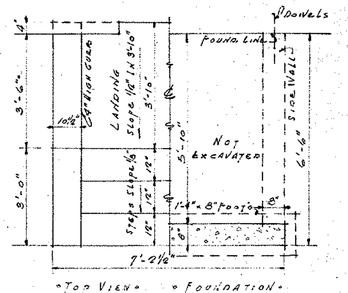
°PART TOP VIEW PLAN° °PART FOUNDATION PLAN°



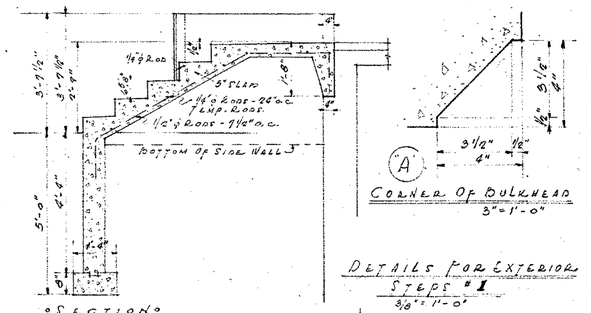
°PART TOP VIEW PLAN° °PART FOUNDATION PLAN°



°PART TOP VIEW PLAN° °PART FOUNDATION PLAN°

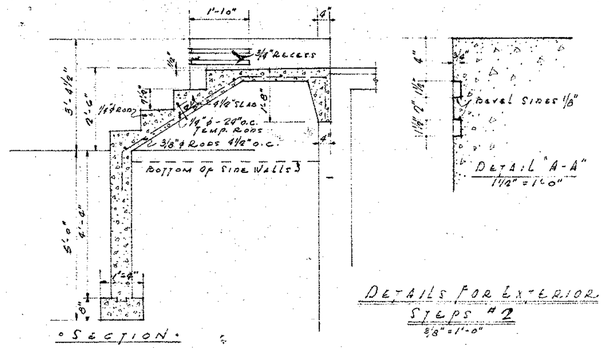


°TOP VIEW° °FOUNDATION°



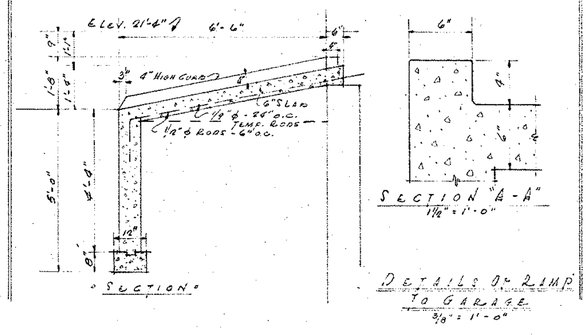
°SECTION°

DETAILS FOR EXTERIOR STEPS #1
3/8"=1'-0"



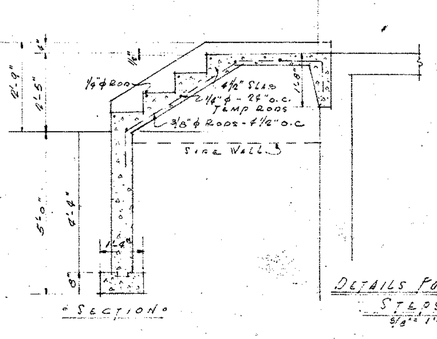
°SECTION°

DETAILS FOR EXTERIOR STEPS #2
3/8"=1'-0"



°SECTION°

DETAILS OF RAMP TO GARAGE
3/8"=1'-0"

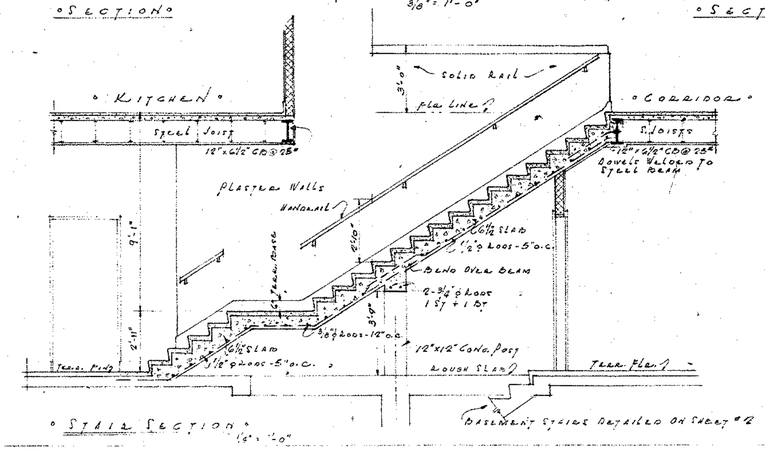


°SECTION°

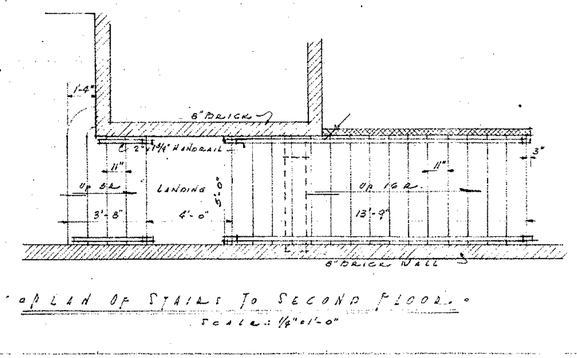
DETAILS FOR EXTERIOR STEPS #3
3/8"=1'-0"

°°STAIR DETAILS°°

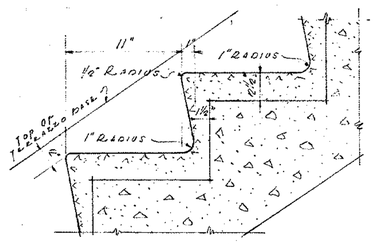
LOCATION SHOWN ON FLOOR PLANS



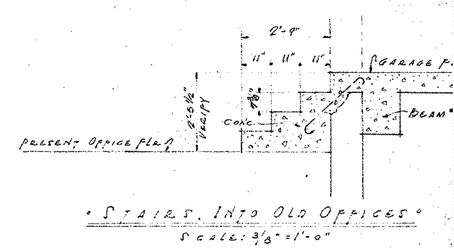
°STAIR SECTION°
½"=1'-0"



°PLAN OF STAIRS TO SECOND FLOOR°
SCALE: ¼"=1'-0"



°°TERRAZZO STAIR DETAIL°°
SCALE: 1½"=1'-0"



°STAIRS INTO OLD OFFICES°
SCALE: 3/8"=1'-0"

°CITY HALL FOR°
°CITY OF GRAFTO
GRAFTON, NO. DAK.

PLAN No. 3703	THEODORE R. WELLS ARCHITECT
W.P.A. File 2852	GRAND FORKS, N.D.

APRIL 25, 1939

63'-6"

35'-11½"

2'-9¾"

12'-10"

2'-9¾"

9'-11"

37'-9"

R & W 9'-7" Slope IN 37'-9"

9'-0"

UP

8" Conc. Wall

41'-0"

Col. 16

Col. 17

Col. 18

Col. 19

Col. 20

Col. 21

Col. 22

Col. 23

Col. 24

Col. 25

Col. 26

Col. 27

Col. 28

Col. 29

Col. 30

Col. 31

Col. 32

Col. 33

Col. 34

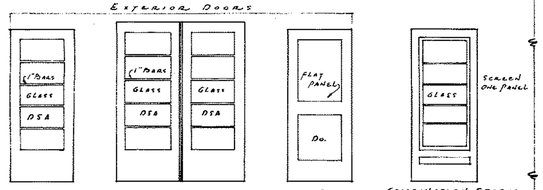
Col. 35

Col.

ROOM FINISH SCHEDULE

NO	NAME	FLOOR	BASE	WALLS	CEILING
		"FIRST FLOOR"			
101	VESTIBULE	TERRAZZO	6" TERR.	PLAS.	PLAS.
102	L.F.W. DEPT.	Do.	Do.	Do.	ACOUSTIC TILE
103	VAULT	Do.	Do.	Do.	PLAS.
104	LEST ROOM	Do	Do.	Do.	ACOUSTIC TILE
105	TOILET	Do.	Do.	Do.	PLAS.
106	CLOSET	Do.	Do.	Do.	Do.
107	OFFICE	Do.	Do.	Do.	ACOUSTIC TILE
108	WOMENS TOILET	Do.	Do.	Do.	PLAS.
109	MENS TOILET	Do.	Do.	Do.	Do
110	HALL	Do	Do.	Do.	Do.
111	ENTRY	Do.	Do.	Do.	Do.
112	GARAGE	CEMENT	NONE	UNFINISHED	Do.
113	POLICE OFFICE	Do.	CEMENT	PLAS.	Do.
114	RECEIVING R.M.	Do.	Do.	Do.	Do.
115	CELLS	Do.	Do.	Do.	Do.
116	WAREHOUSE	Do	Do.	UNFINISHED	UNFINISHED
117	RAMP	Do.	Do.	Do	PART FIN.
118	JANITORS CLOS	Do.	Do.	PLAS.	PLAS.
		"SECOND FLOOR"			
201	COUNCIL ROOM	TERRAZZO	6" TERR.	PLAS.	ACOUSTIC TILE
202	OFFICE	Do.	Do.	Do.	Do.
203	COAT ROOM	Do.	Do.	Do.	PLAS.
204	MENS TOILET	Do.	Do.	6"-6" TERR. WAIN. PLAS.	Do.
205	WOMENS TOILET	Do.	Do.	PLAS.	Do.
206	CORRIDOR	Do	Do.	Do.	ACOUSTIC TILE
207	KITCHEN	Do.	Do.	Do.	Do.
208	ASSEMBLY	MAPLE	WOOD	Do.	Do.
209	LOBBY	TERRAZZO	6" TERR.	Do.	Do.
210	STORAGE	Do.	Do.	Do.	Do.
211	LEGION ROOM	Do.	Do.	Do.	Do.
212	HALL	Do.	Do.	Do.	Do.
213	FIREMENS STOR.	Do.	Do.	Do	Do.
214	DORMITORY	Do.	Do.	Do	Do.
215	BATH	Do.	Do.	Do.	PLAS.
216	LOUNGE	Do.	Do.	Do.	ACOUSTIC TILE
217	STAIRS TO ROOF	Do	Do.	UNFINISHED	NONE
218	BROOM CLOSET	Do.	Do.	PLAS.	PLAS.

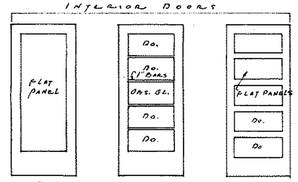
EXTERIOR DOORS



"A" "B" "C"

COMBINATION STORM & SCREEN DOOR FOR ENTRANCES "B" & "C"

INTERIOR DOORS

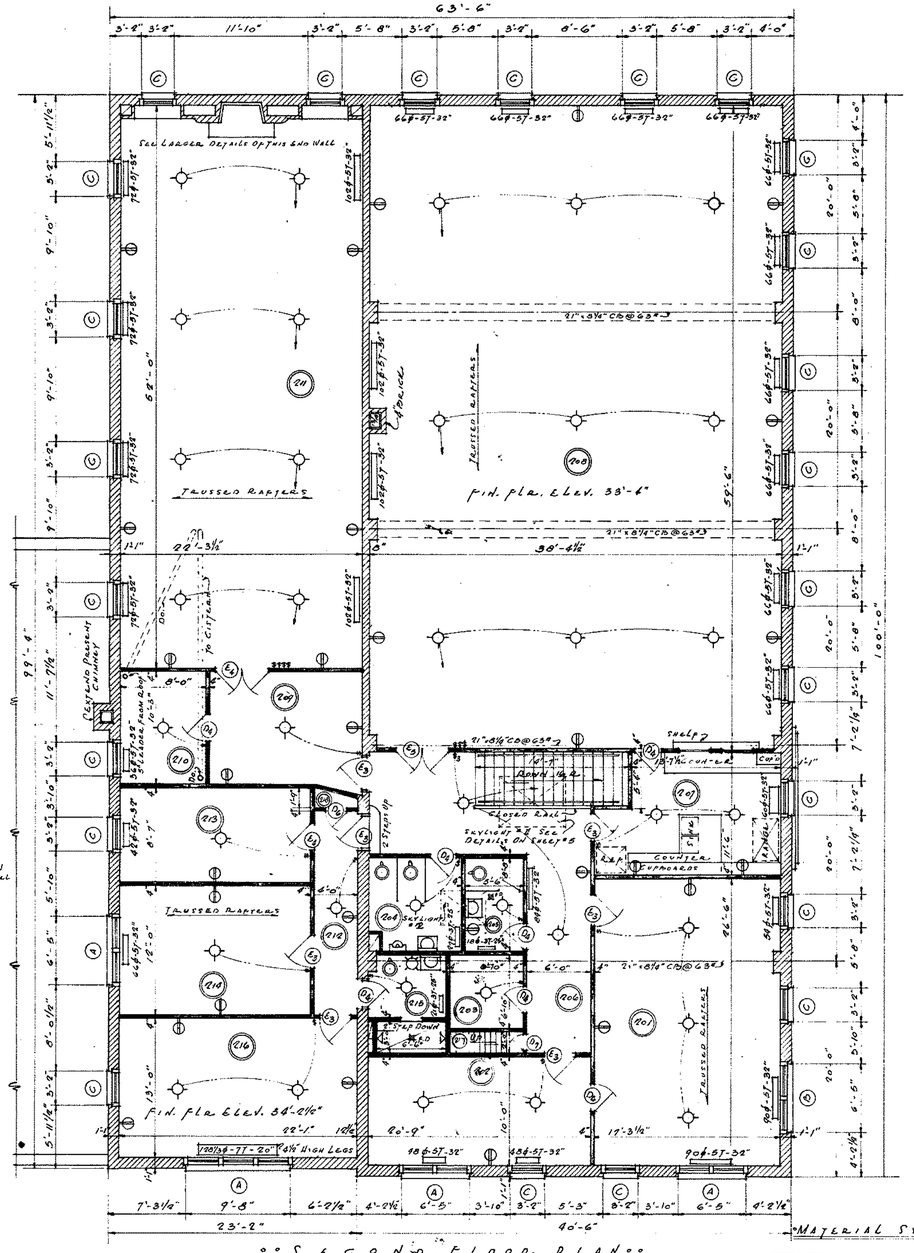


"D" "E" "F"

SIZES	
NO	SIZE
1	3'-0" x 7'-4" x 2 1/4"
2	3'-0" x 7'-0" x 2 1/4"
3	3'-0" x 7'-0" x 1 3/4"
4	2'-6" x 7'-0" x 1 3/4"
5	2'-4" x 7'-0" x 1 3/4"
6	2'-0" x 7'-0" x 1 3/8"
7	1'-6" x 7'-0" x 1 3/8"

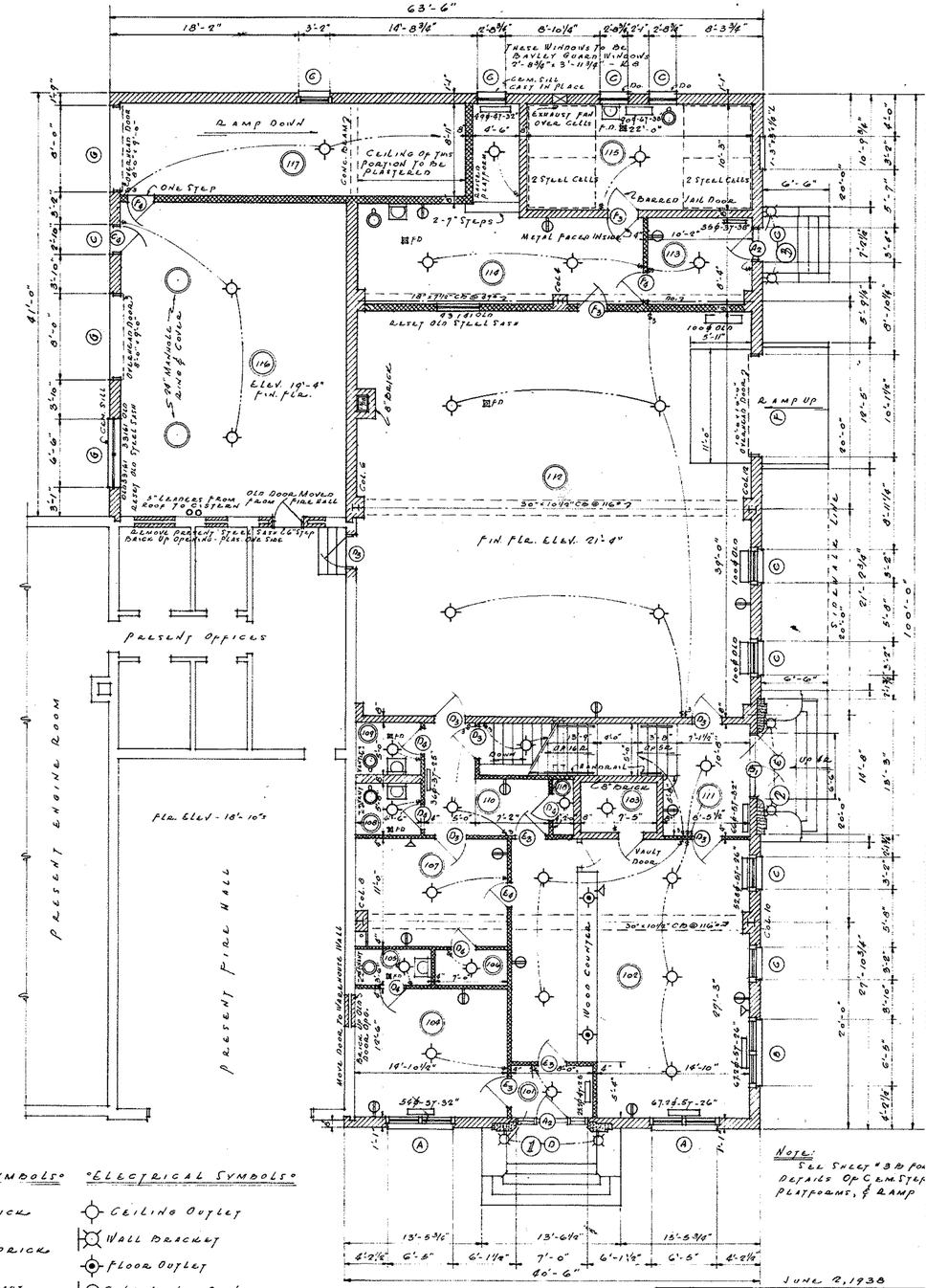
NOTE: ALL DOORS TO HAVE OVOLO STICKING

DOOR TYPES & SIZES



"SECOND FLOOR PLAN"
SCALE: 1/8" = 1'-0"

NOTE: ALL BRICK PILASTERS ON 2nd FLOOR TO HAVE 8½" PROJ. - 2'-0" WIDE. SEE SHEET #8 FOR DIMENSIONS FOR PILASTERS ON 1st FLOOR



NOTE: SEE SHEET "8" FOR DETAILS OF CEM. STEPS, PLATFORMS, & RAMP

"FIRST FLOOR PLAN"
SCALE: 1/8" = 1'-0"

NOTE: SYMBOLS AT ALL EXTERIOR WALL OPENINGS INDICATE LINTEL TYPES & SIZES - SEE SHEET #

"MATERIAL SYMBOLS"

- FACE BRICK
- COMMON BRICK
- STONE - CAST
- HOLLOW BRICK
- CONCRETE
- HOLLOW TILE

"ELECTRICAL SYMBOLS"

- CEILING OUTLET
- WALL BRACKET
- FLOOR OUTLET
- CONVENIENCE OUTLET
- TELEPHONE
- SWITCH - SINGLE
- SWITCH - 3 WAY

JUNE 2, 1938

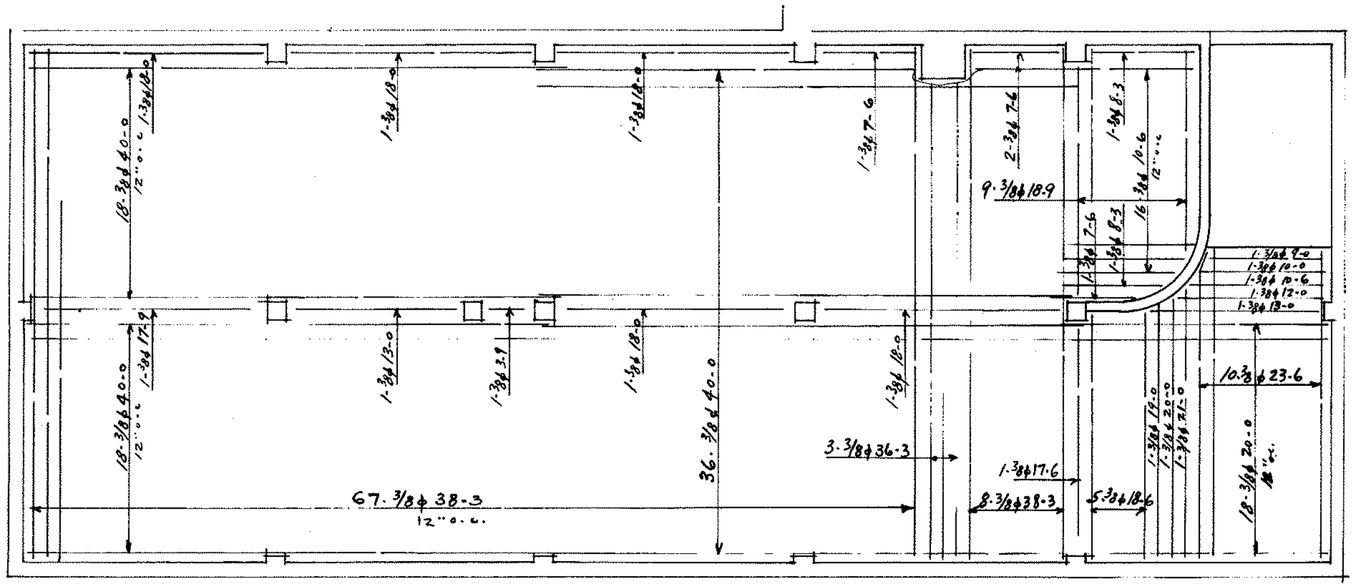
A CITY HALL FOR CITY OF GRAFTON

GRAFTON, NO. DAK.

PLAN NO 3703
WPA FILE 2305

THEODORE B. WELLS ARCHITECT
GRAND FORKS, N.D.

SHEET 4



BASEMENT FLOOR

BEAMS

B1 + B5, 14x26, 2 THUS
2-1ϕ 19-3
2-1ϕ 26-2 B1
18-3/8ϕ 5-6 T1
2" 2@5, 3@6, 9, 12, 16
4-144 BM. CHAIRS

B2 + B9 14x26 2 THUS
2-1ϕ 19-3
2-1ϕ 26-2 B1
9-3/8ϕ 5-6 T1
9-3/8ϕ 5-4 T2
2" 2@5, 3@6, 9, 12, 16
4-144

B3 14x20
2-7/8ϕ 14-8
2-7/8ϕ 21-4 B3
14-3/8ϕ 4-6 T3
2, 3-5, 6, 9, 12
2-144

B4 14x26
2-1ϕ 19-4
2-1ϕ 25-6 B4
18-3/8ϕ 5-6 T1
2" 2@5, 3@6, 9, 12, 16
4-144

B6 14x20
2-3/4ϕ 19-6
2-7/8ϕ 26-1 B6
18-3/8ϕ 4-4 T4
2, 2-5, 3-6, 9, 12, 16
4-144

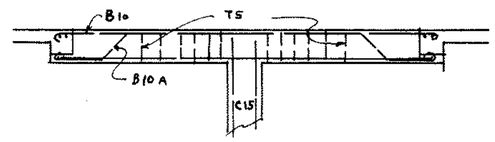
B7 14x20
2-3/4ϕ 20-0
2-7/8ϕ 30-11 B7
18-3/8ϕ 4-4 T4
2, 2@5, 3-6, 9, 12, 16
4-144

B8 14x20
2-3/4ϕ 20-0
2-7/8ϕ 30-11 B7
18-3/8ϕ 4-4 T4
2, 3-5, 6, 9, 12
4-144

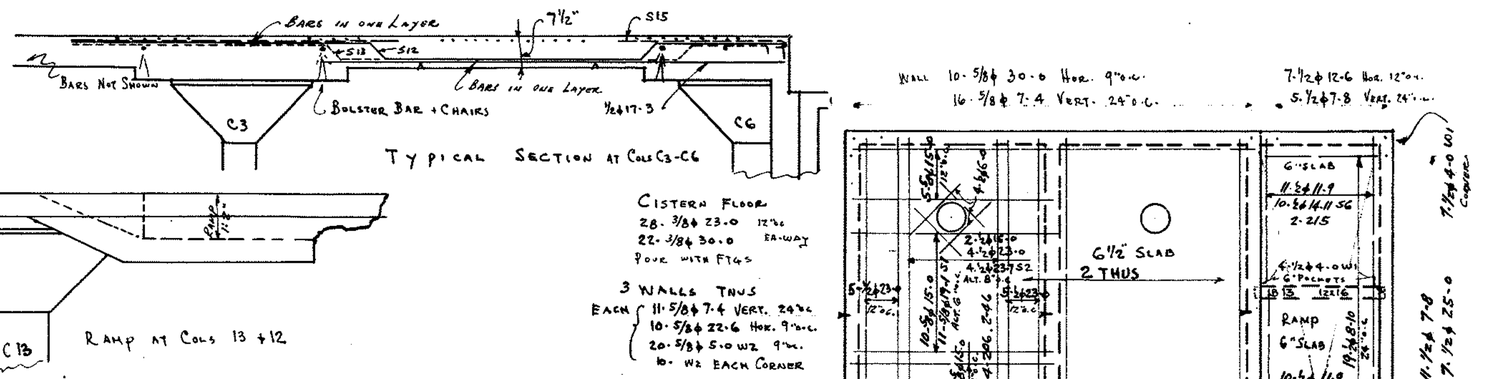
B10 10x14
1-3/4ϕ 15-6 B10 Top over Col.
1-3/4ϕ 16-1 B10A Top " "
2-1/2ϕ 14-0 BOTTOM
10-3/8ϕ 3-0 T5
2" 3@6", 9, 9" EACH SIDE COL.
2-103

B11 + B12 10x10 2 THUS
2-3/4ϕ 8-0 B11 Top
LAP INTO FLAT SLAB
2-1/2ϕ 5-3 BOTTOM
5-3/8ϕ 2-4 T6
2, 6, 3@12" FROM B2-B9
2-103

B13 12x16
1-7/8ϕ 9-8
1-7/8ϕ 11-10 B13
10-3/8ϕ 3-5 T7
3, 6, 9, 9, 12
2-123



BEAM B10



TYPICAL SECTION AT COLS C3-C6

CISTERN FLOOR
28-3/8ϕ 23-0 12"o.c.
22-3/8ϕ 30-0 EA. WAY
POUR WITH FTGS

3 WALLS THUS
EACH { 11-5/8ϕ 7-4 VERT. 24"o.c.
10-5/8ϕ 22-6 HOR. 9"o.c.
20-5/8ϕ 5-0 W2 9"o.c.
10-W2 EACH CORNER

WALL 10-5/8ϕ 30-0 HOR. 9"o.c.
16-5/8ϕ 7-4 VERT. 24"o.c.
7-½ϕ 12-6 HOR. 12"o.c.
5-½ϕ 7-8 VERT. 24"o.c.

FOUNDATION & 1ST. FLOOR PLAN

BASEMENT COLUMNS

C1, C3, C11, C13, C15
5 THUS 16x16"
4-3/4ϕ 9-8
9-1/4ϕ 4-3 T12 12"o.c.

C2, C4, C6, C8
4 THUS 16x16
8-7/8ϕ 9-8
1-1/4ϕ 13-13/4 x 9-8 E1

C5-C7
2 THUS 16x16
6-7/8ϕ 9-8
1-1/4ϕ 13-2 1/8 x 9-8 E2

C9, C14
2 THUS 16x16"
4-5/8ϕ 9-8
9-1/4ϕ 4-3 T12 12"o.c.

C10, C12
2 THUS 16x16
4-7/8ϕ 9-8
15-1/4ϕ 4-3 T12, 8"o.c.

STOCK FOR LINTELS, ETC.
10-½ϕ 30-0

ORDER OF PLACING FLAT SLAB REINFORCING.
1ST: COLUMN BANDS ↕ WITH
4 BOLSTERS "A"
EACH 2-5/8ϕ 4-6, 4-CHS, CHAIRS
1 BOLSTER "B"
2-5/8ϕ 4-6, 2-CH8½, 2-CHS
4 BOLSTERS C
EACH 2-5/8ϕ 9-6, 4-CH5, 2-CH8½
2 BOLSTERS "D"
EACH 2-5/8ϕ 9-6 4-CH5, 2-CH8½
1 BOLSTER E
2-5/8ϕ 4-6 4-CH8½
2ND- COLUMN BANDS ↔
3RD - MIDDLE BANDS ↕
7 BOLSTERS F
EACH 2-5/8ϕ 9-6 6-CH5½
1 BOLSTER G
2-5/8ϕ 9-6 6-CH9
4TH MIDDLE BANDS ↔
8 BOLSTERS H
EACH 2-5/8ϕ 9-6 6-CH5½

BETHLEHEM STEEL CO.
ST. PAUL, MINN. OFFICE
JOB CITY HALL
ORWG. COVERS BSMT. AND FIRST FLOOR
LOCATION GRAFTON, N.D.
ARCHITECT THEODORE B. WELLS
CONTRACTOR
MADE BY R.S.R. CHECKED BY
DATE JAN. 26, 1938 REVISED
7270 R-1 of 1

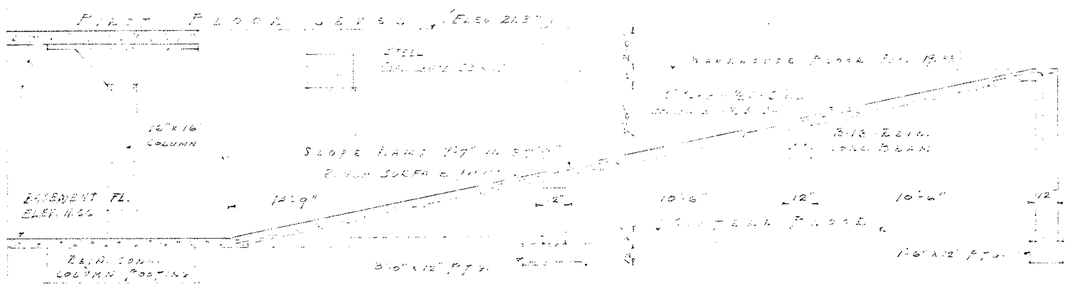
REINFORCING STEEL

KEUFFEL & ESSER CO., N.Y. TRACING CLOTH

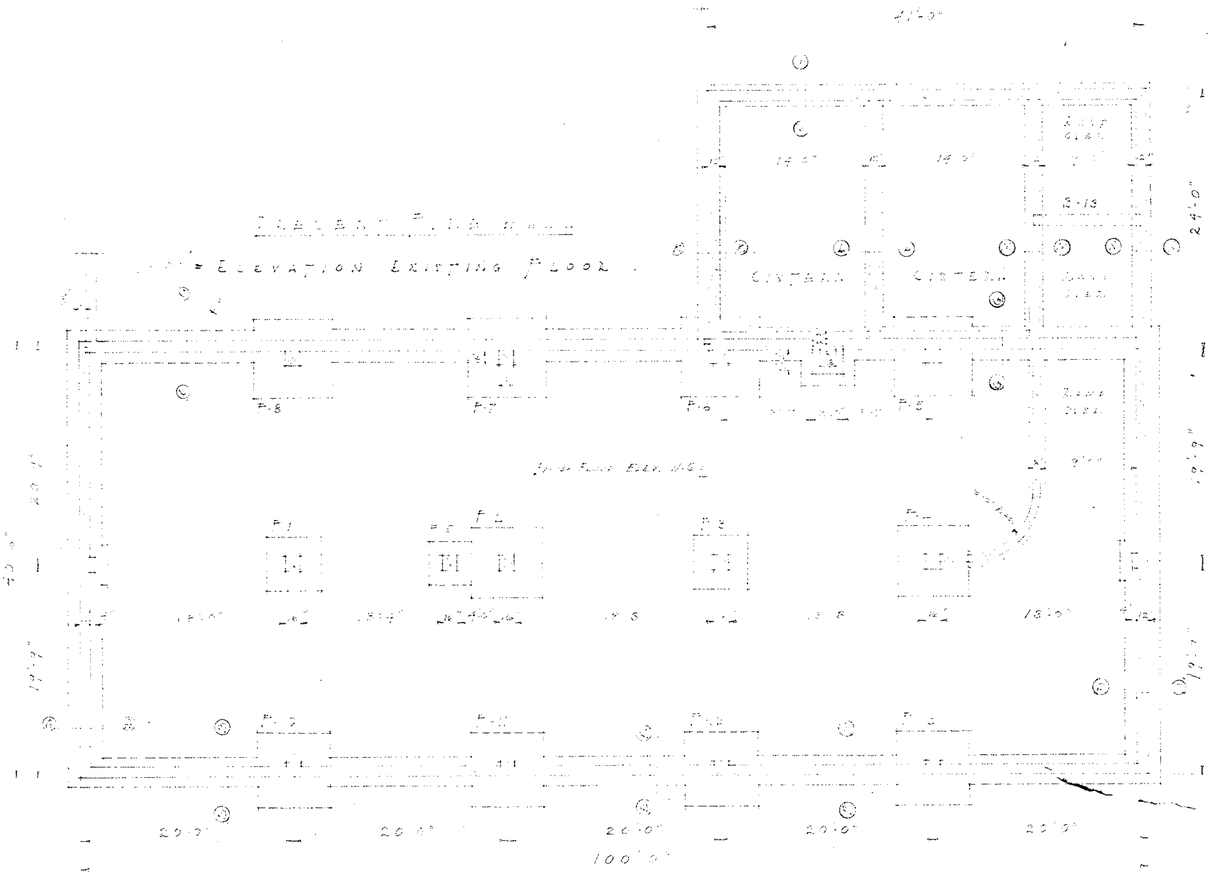
FOOTING SCHEDULE

Ftg. Mark	Reinforcing Steel No. Each Direction	Total	Size	Length	Dowels Number per Ea.	Size	Length	Length	Width	Depth	Ftg. Mark
F 1	9	18	½" φ	5'-0"	4	[illegible]	30"	5'-0"	5'-0"	18"	F 1
F 2	15	30	½" φ	[illegible]		[illegible]	34"	6'-8"	6'-8"	20"	F 2
F 3	9	18	½" φ	5'-0"	4	[illegible]	30"	5'-0"	5'-0"	18"	F 3
F 4	15	30	½" φ	[illegible]	[illegible]	[illegible]	34"	6'-8"	6'-8"	20"	F 4
F 5	16	32	½" φ	[illegible]	[illegible]	[illegible]	34"	7'-0"	7'-0"	20"	F 5
F 6	16	32	½" φ	[illegible]	8	[illegible]	34"	7'-4"	7'-4"	20"	F 6
F 7	16	32	½" φ	[illegible]	6	[illegible]	34"	7'-0"	7'-0"	20"	F 7
F 8	16	32	½" φ	[illegible]	8	[illegible]	34"	7'-4"	7'-4"	20"	F 8
F 10	16	32	½" φ	[illegible]	4	[illegible]	34"	7'-0"	7'-0"	20"	F 10
F 11	[illegible]	30	½" φ	[illegible]	4	[illegible]	34"	6'-8"	6'-8"	20"	F 11
F 12	[illegible]	32	½" φ	[illegible]	4	[illegible]	34"	7'-0"	7'-0"	20"	F 12
F 13	[illegible]	30	½" φ	[illegible]	4	[illegible]	34"	6'-8"	6'-8"	20"	F 13
F 15	8	[illegible]	½"	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	F 15

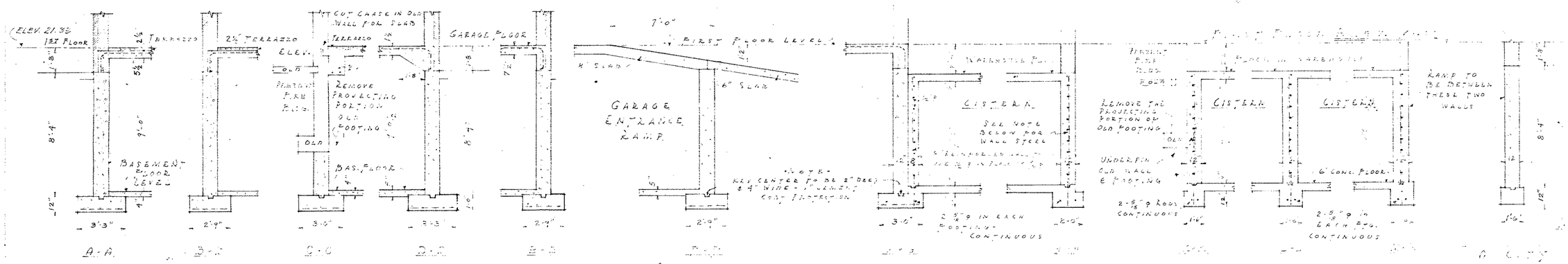
NOTE: [illegible]



SECTION THRU RAMP & BASEMENT - SCALE 1/4"=1'-0"



BASEMENT FLOOR PLAN FOOTING LAYOUT
SCALE - 1/8" = 1'-0"



NOTE: [illegible]

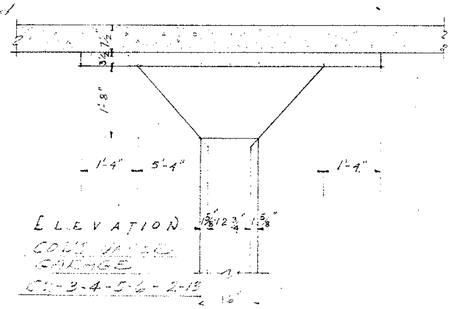
BEAM SCHEDULE

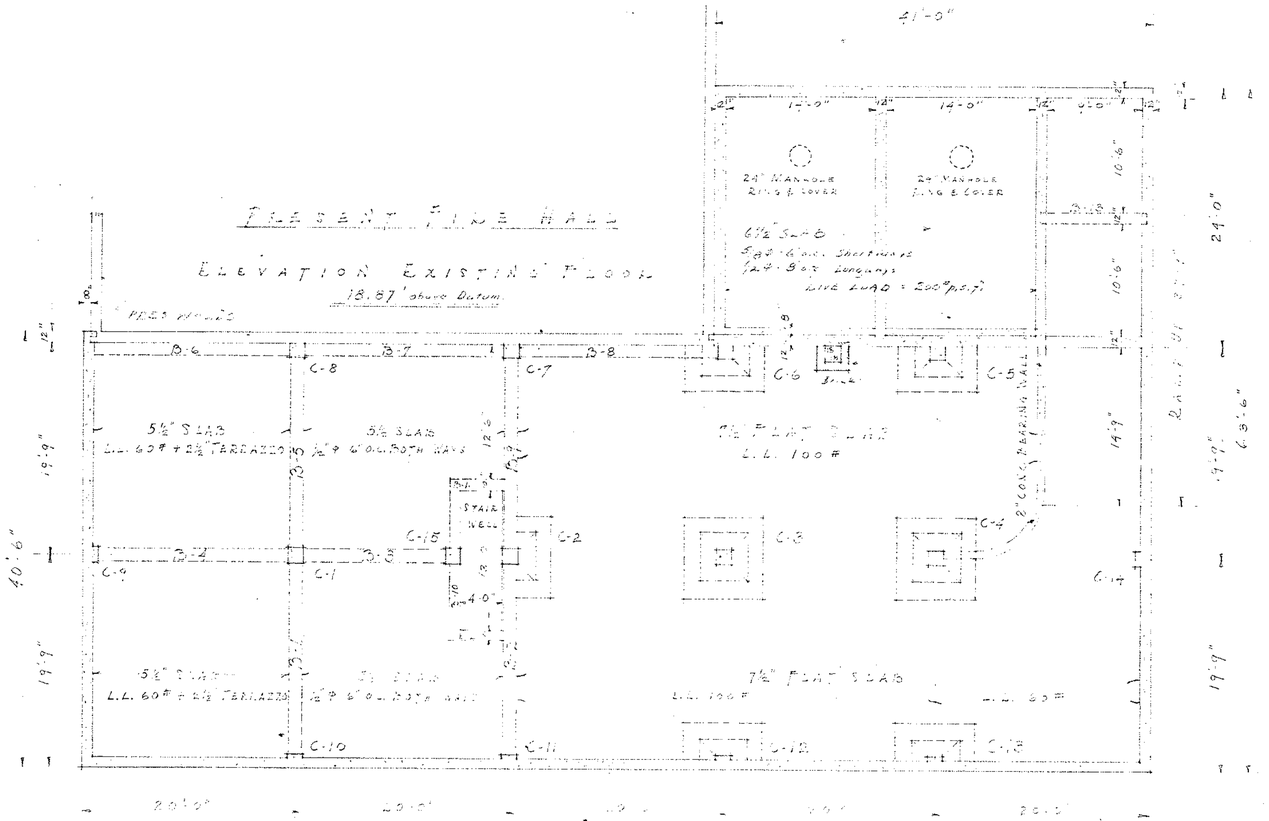
BEAM MARK	SIZE	REINFORCING STEEL: STRAIGHT	BENT
B-1	14"x26"	2-1" ϕ	2-1" ϕ
B-2	14"x26"	2-1" ϕ	2-1" ϕ
B-3	14"x20"	2-⅞ ϕ	2-⅞ ϕ
B-4	14"x26"	2-1" ϕ	2-1" ϕ
B-5	14"x26"	2-1" ϕ	2-1" ϕ
B-6	14"x20"	2-¾ ϕ	2-⅞ ϕ
B-7	14"x20"	2-¾ ϕ	2-⅞ ϕ
B-8	14"x20"	2-¾ ϕ	2-⅞ ϕ
B-9	14"x26"	2-1" ϕ	2-1" ϕ
B-10	10"x14"	1-¾ ϕ	1-¾ ϕ
B-11	10"x10"	1-¾ ϕ	1-¾ ϕ
B-12	10"x10"	1-¾ ϕ	1-¾ ϕ
B13	12"x16"	1-⅞ ϕ	1-⅞ ϕ

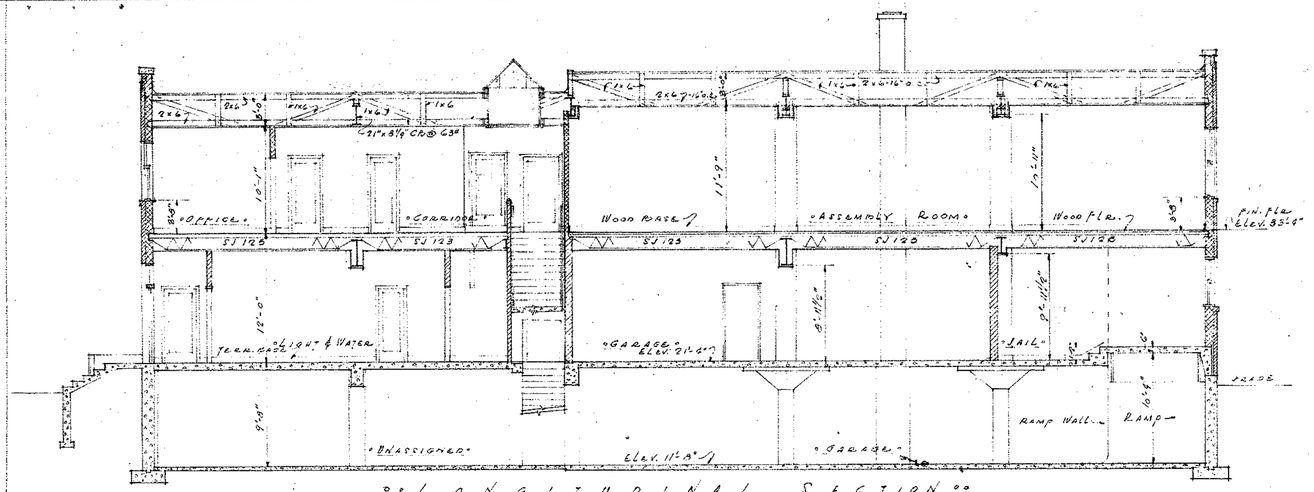
COLUMN SCHEDULE

COL. MARK	SIZE	VERTICAL STEEL: NUMBER OF RODS	SIZE	LENGTH	TIES & HOOPS
C-1	16"x16"	4	-¾" ϕ	9-10	12" CORE - ¼" ϕ TIES @ 12" O.C.
C-2	16"x16"	8	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-3	16"x16"	4	¾" ϕ	do	12" CORE - ¼" ϕ TIES - @ 12" O.C.
C-4	16"x16"	8	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-5	16"x16"	6	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-6	16"x16"	8	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-7	16"x16"	6	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-8	16"x16"	8	⅞" ϕ	do	13" CORE - 5/16" ϕ HOOPS - 2" PITCH
C-9	16"x16"	4	⅝" ϕ	do	12" CORE - ¼" ϕ TIES - 12" O.C.
C-10	16"x16"	4	⅞" ϕ	do	12" CORE - ¼" ϕ TIES - 8" O.C.
C-11	16"x16"	4	¾" ϕ	do	12" CORE - ¼" ϕ TIES - 12" O.C.
C 12	16"x16"	4	⅞" ϕ	do	12" CORE - ¼" ϕ TIES - 8" O.C.
C-13	16"x16"	4	¾" ϕ	do	12" CORE - ¼" ϕ TIES - 12" O.C.
C-14	16"x16"	4	⅝" ϕ	do	12" CORE - ¼" ϕ TIES - 12" O.C.
C-15	16"x16"	4	¾" ϕ	do	12" CORE - ¼" ϕ TIES - 12" O.C.

NOTE:-
All details of Design and fabrication and Bending shall meet the requirements of the Minneapolis Building Ordinance. and Shop Drawings shall be submitted to Architect for approval.
Provide all bolsters, stirrups, dowels, tie wires, temperature rods, etc. as required.
Provide 300 lin. feet of ½"ϕ ¼ to be cut on job for reinforcing around windows, stairways, etc. as directed
All steel shall be intermediate grade @ 18000 lbs.

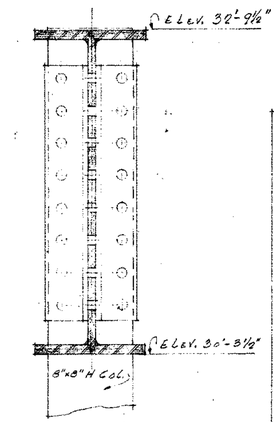




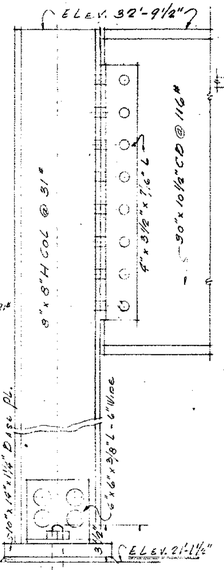


"LONGITUDINAL SECTION"

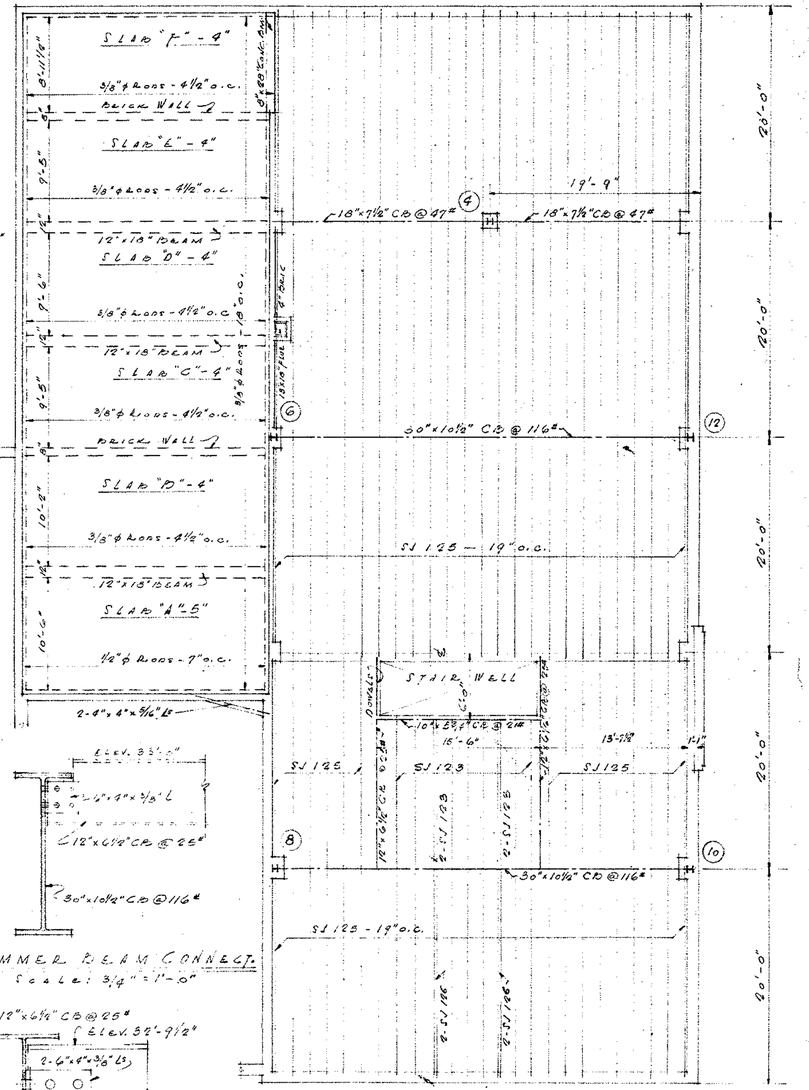
SCALE 1/8" = 1'-0"



"END ELEV."

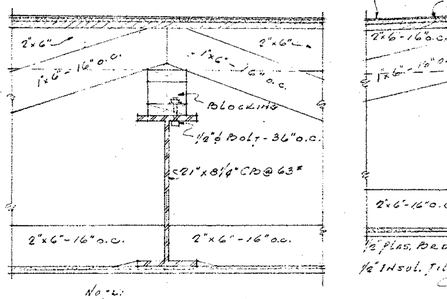


"PLAN"



"SECOND FLOOR FRAMING PLAN"

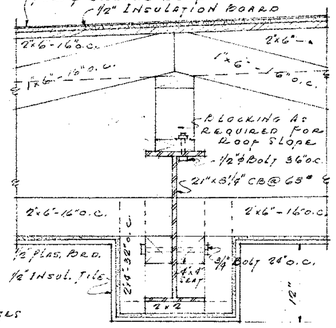
SCALE 1/8" = 1'-0"

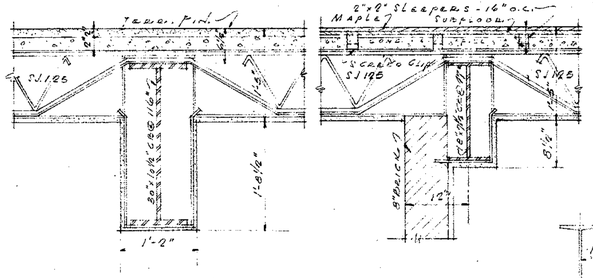


NOTE: PROVIDE 12"x16"x5/16" BEARING PLATES FOR EACH OF THE 21" CB.

"TYPICAL ROOF FRAMING DETAILS"

SCALE: 1" = 1'-0"



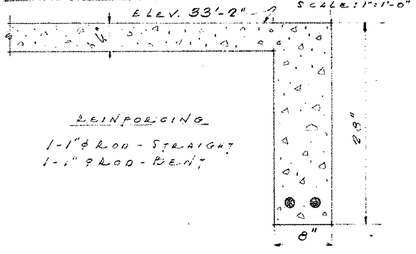


"TYPICAL 2nd FLOOR FRAMING"

SCALE: 3/4" = 1'-0"

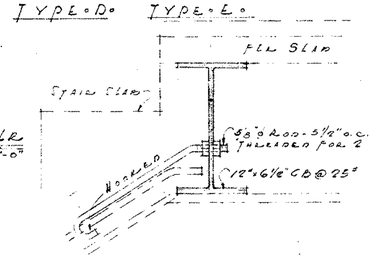
TYPICAL CONCRETE BEAM - 2nd FLR

SCALE: 1" = 1'-0"



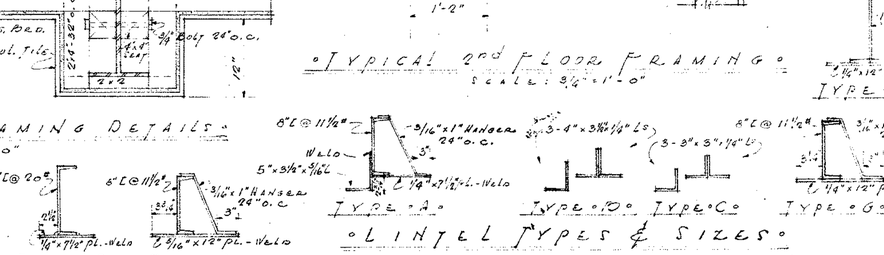
CONCRETE BEAM OVER RAMP

SCALE: 1" = 1'-0"

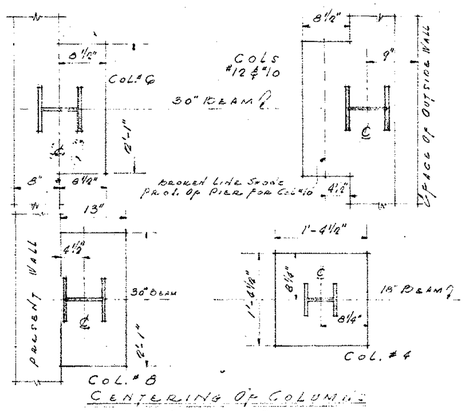


DETAIL OF STEEL BEAM AT 2nd FLR. STAIR LANDING

SCALE: 1½" = 1'-0"

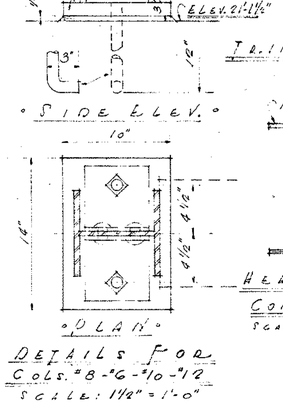


"LINTEL TYPES & SIZES"



CENTERING OF COLUMNS IN BRICK PIERS

SCALE: 3/4" = 1'-0"

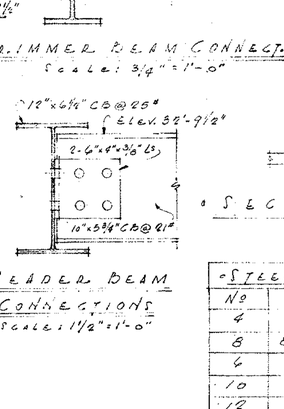


"SIDE ELEV."

"PLAN"

DETAILS FOR COLS. #8-#6-#10-#12

SCALE: 1½" = 1'-0"



HEADER BEAM CONNECTIONS

SCALE: 1½" = 1'-0"

TIMMER BEAM CONNECT.

SCALE: 3/4" = 1'-0"

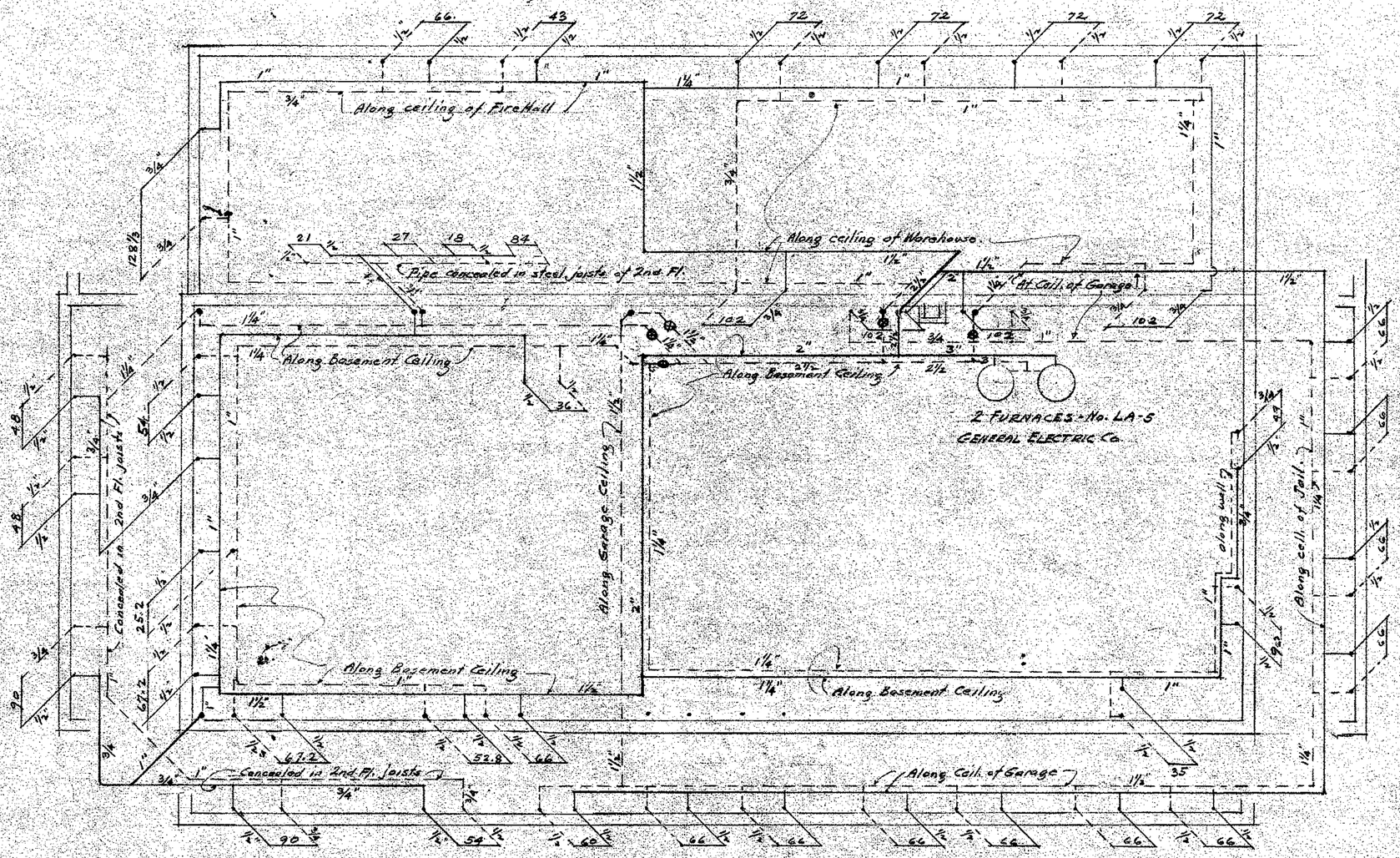
"STEEL COLUMN SCHEDULE"

No	SIZE
4	6"x6" H COL @ 18#
8	8"x8" H COL @ 31#
6	DO.
10	DO.
12	DO.

April 29, 1938

A CITY HALL FOR CITY OF GRAFTON
GRAFTON NO. DAK.

DRAWN NO. 8703	THEODORE B. WELLS ARCHITECT GRAND FORKS, N.D.	SHEET 8
TRACED 2805		



HOT WATER PIPING LAYOUT (Tentative)

SCALE 1/8" = 1'-0"

CITY HALL FOR THE CITY OF GRAFTON

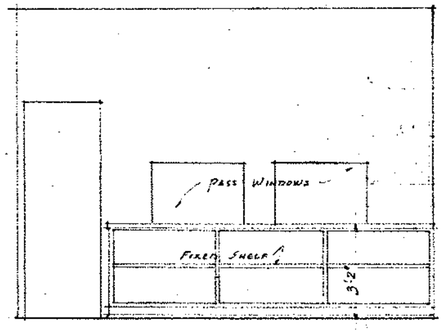
GRAFTON, NO. DAK.

PLAN NO. 3703
W.P.A. FILE 2305

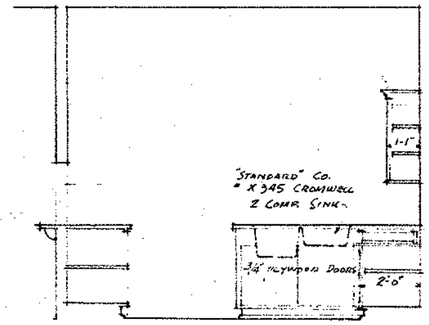
THEODORE B. WELLS
ARCHITECT
GRAND FORKS, N.D.

SHEET #11

MAY 15, 1936
April 23, 1936

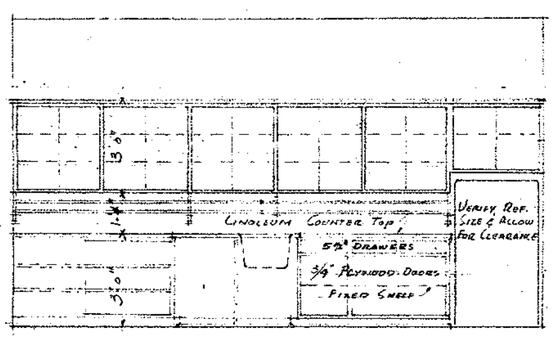


EAST WALL

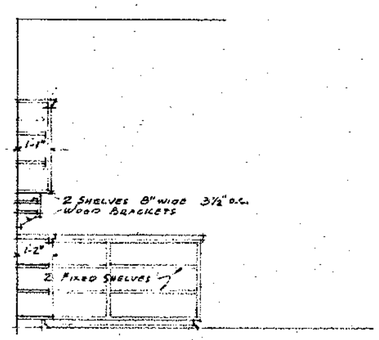


SOUTH WALL

Scale 1/4" = 1'-0"

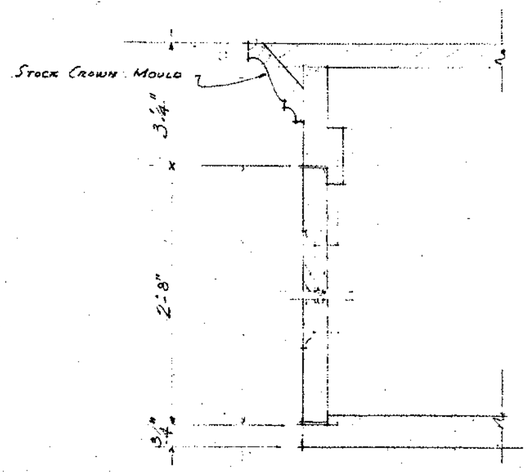


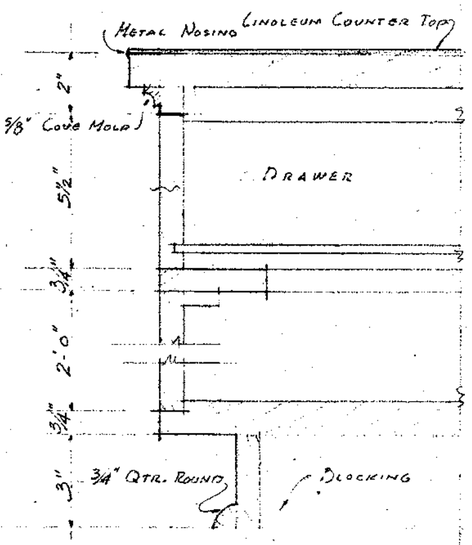
WEST WALL



PART NORTH ELEV

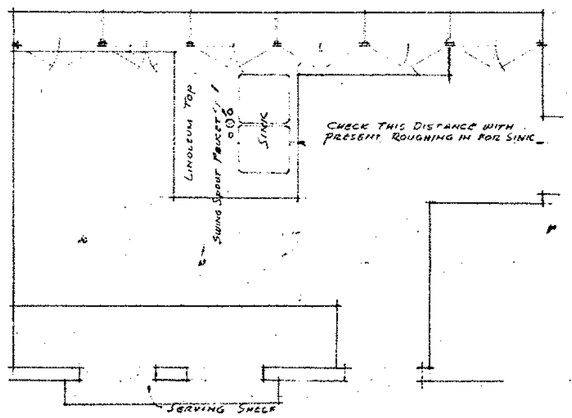
Scale 1/4" = 1'-0"



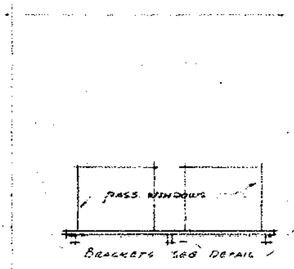


SECTION THRU CUPBOARD

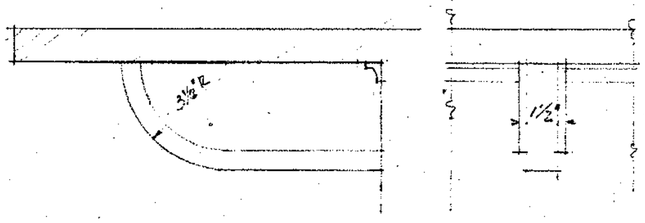
Scale 3" = 1'-0"



PLAN



ELEV. SHOWING SERVING SHELF



SECTION PART ELEV

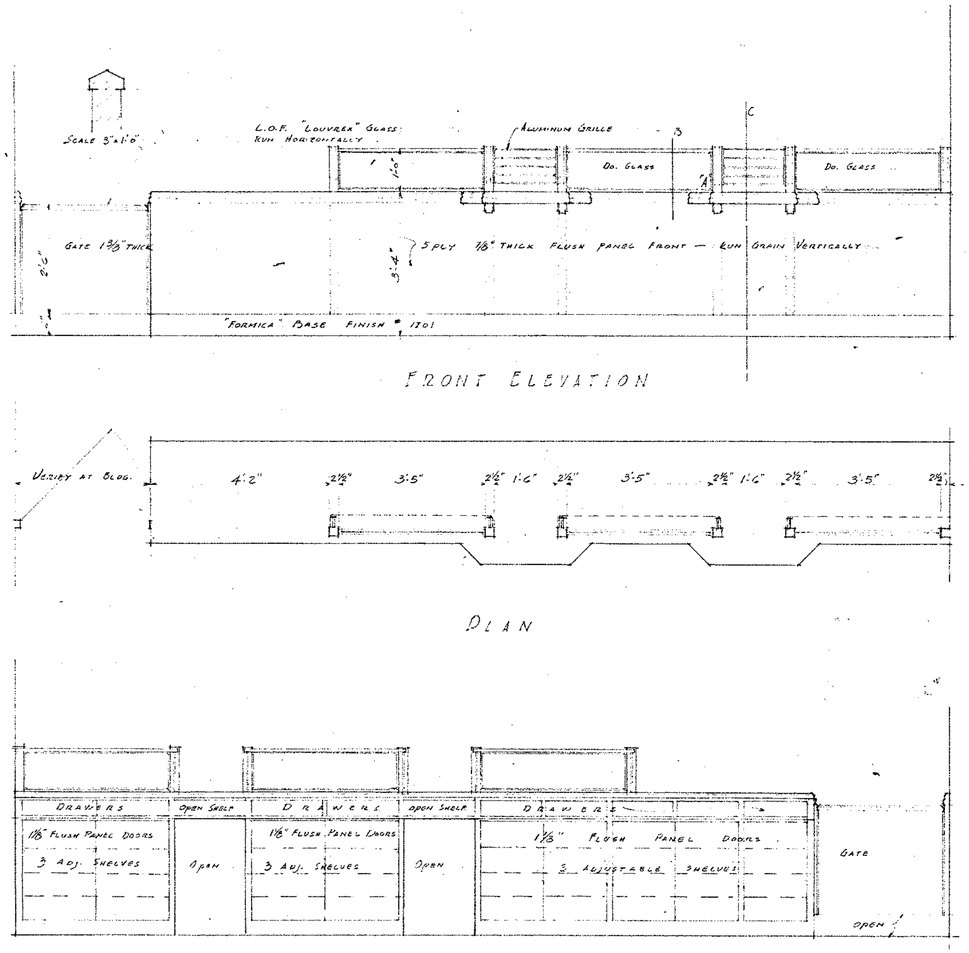
DETAILS OF SERVING SHELF

Scale 3" = 1'-0"

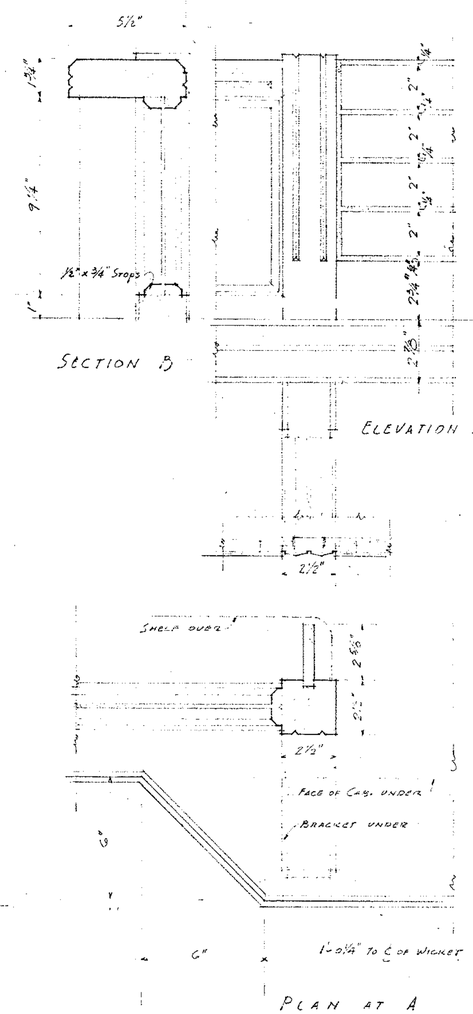
Scale 1/4" = 1'-0"

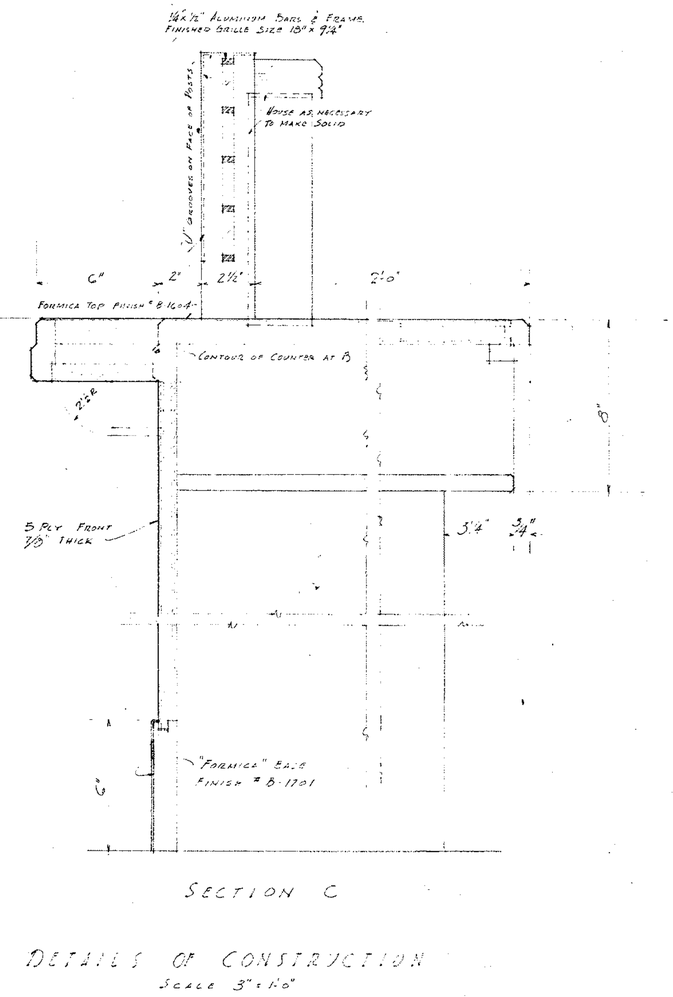
DETAILS OF CABINET WORK IN ROOM NO. 207

	A CITY HALL FOR CITY OF GRAFTON. GRAFTON, NO. DAK.	
PLAN NO. 3703 W.R.A. FILE 2305	THEODORE B. WELLS ARCHITECT GRAND FORKS, N.D.	SHEET



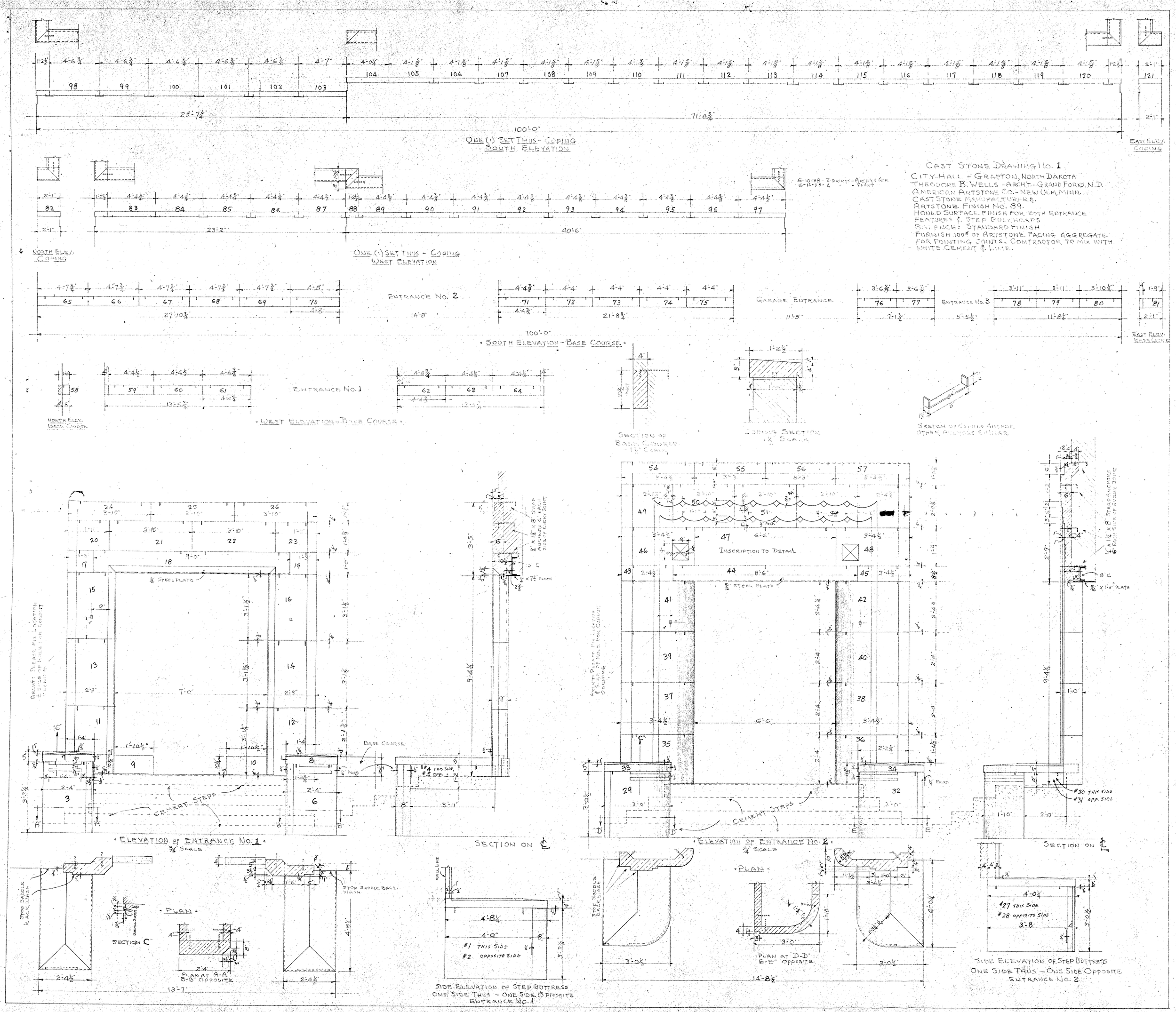
Note: Doors & All other Laminated Members Must be Carefully Stripped on all Exposed Edges. Dowel or House Members Together and Provide all Necessary Blocking to insure a Stought Finished Product.



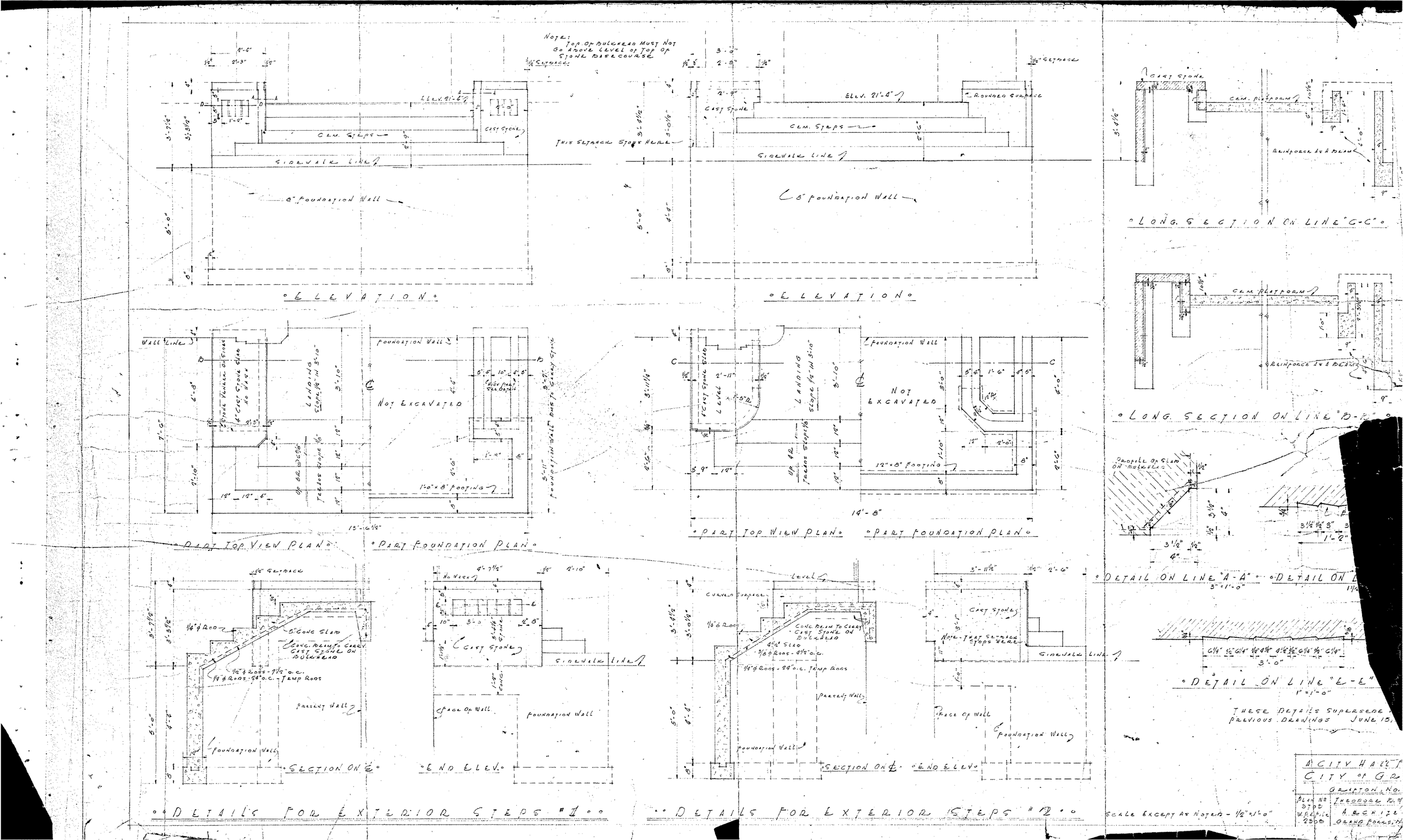


Details of Construction
Scale 3"=1'-0"

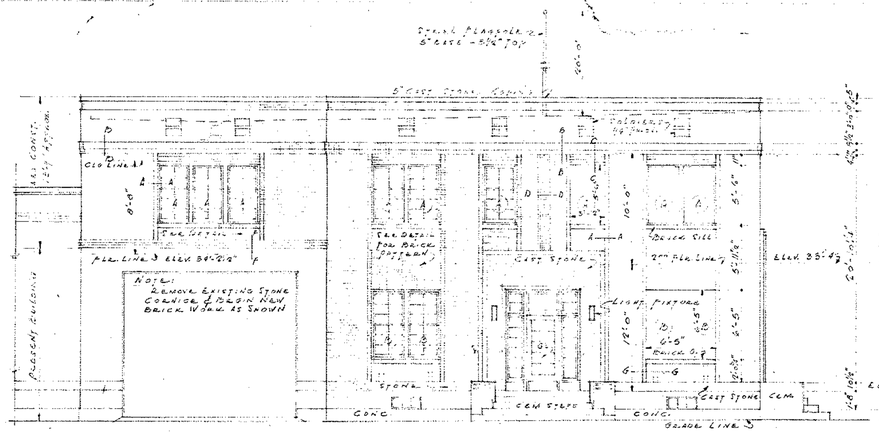
A City Hall for City of Grafton
Grafton No. Dak.
Plan No. 3703 Wpa Fre
Theodore B Wells Sheet



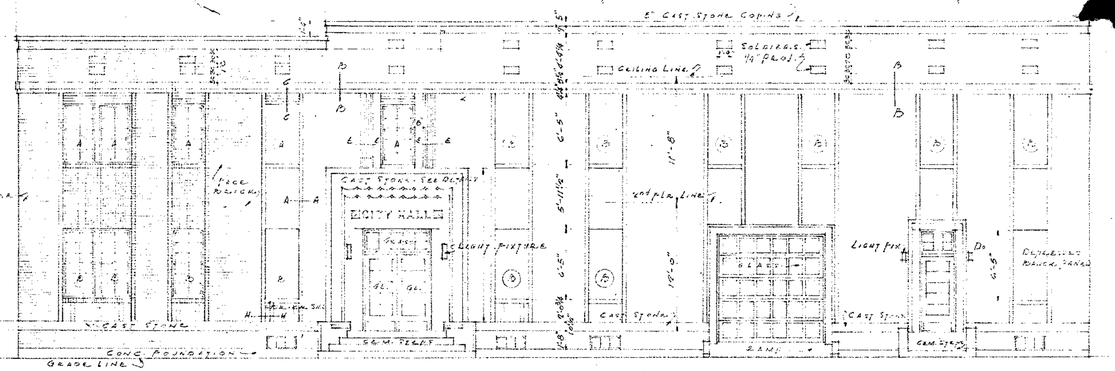
CAST STONE DRAWING No. 1
CITY HALL - GRAFTON, NORTH DAKOTA
THEODORE B. WELLS - ARCH'T. - GRAND FORKS, N.D.
AMERICAN ARTSTONE CO. - NEW ULM, MINN.
CAST STONE MANUFACTURERS.
ARTSTONE FINISH No. 89.
HOUED SURFACE FINISH FOR BOTH ENTRANCE FEATURES & STEP BULKHEADS
BALANCE: STANDARD FINISH
FURNISH 100# OF ARTSTONE FACING AGGREGATE FOR POINTING JOINTS. CONTRACTOR TO MIX WITH WHITE CEMENT & LIME.
ONE (1) SET THUS - COPING
SOUTH ELEVATION
EAST ELEV. COPING
NORTH ELEV. COPING
ONE (1) SET THUS - COPING
WEST ELEVATION
6-10-38 - 2 PRINTS - ARCH'TS APP.
6-15-38 - 4 - PLANT
ENTRANCE No. 2
GARAGE ENTRANCE
ENTRANCE No. 3
SOUTH ELEVATION - BASE COURSE
EAST ELEV. BASE COURSE
ENTRANCE No. 1
WEST ELEVATION - BASE COURSE
NORTH ELEV. BASE COURSE
SECTION OF BASE COURSE
COPING SECTION
SKETCH OF COPING ANCHOR
INSCRIPTION TO DETAIL
CEMENT STEPS
BASE COURSE
ELEVATION OF ENTRANCE No. 1
3/4 SCALE
SECTION ON ℄
ELEVATION OF ENTRANCE No. 2
3/4 SCALE
SECTION ON ℄
PLAN
SECTION C
PLAN AT A-A B-B OPPOSITE
PLAN AT D-D E-E OPPOSITE
SIDE ELEVATION OF STEP BUTTRESS
ONE SIDE THUS - ONE SIDE OPPOSITE
ENTRANCE No. 1
SIDE ELEVATION OF STEP BUTTRESS
ONE SIDE THUS - ONE SIDE OPPOSITE
ENTRANCE No. 2



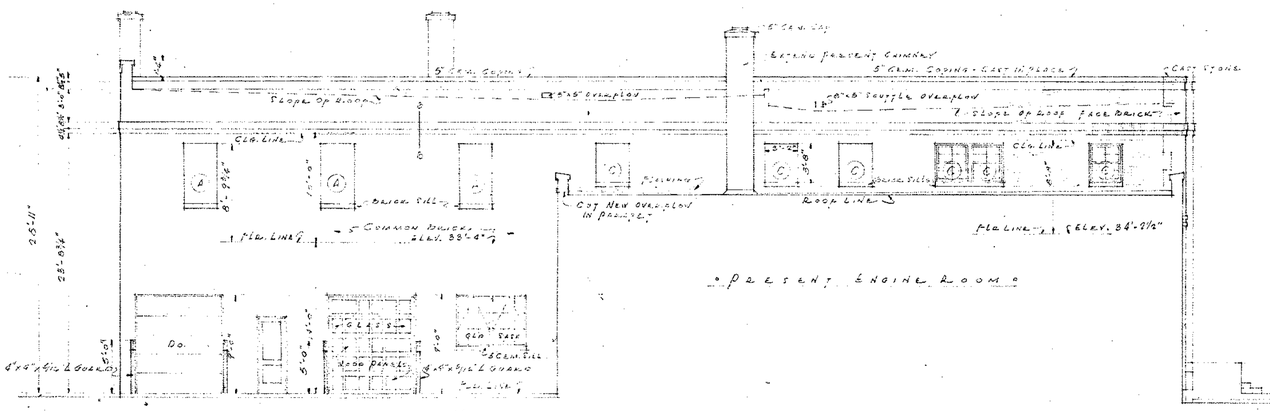
NOTE: TOP OF BULKHEAD MUST NOT GO ABOVE LEVEL OF TOP OF STONE BASECOURSE
ELEVATION
ELEVATION
LONG. SECTION ON LINE "C-C"
LONG. SECTION ON LINE "B-B"
PART TOP VIEW PLAN
PART FOUNDATION PLAN
PART TOP VIEW PLAN
PART FOUNDATION PLAN
DETAIL ON LINE "A-A"
DETAIL ON L
DETAIL ON LINE "E-E"
SECTION ON ℄
END ELEV.
SECTION ON ℄
END ELEV.
DETAILS FOR EXTERIOR STEPS #1
DETAILS FOR EXTERIOR STEPS #2
THESE DETAILS SUPERSEDE PREVIOUS DRAWINGS JUNE 15,
SCALE EXCEPT AS NOTED - 1/2"=1'-0"
CITY HALL
CITY OF GR
GRAFTON, NO.
THEODORE B.
ARCHITE
GRAND FORKS, N



◦WEST ELEVATION◦
SCALE: 1/8"=1'-0"

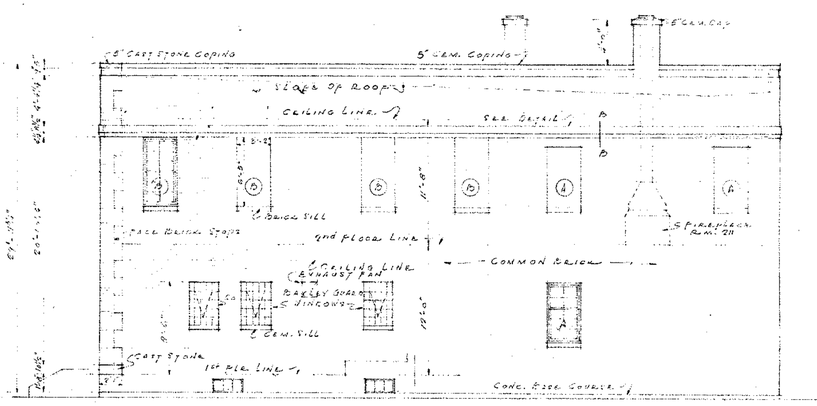


◦SOUTH ELEVATION◦
SCALE: 1/8"=1'-0"

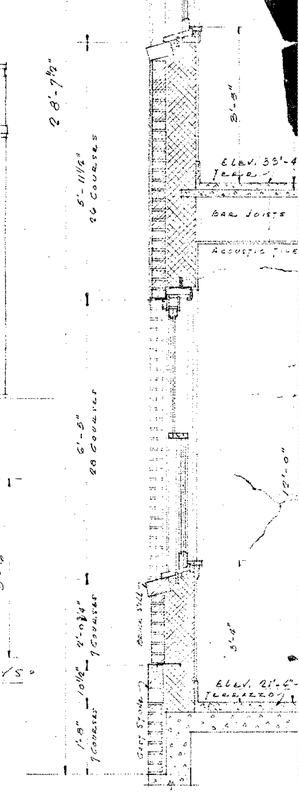


◦PRESENT ENGINE ROOM◦

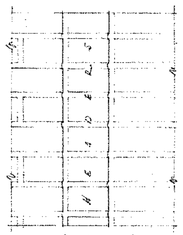
◦NORTH ELEVATION◦
1/8"=1'-0"



◦EAST ELEVATION◦
SCALE: 1/8"=1'-0"

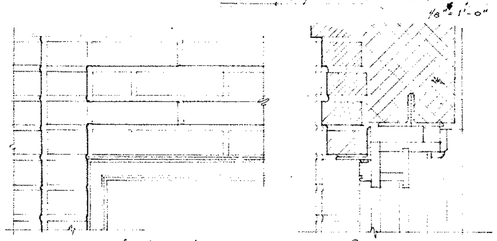


◦TYPICAL WALL SECTION◦
SCALE: 1"=1'-0"

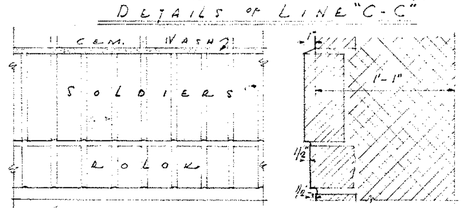


PLAN

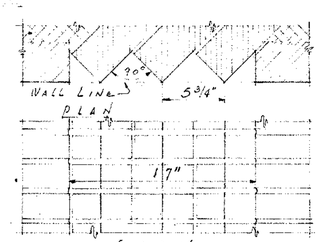
◦DETAILS OF LINE "A-A"◦



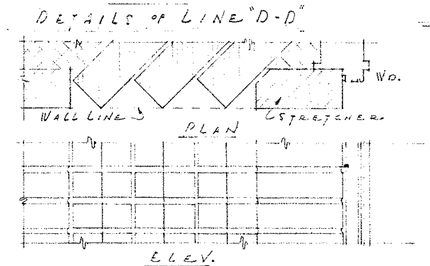
DETAILS of LINE "C-C"



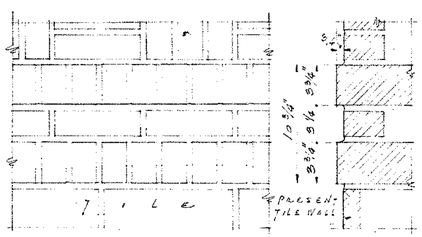
DETAILS of LINE "B-B"



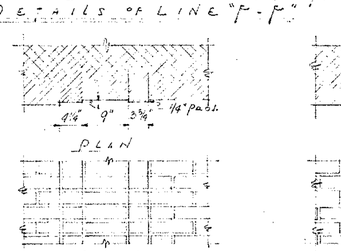
DETAILS of LINE "D-D"



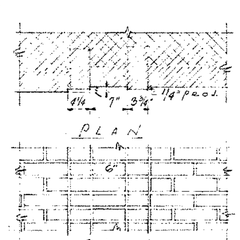
DETAILS of LINE "E-E"



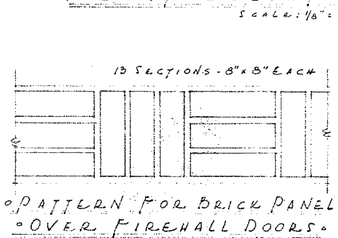
DETAILS of LINE "F-F"



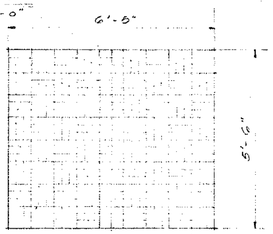
DETAILS of LINE "G-G"



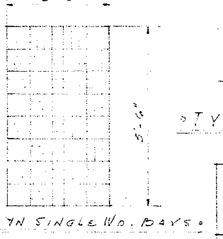
DETAILS of LINE "H-H"



◦PATTERN FOR BRICK PANEL◦
◦OVER FIREHALL DOORS◦
1½"=1'-0"



◦PANEL IN MULLION WD BAYS◦

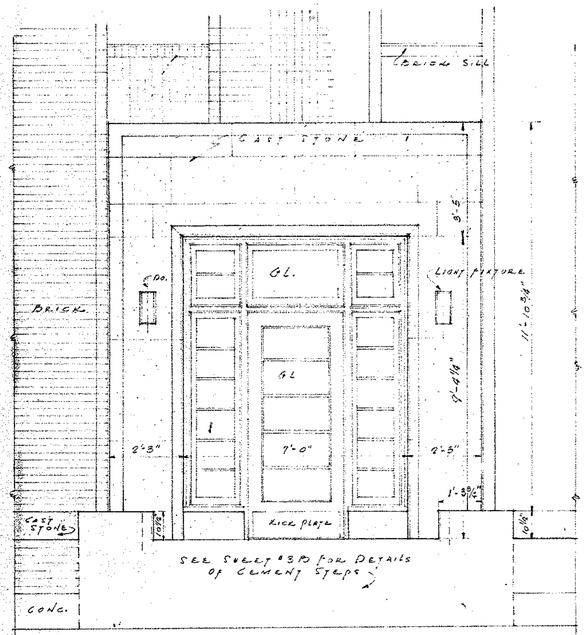


◦PANEL IN SINGLE WD. BAYS◦

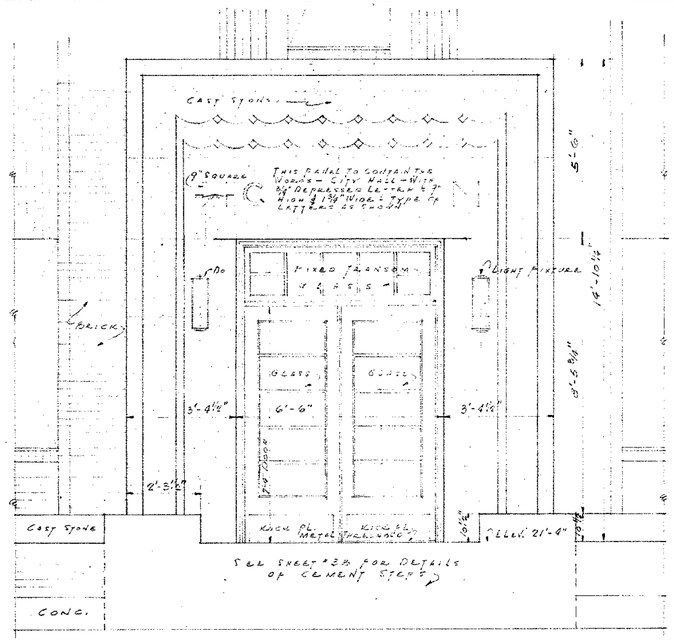
◦BRICK PATTERN FOR◦
◦WINDOW SPANDRELS◦

A CITY HALL FOR
◦CITY OF GRAFTON
GRAFTON, N. DAK.

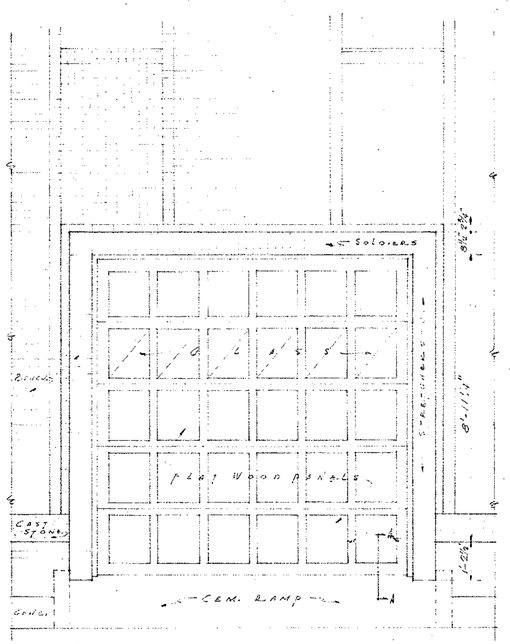
PLAN No 3702 W.P.A. PROJ. 2508	THEODORE B. WELLS ARCHITECT GRAND FORKS, N. DAK.	SHEET



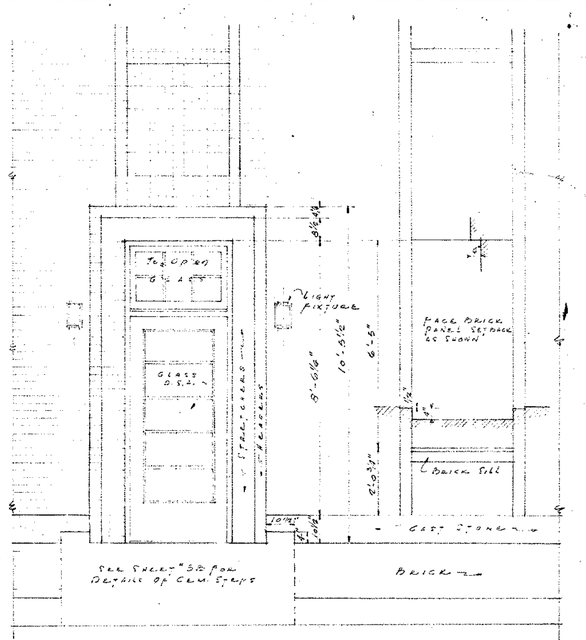
◦ELEV. of ENTRANCE #1◦
3/8" = 1'-0"



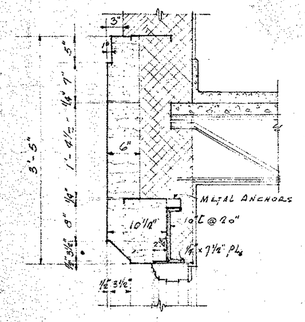
◦ELEVATION of ENTRANCE #2◦
3/8" = 1'-0"



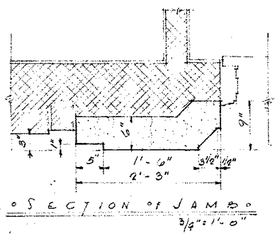
◦ELEVATION of DOOR to GARAGE◦
3/8" = 1'-0"



◦ELEVATION of ENTRANCE #3◦
3/8" = 1'-0"

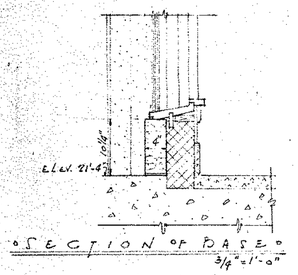


◦SECTION of HEAD◦
3/4" = 1'-0"

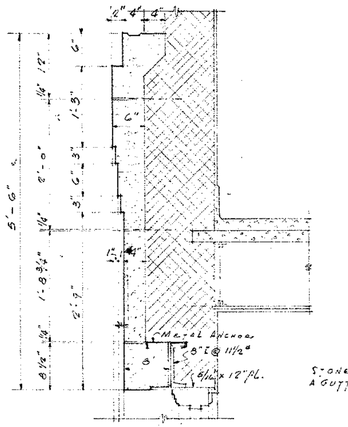


◦SECTION of JAMB◦
3/4" = 1'-0"

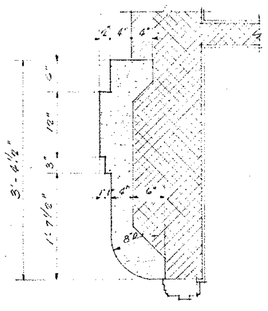
◦STONE DETAILS FOR◦
◦ENTRANCE #1◦



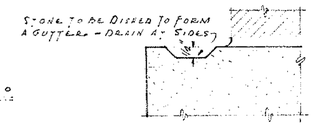
◦SECTION of BASE◦
3/4" = 1'-0"



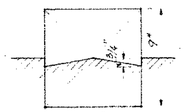
◦SECTION THRU HEAD◦
3/4" = 1'-0"



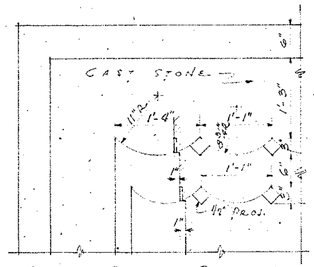
◦SECTION THRU JAMB◦
3/4" = 1'-0"



◦DETAIL of CAP◦

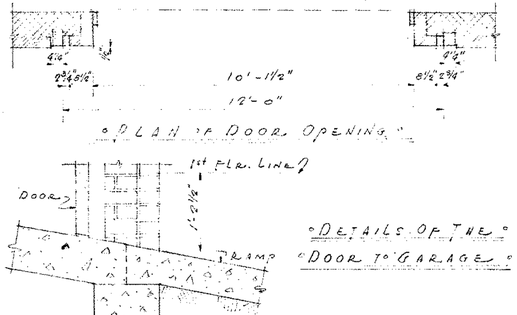


◦DEPRESSED PANEL◦
1½" = 1'-0"



◦CAST STONE DETAIL◦
3/4" = 1'-0"

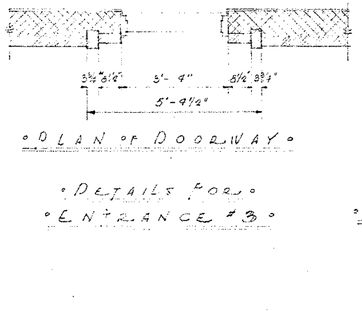
◦STONE DETAIL FOR◦
◦ENTRANCE #2◦



◦PLAN of DOOR OPENING◦

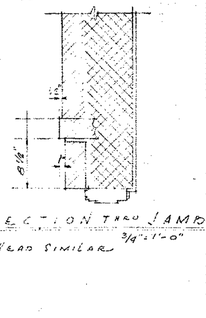
◦DETAILS OF THE◦
◦DOOR to GARAGE◦

◦DETAIL "A-A"◦
3/4" = 1'-0"

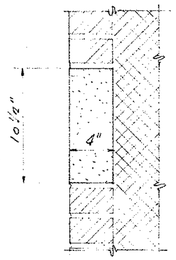


◦PLAN of DOORWAY◦

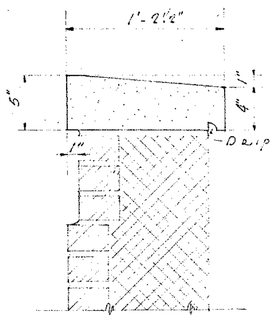
◦DETAILS FOR◦
◦ENTRANCE #3◦



◦SECTION THRU JAMB◦
HEAD SIMILAR
3/4" = 1'-0"



◦CAST STONE◦ ◦BASE COURSE◦
1½" = 1'-0"



◦CAST STONE◦
COPING◦
1½" = 1'-0"

A[illegible]Y WALL FOR
CITY of GRAFTON
GRAFTON, NO. DAK.

PLAN No. 3708 W.C.A. FILE 2305	THEODORE B. WELLS ARCHITECT GRAND FORKS, N.D.	SHEET # 7

METAL COR. BEAD
7030
12"
CAULK
1⅛"
1⅛"
3"x⅜"x¼" CAULKING
HEAD

3"
6⅜"
2¼"
1¾"
CAULKING
JAMB

FINISH
5"
MULLION

1⅜"
CHECK RAIL

ANCHOR FOR MOULION WOR
⅛"
3¼4"
1⅜"
1⅛"
CAULKING
BACK
SILL
TYPICAL DETAILS FOR DOUBLE-HUNG WINDOWS

METAL COR. BEAD
2¼"
HEAD

COLLAPSED MASONRY
1¼"
2¼"
JAMB

HEAD & JAMBS DETAILS FOR D-H WDS IN R.M. NO. 207
WINDOWS SET IN MASONRY OPENINGS

⅝"
1⅛"
1⅛"
F. S. MUNTIN

JAMB ANCHORS
LINTEL
CORRIDOR SIDE
2"x6"
2¾"
3⅝"
HEAD & JAMB SIMILAR
DOOR FRAME IN 12" WALL

STONE
3"
2¾"
2"x6"
1⅜"
1⅜"
2"
HEAD

STONE
3"
2⅜"
1¼"
1¾"
2"
HEAD

HEAD
JAMB SIMILAR
2"

DIAGRAM OF SINGLE WEIGH FOR MULLION
TO SASH
TO SASH
PULLEY
SASH WEIGHT

METAL COR. BEAD
4"
2½"
3⅝"
2"
HEAD

2 THUS
LINTEL
ANCHOR
CORRIDOR SIDE
2"x6"
2¼"
3⅝"
HEAD & JAMB SIMILAR
DOOR FRAME IN 8" WALL

2¼"
3"
1⅜"
2¼"
TRANSOM BAR

3"
2⅜"
2"x5½"
2½"
TRANSOM BAR

3"
3"
1⅝"
2"
TRANSOM BAR
DETAILS FOR ENTRANCE #3

OMIT
⅜"
1¾"
TRANSOM BAR

SIDELIGHT
3"
1⅝"
1½"
2"
PROVIDE ¾" RABBET ON LOCK SIDE OF DR. FRAME
DOOR
MULLION

3 THUS
ANCHOR
2½"
1⅜"
GARAGE SIDE
DOOR FRAMES IN R.M. #112
2 THUS

8" RAD.
JAMB ANCHOR
CAULKING
3"
2"x6½"
1⅝"
2¼"
JAMB

1½ F.S. BASE IN R.M. #208

1¼"
3"
1¼"
3¼"
METAL COR. BEAD
SECT.
PLASTE
ELE
CAP FOR STAIR R

JAMB ANCHOR 3 EACH SIDE TERR. BASS
2¼"
PLINTH
1⅜"
DOOR
SILL

FRAMES IN 4" WALL
TRANSOMS ONLY WHERE SHOWN
INTERIOR DOOR FRAME DETAILS

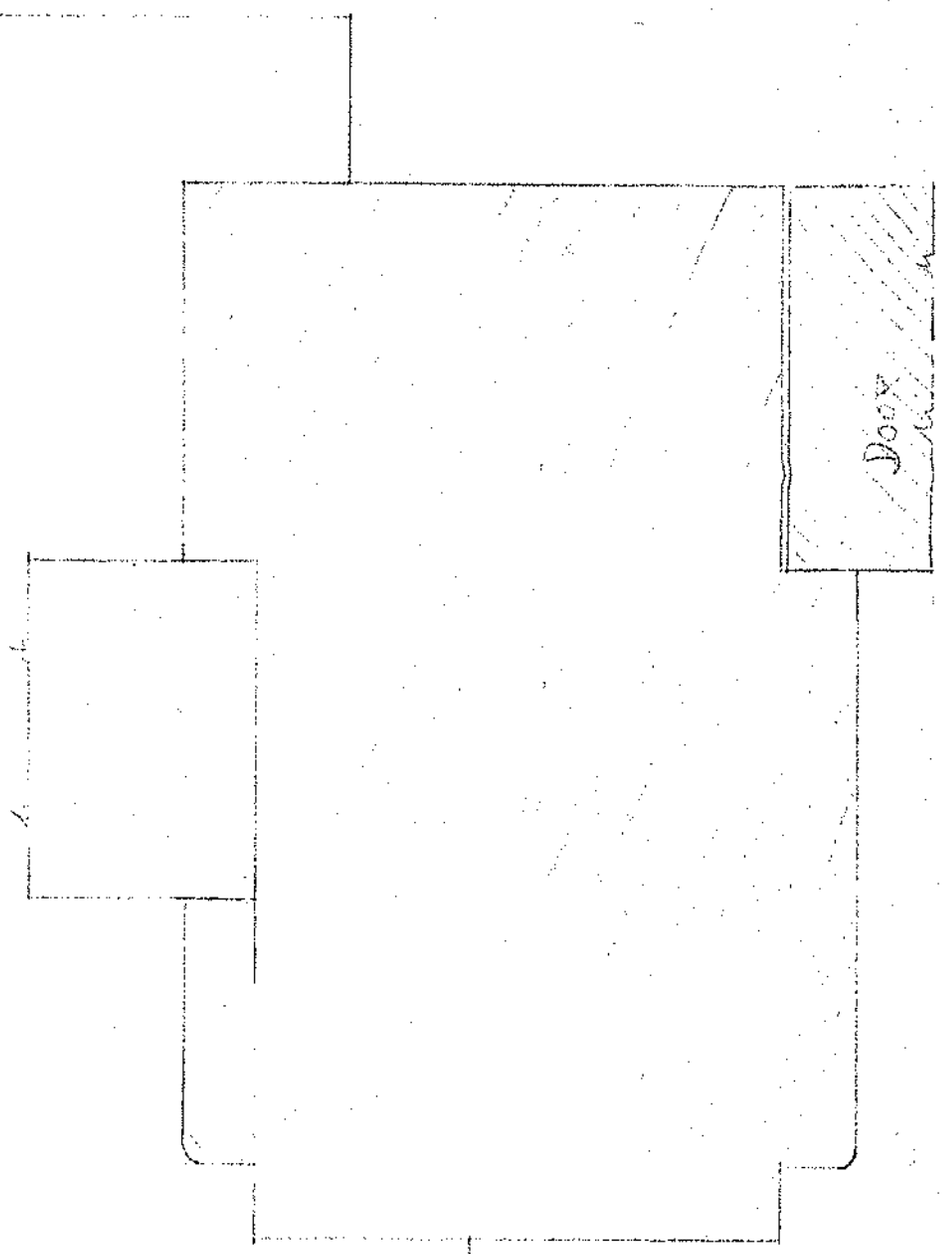
DETAILS FOR ENTRANCE #1

DETAIL FOR ENTRANCE #2

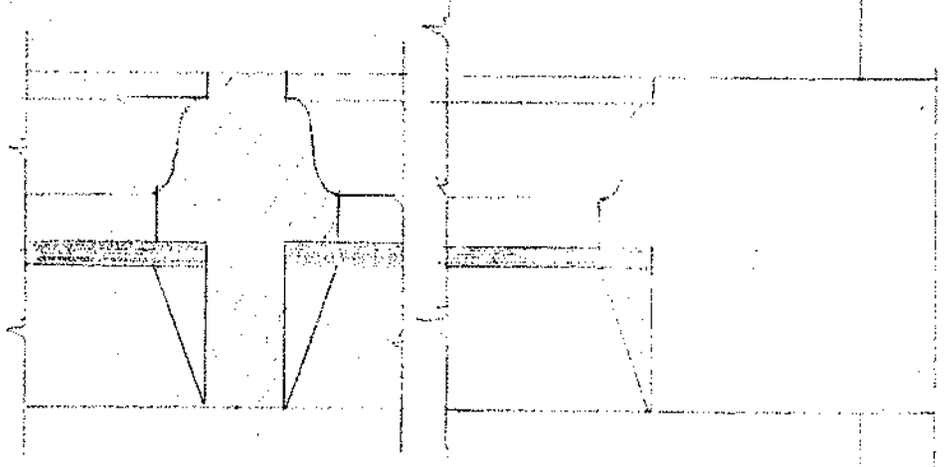
EXTERIOR DOOR FRAME DETAILS

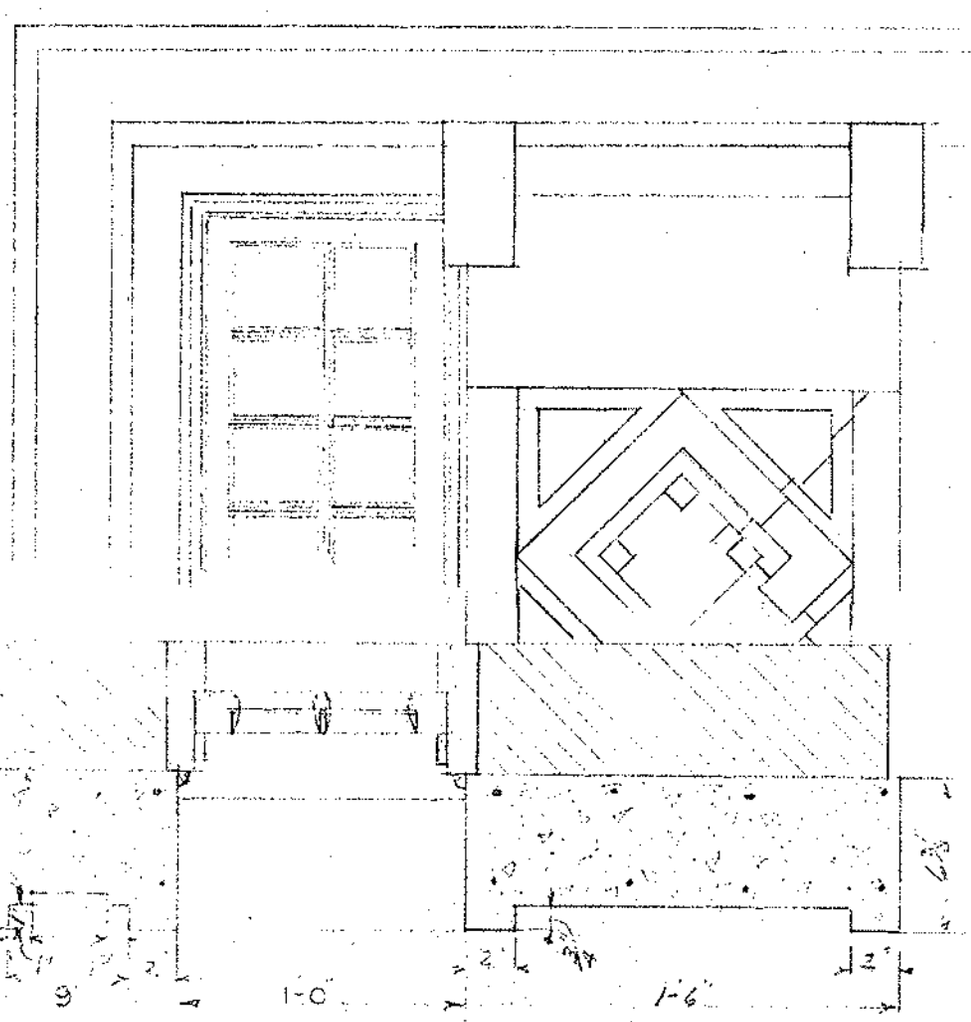
Note: ALL DETAILS AT SCALE 3"=1'-0"

A CITY HALL
CITY OF GR
GRAFTON, N



F.S. of Door Post, Sash & Frame





Cast Stone Details at Front.

Scale 1½" = 1'-0"

Municipal Water Plant & Fire D.

for

The City of Grafton, N.D.

Designed by

Municipal Engineers

St. Paul, Minn.

Walter J. MacLeith, C.E.

1/4"=1'0" Reverse Grade Line Coal Chute.

W.I. Ladder & Gas Pipe Hand Rail

Sump Hole

Pump Pit 7'-0" Deep for Portable Ejector to Sewer.

Waterproofing as Specified

1" Conn. to sewer. See Spec. Specifications.

Bay "D"

Waterproof to be Ironite Treatment - Finish cement color in Pits.

4" W.I. Ranlectro - Nave fast to Truss — To Pitch 1/2" to 1'-0"

Steel Truss

NOTE ALL ELECTRIC WIRE TO BE IN G.I. RIGID CONDUIT IN THIS ROOM
ALL OTHER SHALL BE FLEXIBLE ARMORED CABLE.

Bay "C"

Floor Drain

Steel Truss

ENGINE ROOM.
4½" Concrete Floor, Cement Finished.
To be marked into 16" sq tile pattern.
Floor to pitch to Drains 1" in 15'-0"
3/8" rods 12" c.c. each way.

Bay "B"

12"x12"x½" B.P.

Steel Truss

Bay "A"

Note: Frame 3'-0" x 6'-0" x 4" C.I. Box Set in Floor

Steel Truss

Boiler Base

Coal Bunker

Concrete Floor 4" High (Cement Finish)

Steel Truss

3-3"x3"x10"x2"

This Entire Frame & Glazing Removable

Line of Roof

47'-0"

71'-2"

Trans. over

Do

2" C.I.

4" C.I.

Floor Drain

Boiler Base

2" C.I.

4" C.I.

Floor Drain

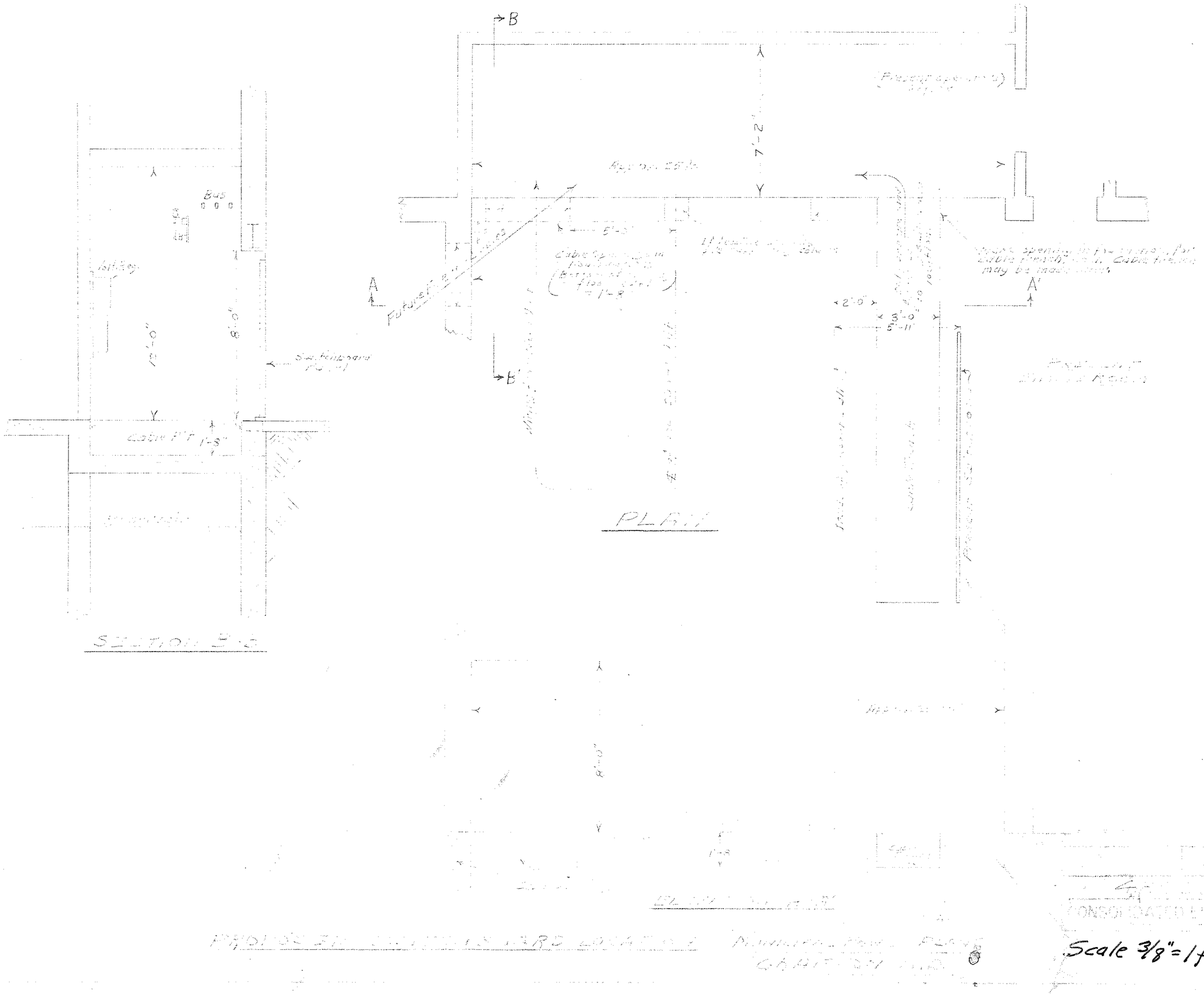
Boiler Base

2" C.I.

Steel Truss

Steel Truss

Steel Truss


B
B'
A
A'
Y
Y
7'-2"
Apron slab
Bus
Footpath
Cable trench
Cable trench
Cable trench

Fire Station Facility

Grafton Fire Department Grafton N Dak

Board of Directors

Leroy Erickson	President
Thomas LaHaise	Vice President
Leroy Nelson	Secretary Treasurer
Dennis Lykker	Director
Clayton LaMont	Director

Miles Haug Building Committee President

Drawing Sheet Index

1. Site Plan & Title Sheet
2. First Floor Plan Shedules & Details
3. Footing & Foundation Plan & Details
4. Elevations & Details
5. Building Sections & Details
6. First Floor Plumbing Plan & Schedules
7. First Floor Electrical Plan & Schedules

Construction Notes

1. The CONTRACTOR shall employ a Registered Land Surveyor to establish Property corners,Building location and first floor elevations in reference to the established bench marks and site design

2. The CONTRACTOR shall verify prior to submitting the proposal,with the appropriate municipal authority,locations of city sewer line(existing and proposed),water lines and stub-ins, and shall determine depths of sewer lines for verification of slope to drainfor the project. Municipal requirements relating to connections to city utilities shall be determined and any costs to be incurred shall be reflected in the proposal.

3. The CONTRACTOR shall verify prior to submitting the proposal with the appropriate utility authority,including the Telephone Company,locations of electric service lines,transformers,telephone lines,gas service lines,and meter locations and secure the necessary approvals and reflect in the proposal any costs to be incurred relating to utility company requrements for connection

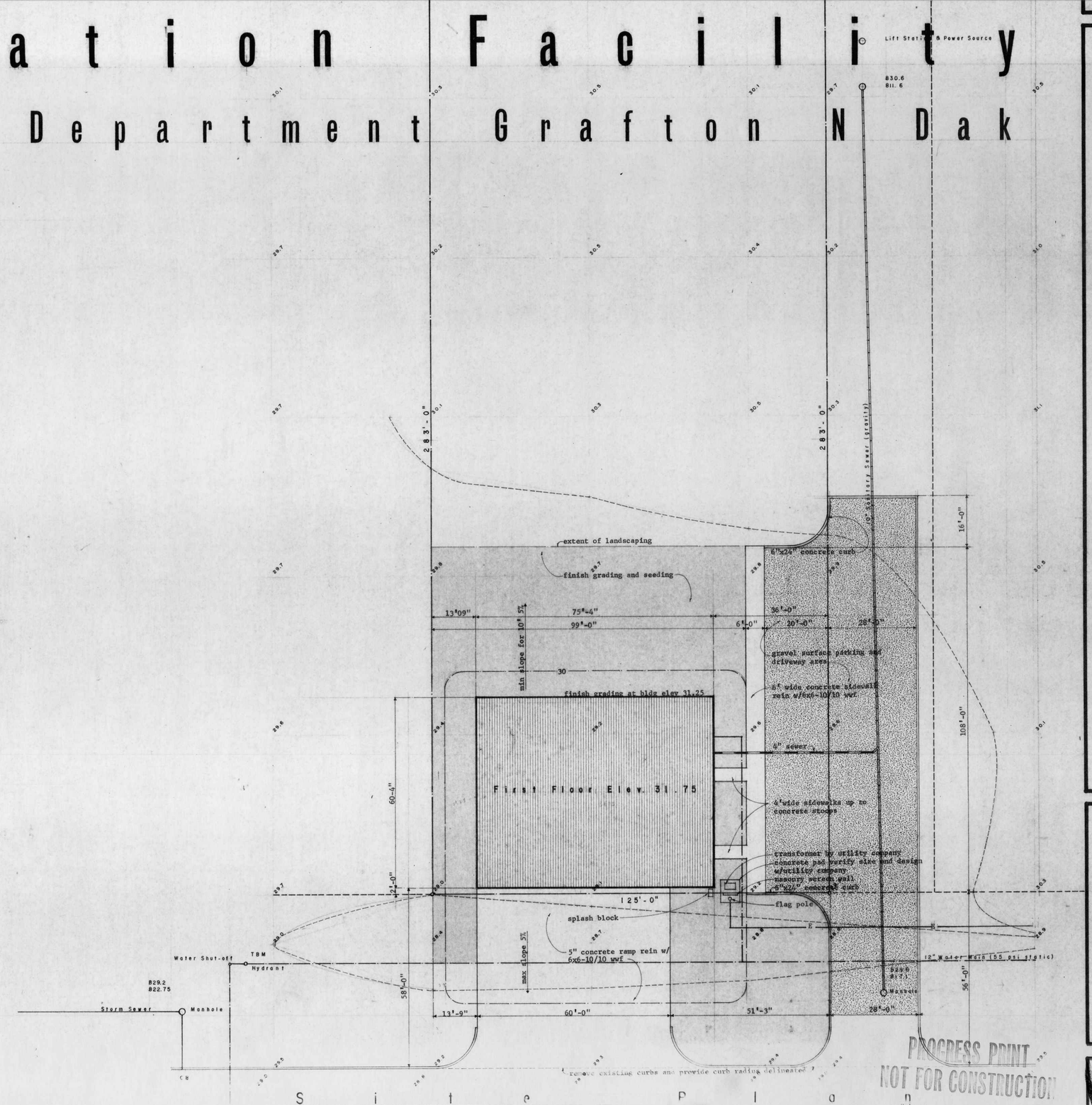
4. The CONTRACTOR shall employ a soil testing company for any necessary observations and reccommendations relative to exposed slab and footing bearing strata after excavation work has been completed. Fill for slab bearing shall be approved and compacted to a density of 95% of the maximum dry density and be substantiated by test reports

5. The CONTRACTOR shall reveiw and compliment with appropriate allowances if necessary all Sub Contractor and Supplier quotations to insure that proposal are all inclusive to provide the necessary components and servicesrequired by the Contract

6. The CONTRACTOR shall bring to the ARCHITECTS attention any discrepancies in the construction documents or code violations called for in the documents prior to submitting the proposal.

7. The CONTRACTOR shall provide finish grading to accomodate slope to drain and for pedestrian and vehicular access as follows

Paved Areas	1.5% Min	Sidewalks	5.0% Max
Seeded Areas	2.0% Min	Slope away from bldg	5.0% Max



Site Plan

PROGRESS PRINT
NOT FOR CONSTRUCTION

DOOR SCHEDULE

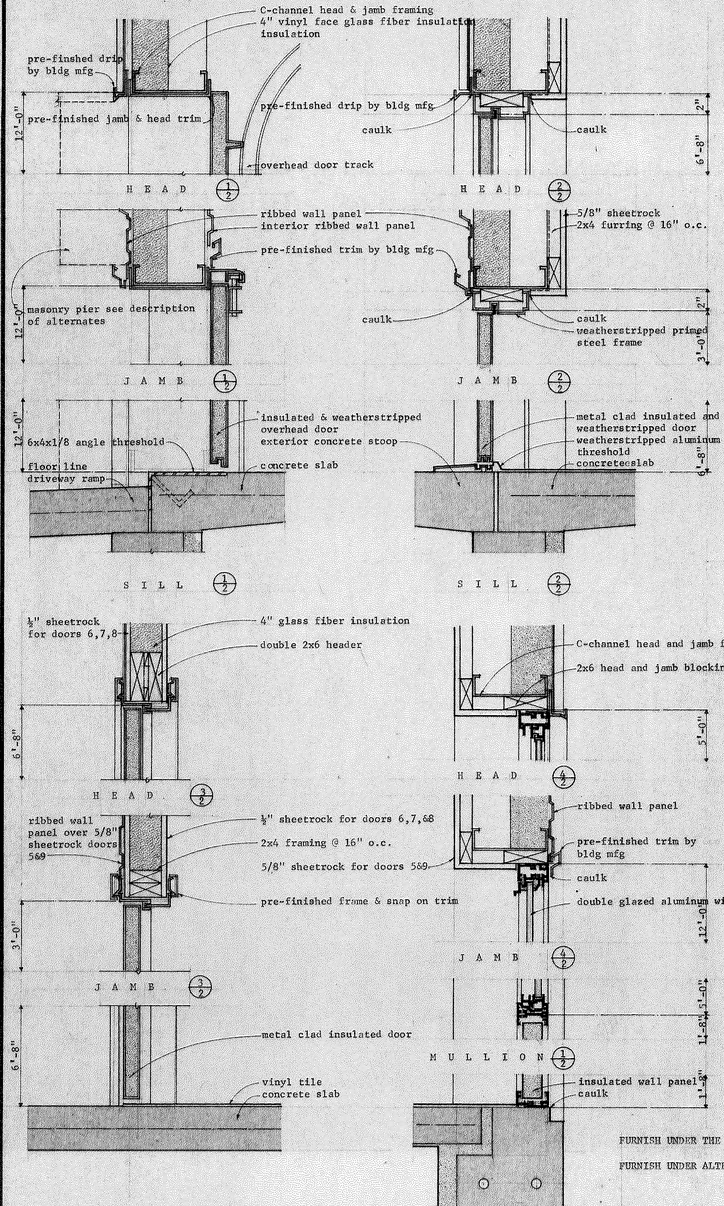
NO	DOOR SIZE	AMT	DOOR MATERIAL	DOOR FINISH	FRAME MATERIAL	FRAME FINISH	HDW	HEAD	JAMB	SILL	REMARKS
1	12'-0"x 12'-0"x 2"	4	Galvalume Clad	Pre-Finished	26 Gauge	Patrican Bronze	1	1	1	1	Steel/polyurethane sandwich Panel
2	3-0" x 6'-8" x 1 3/4"	1	Steel Clad Insul	OW-61 *	18 Gauge	" "	2	2	2	2	Paint frame to match Patrican Brn
3	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	" "		2	2	2	" " " "
4	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	" "		sim to 2	sim to 2	sim to 2	" " " "
5	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	Pre-Finished		sim to 3	sim to 3	sim to 3	See Description of Alternates
6	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	"		3	3	3	" "
7	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	"		3	3	3	" "
8	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	"		3	3	3	" "
9	3-0" x 6'-8" x 1 3/4"	1	" "	"	"	"		3	3	3	" "

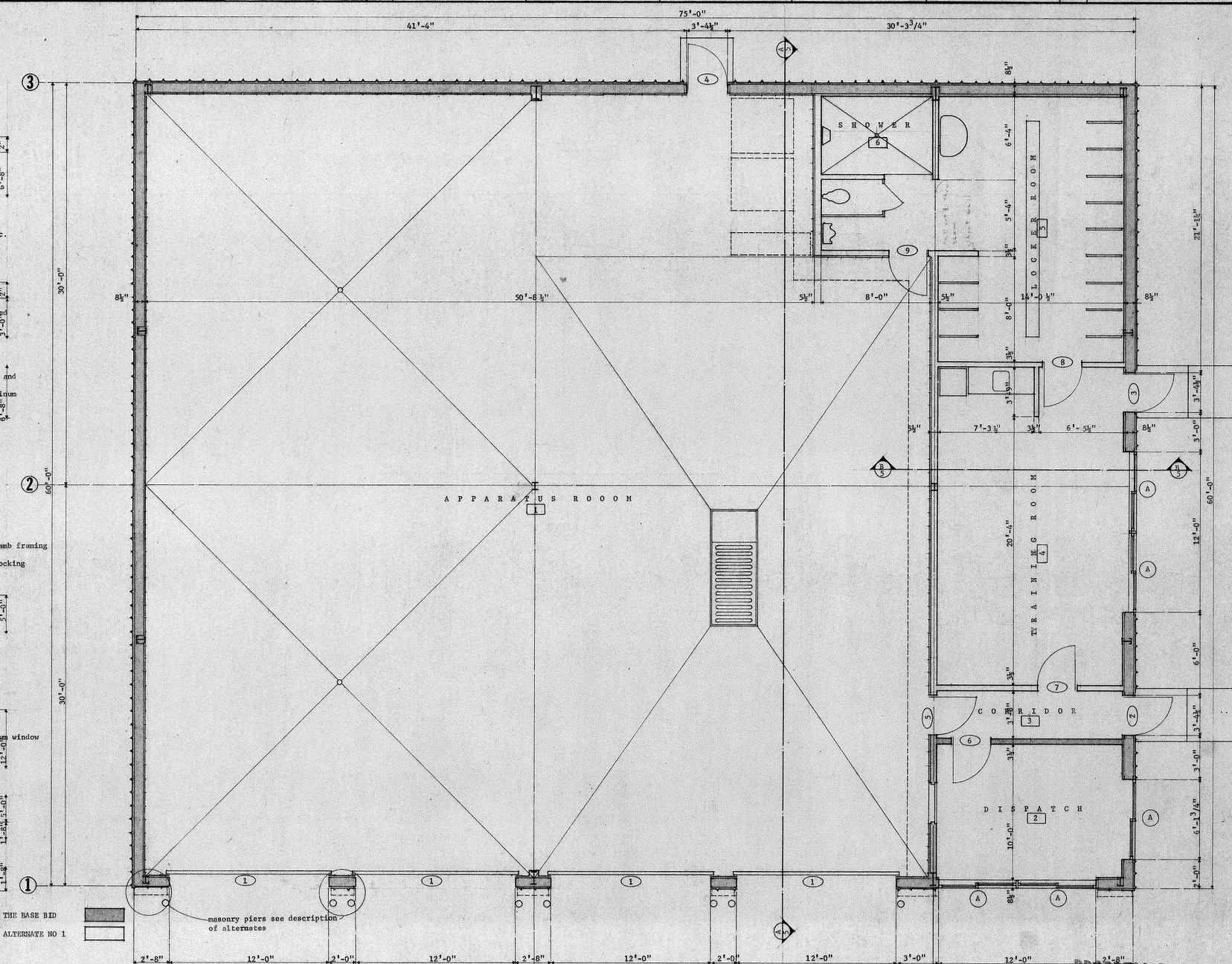
ROOM SCHEDULE

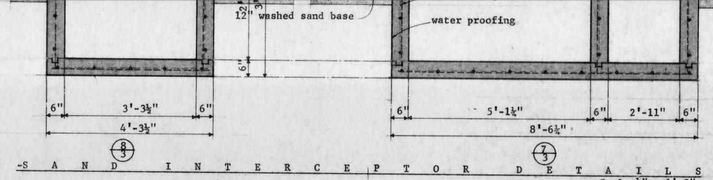
NO	ROOM	FLOOR MATERIAL	FLOOR FINISH	WALL MATERIAL	WALL FINISH	BASE MATERIAL	BASE FINISH	CEILING MATERIAL	CEILING FINISH	HT	REMARKS
1	Apparatus Room	Concrete	Steel Troweled	26 ga liner	Pre-Finished	None		Exposed Insul	White Vinyl	varies	
2	Dispatch	Vinyl Tile	52100 Putty	Sheet Rock	Sand	Vinyl	Russet KC-2	2x4 Lay-in Tile	Fissured	8'-0"	See Description Alt
3	Corridor	" "	" "	" "	"	"	" "	"	"	"	" " " "
4	Training Room	" "	" "	" "	"	"	" "	"	"	"	" " " "
5	Locker Room	" "	" "	" "	"	"	" "	"	"	"	" " " "
6	Shower	Ceramic Tile	1361 Tan	Ceramic Tile	733 Sand	Ceramic Tile	1361 Tan	Sheet Rock	Orange Peel	"	" " "
7	Storage	Plywood	Unfinished	Exposed Insul	White Vinyl	None		Exposed Insul	White Vinyl	varies	" " "

WINDOW SCHEDULE

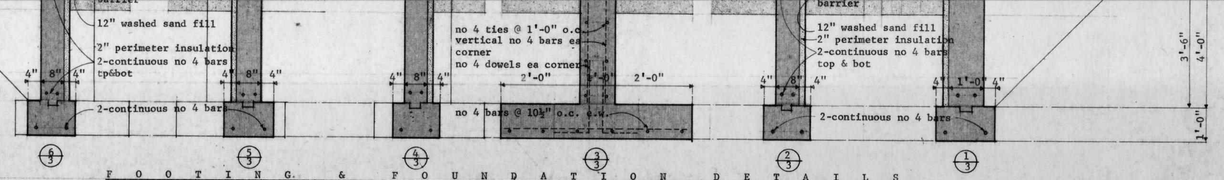
NO	MANUFACTURER	SERIES	UNIT NUMBER	FINISH	FRAMED OPENING	AMT	REMARKS
A	E.R. Young	1600	6050	Bronze		5	





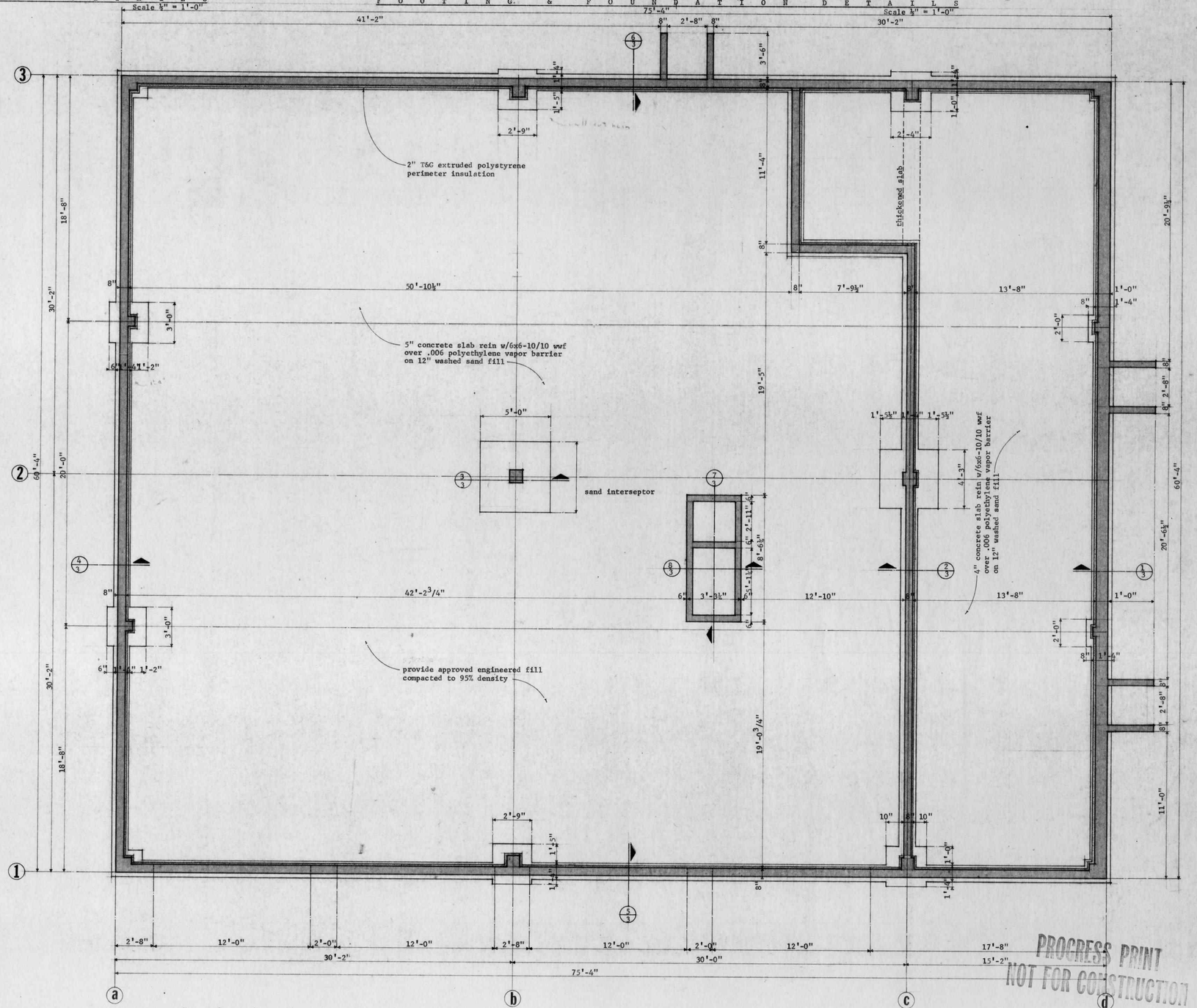


-S A N D I N T E R C E P T O R D E T A I L S



F O O T I N G & F O U N D A T I O N D E T A I L S

Scale ½" = 1'-0"



F O O T I N G & F O U N D A T I O N P L A N

Scale ⅛" = 1'-0"

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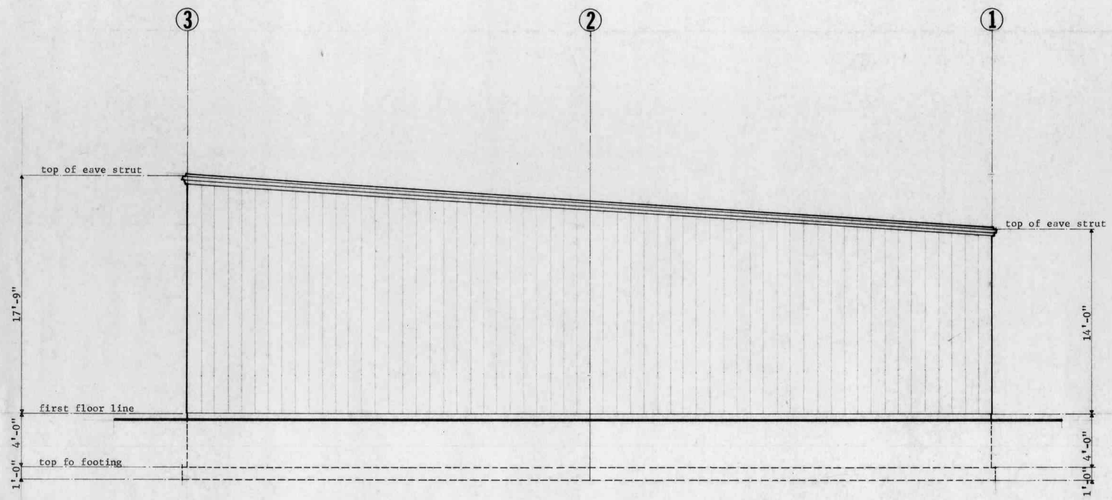
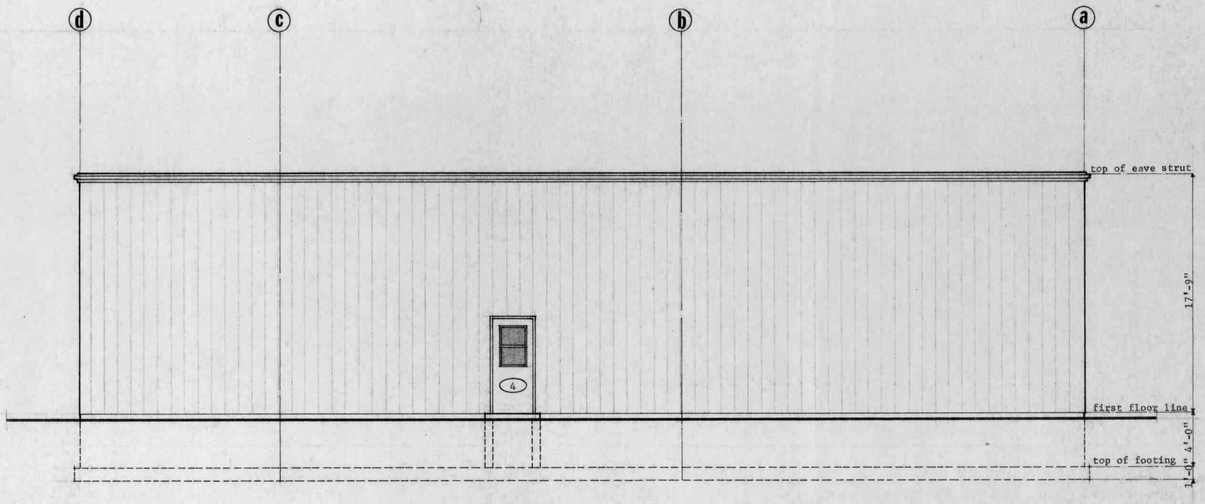
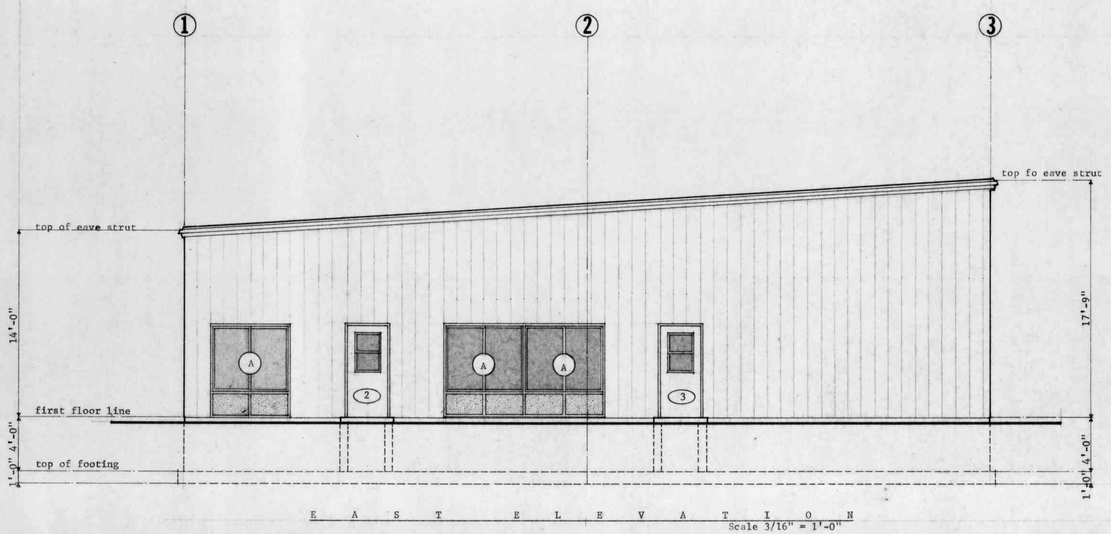


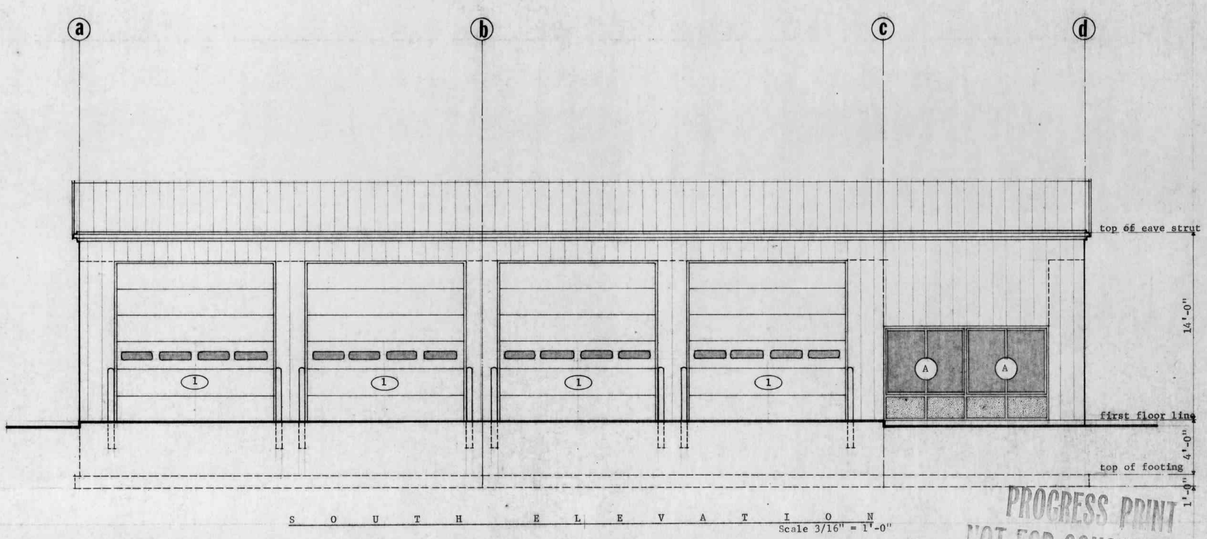
W E S T E L E V A T I O N
Scale 3/16" =1'-0"



N O R T H E L E V A T I O N
Scale 3/16" = 1'-0"



E A S T E L E V A T I O N
Scale 3/16" = 1'-0"



S O U T H E L E V A T I O N
Scale 3/16" = 1'-0"

PROGRESS PRINT
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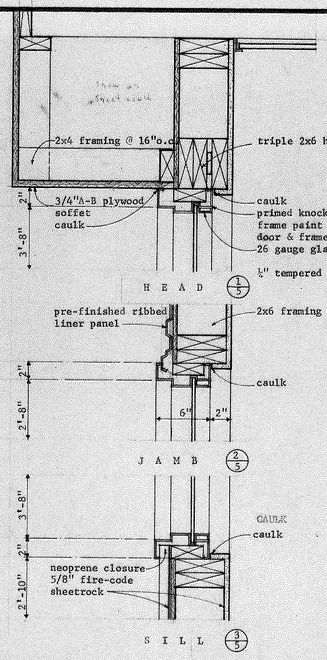
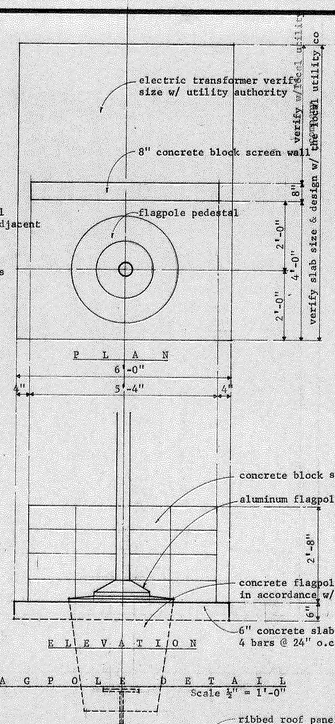
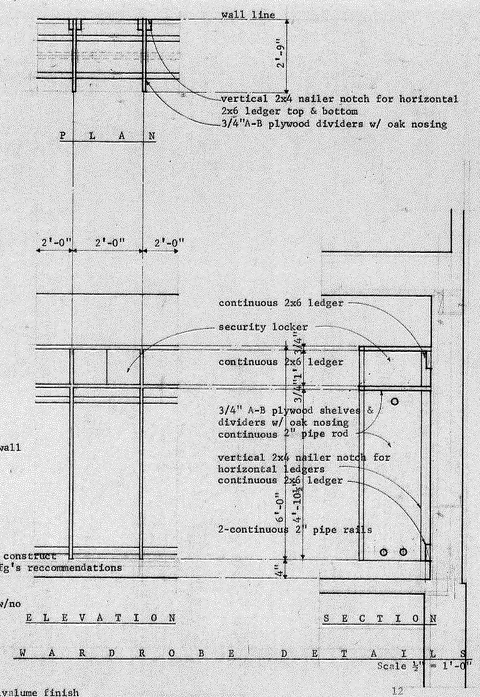


O B S E R V A T I O N W I N D O W
Scale 1½" = 1'-0"



F L A G P O L E D E T A I L
Scale ½" = 1'-0"



W A R D R O B E D E T A I L S
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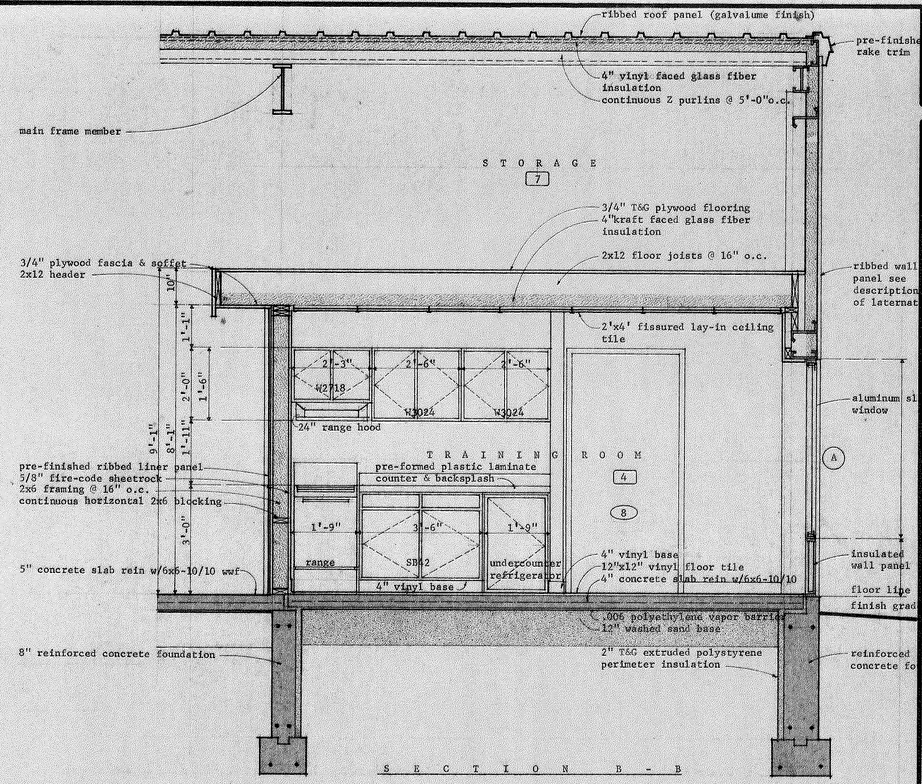
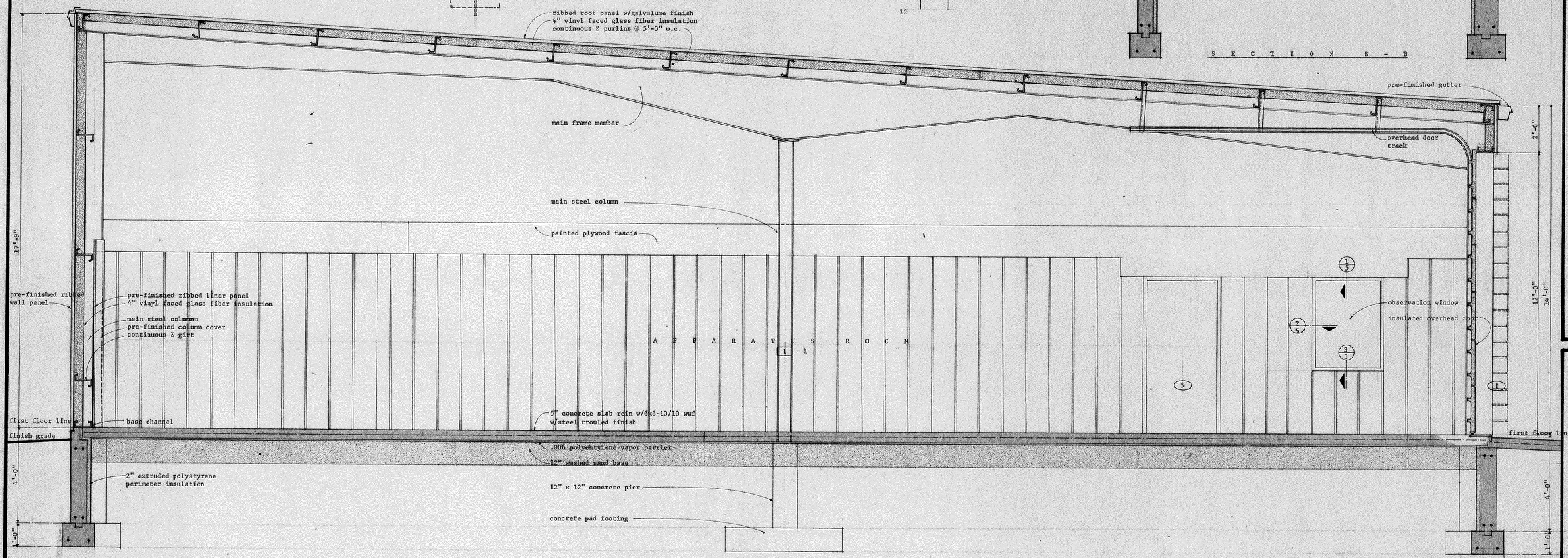


S E C T I O N B - B



S E C T I O N A - A
Scale ½" = 1'-0"

PROGRESS PRINT
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L I G H T F I X T U R E S C H E D U L E

MRK	LOCATION	AMT	MANUFACTURER	NUMBER	LAMPS	MOUNTING
A	Apparatus Room	20	Lithonia	EJ 296 HO	2-F96T12 CO/HO	Suspended 14' from floor
B	Office,Training&Locker	19	"	LB 240 A	2-F40 CW	Ceiling surface
C	Apparatus Room	3	"	UN 296	2-F96T12CW/HO	Underside of soffet
D	Shower Area	2	"	DV 240 A	2-F40 OW	Ceiling surface
E	Locker Room	1	"	22-HB A4 220 WD	2-F40	Wall
F	Training Room	1	Thomas	M-344	1-F18	Underside of wall cabinet
G	Exterior	3	Keene	323-70LX	1-70W HPS	Wall
H	Exterior	4	"	323-150LX-VP	1-150W HPS	Wall
I	Apparatus,Train&Corr	4	Sure-Lite	EA-1C-R	20T 6½	Wall ,Ceiling & face of Soffet

E X H A U S T F A N S C H E D U L E

MRK	LOCATION	AMT	MANUFACTURER	SERIES	POWER V	Ph	Hz	CFM	MOUNTING
EF-1	Shower Room	1	Nu Tone	8870	120	1	60	80	Thru-wall
EF-2	Storage Area	1	Penn	CD 24T4	120	1	60	5,500	thru-wall w/shutter

W A T E R H E A T E R S C H E D U L E

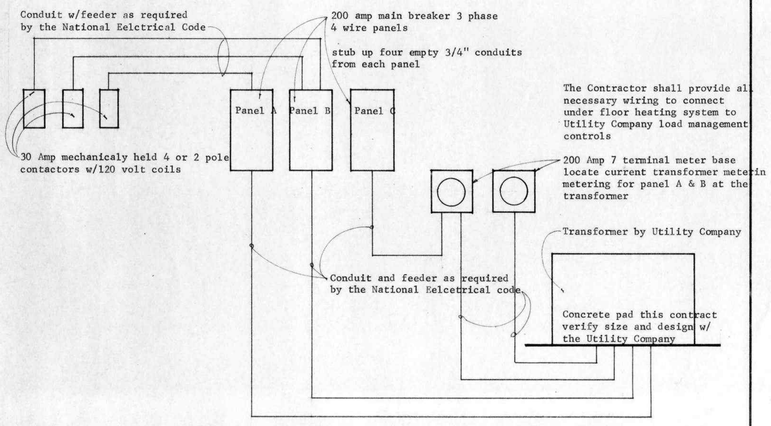
MRK	LOCATION	AMT	MANUFACTURER	SERIES	POWER V	Ph	Hz

P A N E L C 2 0 0 A m p M a i n B r e a k e r 3 P h a s e 4 W i r e

LOAD	AMP	CIR	CIR	AMP	LOAD
Work Bench Receptacle	20	1	2	50	Welder Receptacle
Work Bench Receptacle	20	3	4	50	Welder Receptacle
Work Bench Receptacle	20	5	6	50	Range
Work Bench Receptacle	20	7	8	50	Range
Water Heater	30	9	10	20	Door Operator
Water Heater	30	11	12	20	Door Operator
Main Area Receptacles	20	13	14	20	Dispatch,Training & Locker Receptacles
Main Area Receptacles	20	15	16	20	Dispatch,Training & Locker Receptacles
Locker & Kitchen Receptacles	20	17	18	20	Apparaturs & Storage Area lighting
Locker & Kitchen Receptacles	20	19	20	20	Apparatus & Storage Area lighting
Apparatus & Storage Area lighting	20	21	22	20	Exterior Lighting
Apparatus & Storage Area Lighting	20	23	24	20	Soffet Lighting
Dispatch Lighting	20	25	26	20	Training Room Lighting
Locker Room Lighting	20	27	28	20	Exit Lighting
Exterior Lighting	20	29	30	20	Exhaust Fan
Spare	20	31	32	20	Future Hose Dryer
Spare	20	33	34	20	Future Hose Dryer
Spare	20	35	36	20	Future Hose Dryer
Spare	20	37	38	20	Future Hose Dryer
Space					Space

N O T E

1. Office,Training and Locker Room Areas&Lighting and associated wiring shall be provided under alternate No 1
2. Conceal conduit stubed up from under floor heat cables to junction boxes and contactors behind wall liner panels
3. Install P&S 1200 door switch and rough in conduit from switch to above finished ceilings
4. Install all necessary conduit and wiring for 4 commercial door operators designated circuits 10 & 12
5. Control each ceiling suspended unit heater with one thermostat located adjacent to observation window



S W I T C H G E A R D I A G R A M E
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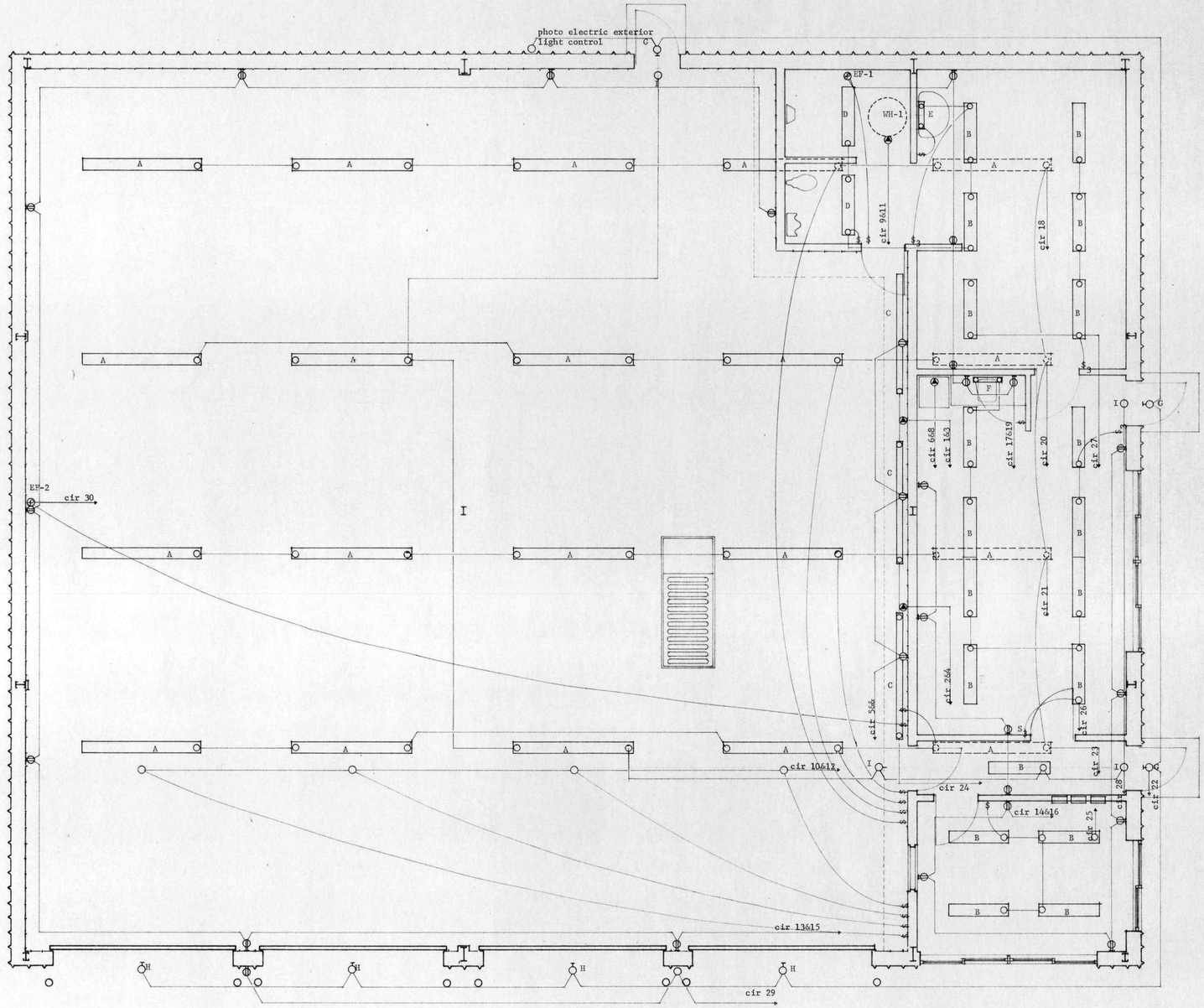


F I R S T F L O O R E L E C T R I C A L P L A N
Scale ¼" = 1'-0"

PROGRESS PRINT
NOT FOR CONSTRUCTION

ELECTRIC HEAT CABLE SCHEDULE

MRK	LOCATION	MANUFACTURER	NUMBER	AMT	LENGTH	SPACING	W	A	BTU	V	REMARKS
1	Apparatus Room	Smith Gates	6P8-4000	4	636	8	4,000	16.7	13,468	208	
2	Apparatus & Train	" "	6P8-4500	4	699	8	4,500	18.8	15,354	208	
3	Apparatus & Train	" "	6P8-5000	1	629	8	5,000	20.8	17,060	208	

ELECTRIC UNIT HEATER SCHEDULE

MRK	LOCATION	MANUFACTURER	NUMBER	AMT	WATTS	BTU	VOLT	PHASE	CFM	REMARKS
UH-1	Apparatus Room	Berko	DUH-1520-A	2	15,000	51,195	208	3	1260	

PANEL A 200 Amp Main Breaker 3 Phase 4 Wire

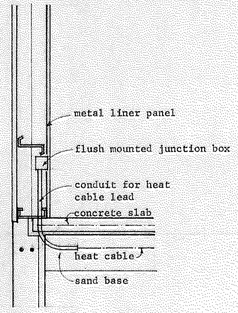
LOAD	AMP	CIR	CIR	AMP	LOAD
Floor Heat	30	1	2	30	Floor Heat
Floor Heat	30	3	4	30	Floor Heat
Floor Heat	30	5	6	30	Floor Heat
Floor Heat	30	7	8	30	Floor Heat
Floor Heat	30	9	10	30	Floor Heat
Floor Heat	30	11	12	30	Floor Heat
Floor Heat	30	13	14	30	Floor Heat
Floor Heat	30	15	16	30	Floor Heat
Floor Heat	30	17	18	30	Spare
Floor Heat	30	19	20	30	Spare
Space		21	22		Space
Space		23	24		Space
Space		25	26		Space
Space		27	28		Space
Space		29	30		Space

PANEL B 200 Amp Main Breaker 3 Phase 4 Wire

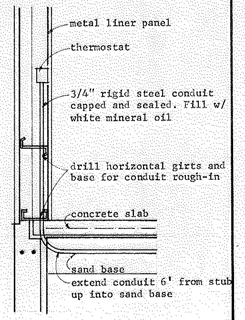
LOAD	AMP	CIR	CIR	AMP	LOAD
Unit Heater	90	1	2	90	Unit Heater
Unit Heater	90	3	4	90	Unit Heater
Unit Heater	90	5	6	90	Unit Heater
Unit Heater	90	7	8	90	Unit Heater
Unit Heater	90	9	10	90	Unit Heater
Unit Heater	90	11	12	90	Unit Heater
Space		13	14		Space
Space		15	16		Space
Space		17	18		Space
Space		19	20		Space
Space		21	22		Space
Space		23	24		Space
Space		25	26		Space
Space		27	28		Space
Space		29	30		Space

CONSTRUCTION NOTES

1. Conduct electrical continuity test on heat cable as follows
   a. When cables are removed from the carton
   b. After cables have placed in position
   c. After slab has been poured but prior to concrete setting
2. Maintain a minimum 3" cable spacing and distance from any building components
3. Install cable in sand base 8" below the underside of the concrete slab
4. Rough-in control thermostat capillary tube extended 6' horizontally in concrete slab
5. Extend thermo-cut off capillary tube 10' horizontally in sand base directly over heating cables



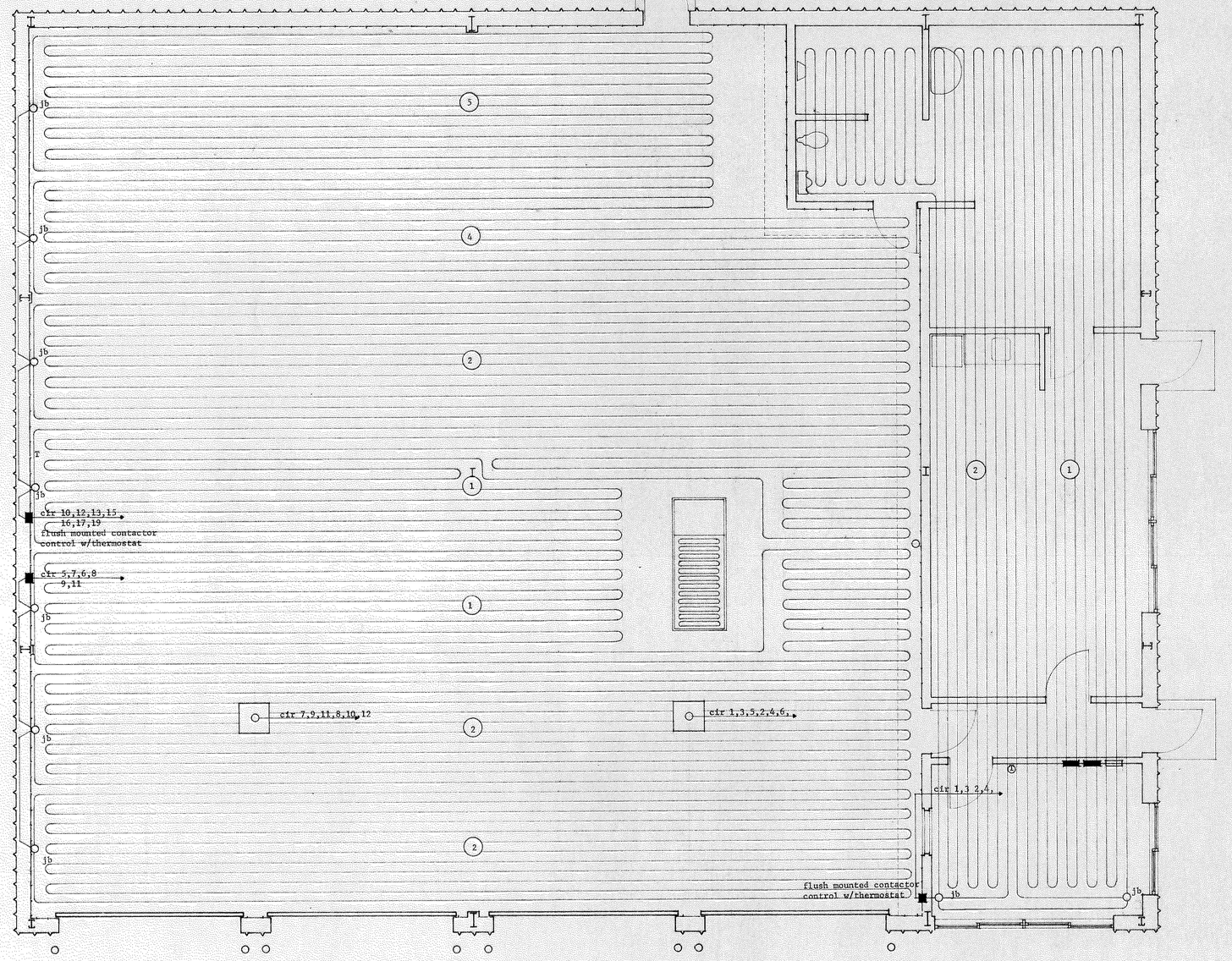
CONDUIT ROUGH-IN DETAIL
Scale ½" = 1'-0"



THERMOSTAT ROUGH-IN DETAIL
Scale ½" = 1'-0"

HEAT LOSS CALCULATION

NO	ROOM	WALL SQ FT	WALL U X T	WALL BTU/HR	CEILING SQ FT	CEILING U X T	CEILING BTU/HR	WINDOW SQ FT	WINDOW U X T	WINDOW BTU/HR	DOOR SQ FT	DOOR U X T	DOOR BTU/HR	FLOOR LIN FT	FLOOR BTU/F T	FLOOR BTU	INFILTRATION SQ or L F	INFILTRATION C F X 1.8	INFILTRATION BTU	TOTAL BTU	TOTAL WATTS
1	Apparatus	2,260	12	27,120	3,600	12	43,200	11	55	605	565	11	6,215	180	50	9,000	576 sq ft	3.6	3,732	89,872	26,340
											20	14	280				20 lin ft	30	1,080	1,360	399
2	Dispatch	105	12	1,260	150	1.1	165	90	55	4,950				25	50	1,250	48	12.6	1,088	8,713	2,554
		30	11	330																330	97
		78	1.3	101																101	30
		12	22.6	271																271	79
3	Corridor	16	12	192	60	1.1	66	6	113	678	14	14	196	4	50	200	20	30	1,080	2,412	706
		16	1.3	21							20	2.8	56							77	23
4	Training	116	12	1,392	360	1.1	396	60	55	3,300	20	14	280	24	50	1,200	32	12.6	726	7,294	2,138
		20	11	220													20	30	1,080	1,300	381
		216	1.3	281																281	82
5	Locker Room	396	12	4,752	417	1.1	459				20	2.8	56	44	50	2,200				7,467	2,188
		241	1.3	313																313	92
7	Storage	1,428	12	17,136	900	12	10,800													12,536	3,674



FIRST FLOOR ELECTRIC HEAT PLAN
Scale ⅛" = 1'-0"

PROGRESS PRINT
NOT FOR CONSTRUCTION

PLUMBING FIXTURE SCHEDULE

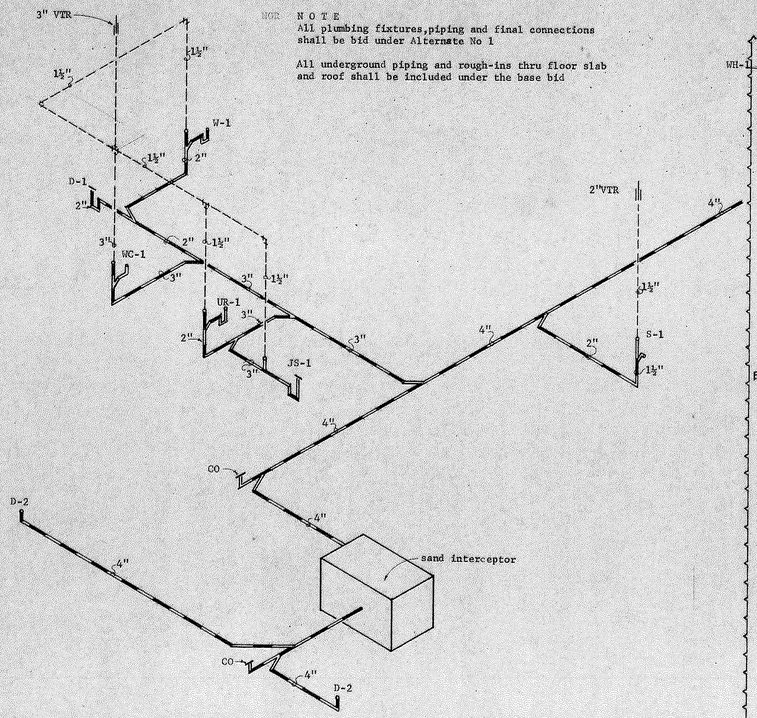
MRK	AMT	TYPE	MOUNTING	CONNECTIONS CW	HW	WASTE	VENT	MANUFACTURER	NUMBER	REMARKS
WC-1	1	Floor set elongated		1"		3"	1½"	American Standard	Medera # 2221.018 w/#5334 seat and #110-3 Sloan flush valve	
UR-1	1	Wall hung siphon jet	24" to rim	3/4"		2"	1½"	American Standard	Trimbrook # 6560015 w/ # 186YB Sloan flush valve	
S-1	1	Stainless steel sink		½"	½"	2"	1½"	Just	# 17519 ARG-1 w/ Chicago # 50-E3 faucet ,#J-35 strainer ,17 ga trap and stop valves	
W-1	1	semi circular floor mounter wash fountain		3/4	3/4	2"	1½"	Bradly	# CFC-36 w/terrazzo bowel and standard equipment	
SH1	1	wall mounted three person shower	head 6' to fl	3/4"	3/4"			Bradly	#3WMT-TVST	
D-1	1	Shower drain				2"		J.R. Smith	# 2005-A w/5" nickel bronze top	

PLUMBING FIXTURE SCHEDULE

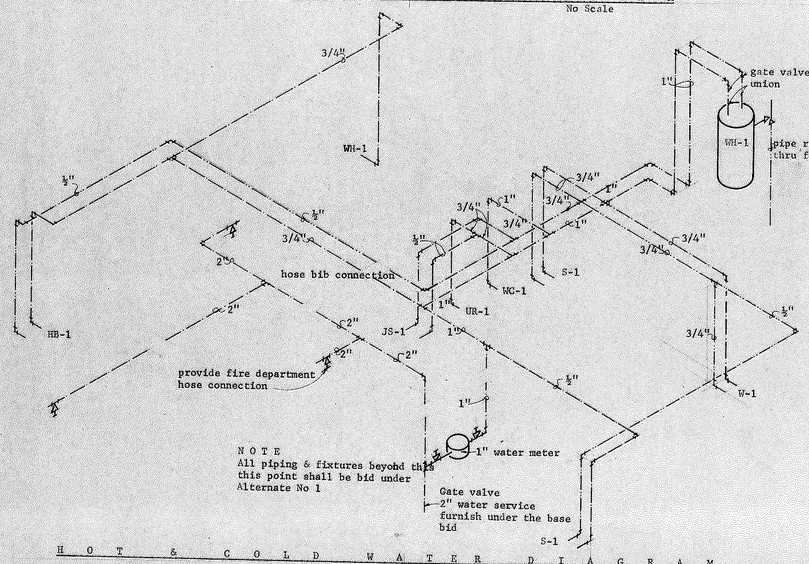
MRK	AMT	TYPE	MOUNTING	CONNECTIONS CW	HW	WASTE	VENT	MANUFACTURER	NUMBER	REMARKS
D-2	2	Heavy duty floor drain				4"		J.R. Smith	#2233 w/ sediment bucket and tractor grate	
CO-1	3					4"		J.R. Smith	#4220 w/ cast iron top	
WH-1	1	Wall Hydrant	24" above grade	½"	½"			Woodford	# 65C	
HB-1	1	Hose Bib	42" above floor	½"	½"			Chicago	#897RCF	
JS-1	1	Floor set Janitor sink		½"	½"	3"	1½"	Fiat	# MSB-2424 w/ Chicago # 897 RCF # 832AA Hose and bracket and # 889CC	

NOTE
All plumbing fixtures,piping and final connections shall be bid under Alternate No 1

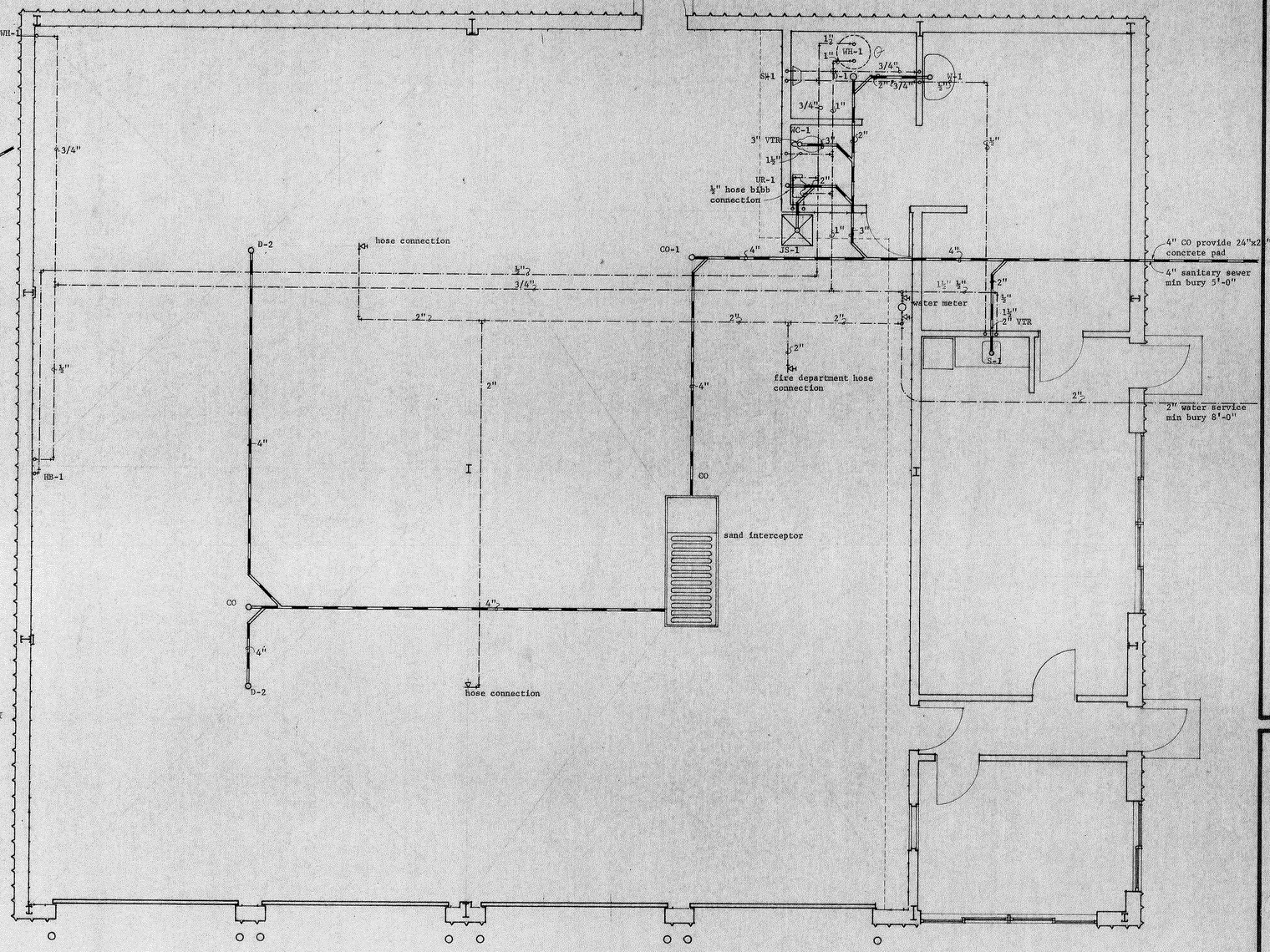
All underground piping and rough-ins thru floor slab and roof shall be included under the base bid



WASTE & VENT DIAGRAM
No Scale



HOT & COLD WATER DIAGRAM
No SCale



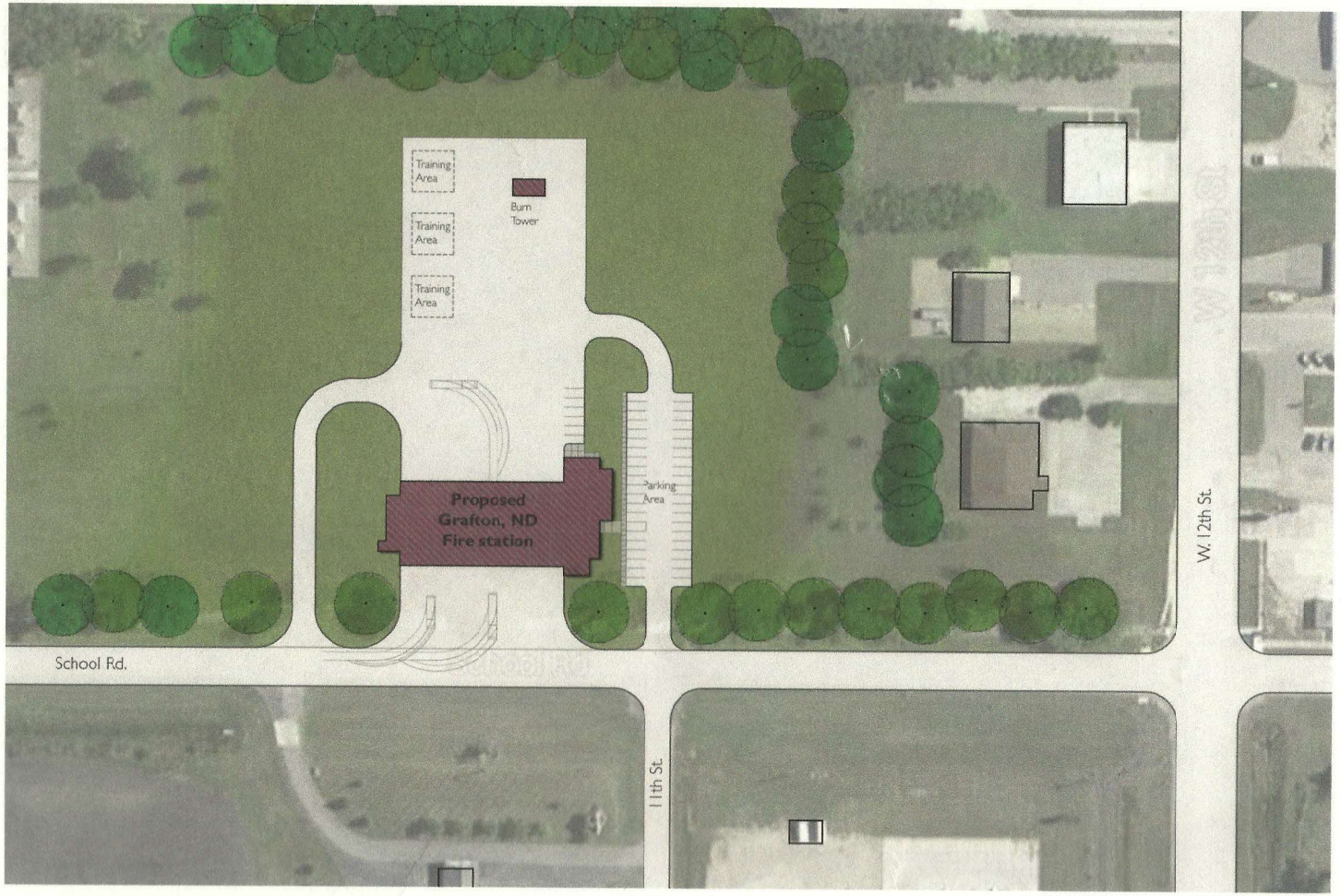
FIRST FLOOR PLUMBING PLAN
Scale ¼" = 1'-0"

PROGRESS PRINT
NOT FOR CONSTRUCTION

To see all the details that are visible on the screen, use the "Print" link next to the map.

Google





City of Grafton, ND

Fire Department Concept Plan
11/21/2014

Conceptual Site Plan

BKV GROUP

7847

DAKOTA
Center for Independent Living

3111 E Broadway Avenue, Bismarck, North Dakota 58501

Chairman Holmberg and members of the Senate Appropriations Committee,

My name is Vicki L. Laraway, and I am a Systems Community Advocate with the Dakota Center for Independent living. I am writing in support of the funding for ND Council for Developmental Disabilities. They have helped with grants for our Youth Empowering Social Status Group, (YESS) which is a group formed in 2019 for youth with and without disabilities. Without their support I don't believe that we would have seen the success that we have with this group. The testimonies of these young people are truly amazing as to how this YESS group has changed their lives. They have said that they felt alone, depressed, and like they had no purpose.

The funding that they have through their grant program has allowed us to host a yearly conference for youth called, "Embrace Your Disability". They have been able to pay for taxi rides for our youth to attend our events and our Advisory Board Meetings. They play a very important part of our success.

I am asking again, that you will pass HB 1012.

Thank you.

Vicki L. Laraway

7864

DAKOTA
Center for Independent Living

3111 E Broadway Avenue, Bismarck, North Dakota 58501

Chairman Holmberg and members of the Senate Appropriations Committee.

My name is Vicki L. Laraway and work at the Dakota Center for Independent Living as a Systems Community Advocate. While I wear many hats here, I will tell you that my whole life has trained me to be at this position. I will list a few of the opportunities that I have had the privilege of participating in while working here the past 6 years.

- Helped start a Youth Empowering Social Status Group (YESS) which is a group for youth with and without disabilities. This group goes into the community to educate people first hand what it is like living with a disability. They also volunteer in the community for other non-profits, giving back to their community.
- YESS has helped when I go into the local Senior Centers to teach our elderly how to use their electronic devices.
- We teach disability etiquette to the elementary schools and have joined in with the Morton/Mandan Library in their Bookworm program, reading books online that help young people understand people with disabilities.
- We teach people with disabilities how to get involved in the testimony to local and state governments.
- We teach self-advocacy to people of all ages.
- We teach leadership skills to people of all ages.
- We go into the schools as a surrogate parent for IEP meetings.
- We teach Drivers Education to people of all ages that want to get a drivers permit.
- We help people of all ages to apply for Social Security.

These are just a few things that we do with out consumers. I have heard so many testimonies from people that have reached the goals that they have set for themselves here at DCIL and how very thankful that they are for our agency.

I am asking you to pass HB 1012, so that we can continue to carry on with helping our community of people that need a hand up, be successful in reaching the goals that they set for themselves, and learn to be self-advocates and be independent.

Thank you.

Vicki L Laraway

8228

Bismarck Police Department

February 25,2021

From: Dave Draovitch
Chief of Police

To: Senate Appropriations
chairman: Senator Ray Holmberg

Subj: HB 1012

I write you today to seek your support of HB 1012 particularly related to funding needs of Edwinton Place which is located in Bismarck. Edwinton Place serves a segment of our population that was homeless with addiction issues. Before Edwinton Place existed, our department spent a lot of time and resources dealing with this population. Since Edwinton Place has begun operating (November 2019) our interactions with this population has greatly diminished which has allowed us to focus our efforts on law enforcement matters rather than social matters this population usually needs e.g. intoxication management, housing etc.

Our department still has interactions with this population but they are much different than before Edwinton Place. Most oftentimes the interaction is to help them with a law enforcement issue rather than a social issue.

A major component that makes Edwinton Place successful in serving this population is having staff present 24 hours a day / 7 days a week. The reason this is needed, particularly at night, is to keep the residents in check and to ensure non-resident bad influencers are kept out. I fear that without staff 24/7 Edwinton Place fails in its mission and our department will once again have to devote significant resources to this population. I have been told the funding Edwinton Place is seeking regarding HB 1012 will help them ensure the capability of having staff on-site 24/7.

Thank you for considering this information as this bill moves through the committee. We would respectfully request that you add the $640,000 to this bill in support of the front door monitoring service as these costs are not covered by the 1915i Medicare amendment that the State approved last legislative session. This is a much-needed service for this population.

If you have any questions feel free to contact me at your convenience. I may be reached at ddraovitch@bismarcknd.gov or 701-223-1212.

Respectfully,

Dave D

DAVE DRAOVITCH
Chief of Police

Dave Draovitch, Chief of Police
Phone: 701-223-1212 ★ FAX: 701-355-1861 ★ Tdd: 701-221-6820 ★ 700 S. Ninth Street ★ Bismarck, ND 58504-5899

EQUAL HOUSING OPPORTUNITY

House Bill 1012
Appropriations – Human Resources Division
Senate Appropriations
Chairman: Senator Ray Holmberg
March 9, 2021

Written Testimony submitted by: Keith J. Hunke, Bismarck City Administrator

Burleigh County Housing Authority has partnered with Beyond Shelter, Inc. in Fargo to develop a permanent supporting housing project for the homeless in Bismarck called Edwinton Place. It is located at 1121 S. 11th Street, Bismarck just south of Cash Wise on Bismarck Expressway. This project has 40 – one bedroom apartments. This project was developed under the Federal Housing First model. Most of the Edwinton Place tenants have come from homeless situations and are dealing with mental illness and/or drug/alcohol addictions and are in need of supportive services.

Edwinton Place has been open for just over one year, serving 45 individuals during that time. Persons identifying as having a disabling condition due to mental health is 74% and alcohol and drug abuse is 76%. Edwinton Place has been very beneficial for the Bismarck Police Department serving a population that had frequent interactions with law enforcement in the past. Edwinton Place contracts with the Dacotah Foundation to provide 24/7 Housing Support Specialist staff. They are Mental Health Technicians, certified by DHS, and they provide year-around 24/7 front door coverage, as well as the necessary tenancy supports and interventions to create and maintain a safe and supportive environment for tenants. They screen visitors, track tenants coming and going, establish limits and monitor alcohol being brought in, do wellness checks if they haven't been seen each day, engage with tenants and give staff updates on behaviors that may need some attention, de-escalate situations when they can and call for back up when they need it. Services provided by Dacotah foundation at Edwinton Place have greatly reduced the need for any involvement of the Bismarck Police Department with tenants of Edwinton Place.

In addition to the 24/7 support, Edwinton Place also provides space for support services to come in such as West Central Human Services, Housing and Employment Specialists from Community Options, Sanford Health provides case management and assists the tenants in accessing and maintaining health insurance. On-site staff coordinate food bank drop offs from Great Plains Food Bank and meals on wheels.

Edwinton Place is housing for tenants that are similar to the ones that live at Cooper House in Fargo and LaGrave on 1st in Grand Forks but Edwinton place has not received funding for 24/7 front door service. Edwinton Place also expected that the Medicare provision of section 1915i, which you passed last legislative session, would be available to cover these qualified costs. At this time the funds are still not available.

I oppose HB1012 as it currently is written as it does not include funding for the much needed 24/7 front door coverage and additional service supports required for the ongoing success of Edwinton Place. I respectfully request that you include the $640,000 for these service supports for Edwinton Place.

Thank you for your time and support. This funding investment provided in HB 1012 truly helps those most in need and the most vulnerable of our States population.

Dear Senate Appropriations Committee,

I am writing this letter to you to **maintain the brain injury funding in HB 1012 restored by the House including the funding for the North Dakota Brain Injury Network.** As a speech-language pathologist and certified brain injury specialist at Onward Therapy in Fargo, ND, we work closely with the NDBIN to best support our brain injury population throughout the state of North Dakota. Working with survivors of brain injury is one of the most rewarding areas in my field. Their lives have significantly and unexpectantly changed, which requires me to create a plan of care to best meet their daily functional needs. This journey is very challenging for most and it is my pleasure to walk with them, encourage them, and educate them as they strive to reach therapeutic and functional goals.

The NDBIN is extremely valuable to us as providers, as well as survivors and families. This network places great emphasis on educating about brain injury by providing valuable resources for education and awareness, as well as hosting continuing education opportunities to stay updated on the current research to best serve our patients. The NDBIN is much appreciated and is unlike any other service offered in our state. Reducing funding for the NDBIN would be detrimental to the brain injury population-the population that desperately needs us to advocate for them as they demonstrate resilience and grit in their journey to a "new normal".

Please reconsider funding the **NDBIN** so they can continue their mission to support and educate providers, survivors, and family members. Thank you for your time and consideration of this request. Please contact me with any questions you may have.

Sincerely,

Whitney Johnson, MS. CCC-SLP, CBIS

Whitney Johnson, M.S., CCC-SLP, CBIS
Email: whitney@onwordtherapy.com
Phone: 701.364.5433

March 9, 2021

Re: HB 1012

Chairman Holmberg and committee members,

I am disappointed to hear of the proposed plan to discontinue Section 11 supports for individuals with disabilities in North Dakota. As the previous Executive Director of Community Living Services from 1983 through 2019, I supervised the provision of services for approximately 33 of the people with intellectual disabilities that would be denied services if this proposal is enacted. Approximately 20 years ago the Division of Developmental Disabilities proposed the discontinuation of funding for this same group of individuals, arguing that, despite their documented limited intellectual abilities and the great challenges they face in dealing with daily life issues, these people were not disabled enough to require state support. At that time, we provided testimony to the legislature and an agreement was made that the ND Division of Developmental Disabilities would fund 50% of the cost of services for these folks and that service providers would cover the other 50%. Community Living Services has provided that match since that time and, in fact, because the amount being funded by the State of North Dakota has not increased over those 20 years, Community Living Services' share of the costs has risen to 60%-70%.

CLS felt at that time and continues to feel today, that those individuals require some level of support in order to survive in the community. We believe that, without some level of support, these people are at great risk of homelessness, incarceration, or health decline. I have always felt that the type of service provided for these Section 11 people is one of the best, most economical, financially responsible uses of state funding. Generally, these individuals live in their own homes, many have jobs, and most require only help in some specific parts of their lives, like paying bills, following through with health issues, dealing with personal concerns, and maintaining their housing. The costs per individual are very limited and with the providers covering the great percentage of the total costs, the states commitment is minimal.

Our fear, again, is that if supports are terminated, other parts of the system will necessarily be required to step in. These would include housing assistance, the police department and the medical system.

I am requesting that your committee does not support the proposal to discontinue funding for the Section 11 for individuals with disabilities in North Dakota.

James Berglie

March 9, 2021

RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a caregiver of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

The individuals receiving Section 11 services continue to need these services to live normally in the community as viable, employed and self-reliant citizens. We provide money management services, medical appointment assistance, in-home and self-care services to them. These services are the only services they qualify for, and without them they cannot function properly in the community.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Bonnie Lein

Printed Name: Bonnie Lein

North Dakota address: 1815 5th St N, Fargo, ND 58102

I *am writing to you to make you aware of the termination of a program under the Department of Human Services in the Developmental Disabilities Budget, the Experienced Parent program. This program allows for the hiring of parents with lived experience of having a child who receives our Part C Early Intervention services (birth to 3). Experienced parents have been in existence for close to 25 years working in conjunction with the North Dakota Early Intervention system.*

This loss of the Experienced Parent program is not showing up in the detail from the Department and is not reflected on the Savings Plan. The reason we were given is that: the funds used for it have been repurposed for direct services. In the 2017 session, this also happened, and advocates worked with legislators to get $100,000 of state general funds reinstated and $160,000 of the federal Part C grant dedicated to the program.

I gave testimony then as well, with my baby daughter in the room (and on my hip at one point), reminding representatives that North Dakota takes great pride in the claims to be "pro-life" while a woman is pregnant, yet limits the support she and her child receive once that child is born. It is confusing and disheartening, for the government of North Dakota to claim it cares for children and families as there is active voting to reduce budgets that directly support them. Having a child with a disability teaches you a lot of things, but after learning how to love everyone, it's how to budget, because therapy is expensive. I know you can find the money for these positions. I would not be where I am today, finding the resources and specialists necessary for my daughter to thrive if it were not for the help I received from the Experienced Parent program. The support of the parents who came before me, walking this path and know who to reach out to and how to ask questions to make sure my daughter receives the care that she needs has been invaluable. They are there for you on a personal level, walking with you hand in hand, leading the way all while reminding you that it will be okay; and when it's not, that your family will be okay.

I support the Experienced Parent program whole-heartedly. Think of the statistics of childhood disabilities, and sleep better knowing that when someone in your family needs them, they will be there.

We would like the funding fully restored. Because we have fought this battle as little as 4 years ago, we are open to what other avenues are available to get this funding out to be used ASAP.

Thank you for your attention.

Layla Ligutom

Testimony in on HB1012
Requesting Full Funding of Permanent Supportive Housing Services
Cody J. Schuler, Executive Director, Fargo-Moorhead Coalition to End Homelessness, NDL#367
North Dakota Senate Appropriations Committee
March 10, 2020

Mr. Chairman, members of the Committee, I offer testimony in opposition to the inadequate level of funding in HB 1012 for permanent supportive housing facilities in Bismarck, Fargo, and Grand Forks. Permanent supportive housing provides vital services for our state's citizens experiencing chronic homelessness. Permanent supportive housing creates housing and provides services for some of our most vulnerable citizens. While bringing dignity to those experiencing chronic homelessness, supportive housing is also an investment that is proven to reduce costs to the community at large.

In our community, Cooper House has been an essential asset in our work to end homelessness (a goal of making homelessness a rare, brief, and one-time experience). In its initial year of existance, a study showed that Cooper House helped realize over $200,000 of saving to the community. Since that time, other programs in the Fargo area, similarly serving formerly chronic homeless, has demonstrated over $1 million over the past three years.

Now is not the time to reduce funding for Cooper House and other permanent supportive housing in the state. The 1915(i) is a new and important resource in addressing homelessness in our state. However, as a new opportunity, there are several unknowns about how many residents at Cooper House will qualify or if the reimbursements will be enough to cover the proposed reduction in funds. It is imperative that this funding be restored for another biennium, giving the Department of Human Services and local service providers the opportunity to ensure the 1915(i) is implemented without any gaps in services.

Should gaps in services occur, it is likely that the stability, safety, and security of the residents of Cooper House would be compromised. Furthermore, there is a real concern that calls to and interventions by law enforcement would increase. This is both unnecessary, costly, and preventable.

Thank you in advance for your support of restoring adequate funding of permanent supportive housing in the Department of Human Services budget and providing adequate services to vulnerable citizens.

Attachments:
1. *State of Homelessness in the Fargo-Moorhead Metro Area, 2020 (cost of savings outlined on pp 47-48)*
2. *Cooper Housing Impact Report, A study of the impact of Housing North Dakotas' Chronically Homeless Population, 2010*



Experience the Eide Bailly Difference

Cooper House Impact Report

A Study of the Impact of Housing North Dakota's Chronically Homeless Population

EideBailly®

CPAs & BUSINESS ADVISORS

Cooper House Impact Report & Cost Study

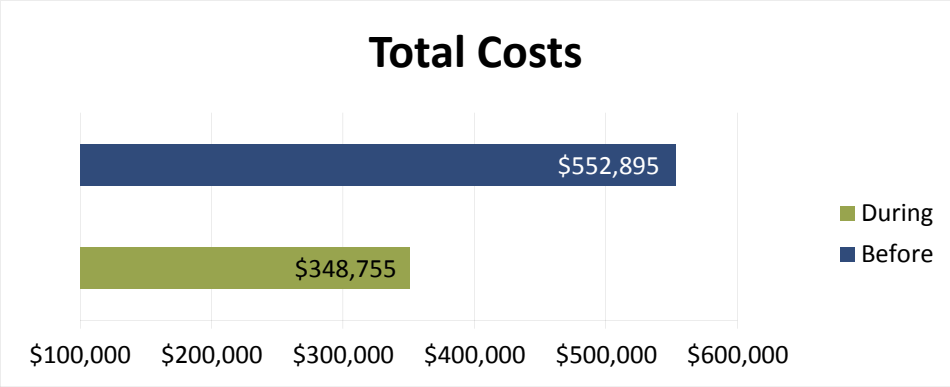
Eide Bailly was engaged by the Fargo Housing & Redevelopment Authority (FHRA) to compile cost data for a group of residents of Cooper House, a supportive housing for the homeless project managed by FHRA. We have compiled data showing the costs to society prior to when these people secured housing at Cooper House and then 12 months during their time housed at Cooper House. Because people move in and out not all dates line up over the same time frame. We have attempted to collect data showing 12 months prior to being housed at Cooper House and during their stay at Cooper House. We have not audited, reviewed or tested this information beyond simple due diligence while collecting it.

Background:

Cooper House opened in Fargo, ND in May of 2010. The Cooper House apartment's provide permanent supportive housing for homeless persons and is a stabilizing next step in the lives of people coming out of shelters or transitional housing programs. It consists of 42 apartments, 32 of which are efficiencies and 10 are one bedroom units. The apartments are rented exclusively to individuals who are documented as homeless. Preferences are given to those experiencing chronic or long-term homelessness, veterans, and people with disabilities. Homeless is defined as an individual or family who lacks a fixed, regular, and adequate nighttime residence. Chronic or long-term homelessness is considered to be anyone being homeless for 12 consecutive months or 4 times in the past 3 years.

Mental Health Technicians are on staff 24 hours, seven days a week at Cooper House, and a part time Licensed Addiction Counselor and a full time Case Manager are in the building daily, working with the clients and offering needed services. Family Health Care Center provides a part time nurse on site who provides medication management, infection control, health assessment, and referrals and follow up.

Cooper House employs a "Housing First" hybrid model, where people are provided a home first and then are offered a variety of services to help improve their lives and keep them in housing.



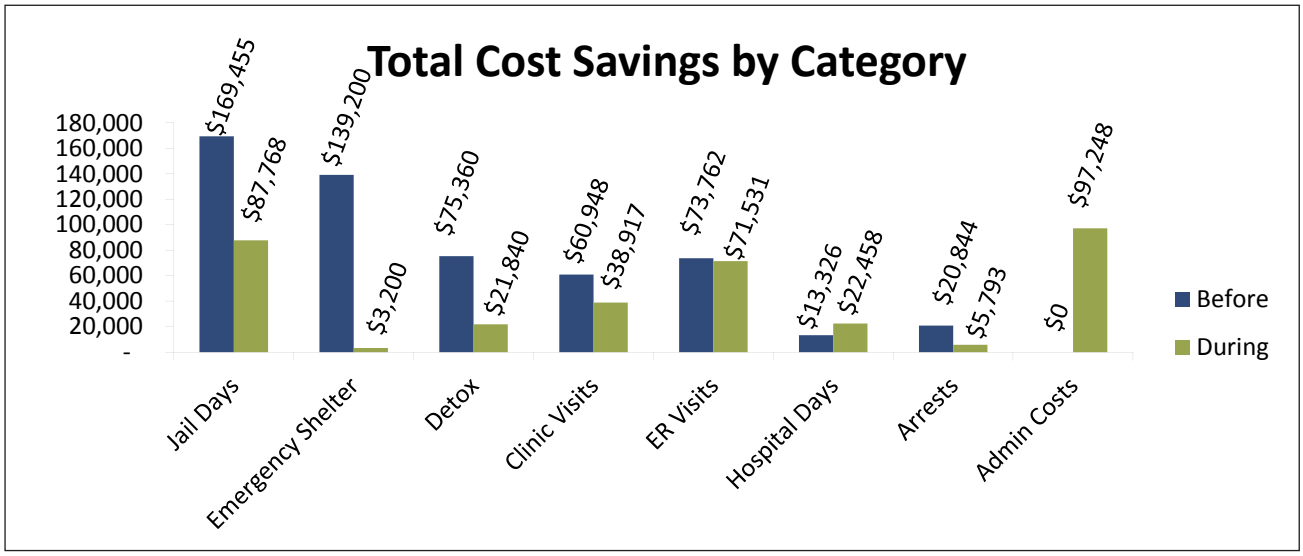
Conclusion:

Based on the results from the cost study, it is evident that housing the chronically homeless is "the smart way to do the right thing." There was a total of $204,140 savings in costs for those who lived at Cooper House for the time period that this study was conducted, through October 31, 2011. Being proactive in helping the homeless population is shown to help save the tax payers money and to make the community a better place to live.

The Study:

This study is meant to be a snapshot of the impact of housing North Dakota's chronically homeless population. The data of this study was collected with the consent of 66 tenants (the Study Group) who have lived at Cooper House at various times since it opened. Area service providers, shelters, law enforcement, the court system, and healthcare providers have all cooperated in providing the information gathered throughout this study. Once the information was consolidated then an average per person per month cost was calculated and this was used to calculate the group average.

Below is an overview of the costs comparisons for a one year period prior to being housed and a one year period ending October 31, 2011.



Note: There are two significant public cost drivers not captured by this study. Those of the judicial system which includes all costs related to court processing, arrests, and those costs related to state hospital days attributed to court ordered rehab. For some individuals this was up to dozens of times prior to living at Cooper House.

Healthcare & Medical Costs:

Based on the information received from Sanford Hospital, the Cost Study Group, costs went from $148,036 to $132,906 for a 10% decrease in costs or a savings of $15,130. The healthcare and medical cost data was compiled through October of 2011.

Law Enforcement & Legal costs:

Based on the information received from the Fargo Police Department, the cost associated with arrests declined from $21,000 to $6,000, which resulted in a decrease of $15,000, or 72%. The jail day costs were reduced from $170,000 to $87,800 for an $81,687 or 48% decrease.

Overall, legal and law enforcement saw a cost savings of $96,738 for those living at Cooper House, with some individuals having 100 less jail days than before they were homeless. The law enforcement and legal cost data was compiled through October of 2011.

Detox Costs:

Based on the information received from the Fargo Police Department, the average cost per detox visit is $120, not accounting for police officers time to collect and transport individuals to the facility. The total cost for detox visits decreased from $75,360 to $21,840. For the Cost Study Group, this is a cost savings of 71% or $53,520. In addition, this particular Study Group has seen 446 fewer visits. The detox cost data was compiled through October of 2011.

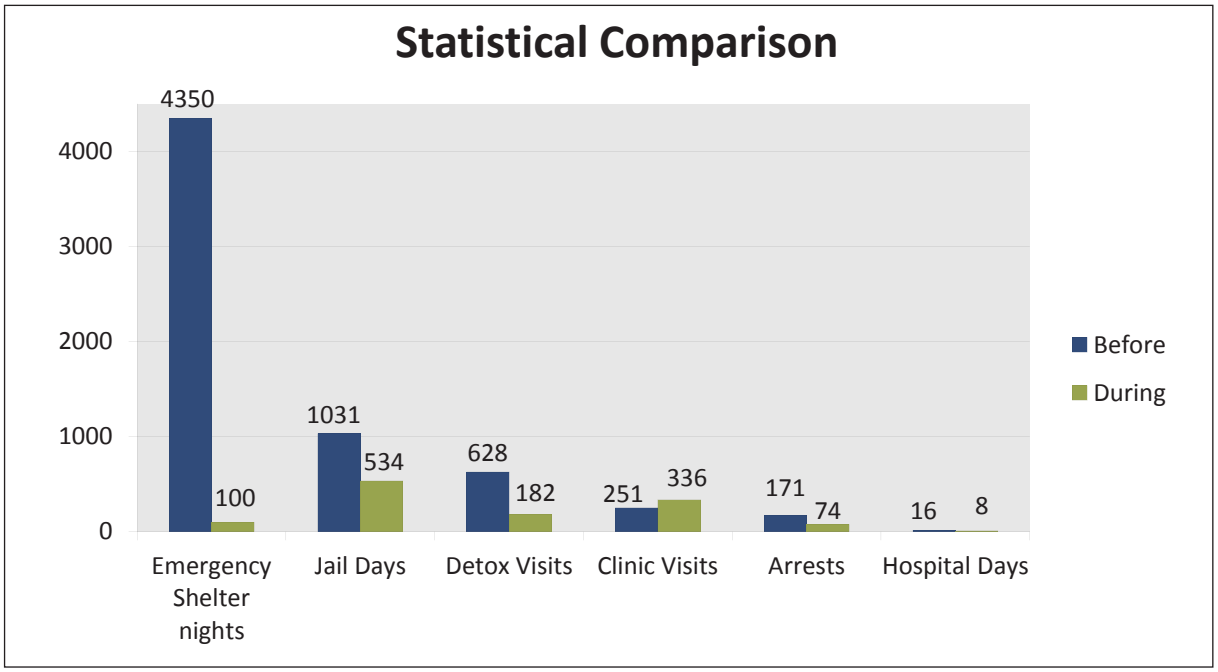
Administration Costs:

The capital outlay of the administration costs is $97,248. This service is provided by Dacotah Foundation through a contract with Southeast Human Services. The front desk is staffed 24/7 and these individuals are considered key to the success and integration back into the community. They staff check tenants and guests in and out of the building, monitor the security system, help with wellness checks, and work to link tenants to appropriate services.

Emergency Shelter:

Based on the information provided by only one of several homeless shelters in Fargo, the Study Group costs were reduced from $139,200 to $3,200, for a total cost savings of $136,000 or 98%. The number of emergency shelter nights was reduced from 4,350 to 100. The emergency shelter cost data was taken from averaging the costs for 2010 and 2011 to determine the average cost per year. The number of times accessed was taken compiled through October 2011.

Below is a statistical comparison of the number of times a service was accessed for the Cost Study Group before and during their residency at the Cooper House:



Places of Birth:

Many of the participants in the cost study call North Dakota their home and have lived here their entire life. Below, the red stars indicate where a portion of the Cost Study Group individuals are originally from.



Please note that not all costs were captured during the study. Some services accessed are not accounted for here and the cost of working with these individuals on the street is understated. For example, only one of several homeless shelters and one of the two hospitals were contacted for this study. Meals from community based organizations are also not accounted for here. In addition, costs accumulated here are only based on the individuals costs accumulated while living in Fargo and do not account for costs incurred in other locations.

FM COALITION TO END HOMELESSNESS

United Way of Cass-Clay



THE 2020 STATE OF HOMELESSNESS

IN THE FARGO–MOORHEAD METRO AREA

A REPORT OF THE FM COALITION TO END HOMELESSNESS IN COLLABORATION WITH UNITED WAY OF CASS-CLAY

ABOUT THE FM COALITION TO END HOMELESSNESS

For 30 years, the FM Coalition to End Homelessness (the Coalition) has been working to address the concerns surrounding homelessness in the Fargo-Moorhead Metro. In response to a growing concern to a local rise in homelessness, four local emergency shelters came together in 1989 to form the Fargo-Moorhead Coalition for Homeless Persons to improve service delivery. As the Coalition became a forum for discussion about the particular circumstances related to working with those experiencing poverty and homelessness, the Coalition grew to include other organizations serving homeless and low-income populations. The Coalition's purpose was to coordinate and improve service delivery in the most humane and efficient manner possible, and it grew to become an active force to provide, expand, and obtain new services. In 2007, the Coalition became a 501(c)(3) nonprofit corporation, hired its first director, and became the key leader in implementation of the City of Fargo's Ten-Year Plan to End Homelessness.

Today, more than 70 partners from service areas related to housing, physical and behavioral health, recovery, law enforcement, community action, disability, and veterans' issues, as well as faith-based groups and individual community members concerned about homelessness, come together with a unified mission: working in partnership to find permanent solutions to prevent and end homelessness in Fargo, Dilworth, Moorhead, and West Fargo. Through unified advocacy, partner education and trainings, and community and regional collaboration, the Coalition strives to fulfill its mission and live up to its recently refreshed name and make homelessness rare, brief, and one-time for individuals and families in this community.

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For the purpose of this report, we will refer to our geographic location as Fargo-Moorhead Metro (FM Metro). In 2018, the most recent data available, the US Census Bureau's American Community Survey (ACS) estimates the population for the Fargo-Moorhead Metropolitan Statistical Area at 245,471 individuals (source.)

This includes the population in Cass County, North Dakota, and Clay County, Minnesota, who are primarily located in the cities of:

- Dilworth, MN
- Fargo, ND
- Moorhead, MN
- West Fargo, ND

Throughout this report we will use FM Metro as our general location, or specifically Cass County, ND, and Clay County, MN, if there is a difference based on the state boundaries.

Additionally, some of the data and processes included in this report are by established Continuums of Care (CoCs). A CoC is a regional planning body of stakeholders designed to promote a shared commitment to the goal of ending homelessness.

CoC planning includes:

- Gathering and analyzing information to understand homelessness in the region;
- Understanding and supporting compliance with HUD and other funders;
- Implementing strategic plans to end homelessness based on data;
- Operating a regional Coordinated Entry System;
- Measuring results of regional planning and performance; and
- Prioritizing limited resources.

The West Central Minnesota CoC includes the following counties: Becker, Clay, Douglas, Grant, Pope, Otter Tail, Stevens, Traverse, Wadena, and Wilkin, along with the White Earth Reservation. It is one of ten CoCs in the state of Minnesota.

North Dakota operates as one CoC for the entire state.

PLANNING AND ADVOCACY ORGANIZATIONS

The FM Coalition to End Homelessness (the Coaltion) is a principle leader for ending homelessness in the FM Metro and serves as the official North Dakota Region 5 Coalition, the six-county southeastern part of the state. The Coalition is in close partnership with the West Central Minnesota CoC and North Dakota CoC as a platform for cross border collaboration between our two cities, two counties, and two states.
www.fmhomeless.org

The Minnesota Coalition for the Homeless (MCH) is a public policy and advocacy organization working to ensure statewide housing stability and economic security. Working with partners across the housing continuum in direct service to state agencies, MCH generates policies, community support, and local resources for housing and services to end homelessness in Minnesota.
www.mnhomelesscoalition.org

The West Central Minnesota CoC is tasked with developing, implementing, aligning, and monitoring regional planning related to preventing and ending homelessness. Through broad collaboration and planning, the CoC utilizes data, training, information sharing, and planning meetings to move towards making homelessness in West Central MN rare, brief, and one-time.
www.homelesstohoused.com

The North Dakota Coalition for Homeless People (NDCHP) brings together partners across the state to lead the effort in ending homelessness in the state through coordination, education, and advocacy. NDCHP's vision is for ND to have safe, decent, and affordable housing that is available to all. www.ndhomelesscoalition.org

The North Dakota CoC is tasked with developing, implementing, aligning and monitoring regional planning related to ending homelessness. The CoC is composed of representatives of relevant public and private organizations that come together to plan for and provide a homeless response system that is dedicated to preventing and ending homelessness in the state of North Dakota. North Dakota Housing Finance Agency is the collaborative applicant for the North Dakota CoC.
www.ndhomelesscoalition.org/who-we-are-2

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MESSAGE FROM THE EXECUTIVE DIRECTOR

June 23, 2020

As this report is released to our community, we are living through a global pandemic and our nation is facing the most significant conversation about race since the Civil Rights movement. It would be an understatement to say that 2020 is shaping up to be a year few could have imagined. Over the past months, homeless services have had to make a major pivot in response to COVID-19. Providing emergency shelter, moving people into housing, and providing key stabilization services without spreading a dangerous virus has tested our homeless response system and our providers on a personal level. But, the partners of the Fargo-Moorhead Coalition to End Homelessness have demonstrated the creativity, perseverance, and resilience they have shown time and time again. Our partners keep moving forward getting the day to day work done while not losing the vision that homelessness can be ended in our community.

That vision is rooted in social justice and human rights. Our mission to end homelessness relies on vital collaboration as we work together to strategically respond to systems of oppression and injustice that hinder people from thriving so that everyone has a safe place to call home. People of color experience homelessness disproportionate to the population. This calls upon us as a coalition to step up to address racial injustice. Healthcare remains out of reach to many who find themselves in a housing crisis. Therefore we need to get health care providers to see housing as a prescription. Affordable housing is out of reach for many in our community. So, we must step up to address costs and income inequality. This is why this State of Homelessness report is so important: to identify issues, celebrate successes, and use data as a key for finding solutions. This report is more than numbers and charts, this document tells a story and provides a map we can use to chart a new course.

In partnership,

Cody J. Schuler
Executive Director

FM COALITION TO END HOMELESSNESS

The purpose of this document is to provide our community with a comprehensive report of available data related to homelessness in the FM Metro. The writers have made the decision to lay out this report in four sections:

Who are our neighbors experiencing homelessness in our community?

What are the needs of those experiencing homelessness in our community?

What are we doing as a community to address homelessness?

What is next for our community?

In each section, you as the reader should have a better understanding of the answer for each question posed. Additional information can be found in the Appendixes related to the data sources and references used in the creation of this report, as well as definitions for some of the terms used throughout the report and additional resources available.

WHO ARE OUR NEIGHBORS EXPERIENCING HOMELESSNESS IN OUR COMMUNITY?

ESTIMATE OF THE NUMBER OF INDIVIDUALS EXPERIENCING HOMELESSNESS

To estimate the number of individuals experiencing homelessness in our community on any given night, we need to look at the estimates of those:

- sheltered in emergency shelter and transitional housing programs
- staying in a place that is not a regular or permanent place to stay, such as outdoors, in a car, vacant building, or a place of business, and
- doubled up with a friend or family member on a temporary basis because they have nowhere else to go.

Below is an overview of the housing inventory count, which provides a snapshot of the number of individuals homeless service programs can serve at any given time. For more on available programs and services, see the section entitled "What are we doing as a community to address homelessness?".

Project Type	Cass County	Clay County	Both
Emergency Shelter	210	74	284
Transitional Housing	36	73	109
Rapid Re-Housing	36	79	115
Permanent Supportive Housing	168	457	625
Other Permanent Housing	0	0	0
Total	450	683	1,133

With this current inventory we see on any given night there are 246 individuals in Cass County, ND, and 147 individuals in Clay County, MN, who are experiencing homeless in a sheltered location (either in emergency shelter or in a transitional housing program).

We can estimate, through the Emergency Shelter Bed Prioritization list which is managed by all Emergency Shelters in partnership, as of the beginning of April 2020, there are a total of 113 individuals staying in a place that is not a regular or permanent place to stay and actively looking for access to a shelter bed. This could include places such as outdoors, in a car or vacant building, or in a place of business. These 113 individuals include 98 adults, 6 school aged children (ages 5 to 18), and 9 children under the age of 5.

Those currently doubled up continues to be much more difficult number to gather, as those individuals are often the most unseen. As of April 2020, 555 students were identified as homeless in our metro school districts. At this same point, there were 33 school aged children were staying at the two emergency shelters that serve families and 6 school aged children were actively seeking shelter with their parents. The remaining 516 students identified as homeless are most likely to be doubled up. However, we believe that is a significant under-representation of those who are currently doubled up in our community.

Pulling this all together, on any given night, there are 1,022 individuals estimated to be experiencing homelessness in the FM Metro.

Sheltered	393
Unsheltered	113
Doubled Up	516
Total	1,022

This is consistent with last year's estimate of 1,075 individuals estimated to be experiencing homelessness in the FM Metro. While we must rely on an estimate for this number, the rest of this report includes more details and data collected on those in our community that received services to overcome their housing crisis and resolve their homelessness.

DEMOGRAPHICS OF INDIVIDUALS AND HOUSEHOLDS EXPERIENCING HOMELESSNESS

According to data available in the Homeless Management Information System (HMIS), in 2019, 3,322 individuals received homeless services either in Cass County, ND, or Clay County, MN. We need to acknowledge there is a level of duplication in these numbers as Minnesota and North Dakota do operate in separate information systems; for example, if an individual received services in both Fargo and Moorhead, they would be counted twice in the data below.

A majority of individuals experiencing homelessness are working age adults, with 61% of those who received services being between the ages of 18 and 54. Additionally, of those served, 23% were children under the age of 18 and 15% were older adults ages 55 and older.

Ages	Clay	Cass	Total	
Under 5	179	96	275	8%
5 to 12	218	114	332	10%
13 to 17	74	87	161	5%
18 to 24	118	186	304	9%
25 to 34	287	389	676	20%
35 to 44	239	317	556	17%
45 to 54	203	283	486	15%
55 to 61	112	221	333	10%
62+	47	117	164	5%
Don't know or refused	1	3	4	0%
Did not collect	29	2	31	1%
Total	1,507	1,815	3,322	

When looking at gender along with age, adult males make up the majority of the homeless population at 49%. Overall, 61.5% of the total homeless population identify as male and 37.5% as female. Additionally, 13 individuals identify as trans female (male to female), 5 individuals identify as trans male (female to male), and 6 individuals identify as gender non-conforming.

Gender by Age	Male	Female	Trans Female (Male to Female)	Trans Male (Female to Male)	Gender Non-Conforming	Client Doesn't Know/Client Refused	Data Not Collected
Adults	1,639	854	13	4	5	0	4
Percent of Total	49%	26%	0%	0%	0%	0%	0%
Children	382	383	0	1	1	0	1
Percent of Total	11%	12%	0%	0%	0%	0%	0%
Unknown Age	21	10	0	0	0	0	4
Total	2,042	1,247	13	5	6	0	9
Percent	61.5%	37.5%	0.4%	0.2%	0.2%	0%	0.3%

In total, this is an increase of only 39 individuals compared to the number of individuals who received homeless services either in Cass County, ND, or Clay County, MN in 2018. There is no major difference in age distribution or gender. Although, there was an increase in the number of individuals identifying as transgender or gender non-conforming. In 2019, a total of 24 individuals (roughly 1% of all individuals served) identified as transgender or gender non-conforming compared to only 15 in 2018.

In 2019, just under half of individuals who received homeless services identified their race as White, showing a significant racial disparity which exists among the homeless population compared to the general population in the FM Metro. As of 2018, US Census Bureau's American Community Survey (ACS) estimates show 87.1% of the total population in the FM Metro identify as White alone. With 19% of the homeless population identifying as Black or African American and 20% identifying as American Indian, we see significant racial disparities as these populations are overrepresented compared to the general population. The US Census estimates show only 6.1% of the general population identify as Black or African American alone and 1.4% as American Indian and Alaska Native alone (Census Estimates).

Race	Total	Percent of Total
White	1,620	49%
Black or African American	627	19%
Asian	9	0%
American Indian or Alaska Native	669	20%
Native Hawaiian or Other Pacific Islander	25	1%
Multiple races	277	8%
Client Doesn't Know/ Client Refused	26	1%
Data Not Collected	69	2%
Total Persons	3,322	

This is a slight increase in the rate of individuals of color who are experiencing homelessness. In 2018, 50% of individuals experiencing homelessness identified as White alone.

Additionally, 10% of individuals experiencing homelessness identify their ethnicity as Hispanic/Latino. Again, this is an overrepresentation compared to the general population, which is currently estimated at only 3.2% (Census Estimates).

Ethnicity	Total	Percent of Total
Non-Hispanic/Non-Latino	2,918	88%
Hispanic/Latino	324	10%
Client Doesn't Know/Client Refused	10	0%
Data Not Collected	70	2%
Total Persons	3,322	

The 3,322 individuals served throughout 2019 make up a total of 2,325 separate households. A vast majority (84%) of the households do not include children.

Household Type	Total	Percent of Total
Singles: Adults without children	1,943	84%
Families: Adults with children	313	13%
Youth: Youth only, no adults, with or without their own children	43	2%
Unknown Household Type	26	1%
Total Households	2,325	

This is a very consistent breakdown of households, from 2018, although there was an increase of 44 households served from last year.

Chronically Homeless

Individuals who are considered chronically homeless are typically more vulnerable and have significantly higher barriers, meaning they require more supportive services and longer-term support to be successful in ending their continued homelessness episode or episodes.

To be classified as chronically homeless, individuals must meet all the following:

- Currently experiencing homelessness,

- Been homeless for at least one year during the current episode OR homeless for less than one year in the current episode, but homeless at least four times in the previous three years, and
- Disabled (those who have a physical, mental, or other health condition that limits the kind of work they can do OR those who have a physical, mental, or other health condition that makes it hard for them to bathe, eat, get dressed, get in and out of bed or chair, or get around by themselves).

In HMIS, 22% (720) of individuals served in 2019 were considered chronically homeless. They make up 25% of all the households served. We must acknowledge that 10% of individuals served throughout 2019 did not have data collected on this classification, and thus results may differ if we had access to this information. Although, this does show improvement in data collection from last year, as in 2018, 30% of individuals served did not have data collected on this classification.

Like the overall homeless population, a majority of the chronically homeless individuals are working age adults. Of the individuals who are considered chronically homeless, 68% are between the ages of 18 and 54, with only 14% under 18. Aging adults are classified as chronically homeless at a higher rate compared to the general homeless population, with 18% of the chronically homeless population age 55 and older (compared to 15% of the general homeless population).

Age	Total	Percent of Total
Age 0-17	102	14%
Age 18-24	42	6%
Age 25-34	146	20%
Age 35-44	141	20%
Age 45-54	161	22%
Age 55-61	91	13%
Age 62 and above	37	5%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	720	

Like the general homeless population, a majority (65.8%) of the chronically homeless identify as male, followed by 33.5% identifying as female. Three individuals who are considered chronically homeless identify as trans female (male to female) and one individual identifies as gender non-conforming.

Gender	Total	Percent of Total
Male	474	65.80%
Female	241	33.50%
Trans Female (Male to Female)	3	0.40%
Trans Male (Female to Male)	0	0.00%
Gender Non-conforming	1	0.10%
Client Doesn't Know/ Client Refused	0	0.00%
Data Not Collected	1	0.10%
Total Persons	720	

Overall, compared to last year's data, the chronically homeless population is slightly younger with a 3% increase in those under the age of 18 and a 3% decrease in those over the age of 55. This may be due to better data regarding this sub-population.

In 2019, the 720 individuals considered chronically homeless made up a total of 591 separate households. A vast majority (93%) of the households do not include children.

Household Type	Total	Percent of Total
Singles: Adults without children	547	93%
Families: Adults with children	44	7%
Youth: Youth only, no adults, with or without their own children	0	0%
Unknown Household Type	0	0%
Total Households	591	

Youth

Youth homelessness is often harder to track. According to data available in HMIS, in 2019, 324 youth received homeless services either in Cass County, ND, or Clay County, MN. These are young adults 24 years old or younger, living without parents or guardians and may be parenting themselves.

Age	Total	Percent of Total
Age 12-17	60	19%
Age 18-24	264	81%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	324	

Unlike the general homeless population, youth are more diverse in their gender identity, with only 46% identifying as male. In addition to 48% identifying as female, 2% identifying as trans female (male to female), 2% as trans male (female to male), and 2% as gender non-conforming.

Gender	Total	Percent of Total
Male	150	46%
Female	157	48%
Trans Female (Male to Female)	6	2%
Trans Male (Female to Male)	5	2%
Gender Non-conforming	6	2%
Client Doesn't Know/ Client Refused	0	0%
Data Not Collected	0	0%
Total Persons	324	

LGBTQ+ youth experience homelessness at a high rate than their peers. As part of the 2021 State of Homelessness Report, we hope to include more data on this and the unique experiences of youth homelessness in our community.

Of the 324 youth served in 2019, 31 youth are parents themselves and between the ages of 18 and 24 years old. They have a combined total of 49 children in their care.

Youth are assessed for housing services utilizing a specialized tool geared towards those under 24 years of age. Within this assessment, 56% of youth answered that their lack of housing was because of an unhealthy relationship, either at home or elsewhere (emotional, physical, psychological, or sexual).

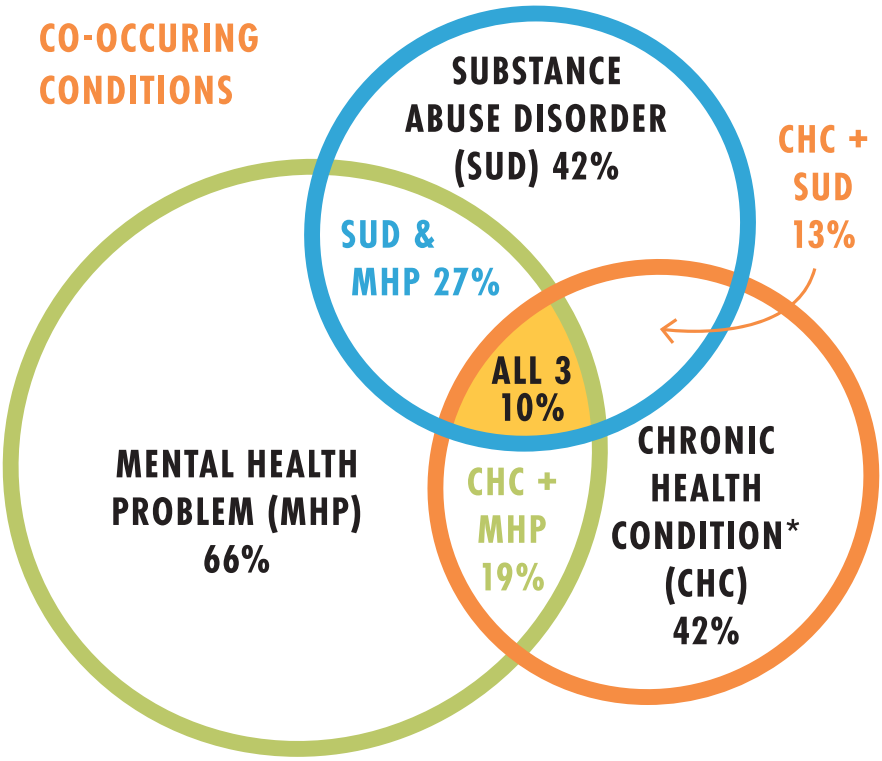
Health Conditions & Co-occurring Conditions

Physical health, mental health, and substance abuse are significant concerns and barriers among the people experiencing homelessness in our community. According to data available in HMIS, 44% of the individuals served in 2019 have a disability of long duration. This includes any disability that is ongoing, continued, or for an indefinite duration.

Of individuals diagnosed with a disability:

- 42% have been diagnosed with a chronic health condition, physical disability, or developmental disability.
- Two thirds (66%) have been diagnosed with a mental health problem.
- 42% have a substance abuse disorder (to either drugs, alcohol, or both).

Often individuals experiencing homelessness also experience co-occurring conditions. When looking at those who reported being diagnosed with a chronic health condition, serious mental health problem, and/or substance abuse disorder, 41% of respondents have been diagnosed with more than one of these conditions and 10% report all three.



These results differ from the numbers published last year because last year's data was based on self-responses as part of the Everyone Counts survey administered in October 2018 by homeless

service providers. Due to the different data sources from this year to last, we are unable to compare the annual results.

Overall, most individuals with a chronic health condition, substance abuse disorder, mental health problems, or a combination of these conditions in our community are housed. Individuals experiencing homelessness are not experiencing their housing crisis because of these conditions alone – rather it is due to a unique combination of experiences, traumas, lack of support networks, and access to services or supports. This section is included to highlight the fact that many individuals in our homelessness response system need access to additional services, in addition to housing support. Moving from homeless to housed looks different for each individual and each household; and often includes many other aspects of our community social services network.

Prior Living Arrangements

In HMIS, shelter and supportive housing programs in the FM Metro collect information regarding prior living arrangements for individuals who entered services. In 2019, almost half (46%) of individuals stated they were homeless, meaning they were staying at a shelter, transitional housing, or place not meant for human habitation.

Another 11% of individuals came from an institutional setting, including psychiatric hospital/facility, substance abuse facility, hospital, jail, prison, long-term care facility, or halfway house. 14% identified they were living in their own apartment or home with or without subsidies or support, and 21% were staying with a friend or family member.

Prior Living Arrangements - All Clients	Total	Percentage
Homeless	1,196	46%
Institutional Settings	288	11%
Permanent Housing/Own/ Rental	365	14%
Doubled Up (Staying with Friends or Family)	532	21%
Hotel or Motel without Voucher	77	3%
Client Doesn't Know/Refused	19	1%
Data Not Collected	114	4%
Total	2,591	

As a community, we are very concerned with the percentage of individuals and families entering homelessness from permanent housing. This intensifies when we look at families with children and youth experiencing homelessness.

With families entering services, 31% are coming from permanent housing, previously living in their own apartment or home with or without subsidies or support. This is a significant increase compared to the overall population.

Prior Living Arrangements - Families	Total	Percentage
Homeless	162	39%
Institutional Settings	7	2%
Permanent Housing/ Own/Rental	130	31%
Doubled Up (Staying with Friends or Family)	93	22%
Hotel or Motel without Voucher	18	4%
Client Doesn't Know/Refused	1	0%
Data Not Collected	3	1%
Total	414	

With youth experiencing homelessness, we see a significant increase in the percentage of individuals previously doubled up or staying with friends or family prior to entering homelessness, 37% compared to 21% with the general homeless population.

Prior Living Arrangements - Youth	Total	Percentage
Homeless	96	30%
Institutional Settings	22	7%
Permanent Housing/ Own/Rental	37	11%
Doubled Up (Staying with Friends or Family)	121	37%
Hotel or Motel without Voucher	9	3%
Client Doesn't Know/Refused	8	2%
Data Not Collected	31	10%
Total	324	

Prior Experiences

According to data collected in HMIS, of the 3,322 individuals served, 2,591 individuals entered programming or began receiving services in 2019. Almost a fourth (24%) of these new entries had a history of Domestic Violence. We must acknowledge 21% of individuals who entered services throughout 2019 did not have data collected on their domestic violence history, and thus results may differ if we had access to this information.

Of those with a history of Domestic Violence, 34% identified fleeing domestic violence as the reason for their current homeless situation.

Domestic Violence History	Total	Percent of Total
Fleeing Domestic Violence	207	34%
Not Fleeing Domestic Violence	361	59.30%
Client Doesn't Know/ Client Refused	3	0.50%
Data Not Collected	38	6.20%
Total Households	609	

This data does not capture the full impact and history of violence for many individuals experiencing homelessness. Violence may often be the primary reason why someone is experiencing homelessness but may not reported as the immediate cause. Additionally, research shows for many chronically homeless individuals, one of their first times experiencing homelessness was as a victim of violence. However, this is not captured in this data as it only reflects their current episode of homelessness.

According to agency specific data, 80% of the individuals who stay with YWCA of Cass Clay (YWCA), are seeking services due to violence. This is in line with national research which has shown being a victim of violence is the number one reason that woman become homeless (Source). To get a more accurate number the YWCA has changed how they ask clients about their history of violence. Previously, those seeking shelter were asked, "why are you checking into the shelter". However, many who had initially fled an unsafe situation may have temporarily sought shelter with a family, friend or elsewhere, leading them to select that they were homeless. In recognizing the low response in initial reporting of fleeing violence as women entered the shelter, YWCA staff were coached on how to ask probing questions on what lead to the woman's homelessness.

Of those who had been assessed for housing programs utilizing the VI-SPDAT tool, a staggering 58% of participants responded that their current period of homelessness had been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma they have experienced. In addition, approximately 34% of people experiencing homelessness, who were assessed for housing services, identified that they had been attacked or beaten up since becoming homeless.

As part of the Everyone Counts Survey conducted in October 2018, 243 respondents were asked about adverse childhood experiences and traumatic events in their lives. Among the adverse childhood experiences inquired about in the survey, those experienced the most were:

- Living with a substance user (54%)
- Witnessing abuse of other family member (44%)
- Being physically abused as a child (36%)
- Living with a parent or guardian who struggled with mental health issues (32%)

Additionally, as children, about one-fourth of respondents (28%) lived in a foster home and 18% lived in a group home. About 30% were held for more than a week in a juvenile detention center or other juvenile facility or camp.



WHAT ARE THE NEEDS OF THOSE EXPERIENCING HOMELESSNESS IN OUR COMMUNITY?

INCOME, EMPLOYMENT, AND EDUCATION

Income and employment data were collected for the 2,519 adults served throughout 2019. Income and sources were collected at the start of their services along with when they exited services (Leavers) or at an annual check point if they remained in services (Stayers).

In 2019, only 48% of individuals who started services had a known source of income (one or more). Of those who left services in 2019, only 43% had one or more sources of income.

Number of Adults with Income	Start		Stayers		Leavers	
Total Adults	2,519		830		1,689	
1 or More Source of Income	1,217	48%	77	9%	719	43%

Below is a breakdown of cash income sources.

Cash Income Sources	Start	Stayers	Leavers
Earned Income	423	18	290
Unemployment Insurance	8	0	5
Supplemental Security Income (SSI)	267	32	168
Social Security Disability Insurance (SSDI)	166	16	104

Breakdown of cash income sources, continued:

Cash Income Sources	Start	Stayers	Leavers
VA Service - Connected Disability Compensation	69	1	28
VA Non-Service Connected Disability Pension	25	2	13
Private Disability Insurance	3	0	2
Worker's Compensation	61	9	22
Temporary Assistance for Needy Families (TANF)	68	10	25
General Assistance (GA)	196	9	46
Retirement Income from Social Security	19	0	10
Pension or retirement income from a former job	8	2	6
Child Support	46	6	22
Alimony and other spousal support	1	0	0
Other Source	38	14	21

Below is the breakdown of cash income ranges for all adults on a monthly basis.

Breakdown of Monthly Income Range	Start		Stayers		Leavers	
No Income	1,070	42%	34	4%	739	44%
$1 - 150	158	6%	5	1%	39	2%
$151 - $250	73	3%	5	1%	43	3%
$251 - $500	88	3%	9	1%	49	3%
$501 - $1000	361	14%	30	4%	220	13%
$1001 - $1500	148	6%	10	1%	90	5%
$1501 - $2000	122	5%	7	1%	69	4%
$2001 +	136	5%	8	1%	105	6%
Client Doesn't Know/Refused	3	0%	0	0%	4	0%
Data not collected	360	14%	0	0%	331	20%
Adult stayers not yet required to have an annual assessment			427	51%		
Adult stayers without required annual assessment			295	36%		
Total Adults	2,519		830		1,689	

In 2019, the federal poverty guidelines were set as a single adult making $12,490 annually or about $1,040 per month. Noting most individuals experiencing homelessness are not in family units, you can see that 68% are below that $1,000 per month threshold. Additionally, if we factor in family units, a family of four making $25,750 per year or less is within the 2019 poverty guidelines – this is roughly $2,145 per month (Source).

In addition to employment and cash income, data is collected on non-cash benefits individuals are receiving. A majority of individuals when starting and leaving services had no sources of non-cash benefits.

Non-Cash Benefit Sources	Start		Stayers		Leavers	
No Sources	1,343	53%	18	2%	928	55%
1 + Source(s)	846	34%	86	10%	463	27%
Client Doesn't Know/ Client Refused	3	0%	0	0%	2	0%
Data Not Collected/ Not stayed long enough for Annual Assessment	327	13%	726	87%	296	18%
Total	2,519		830		1,689	

Of those who receive non-cash benefits, most are enrolled in Supplemental Nutrition Assistance Program or SNAP (previously known as Food Stamps).

Type of Non-Cash Benefit Source	Start	Stayers	Leavers
Supplemental Nutrition Assistance Program (SNAP)	812	81	447
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	68	7	37
TANF Child Care Services	9	1	5
TANF Transportation Services	0	0	0
Other TANF-Funded Services	4	0	2
Other Source	145	51	57

For more details on the benefits programs included in this section along with benefit eligibility, please visit:

- Cass County, ND Human Services Website: https://www.casscountynd.gov/our-county/human-services/economic-assistance-division
- Clay County, MN Social Services Website: https://claycountymn.gov/207/Financial-Assistance-Services

As part of the Everyone Counts Survey conducted in October 2018, respondents currently experiencing homelessness were asked about their education and employment. Almost two-thirds (63%) of respondents had at least a high school diploma or some level of college education.

Educational Attainment	Total	Percentage
8th grade or less	10	4%
Some high school but did not finish 12th grade	78	32%
12th grade (high school graduate)	69	28%
Some college but no degree	49	20%
Completed any college degree (2-year Associate or higher)	36	15%
Refused	1	0%
Don't know	0	0%
Total Individuals Surveyed	243	

Additionally, while in grade school, 31% of individuals surveyed had an Individualized Education Plan or required some level of Special Education.

While 48% of adults entering services this past year had some level of income and 34% were enrolled in non-cash benefits, they still experienced a housing crisis that resulted in them becoming homeless. In later sections of this report, there are more details on additional barriers to housing that many individuals experience, along with how our system works to help move these individuals from homelessness to housing regardless of income or employment.

BARRIERS TO SUSTAINABILITY

Individuals experiencing homelessness in our community face many barriers to sustainability or the ability to lead a stable life, specifically when it comes to gaining and maintaining livable-wage employment and safe, stable housing. Poor credit and rental history, access to employment and livable-wages, transportation, and affordable housing are the common themes individuals self-identified as the reasons why they are experiencing homelessness.

According to 5-year estimates by the Census Bureau, as of 2018, in the FM Metro 43% of occupied housing units are rented. Rent prices and low income are causing many renters to be cost burdened. This is when housing costs require more than 30% of a household's income each month. 42% of renters

in our community are considered cost burdened. This is significantly higher than those who own their home at 14%. (Census Estimates)

The rate of cost burdened households changes drastically based on the household's income. Below is a breakdown of those who are housing cost burdened by income level.

Percentage of households who are housing cost burdened by income level	Overall		Owners		Renters	
Less than $20,000	11,991	90%	2,064	81%	9,927	92%
$20,000 to $34,999	7,308	59%	1,782	45%	5,526	66%
$35,000 to $49,999	3,284	27%	1,483	29%	1,801	26%
$50,000 to $74,999	2,113	12%	1,756	17%	357	5%
$75,000 or more	861	2%	689	2%	172	2%
Total Housing Cost Burdened Households	25,557	26%	7,774	14%	17,783	42%

For more information on our region's access to affordable housing, check out:

- The National Low Income Housing Coalition's "Out of Reach" report: https://reports.nlihc.org/oor
- Minnesota Housing Partnership "State of the State's Housing" report for Clay County: https://www.mhponline.org/images/stories/images/research/coprofs/2019/Clay.pdf

The top reasons why people are experiencing homelessness, from respondents of the Everyone Counts Survey conducted in October 2018, included:

- Eviction or did not have leases renewed,
- Not able to afford rent or house payments, and
- Loss of job or work hours cut.

These situations compound when we consider the barriers these individuals face in being able to rent an apartment or getting housing. The top barriers to accessing housing were identified as:

- Credit problems,
- No affordable housing,
- Criminal backgrounds,
- Bad rental history or past evictions, and
- No local rental history or references.

When respondents were asked about supports they felt they needed to access housing, they identified:

- Available affordable housing,
- Deposit assistance,
- Ongoing case management/support services,

- Reliable and affordable transportation,
- Increased income or employment, and
- Ongoing rental subsidies.

When asked about what would help them to maintain stable housing, survey respondents identified employment, affordable housing, and transportation as the top three.

PUBLIC HOUSING ASSISTANCE

Public Housing Agencies (PHA's) are the largest mainstream providers of affordable housing for local communities. In Cass and Clay Counties, three PHA's have made it part of their mission to prioritize families experiencing homelessness and people with disabilities for housing resources. Fargo Housing & Redevelopment Authority (FHRA), Moorhead Public Housing (MPHA), and Clay County HRA (CCHRA) are all active participants in the Coordinated Access, Referral, Entry, and Stabilization (CARES) System and work towards the goals of ending family, youth, veteran, and chronic homelessness in our region. More details about the CARES System can be found in the next section, "What are we doing as a community to address homelessness?".

In 2019, the United States Department of Housing and Urban Development (HUD) allowed PHA's to apply for additional Mainstream Housing Choice Vouchers, commonly called Section 8 vouchers. These vouchers are meant to target adults with disabilities who are experiencing homelessness, initialization, or housing insecurities. Due to their work in showing the great need for additional affordable housing resources in our community, FHRA and CCHRA were able to apply for and were awarded new vouchers for Cass and Clay counties. This was the largest new allotment of vouchers given to CCHRA since its inception. The amount awarded FHRA and CCHRA together was larger than those awarded to other larger metropolitan areas across the nation.

In 2019:

- Moorhead Public Housing reported 83% of new admissions were exiting homelessness.
- Fargo HRA had 480 new admissions listed as previously being homeless throughout their programs.
- Clay County HRA served 360 households in their homeless programs and reported 93% of new admissions to Housing Choice Vouchers had experienced homelessness.

Even with the new vouchers, waiting lists for these programs remain long. The waiting lists for tenant-based Housing Choice Voucher at FHRA and CCHRA are both closed, as the waiting list grew too extreme for new applications. Those on the list can expect to wait two or more years before receiving

vouchers. Other site-based programs such as Public Housing or units for people who are elderly and/or disabled have various waiting lists, with larger units for families having the longest.

NEEDS ASSESSMENT

CAPLP (Lakes & Prairies Community Action Partnership, Inc.) completed a needs assessment for Clay County, MN, in 2018. SENDCAA (Southeastern North Dakota Community Action Agency) completed the same needs assessment in March 2019 for Cass County, ND. There were three parts to this needs assessment:

- A survey for people currently seeking housing services
- A survey for homeless related service providers
- A survey for people previously served by a homeless prevention and assistance program at CAPLP and SENDCAA

Clay County, MN:

Results indicated the top contributor to respondents' housing crisis was not being able to afford their rent. A mental health symptom or chemical use was the second highest contributor to their current housing crisis (50%). Roommate/neighbor issues, and poor credit/poor criminal history were also noted as causes to a current housing crisis.

When asked what would help the most to solve the current housing crisis, the top three responses were case management or other support services (44%), ongoing rent assistance (41%) and credit repair/budgeting (41%). Deposit assistance (35%) and transportation (38%) were also of note (respondents were able to check all that applied).

The provider survey was sent out via an online surveying tool to the Housing Advisory Committee made up of homeless service providers, the FM Coalition to End Homelessness, and various community partners.

- For prevention and homeless assistance, providers felt housing search assistance, landlord/tenant relationships, and financial assistance were most important.
- For families, providers felt the biggest barriers to housing stability were domestic violence, affordable child care, and lack of affordable housing.
- For singles, providers felt criminal history, substance use, and lack of affordable housing were the biggest contributors to housing instability.

- For youth, providers felt youth most often face barriers with little or no rental history, lack of affordable housing options, and employment.

Additionally, a survey was administered via phone for past clients served by Family Homeless Prevention and Assistance Program (FHPAP) at CAPLP in September of 2018. 100% of responding individuals indicated the FHPAP assistance and case management they received from CAPLP helped to stabilize their housing crisis. Rental assistance, utilities, and deposit assistance were stated as being the most helpful to resolving the housing crisis (96%). A third (33%) of people indicated case management was also beneficial (respondents could check all that applied).

Throughout the surveys, multiple themes emerged showing a significant need for affordable housing in our community. Also of note, there is a commonly identified need for supportive services to help find housing, mediate with landlords, and navigate employment and mental health/substance use services.

To gain a deeper understanding of the needs of people who have or are currently experiencing a housing crisis, CAPLP staff conducted two focus groups in January of 2019. The first was with 8 individuals at Micah's Mission, a shelter for families in Moorhead. Respondents were of varying races and ages consistent with shelter population and households served in FHPAP. The top three areas identified as concerns were finding housing, employment, and transportation. Many stated they had barriers on their background that were keeping them from finding housing and employment. They shared that additional case managers to support people with these barriers would be helpful.

An additional focus group was held with clients who are currently housed on CAPLP programs in Clay County, MN. The commonly identified needs by this group included affordable housing options, living-wage jobs, and transportation options to get to important appointments such as apartment viewings or jobs. Respondents felt the services that worked well included Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (MFIP), housing search assistance, landlord mediation with their case manager, and general case management services.

Cass County, ND:

Individuals seeking housing services were asked to identify what contributed to their current housing crisis. Of those surveyed, 42% reported the primary cause to their current housing crisis was that they could not afford rent. Other responses included physical health issues (21%), roommate or neighbor issues (18%), and violence or concerns for safety (13%). Less prevalent responses included chemical or substance usage, mental health symptoms, criminal history, and loss of a job or difficulty finding work.

The top three responses for what would help individuals find and keep stable housing included help with past due rent (48%), on-going rental assistance (38%), and deposit assistance (33%). The top non-financial related support is credit repair and budgeting (23%). Other responses which were noted in the respondents' comments were obtaining and maintaining employment, affordable housing, and sufficient income.

All clients who received rent or deposit assistance in March or April of 2019 were called and asked to complete a survey. Out of the 6 clients, 100% reported the assistance they received helped them stabilize their housing and all clients reported they were satisfied with the services they received.

Thirty-nine providers responded to a survey about resources needed to prevent homelessness.

- Providers reported short-term financial assistance, case management, landlord/tenant relationships, housing search assistance, and transportation assistance were the most important in ending and preventing homelessness.
- For families, providers felt the biggest barriers to housing stability were lack of affordable housing options, affordable child care, and poor credit.
- For singles, providers felt mental health, lack of affordable housing options, and criminal history were the biggest contributors to housing instability.
- For youth, providers felt youth most often face barriers with poor or limited rental history, life skills/financial fitness, and lack of affordable housing options.



WHAT ARE WE DOING AS A COMMUNITY TO ADDRESS HOMELESSNESS?

CARES: OUR HOMELESS RESPONSE SYSTEM

The Coordinated Access, Referral, Entry, & Stabilization (CARES) System is our region's approach to the Department of Housing and Urban Development (HUD) mandate that each Continuum of Care (CoC) operate a Coordinated Entry System. HUD defines coordinated entry as a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. CARES follows this mandate but also includes prevention, diversion, and stabilization services. Research shows that to end homelessness, we need to reduce the number of individuals entering our system, and that while housing ends homelessness, some people also need ongoing supports to continue to remain housed.

CARES includes partner agencies interested in assuring a more coordinated, effective, streamlined, and consumer friendly system. Our system operates in partnership between the ND CoC, West Central MN CoC, FM Coalition to End Homelessness, and White Earth Nation.

As a system, CARES strives to manage scarce system resources in a streamlined, transparent, planful, data-driven, and consumer center manner. The CARES System starts when a person seeks crisis services (ACCESS), first attempting to prevent homelessness when possible through connection with mainstream and prevention resources. If homelessness cannot be prevented, persons are prioritized for emergency shelter and supportive housing programs based on vulnerability, client choice, and program openings and eligibility (ASSESSMENT/ASSIGNMENT). The most vulnerable households are assisted with nav-

igation services. Those offered supportive housing are assisted with identifying and working on goals to obtaining and retaining stable housing (STABILIZATION).

A centralized and coordinated system allows us to have current data on the specific needs and characteristics of those experiencing homelessness or at imminent risk of homelessness. This data is valuable for system planning and analysis; including distribution of resources (to agencies and households seeking services), measuring effectiveness of services and programs, equity analysis, and identification of trends and current housing needs by type and population. Recently, both CoCs committed to transitioning how data is entered into Homeless Management Information System (HMIS) to improve data accuracy and usability.

PROGRAMS AVAILABLE

This section includes an inventory of shelter, transitional housing, rapid re-housing, permanent supportive housing, street outreach, and other homeless support services available for individuals experiencing homelessness in the FM Metro along with an estimated breakdown of funding sources for each type of homeless services.

These estimates are based on program self-reporting which was available at the time of publication. This may not be a comprehensive breakdown of all funding sources.

Cass County, Project Type	Federal Funding (ESG, CoC, etc.)	State Funding	Local Funding	Totals	2019 Total Beds
Shelter	$129,833	$185,500	$301,000	$616,333	210
Transitional Housing	$96,396	$0	$40,000	$136,396	36
Rapid Re-Housing	$18,000	$22,000	$286,813	$326,813	36
Permanent Supportive Housing	$677,376	$0	$18,750	$696,126	168
Street Outreach	$0	$0	$25,000	$25,000	NA
Homeless Supportive Services (including Prevention)	$0	$0	$25,000	$25,000	NA
Total	$921,605	$207,500	$696,563	$1,825,668	450

Clay County, Project Type	Federal Funding (ESG, CoC, etc.)	State Funding	Local Funding	Totals	2019 Total Beds
Shelter	$364,578	$82,284	$288,653	$735,515	74
Transitional Housing	$0	$268,700	$0	$268,700	73
Rapid Re-Housing	$0	$574,776	$44,042	$618,818	79
Permanent Supportive Housing	$841,157	$2,103,741	$0	$2,944,898	457
Street Outreach	$0	$568,306	$0	$568,306	NA
Homeless Supportive Services (including Prevention)	$0	$197,702	$72,500	$270,202	NA
Total	$1,205,735	$3,795,509	$405,195	$5,406,439	683

Definitions for each type of program type:

Shelter:

- Offers temporary shelter (lodging) for homeless households.

Transitional Housing (TH):

- Participants must enter into a lease agreement (sublease or occupancy agreement) for at least one month. Leases must automatically renew upon expiration, except with prior notice by either party, up to a max of 24 months.
- Participants receiving rental assistance may be required to live in a specific structure.
- Support services must be available during entire participation in TH.

Rapid Re-Housing (RRH):

- Provides short-term to medium-term assistance (up to 24 months).
- Lease between households and landlord.
- Household's able to select their unit.
- Providers can restrict max length of financial assistance but not length of time in unit.
- Support services must be offered during entire participation in RRH.

Permanent Supportive Housing (PSH):

- Long-term housing.
- Homeless households with a member who has a disability.
- Support services provided that are designed to meet the needs of participants.

Other Permanent Housing (PH):

- Long-term housing not otherwise considered PSH or RRH.
- PH Housing with Services provides long-term housing and supportive services for homeless per-

sons but does not limit eligibility to persons with a disability.

- PH Housing Only projects provide long-term housing for homeless persons but does not make supportive services available as part of the project.

PREVENTION/DIVERSION

For the past three years, the Homeless Prevention Project (HPP) has continued to provide client-centered homeless prevention services. The HPP includes CAPLP, SENDCAA, Presentation Partners in Housing, and The Salvation Army. The goal of the HPP is to ensure low-barrier access for prevention services in line with coordinated entry to prevent and end homelessness.

Households experiencing a housing related crisis apply at one access point. The HPP reviews all applications and prioritizes available resources based on vulnerability of the household. Resources are matched to households to provide the minimum assistance necessary for the shortest time possible in order to stabilize a household. The HPP maximizes community resources in order to assist as many households as possible. In addition to housing focused case management, the HPP can provide rent, utility, and security deposit assistance for households experiencing homelessness or likely to become homeless.

In 2019, the HPP provided $556,751 in financial assistance to prevent 544 households from eviction:

Payment Type	Payments
Rent/Mortgage Payments	443
Security Deposit Payments	324
Utility Bill Payments	177

Looking towards the future, the HPP intends to expand services to include diversion. Diversion is a service that guides households to safe and appropriate alternative housing options without utilizing emergency shelters. This ensures shelter beds are available for those who truly have no other option.

HMIS data shows the number of individuals who entered a shelter and/or housing support program from an institution setting, permanent housing, or a doubled-up situation. This is a target population for diversion and in 2019 this includes 1,185 individuals.

Prior Living Arrangements	Total Individuals
Institutional Setting	288
Permanent Housing/Own/Rental	365
Doubled Up (Staying w/ Friends or Family)	532
Total	1,185

The HPP is working closely with shelters, housing providers, supportive services, and funders to ensure an end to homelessness where it already occurs, prevention of homelessness where it is on the verge, and prioritization of services to the most vulnerable households. See the later section "Process Highlight – Moving towards a Homeless Prevention and Diversion Orientation" for more details.

SHELTER ENTRY

In 2019, 2,057 individuals, 9 adult couples without children, and 485 families inquired about seeking shelter at one of the FM Metro's emergency shelters.

Household Type	Numbers
Single Men	1,346
Single Female	710
Single Other	1
Single Female with Children	403
Single Male with Children	21
Married/Couple with children	61
Married/Couple with no children	9
Total Households	2,551

The 485 families include a combined total of 975 children. Of those children, 44% are ages 0-5. Below is the breakdown of age for the children included in these families.

Total Children	Number	Percentage
Age 0-5	430	44.10%
Age 6-12	369	37.80%
Age 13-17	94	9.60%
Age 18+	37	3.80%
Unknown	45	4.60%
Total Children	975	

In total, this was an increase of 394 households (both singles and family units) compared to 2018.

This data is tracked through the Shelter Entry List, which is a list shared by all the emergency shelters in the FM Metro and was designed to get the most vulnerable people experiencing homelessness a shelter bed when spaces become available. Prior to this coordinated process, those in the community who were searching for a shelter bed would have to check each shelter daily to see if there was any availability. This prevented some of the most vulnerable in our community from getting a shelter bed, while those with more resources were able to access shelter.

Of the 2,551 unique households seeking services, 76% only sought shelter once throughout 2019. The remaining households sought shelter multiple times throughout the year resulting in a total of 3,343 duplicated households who sought shelter throughout 2019.

Number of Times Households Sought Shelter	Number of Households	Percentage
Sought Shelter 1 Time	2,541	76.00%
Sought Shelter 2 Time	547	16.40%
Sought Shelter 3 Times	177	5.30%
Sought Shelter 4 Times	59	1.80%
Sought Shelter 5 Times	14	0.40%
Sought Shelter 6 Times	4	0.10%
Sought Shelter 7 Times	1	0.00%
Total Duplicated Households Who Sought Shelter in 2019	3,343	

Of those seeking shelter, 953 households or 28.5% were able to receive services and a shelter bed. Only 27 households were diverted, or able to find an alternative place to stay rather than entering an emergency shelter. As of the last two weeks in 2019, there were 86 individuals and 21 families still seeking a shelter bed. The remaining households have dropped off the Shelter Bed List either because shelter staff were unable to contact them, or they were no longer in need of a shelter bed.

As part of the coordinated entry process, households seeking shelter are screened for vulnerabilities and needs. Of those households who sought shelter in 2019:

- 41% self-reported criteria that classifies the household as chronically homeless
- 35% self-reported having a disabling condition
- 21% self-reported a history of domestic violence
- Of those with a history of domestic violence, 24% experienced violence within the last 30 days

COORDINATED ASSESSMENT

Households who present as homeless are assessed for appropriate homeless interventions to assist with their current crises. The tool used to assist with assessing those who are homeless is the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). A VI-SPDAT is a survey administered to individuals who meet United States Department of Housing and Urban Development's (HUD) definition of homeless. Under the HUD definition, a person is homeless if they are living in a place not meant for habitation, in an emergency shelter, in transitional housing, or exiting an institution where they currently reside and were homeless before entering. Individuals can also complete a VI-SPDAT if they do not meet these definitions but are fleeing domestic violence, are a veteran, or youth. The VI-SPDAT is used to determine risk and assist with the prioritization of services for individuals who are experiencing homelessness. There are also specific VI-SPDAT tools utilized for families with children and single youth.

Once an assessment is complete and it is identified which housing program is appropriate, individuals and families are placed on the HMIS Priority List to await a housing program opening. The following chart is the breakdown of the Cass County, ND, and Clay County, MN, list as of the end of 2019.

Household Type	Cass County, ND	Clay County, MN	Totals
Singles: Adults without Children	200	437	637
Youth Singles: Age 18-24 without Children	31	41	72
Families: Adults with Children	60	118	178
Youth Families: Youth with Children	7	19	26
Totals	298	615	913

This data was collected in HMIS, and both North Dakota and Minnesota have a coordinated assessment report which collects these assessment referrals. Due to protection regulation, Domestic Violence providers are unable to use HMIS. YWCA of Cass-Clay (YWCA) is the FM Metro's Domestic Violence emergency shelter provider. The data provided by YWCA from a separate report was integrated with these numbers.

From this list we can see there are more families identified and assessed in Clay County, MN. This may be due to Minnesota having additional homeless programs which consider individuals who are doubled up as homeless. Since Minnesota assesses those who are doubled up and because families are more likely to be in these situations, this may explain why there are more families in Clay County, MN. North Dakota does not have any programs for doubled up households; therefore, these individuals are not assessed in North Dakota.

Below is the breakdown of the Priority List at the end of 2019 where housing intervention was recommended for those who were assessed.

- Those who are recommended for PSH (Permanent Supportive Housing programs) would best be assisted with non-time limited, permanent support or a housing first program.
- Households who were assessed as needing TH/RRH (Transitional Housing or Rapid Rehousing programs) would best be assisted with a program that offers more temporary assistance including rental assistance and case management for around 3-6 months, up to maximum of 2 years.
- The housing assessment also determines if a household would be more appropriate for mainstream services to assist with their housing crisis rather than a housing intervention program. These households would be referred to SNAP, MFIP, Section 8, or other programs not designated for individuals experiencing homeless exclusively.

Cass County, ND Breakdown	Adult Head of Household	Youth Head of Household	Total
PSH Single	159	21	180
PSH Family	48	6	54
TH/RRH Single	41	9	50
TH/RRH Family	16	0	16
Total	264	36	300

Clay County, MN Breakdown	Adult Head of Household	Youth Head of Household	Total
PSH Single	234	18	252
PSH Family	81	12	93
TH/RRH Single	180	17	197
TH/RRH Family	31	7	38
Total	526	54	580

COORDINATED ENTRY

When a housing provider has an opening in a program, they will request a referral of a family or individual on the Priority List. The Systems Specialist, who is employed by the FM Coalition to End Homelessness, is responsible for making these referrals and maintaining the Priority List for the FM Metro. The Systems Specialist accepts requests and pulls referrals from the Priority List, guided by the program's eligibility as well as the Prioritization Policies from CARES. The referrals are taken from the list and given to the housing provider. The housing provider then contacts the household and offers them entry into the housing program.

The West Central CoC recently conducted a major data clean-up effort that resulted in a significant decrease in the number of persons on our Priority List. Having accurate data is essential to CoC planning and helps ensure clients are served in a more rapid manner. The North Dakota CoC will conduct a similar process in June 2020.

The West Central MN CoC was recently awarded funding from HUD that will allow for the expansion of Coordinated Entry data management and training. This role will help assure the CoC is able to ensure data remains accurate and current, as well as provide a more accurate understanding of the demand for homeless services at a more detailed level. This position is targeted to start July 1, 2020.

Referrals provided for Cass County Housing Providers:

Household Type	Referrals Reports Processed	Number of Openings
Single	12	50
Single Youth	8	12
Family	16	46
Family Youth	4	5
Total	40	113

Referrals provided for Clay County Housing Providers:

Household Type	Referrals Reports Processed	Number of Openings
Single	18	37
Single Youth	0	0
Family	15	46
Family Youth	1	1
Total	34	84

EQUITY OF OUR SYSTEM

As mentioned in the demographic overview of those receiving services throughout 2019, homelessness disproportionately impacts people of color and those who identify as Hispanic. Equity in our system is something we are beginning to focus on as a community, really looking into the parts of our system that may be causing individuals and families of color barriers to receiving services to help best resolve their housing crisis and current episode of homelessness.

The West Central CoC conducted an Equity Review in August of 2019. For more details on how this study was conducted or key findings, visit:
https://www.homelesstohoused.com/homeless-information-data

Overall, this study found for individuals experiencing homelessness in West Central MN (including Clay County, MN):

- Persons of color had a disproportionately lower number of entries into transitional and permanent housing.
- Race played little role in who got into shelter.
- Overall, the likelihood of a positive or negative leave from a homeless program does not appear to be related to the following variables: race, ethnicity, or gender.
- Persons who have experienced domestic violence are statistically likely to experience a more positive leave.
- Persons over age 50 are statistically more likely to experience a negative leave.
- Native Americans/Alaskans have a slightly higher likelihood of returning to homelessness.

Additionally, the North Dakota CoC conducted an Equity Review as well in early 2020. At the time this report was published, this review was not publicly available. In next year's report we hope to have better equity data specific to the FM Metro, as we see this as an important measure of the success of our system.

PRESSURE ON OUR SYSTEM

This report includes an overview of each part of the CARES System and our community's response to ending homelessness. In order to achieve this ambitious goal, each part of our system and each partner needs to focus on reducing the number of individuals entering our system and effectively serving those in our system to prevent them from returning unnecessarily.

To judge our progress on this, we need to look at our system's flow. In 2019, there were 2,591 individuals who entered into services or entered our system. This is our system's inflow. During the same time, there were 2,166 leavers or individuals who exited from services or our system. This is our system's outflow.

Over the past three years, with access to better data for our community, we have seen the trend of more entries than exits.

Year	Inflow (Entries)	Outflow (Exits)	System Flow
2017	2,249	2,056	+ 193
2018	2,517	2,118	+ 399
2019	2,591	2,166	+ 425

This means while more individuals and families are exiting homelessness, an even greater number are entering homelessness.

EXIT DESTINATION

One vital data point the CoCs and FM Coalition to End Homelessness utilize to monitor project and system performance is exit destination of clients leaving services. The goal is to increase the percentage of individuals who leave homeless programs (street outreach, emergency shelter, transitional housing, rapid re-housing, or permanent housing) and exit to positive destinations versus temporary destinations, institutional settings, or other destinations.

While the CoCs track outcomes by program type (see the next section for more details and more system metrics), listed below are the 2019 cumulative outcomes for all program types operating in Cass and Clay counties, as well as the definitions of each destination category.

This first graph shows all exit destinations for all client populations. We would like to note that outcomes for individuals exiting permanent housing are typically much higher than those exiting shelter or outreach, which lead to the average shown below.

Exit Destination - All Clients	Total	Percentage
Permanent Destinations	716	33%
Temporary Destinations	290	13%
Institutional Settings	72	3%
Other Destinations	63	3%
Client Doesn't Know/Refused	347	16%
Data Not Collected	678	31%
Total Individuals	2,166	

Below are the exit destinations for families who exited from services in 2019. There is a significant increase in the percentage of households who exit to a permanent destination. We attribute this to the larger number of singles in outreach and emergency shelter. In shelter, singles are often more likely to leave without notifying staff of their plans after exit or declining to complete an exit interview, account-

ing for the high percentage of Data Not Collected and Client Doesn't Know/Refused seen in the chart above.

Exit Destination - Families	Total	Percentage
Permanent Destinations	441	72%
Temporary Destinations	83	14%
Institutional Settings	16	3%
Other Destinations	7	1%
Client Doesn't Know/Refused	0	0%
Data Not Collected	64	10%
Total Individuals	611	

With youth exiting services, there is an increase in the percentage of youth exiting into a temporary destination. This is mainly as youth exit services to stay or live with family or friends on a temporary basis. This is not uncommon for youth in general, as this is a very transitional period in most people's lives.

Exit Destination - Youth	Total	Percentage
Permanent Destinations	70	30%
Temporary Destinations	74	32%
Institutional Settings	16	7%
Other Destinations	6	3%
Client Doesn't Know/Refused	24	10%
Data Not Collected	43	18%
Total Individuals	233	

Exit destination definitions:

- **Permanent Destinations** include houses or apartments that are owned or rented by clients with or without any form of subsidy, rental by clients in a public housing unit, permanent supportive housing programs for formerly homeless persons, or living with family or friends on a permanent basis.
- **Temporary Destinations** include emergency shelter, transitional housing programs for homeless persons, hotel or motel, place not meant for habitation (a vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside), or living with family or friends on a temporary basis.
- **Institutional Settings** include foster care homes or group home, psychiatric hospital or other psychiatric facility, substance abuse treatment facility or detox center, hospital or other residential non-psychiatric medical facility, jail, prison, juvenile detention facility, or long-term care facility or nursing home.

- **Other Destinations** include residential project or halfway house with no homeless criteria, deceased, or other.

OUTCOME REPORTS

HUD, with the updated McKinney-Vento Homeless Assistance Act (the Act), views the local homeless response as a coordinated system as opposed to homeless programs and funding sources that operate independently in a community. To facilitate this perspective, the Act now requires communities to measure their performance as a system, in addition to analyzing performance by specific projects or project types.

The intent is for CoCs to regularly measure their progress in meeting the needs of people experiencing homelessness in their community and to report this progress to HUD. Since 2015, CoCs submit their Performance Measures to HUD annually. These include:

1. Length of Time Homeless
2. Number of persons returning to homelessness once housed
3. Number of Total Homeless
4. Change in income (earned and total income)
5. Number of New persons entering homelessness
6. Number of persons retaining permanent housing or exiting to permanent housing

This data is only available for the entire CoC compared to the rest of the report which is specific for the FM Metro. At this point, we are unable to pull these metrics for local communities.

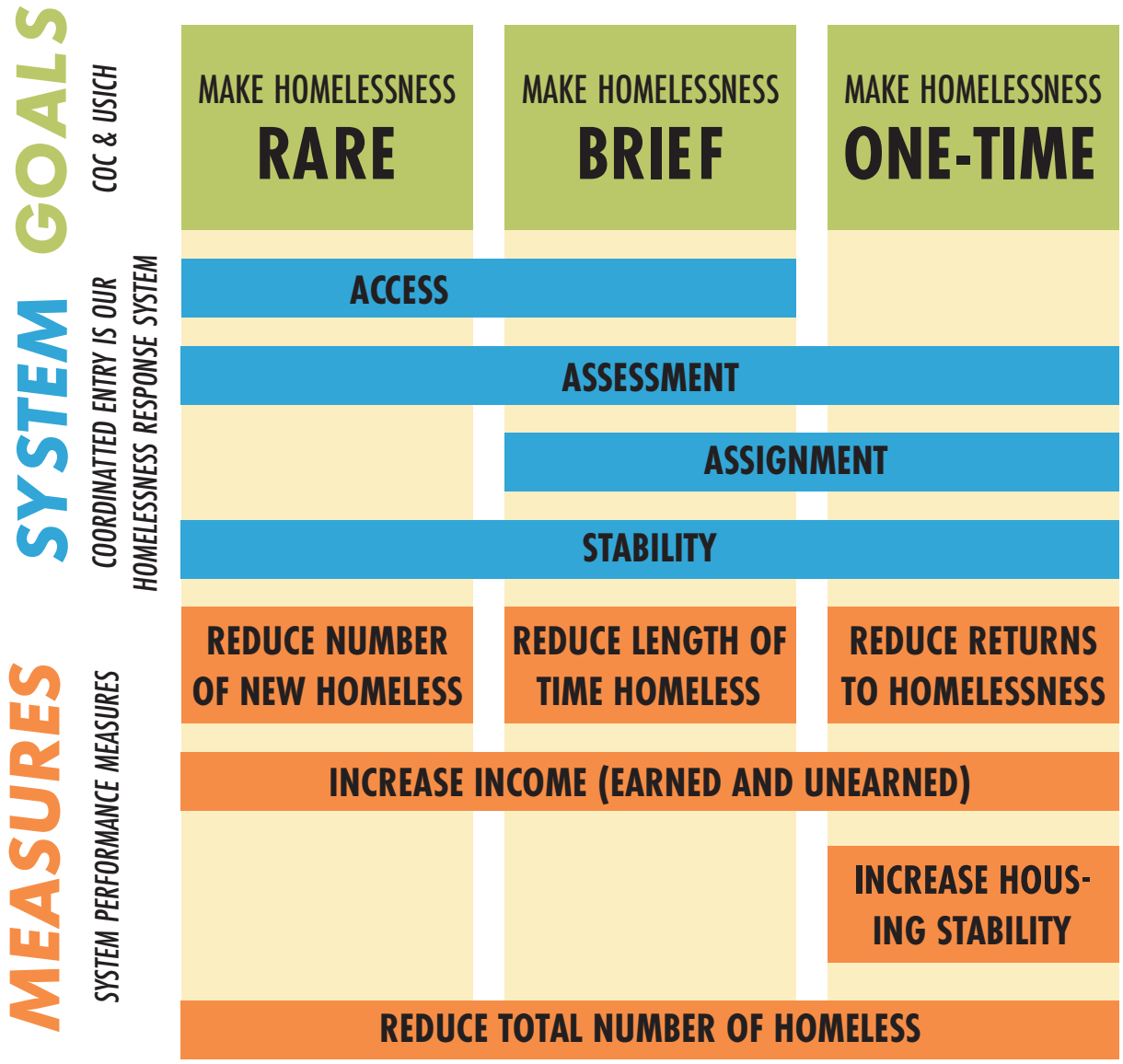


North Dakota CoC

Measures	2015 Baseline Performance	2016 Performance	2017 Performance	2018 Performance	2019 Performance
1. Length of time homeless	205 days ES	**350 days ES**	**405 days ES**	71 days ES	55 days ES
	192 days ES + TH	**360 days ES + TH**	339 days ES + TH	81 days ES + TH	71 days ES + TH
2. Number of persons returning to homelessness once housed	11% in PH in 2 years	**23% in PH in 2 years**	18% in PH in 2 years	14% in PH in 2 years	12% in PH in 2 years
	18% Total in 2 years	18% Total in 2 years	18% in PH in 2 years	**25% Total in 2 years**	20% Total in 2 years
3. Number of total homeless	3,650 HMIS	3,477 HMIS	3,057 HMIS	2,547 HMIS	**3,500 HMIS**
	1,305 PIT	923 PIT	**1,089 PIT**	542 PIT	**557 PIT**
4. Change in income	18% Stayers	20% Stayers	23% Stayers	31% Stayers	42% Stayers
	25% Leavers	25% Leavers	37% Leavers	**26% Leavers**	38% Leavers
5. Number of new persons entering homelessness	2,790	2,184	2,059	**2,066**	1,566
6. Number of persons re-taining permanent housing or exiting to perm. housing	32% All	32% All	**29% All**	34% All	39% All
	87% PH	88% PH	99% PH	**94% PH**	**90% PH**

West Central Minnesota CoC

Measures	2015 Baseline Performance	2016 Performance	2017 Performance	2018 Performance	2019 Performance
1. Length of time homeless	36 days ES	36 days ES	34 days ES	**44 days ES**	37 days ES
	72 days ES + TH	**78 days ES + TH**	**83 days ES + TH**	**112 days ES + TH**	**120 days ES + TH**
2. Number of persons returning to homelessness once housed	8% in PH in 2 years	6% in PH in 2 years	6% in PH in 2 years	5% in PH in 2 years	5% in PH in 2 years
	6% Total in 2 years	6% Total in 2 years	**8% Total in 2 years**	8% Total in 2 years	8% Total in 2 years
3. Number of total homeless	1,220 HMIS	1,215 HMIS	1,047 HMIS	938 HMIS	**978 HMIS**
	242 PIT	211 PIT	**215 PIT**	**246 PIT**	216 PIT
4. Change in income	35% Stayers	41% Stayers	**40% Stayers**	45% Stayers	**40% Stayers**
	50% Leavers	**42% Leavers**	47% Leavers	50% Leavers	64% Leavers
5. Number of new persons entering homelessness	881	**1,081**	927	824	**985**
6. Number of persons re-taining permanent housing or exiting to perm. housing	54% All	**53% All**	**43% All**	**40% All**	**38% All**
	91% PH	91% PH	94% PH	**92% PH**	95% PH



Ultimately, to achieve our community's goals of making homelessness rare, brief, and one-time, we need to monitor our homeless response system through these system performance measures.

Data Highlight: Housing Navigation cost savings from reduced use of costly community services pre- and post-housing

In 2015, United Way of Cass-Clay, in conjunction with members of the FM Coalition to End Homelessness, convened a Design Team of dedicated professionals with a wealth of experience and knowledge spanning nearly 200 years from multiple areas of homeless services. Over the course of three half-day meetings using a consensus model of decision making, the Design Team assessed and developed a Project Summary according to needs based on demographic and geographic populations. Valuing a high level of collaboration and transparency, the Design Team distributed meeting notes and solicited feedback via survey from collaborative stakeholders throughout the process.

This process resulted in a pilot where three new client-centered Housing Navigators would set to work on creating holistic links between existing resources and case management, thus closing gaps and removing barriers in order to achieve housing stability. The goal of this project is to create a new culture of service delivery and enhance collaboration and partnerships among homeless service providers, rooted in the Housing First Philosophy, a proven method of ending all types of homelessness, which offers individuals and families experiencing homelessness immediate access to permanent affordable or supportive housing with a low threshold for entry.

In 2016, Presentation Partners in Housing was selected as the agency to launch this pilot and hired three Housing Navigators. Since the program's inception, Presentation Partners in Housing has hired an additional two Housing Navigators.

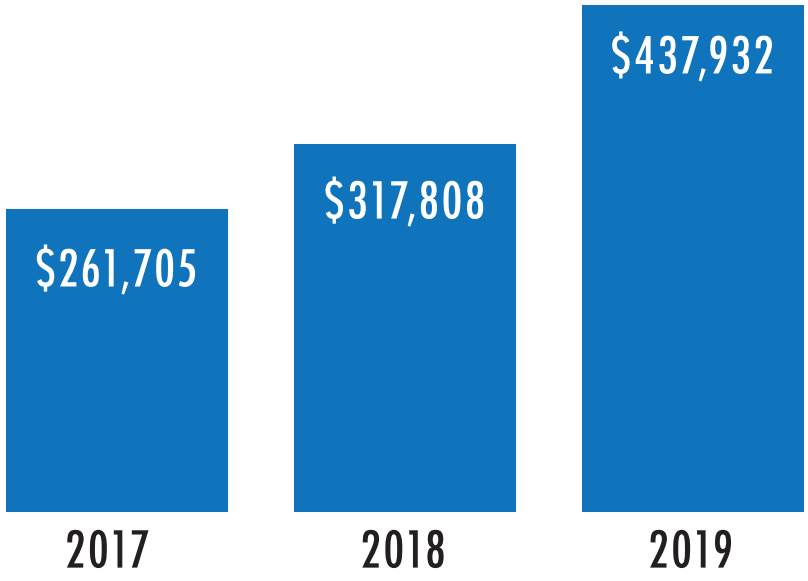
In 2017, after the first complete year of services, 23 active Housing Navigation Program participants were able to attain housing, with 80% stably housed for at least 6 months. Additionally, 20 participants had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services, such as detox admissions, ambulance transports, jail time, emergency room visits, and emergency shelter stays. These 20 participants reduced the usage of these costly services for an estimated cost savings to the community of **$261,705**.

Each of the 20 participants, whose personal data was collected as part of this program, voluntarily agreed to disclose their usage of these community services both while participating in the program and prior to being housed. To calculate the estimated cost savings, actual usage of each community service by each individual participant was collected and compared to the average annual usage of these same services by the same individual participant while homeless in our community.

In 2018, 36 active Housing Navigation Program participants were able to attain housing, with 88% stably housed for at least 6 months. Again, there were 20 participants who had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services. These participants reduced the usage of these costly services for an estimated cost savings to the community of **$317,808**.

In 2019, 47 active Housing Navigation Program participants were able to attain housing, with 100% stably housed for at least 6 months. There were 24 participants who had been enrolled in the program for at least 12 months and had sufficient data to compare their pre- and post-housing usage of costly community services. These participants reduced the usage of these costly services for an estimated cost savings to the community of **$437,932**.

Over the past three years of this program, there has been a combined cost savings estimated at **$1,017,445** for our local community!



THE COST SAVINGS OF HOUSING

Process Highlight:
Moving towards a Homeless Prevention and Diversion Orientation

Historically, community responses to homelessness have focused primarily on addressing the needs of those who have already lost their housing – and our community has been no different. This model has led to communities 'managing' homelessness and, as a result, 'institutionalized' the homeless response system. An effective homeless response will always include providing emergency services and moving people into housing with appropriate supports as rapidly as possible. However, there is a crucial third component to an effective response: homeless prevention and shelter diversion. This third piece has often been under-emphasized and under-resourced in many communities including ours.

Following the lead of exciting new research and evidence-based approaches from communities across the nation, the FM Metro is shifting to a comprehensive, community-based preventative approach to ending homelessness. In designing the local prevention and diversion approach, the FM Metro proactively sought training and guidance from nationally recognized industry experts like OrgCode and the National Alliance to End Homelessness. Additionally, compassionate local providers and incredibly resilient and honest persons with lived experience have continually provided influence and direction on the design of a more robust prevention and diversion system.

No single agency or program can prevent and/or end homelessness. Success of a robust prevention and diversion system requires multi-agency commitment with key collaborations across the local CoCs including social services, public schools, the VA, youth providers, domestic violence providers, mental health and recovery programs, emergency shelters, and many more.

Beginning January 1, 2021, "211" through FirstLink will serve as the primary first point of contact for all households experiencing a housing crisis. Those currently experiencing homelessness and those most at-risk of homelessness will be referred to the Homeless Prevention and Diversion Program at Presentation Partners in Housing (PPiH). Following this referral, a highly trained Homeless Prevention and Diversion Specialist from PPiH will conduct a screening and assessment and work with each household to determine what resources and supports are needed to rapidly resolve their unique housing crisis. The goal is to immediately connect the household to resources as well as develop a housing stability plan that meets their individualized needs. Light touch case management and advocacy are provided along with supports from CAPLP, PPiH, SENDCAA, The Salvation Army, and other important mainstream resources to end homelessness where it occurs and prevent homelessness when it is on the verge. The end outcome is that all households remain housed or have a path to stable housing!

Erin Wixsten from OrgCode spent three days in the FM Metro in February 2020 training local providers and community stakeholders on the framework of successful prevention and diversion programs, in

partnership with FM Coalition to End Homelessness and United Way of Cass-Clay. Erin shared research and examples of communities that have been able to prevent shelter entry for up to 80% of households experiencing a housing crisis, CoCs that were able to close an emergency shelter for good, and high rates of evictions that were prevented as a result of a robust response to homelessness. Erin further stated there is "literally no way" these interventions do not work, and many communities that now embrace these approaches experience guilt that they did not implement prevention and diversion strategies sooner.

The FM Metro is ready to shift to a prevention and diversion orientation and approach to ending homelessness. Support from local city officials, CoCs, FM Coalition to End Homelessness, United Way of Cass-Clay, other local funders, service providers, and consumers have aligned in order to launch this project. We look forward to sharing data and outcomes from the launch of the Homeless Prevention and Diversion Program as part of next year's State of Homelessness Report.



WHAT DOES ENDING HOMELESSNESS LOOK LIKE?

Reasons people find themselves without a home will always exist. But with enough affordable housing in our community, increased employment and income, equity in services and programs, and coordinated service delivery systems, we can make homelessness rare, brief, and one-time for individuals and families in our community—virtually ending long-term homelessness. How do we do that? Our Coalition of service providers, funders, and community members advances our mission through advocacy, education, and collaboration. Our Coalition stands strong that this vision can become a reality.

WHAT IS NEXT FOR OUR COMMUNITY?



Looking to the remainder of 2020 and beyond, the FM Coalition has declared a priority for ending homelessness for youth and families with children. This data based priority was made primarily because it addresses the needs of some of the most vulnerable members of our community while doing the important upstream work needed to prevent future generations of chronic homelessness. We believe it will also work to address other concerns, such as the persistent fact that people of color experience homelessness disproportionate to the rest of the population. Demographic data of individuals experiencing homelessness suggest that early interventions in the lives of children of color will reduce future homelessness in adulthood.

This does not mean we are not working to address all types of homelessness, but making such priorities is how we make the incremental progress to reach audacious goals and accomplish systemic change. 2020–2021 planning and implementation include:

- Leveraging funding support of United Way Cass-Clay, which shares an emphasis on ending homelessness for youth and families with children.
- Create a campaign to increase public awareness about homelessness and efforts being taken to end homelessness.
- Increase awareness of homeless data and issues for local elected leaders as part of a comprehensive policy and funding strategy to advance our work.
- Developing and implementing comprehensive diversion and prevention systems and strategies.
- Developing specific strategies concerning youth and child homelessness.
- Renewed focus on developing strategies to address larger societal and systemic issues such as race, income inequality, and food insecurity.
- Strengthening partnerships with County and State partners in North Dakota and Minnesota.

Our Coalition remains committed to aligning resources and programs to create opportunities for people to thrive so that everyone in Fargo-Dilworth-Moorhead-West Fargo has a safe place to call home.

APPENDIX 1: DATA SOURCES, REFERENCES, AND RESOURCES

Main data sources as they appear:

Homeless Management Information System (HMIS) is the database that many state and federal funders require to be utilized by all homeless service providing agencies and programs.

Fargo-Moorhead Homeless Everyone Counts Survey (Everyone Counts Survey) is based on data provided by the FM Coalition to End Homelessness collected through face-to-face interviews and recorded into an online medium. A total of 243 individuals were surveyed on October 25, 2018, in the FM Metro.

United States Census Bureau Data is the leading source of quality data about the nation's people and economy.

Community Action Needs Assessments were completed by CAPLP and SENDCAA, respectively, in the form of focus groups and interviews. In Clay County, MN, the survey for people currently seeking housing services was administered to anyone that presented to CAPLP offices between the predetermined dates of October 22, 2018, to November 2, 2018. A total of 34 surveys were collected. In Cass County, ND, the survey was conducted for three weeks for anyone who presented at SENDCAA from March 5, 2019, to March 26, 2019. 40 clients applying for deposit or rent assistance completed the needs assessment survey over a three-week time span in March of 2019.

Shelter Entry List the list shared by all the shelters in the FM Metro designed to get the most vulnerable people experiencing homelessness a shelter bed when shelter bed spaces become available.

Coordinated Entry Priority List the active list of households who present as homeless who have been assessed for appropriate homeless interventions utilizing the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SDPAT) to await a housing program opening.

West Central Minnesota CoC Equity Review a summary of three separate equity reviews compiled by the West Central Minnesota CoC.

References as they appear:

United States Census Bureau, ACS Demographics and Housing Estimates, 2018: ACS 1-Year Estimates Data Profiles. Retrieved from https://data.census.gov/cedsci/table?g=310M400US22020&tid=ACSDP1Y2018.DP05&hidePreview=false&vintage=2018&layer=VT_2018_310_M4_PY_D1&cid=DP05_0001E

United States Census Bureau, Financial Characteristics, 2018: ACS 5-Year Estimates Subject Tables. Retrieved from https://data.census.gov/cedsci/table?g=310M400US22020&tid=ACSST5Y2018.S2503&t=Housing&vintage=2018&hidePreview=false&layer=VT_2018_310_M4_PY_D1&cid=DP04_0001E

Safe Housing Partnership, Understanding the Intersections. Retrieved from https://safehousingpartnerships.org/intersection

Office of the Assistant Secretary for Planning and Evaluation, 2019 Poverty Guidelines. Retrieved from https://aspe.hhs.gov/2019-poverty-guidelines

Resources as they appear:

Cass County, ND Human Services Website: https://www.casscountynd.gov/our-county/human-services/economic-assistance-division

Clay County, MN Social Services Website: https://claycountymn.gov/207/Financial-Assistance-Services

The National Low Income Housing Coalition's "Out of Reach" report https://reports.nlihc.org/oor

Minnesota Housing Partnership "State of the State's Housing" report for Clay County: https://www.mhponline.org/images/stories/images/research/coprofs/2019/Clay.pdf

West Central Minnesota CoC Equity Review: https://www.homelesstohoused.com/homeless-information-data

McKinney-Vento Homeless Assistance Act: https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/

APPENDIX 2: KEY TERMS AND DEFINITIONS

For the purpose of this report, **homeless** refers to people who lack a fixed, regular, and adequate night-time residence, including those whose residence is a shelter or transitional housing program, those living in unstable and non-permanent situations, and those forced to stay on a temporary basis with a family member because they have no other place to stay, specifically:

- **Sheltered** includes individuals who are sheltered in emergency shelter and transitional housing programs.
- **Unsheltered** includes individuals who are staying in a place that is not a regular or permanent place to stay, such as outdoors, in a car, vacant building, or a place of business.
- **Doubled up** includes individuals who are staying or living with a friend or family member on a temporary basis because they have nowhere else to go.

Chronically homeless includes individuals who meet all of the following:

- Currently experiencing homelessness,
- Been homeless for at least one year during the current episode OR homeless for less than one year in the current episode, but homeless at least four times in the previous three years, and
- Disabled (those who have a physical, mental, or other health condition that limits the kind of work they can do OR those who have a physical, mental, or other health condition that makes it hard for them to bathe, eat, get dressed, get in and out of bed or chair, or get around by themselves).

Continuum of Care is a regional planning body of stakeholders designed to promote a shared commitment to the goal of ending homelessness.

For the purpose of this report, **exits out of homelessness** are defined by the individuals' destination once they leave services:

- **Permanent Destinations** include houses or apartments that are owned or rented by clients with or without any form of subsidy, rental by clients in a public housing unit, permanent supportive housing programs for formerly homeless persons, or living with family or friends on a permanent basis.
- **Temporary Destinations** include emergency shelter, transitional housing programs for homeless persons, hotel or motel, place not meant for habitation (a vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside), or living with family or friends on a temporary basis.

- **Institutional Settings** include foster care homes or group home, psychiatric hospital or other psychiatric facility, substance abuse treatment facility or detox center, hospital or other residential non-psychiatric medical facility, jail, prison, juvenile detention facility, or long-term care facility or nursing home.
- **Other Destinations** include residential project or halfway house with no homeless criteria, deceased, or other.

Individuals with a disability of long duration are those who have any disability that is ongoing, continued, or for an indefinite duration.

Individuals with a chronic health condition are those who have been diagnosed with a chronic health condition, physical disability, or developmental disability.

Individuals with a mental health problem are those who have been diagnosed with a mental health condition or disorder.

Individuals with a substance abuse disorder are those who have an addiction to alcohol, drugs, or both types of substances.

Youth Homelessness includes young adults 24 years old or younger, living without parents or guardians and may be parenting themselves, who lack a fixed, regular, and adequate night-time residence, including those whose residence is a shelter or transitional housing program, those living in unstable and non-permanent situations, and those forced to stay on a temporary basis with a family member because they have no other place to stay.

Project Type Definitions

Shelter:

- Offers temporary shelter (lodging) for homeless households.

Transitional Housing (TH):

- Participants must enter into a lease agreement (sublease or occupancy agreement) for at least one month. Leases must automatically renew upon expiration, except with prior notice by either party, up to a max of 24 months.
- Participants receiving rental assistance may be required to live in a specific structure
- Support services must be available during entire participation in TH.

Rapid Re-Housing (RRH):

- Provides short-term to medium-term assistance (up to 24 months).
- Lease between household and landlord.
- Household's able to select their unit.
- Providers can restrict max length of financial assistance but not length of time in unit.
- Support services must be offered during entire participation in RRH.

Permanent Supportive Housing (PSH):

- Long-term housing.
- Homeless household with a member who has a disability.
- Support services provided that are designed to meet the needs of participants.

Other Permanent Housing (PH)

- Long-term housing not otherwise considered PSH or RRH.
- PH Housing with Services provides long-term housing and supportive services for homeless persons but does not limit eligibility to persons with a disability.
- PH Housing Only projects provide long-term housing for homeless persons but does not make supportive services available as part of the project.

APPENDIX 3: FM COALITION TO END HOMELESSNESS APPROVED STATEMENT ON ENDING HOMELESSNESS FOR YOUTH AND FAMILIES

To: Members & Partners of the FM Coalition to End Homelessness
From: Cody J. Schuler, Executive Director
Date: August 8, 2019
Re: Approved Statement on Ending Homelessness for Youth and Families

A key component of pursuing strategies to end homelessness in the Fargo-Moorhead Metro area is to identify particular populations where resources can be aligned and timelines established towards a goal of "functional zero" where systemically homelessness is rare, brief, and one-time. At the May 28, 2019 meeting of the general membership of the Coalition, a discussion was held about consideration of a focus population following the successes of previous emphasis on ending Veteran homelessness.

On July 18, 2019 the Board of Directors of the FM Coalition to End Homelessness approved a proposal to create a statement to be distributed to the members of the Coalition to End Homelessness designating a priority on ending homelessness for youth and families with children without distraction from efforts to end homelessness for other populations. The statement and key rational was reviewed (with no action) at the July 23, 2019 meeting of the general membership of the Coalition. **The statement was approved by vote of the membership of the FM Coalition via electronic ballot that closed August 7, 2019.**

Any timelines, strategies, and goals will be identified in the future as the Coalition approves strategies.

Ending Homelessness for Youth and Families with Children Statement

The Fargo-Moorhead Coalition to End Homelessness designates a priority for developing strategies for ending youth homelessness and homelessness among families with children in the Fargo-Moorhead Metro area. This priority includes aligning existing community resources and advocating for new resources. By emphasizing homelessness impacting youth and children, the FM Coalition aims to address root causes, break cycles of poverty, and end future instances of homelessness. While prioritizing youth and families with children, the FM Coalition pledges continued vigilance in seeking strategies and aligning resources for all populations experiencing homelessness, including chronic, veteran, and those fleeing domestic violence.

This designation stands until the FM Coalition states otherwise.

Key rationale for this designation:

- Addressing youth and child homelessness strategically addresses future chronic homelessness.
- Adult homelessness is often rooted in youth/child homelessness and childhood trauma.
- Ending homeless for youth/children is achievable in the near future for our community.
- Placing a priority on this population locally is in line with priorities set by Minnesota's Action
- Plan and the US Interagency Council on Homelessness (USICH).
- Improved services for these populations benefits all populations.
- Public awareness concerning these populations raises awareness about the wider issue of homelessness.
- Prioritizing these populations will not reduce urgency or efforts towards ending homelessness for other populations.

THANK YOU TO:

The State of Homelessness Task Force for expertly preparing this report

United Way of Cass-Clay for partnering in this report and making homelessness part of their bold community goals

Institute for Community Alliances for assisting with data reporting

Sandwich Club Design for layout and design

FM COALITION TO END HOMELESSNESS

United Way of Cass-Clay



RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a long distance sister of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

Greetings: My name is Carol Sipsock (DPOA) writing this letter in behalf of my sister, Phyllis Teich, who has been a client of CLS Fargo since 1990. Phyllis is 72 years old and has intellectual disability / cognitive issues. Phyllis also has many chronic health conditions(heart and kidney) which are progressing . I am happy to share any medical information if necessary.

CLS services for my sister include(but not limited to) :

1. Total money management. Phyllis is unable to manage her finances, and there would be problems paying her rent/other expenses of having an apartment. This would cause eviction and more expenses to "the system".
2. Assistance in managing health related issues by accompanying Phyllis into the physician offices to aid with communication and executing the care plan. For Phyllis this would mean she would not be taking the appropriate medication/physician visits/costs of additional of Emergency Room/Hospital admissions. There is no immediate family in the area to bridge the gaps.
3. CLS has made it possible for Phyllis to live independently in a safe environment; making sure food, medicine, and other basic necessities are available to Phyllis. Without these services, there could be injury to herself, going without food, medicine etc. because she doesn't understand the impact and magnitude this would have.
4. CLS assisted Phyllis with a "job coach" such that Phyllis could work part time. Without these services, Phyllis would not be able to obtain employment on her own/stay employed her and she would have lost out on additional spending money. COVID/loss of employment/health issues have added more challenges in getting employment. Currently loss of job due to business closing.
5. CLS has also intervened on Phyllis behalf on disputes to stop further escalation. Without CLS there would be legal fees and court costs on "the system".

With the loss of these services, Phyllis would “fall through the cracks”.

Phyllis is a lifelong North Dakota resident. CLS has been a driving force for Phyllis to be able to be a contributing member of society. It would be a travesty to take these services away from her.

Thank you for your attention to this matter. I do live in the Detroit, MI area and would be happy to provide any additional information needed.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Carol Sipsock
520 Newburne Pointe
Bloomfield Hills ,Mi
carolsipsock@aol.com
248-563-5606

8693

SANFORD HEALTH

March 10, 2021

Re: North Dakota Dementia Services Program Funding

Dear Mister/Madam Chair and Members of the Committee,

My name is Lindsay Hines and I am a clinical neuropsychologist practicing at Sanford Health in Fargo, North Dakota. I am engaged in evaluation, diagnosis, and treatment planning with individuals with changes in memory, including Alzheimer's disease and other forms of dementia.

As a clinician, I rely on the North Dakota Dementia Care Services Program (DCSP), including the Alzheimer's Association, to facilitate optimal patient care after the dementia diagnosis is made. The services provided by the DCSP are integral to the health and well-being of North Dakotans with dementia, and their families. The services provided by the Alzheimer's Association have helped my patients to effectively decrease number of hospitalizations amongst individuals with dementia, prolong independent living (i.e. decrease length of time needing state-funded skilled nursing services), and decrease "crisis events," such as those involving police or paramedics to manage dementia-associated behaviors that pose a threat to self or others. It is clear that services provided through adequate North Dakota DCSP funding are associated with decreased state expenses and increased quality of life amongst North Dakotans.

I am writing this letter in support of increased state funding for the North Dakota DCSP. I am requesting that funding be increased, so that the Alzheimer's Association can continue to provide the high quality, necessary aspect of patient care to North Dakotans with dementia, and their families. Please vote yes, in support of the bill requesting increase funding for the DCSP to $1,332,000.

Sincerely,



Lindsay J. Hines, Ph.D.
Neuropsychologist | Sanford Brain and Spine Center, Fargo ND
Clinical Investigator | Sanford Imagenetics
Assistant Professor | University of North Dakota Department of Psychology
Phone: 701-234-4021

Chairman Holmberg & Members of the Committee,

My name is Ty Hegland and I serve as the President/CEO of ShareHouse in Fargo, ND. Since 1975, ShareHouse has been the Upper Midwest's leader in Substance Use Disorder (SUD) and Mental Health services. ShareHouse operates two residential facilities, three outpatient clinics, and employees 145 individuals annually. However today I am going to address you as the volunteer chair of the North Dakota Addiction Treatment Providers coalition, which is the association tasked with representing private SUD providers from across the state.

I stand to respectfully ask for your support of the SUD Voucher and restoration of the full $17,000,000 request by the governor . Behavioral Health providers represent one of one of the most critical sectors of the healthcare continuum. Currently we sit at the crossroads of multiple crises which are plaguing our state including a continued Opioid Epidemic, resurgence of Methamphetamines, and the long-term effects of the COVID-19 Pandemic and the toll it has took on the Mental Health of our region.

The SUD Voucher is one of the most important tools for treating addiction patients in North Dakota in three distinct ways;

1) The voucher helps patients get timely access in settings away from the social and environmental areas that fuel their addiction.
2) The voucher allows for provider choice, which creates competition and ultimately leads to better patient care.
3) The voucher supports clinicians in a sector of healthcare which has been traditionally underfunded, but affects everything.

The SUD Voucher represents one of the best opportunities to serve more patients, while also reducing overhead costs for the State of North Dakota. Where some see an increased line item appropriation, providers see the opportunity dramatically reduced the dollars we spend in corrections and healthcare costs. Studies by the National Institute of Health have show that for every $1.00 spent on SUD services, saves $6.00 in corrections costs and/or $13.00 in healthcare costs. The voucher represents less than 1% of the overall DHS Budget, but as the ability to save the state hundreds of millions of dollars in costs. The voucher is an investment in North Dakota which has the ability provide significant return on investment.

We all know the voucher has had its challenges the past year, but it is still one of the most important tools providers have to treat patients. The timing of the suspension of new patients could not have come at a worst time. Though as an association we've pushed providers to do charity care where possible, every company has their limits. I can tell you anecdotally that places like Prairie St. Johns does over $5,000,000 in charity care alone annually, while places like ShareHouse provide multimillions in charity care annually as well.

SHAREHOUSE
Recovery is possible.

Coming off the House Appropriations process, providers are eager to engage in a robust hearing process, as many of the amendments had no feedback from providers on the ground. Providers respectfully ask for consideration for the following;

1) Restoration of the full $17,000,000 request by the governor. Our patient demand will tell you $12,000,000 for direct care will not be enough.

2) Providers adamantly oppose the 30% cap to residential providers. Not only may it violate the federal Mental Health Parity & Addiction Equity Act, it would it provide less resources for the sickest patients in our state and cause carnage in our communities. These are patients that come from ER's, ICU's, jails, and psychiatric facilities. Without residential care they will die.

3) Providers understand the need to be flexible and creative. Whether it may be studies, potential moratoriums, or grant making processes, we simply ask for caution, since certain proposals have put forth spending 24% of the SUD Voucher appropriation in areas that represent less 10% of the state's population.

With the $17,000,000 governors request, we have an opportunity to get ahead of some of the longstanding Alcoholism issues in our state, as well as combat the concurrent Opioid Crisis and the Mental Health effects of the COVID-19 pandemic. Patients and providers need your support, but we are also here to provide guidance on the voucher as we move forward.

Thank you for your time,



President/CEO
ShareHouse

SHAREHOUSE
Recovery is possible.

Testimony on HB 1012

2021 Legislative Session

March 11th, 2021

Chairman Senator Holmberg, Vice Chair Senator Krebsbach and Members of the Senate Appropriations Committee:

My name is Vicki Peterson, and I am testifying to restore the 15% dollars cut to Family Voices of ND, which has been eliminated from the Department of Human Services in the budget for the Department of Human Services flow-through dollars per request of the Governor's Budget. I am requesting to restore the original dollars also to ND Federation of Families.

I am a Family Consultant for Family Voices of ND. I have been a Family Consultant for nearly 18 years. I first gained knowledge of Family Voices of ND through my son's Early Intervention Experienced Parent, (also a vital program that is having funding eliminated). My son, Aaron has Autism with an Intellectual Disability and chronic health conditions. At the time, my son was non-verbal but did not have a diagnosis yet, and our insurance was denying speech therapy. I was angry, how could they deny a child who was non-verbal, speech therapy. I spoke with Donene, the director of Family Voices of ND, she guided me to the resources I needed, and I got two bonuses, the first was help with insurance covering speech therapy and I had a connection to another parent who also had a child with an intellectual disability and turned out as well a diagnosis of autism which my son soon received. This started my path to help other families as well and I was immensely proud when I was asked to be a part of this most wonderful family, Family Voices of ND. Over these years I know I have helped many families just as I was helped.

Family Voices of ND is the Family-to-Family Health Information Center in ND. We navigate all systems of care, including those families who have children and youth with special health care needs, chronic health conditions and disabilities. All systems of care mean physical health, mental and behavioral health, navigation of health programs and insurance both private and public. We offer a unique component, lived experience. All staff has a unique connection to other families who have children with special needs as we all have children with special needs, or young adults now with special needs. This is essential for making those connections, not only with families but providers as well.

I would like to briefly describe what a referral to Family Voices of ND and specifically to me may look like.

- Referrals come from providers, schools, lead agencies, could be anywhere that had connections to families that have children and youth with special needs.
- I contact the family within 72 hrs. of receiving the referral and I pride myself that I stick to that rule, as families many times are connected to us when the family may be experiencing some crisis.
- I first need to listen to the issue, or crisis, and need. It is extremely important that the family knows I understand that I too have had some of the same experiences.
- There may be financial issues, they may need resources to find programs that will be of support to their child, they may need and most often do, emotional support, the need to speak with another parent that has some same experiences, maybe they lost health insurance, maybe there are family members with mental health issues and might need referrals to programs, maybe a child's school plan is not working and need support. Many times, they need multiple resources to, multiple programs, the care coordination and navigation of systems, many systems.
- Average calls are around 35 to 45 minutes. I must make sure to follow-up and follow-through for families, as they are counting on the support.
- Typically, there will be referrals to programs and or other resources, often there are many referrals and research as well to make sure we are looking for all resources.
- A call may come from a provider who already has a family on a case load but does not know how to connect them to informal or other formal supports.
- We are not a 1 call and done. I have families I have and continue to help navigate systems of care for over many years, as their child becomes a teenager, and teenager becomes a young adult.
- I am there to listen, I am there to navigate, I am there to support.

I would like to share a recent referral. Single Dad, 13yr old son has Acquired Traumatic Brain Injury, Mental Health Issues, Physical Disabilities attributed to the TBI. Currently in desperate need for services, and most of all respite, so he can go to his job to try and support his son. If he goes back full time, he will have income over the limit for almost all programs for his son; maybe education services when he returns to school, he goes to parttime, he will not be able to afford to pay for all the needs his son has and afford living expenses and most of all the respite services

he so desperately needs. The 1915i State Plan Amendment, meet some criteria as he does have a TBI, but cannot meet the income criteria. The son does not meet the ID criteria for another waiver program, then we have another Home and Community Based Waiver but even though he cannot currently walk unassisted, does not seem to meet Nursing Care Level to qualify for this program. This family needs support to make sure the programs that should have covered services for this child are being looked at properly and then searching everywhere for the needed support, formal and informal supports. Families need this support, as they are not able to find the services they need and when there may be one, the access to this service is so daunting, when all you can do as a parent is worry about what will happen to your child without the needed supports.

In ND, the need for Family Support for children and youth with Special Health Care Needs, is more than ever. Many families due to Covid-19, or terrible accidents as mentioned above, or loss of job, or divorce of parents, or finding out your unborn child will have an exceedingly rare disorder requiring enormous medical attention; Family Voices of ND is there to navigate this confusing system of care.

Family Voices of ND helps train many family members to become strong advocates for their children, a voice. We help families with positive communication with the providers. We help providers communicate with families.

You will hear many times throughout this session, about Person- Centered Planning, keeping children and youth from being institutionalized, more focus on home and community-based services, juvenile justice reform, family-centered care. Family Voices of ND is a part of this, we are all about family-centered care. We focus on the family with children with special needs. Wrap-around services must be in place for the families. If the family is not healthy, the child will not be healthy.

You will be hearing testimony on the ND Autism Voucher Program, where the Department of Human Services is eliminating funding for the program entirely and stating dollar will be added to the ND Autism Waiver to cover the waitlist that exists. In the 2013-2014 ND Legislative Session, HB 1038 passed, and the Governor signed a bill to create an autism voucher program that ND advocates came together to bring forward. This program allows person with autism spectrum diagnosis to access funding for an array of services such as assistive technology, respite service, safety equipment, sensory items and more. Eliminating this program will create a new gap, again, for families who have children and youth with autism without access to any other program. Most of these children will be unable to meet the criteria of Institutionalize Level of Care that is required for the ND Autism Waiver. Once again,

the 1915i will also be out of reach for most. The proposed slots that will be opened by moving the dollars from the Autism Voucher to the waiver will not cover the current waitlist and so even if a child would be able to meet the criteria, would be faced with a waitlist, which has been sometimes 2 years in ND. This program can prevent the very topic you are hearing about in this legislative session which is juvenile justice and keep people out of institutions. The Autism Voucher program needs to be amended to serve the families properly instead of allowing dollars you as legislators allocated for this program be moved to areas of the ND Department of Human Services choosing. There are proposed amendments to SB2089, and I hope you take all of those in consideration. I am a former member of the ND Autism Task Force and for all the years I served as an appointed member the dollars for this program have not been utilized to support the families, just that, the support needs to be for the family, as having a child with autism, effects the whole family. The subject of addressing this was shut down many times. Please consider restoring all funding for this very vital program.

Being a part of Family Voices of ND, has changed my life. It has made me a better communicator and better person. I have opportunities to make a difference in the lives of families with children and youth with disabilities and chronic health, because someone made that difference for me and my family. Family Voices of ND is reaching out to the 1 in 5 children in ND that have those special needs.

I am requesting to restore the full funding of dollars that were cut from the Department of Human Services Budget so that we can continue to do what we need to for those families that need us the most, the most vulnerable.

Thank you for your time and consideration.

Vicki L Peterson

Family Voices of ND

Family Consultant

vickiasdc@bis.midco.net

701-258-2237 #293

Testimony
House Bill 1012
Grand Forks Growth and Support Center by Julie Erickson
Senate Appropriations – Hon. Ray Holmberg, Chairman
March 11, 2021

My experience with the developmental disability field over the past 15 years has been unique, challenging at times, and very passion filled. For you to best understand my perspective, I will share the trifold areas of different roles in my life that have shaped this view. First, I am the executive director for a Day Support program in Grand Forks called Grand Forks Growth and Support Center. Secondly, I had the privilege of teaching at the University of North Dakota in the rehabilitation and human services Undergraduate program. Lastly, and what I believe to be my most important role, I have the honor of being the mother to an amazing 14-year-old boy named Ryan.

Ryan is my third child and I knew he was a little bit different from my other children almost immediately after he was born. He did not meet his milestones at the same rate as my other two children and would often learn a skill and then lose that skill such a smiling or sitting up. We started Ryan in the infant development program to start tracking his progress and laying the foundation for services to help him thrive. At seven months old, Ryan began having severe seizures that ranged from 2 to 10 minutes long. There were periods of time where all Ryan did was seizure or sleep. He tried and failed seven different seizure medications before we were sent to Saint Paul Children's Hospital for further help. Ryan underwent a left functional hemispherectomy at the age of 11 months old. As his parents, we were very aware that the removal of the left hemisphere of Ryan's brain would have many impacts on his functioning and skills throughout his whole life. We also knew the other option is that he would probably die from his seizures if we did not choose this surgery. Ryan had two major brain surgeries within a week of each other to remove the tissue that was causing the seizure activity. The surgery was successful but left him with many major deficits. His right peripheral vision field is cut and will never be repaired, he can use his right arm but his hand is not functional to do skills with. He walks and gallops with a limp and an uneven gait pattern. And lastly, since they removed his speech center, Ryan has many challenges with communicating. Intellectually, he functions at about a three or four-year-old level. He can understand anything and everything that people say to him and is able to talk in small phrases that are sometimes hard to understand. He is the most loving, sensitive, caring, and exceptional boy I have ever met. He values the small things in life like his family teachers and those around him and just really likes to be with people. He is in eighth grade at Schroeder Middle School in Grand Forks and is surrounded by a wonderful staff and also has a wonderful medical team. Ryan has received

services through North Dakota Medicaid since he was nine months old. He has been through five brain surgeries, three orthopedic surgeries, months and months of hospital stays filled with uncomfortable tests and procedures. He has been through more hours of therapy than I can count. He is a fighter! He is my why! I tell you about my son Ryan not for your pity or for you to admire me for surviving the tough times that I have been through, but to show you the credibility of my testimony not only as a developmental disabilities provider but as the mother of a child with very severe disabilities.

The skills I gained navigating through the years of raising a special needs child actually was the greatest experience I could have had to become the director of Grand Forks Growth and Support which was formally known as Agassiz Enterprises. Agassiz enterprises was a developmental disability provider that started in the late 1970s. When I took over as their director in 2017, I most definitely had my hands full and many challenges against me. In a nutshell, I took a place that was basically functioning as a bland institution type center. A place that needed tremendous updates to be accessible, ethical, and most of all a place that I would even feel comfortable bringing my son for care someday. This set the bar very high for all employees that worked at our center. After seven weeks as the executive director, we rebranded and changed our business name to begin a new start. I couldn't be more proud of the team that I have and how far we have come in 3 1/2 years. This experience gave me the perspective to know that the disability field still needs so much work and it needs to come from multiple entities who come together to work for the greater good of this community.

I will speak now to what I have seen in the last 3 1/2 years of being a provider of developmental disabilities services. As a standalone day support program our agency relies solely on the funds of Medicaid. We do not get paid for the services if the individuals that we support do not attend day program. During the Covid pandemic, We have faced major financial challenges from the decrease in attendance of those who attend our day program due to obstacles that were outside of our control. We were fortunate to apply and receive the PPP loan funding in April which eventually turned into a grant. This funding however was not enough. Myself and a few other smaller providers gathered and asked for more financial assistance from the state. We were able to Apply and received four separate retainer payments which have helped us maintain our staff and stay open. We have 36 people who attend our day program close to 40 hours a week and there were days in November when we only had nine of these people present for services due to many Covid related reasons. Somehow, we survived 2020 and have started to return back to more of a normal attendance rate in the new year. Although we survived this challenging time, we do not have much left in our reserve fund going

forward and any cuts to developmental disability providers would severely impact us. I fully believe that people should have options for their services in their life. Without smaller providers these options would be taken away. I think it is important to look at a smaller providers as the small town businesses. We have heart, integrity and passion for our work and those we support at our agencies. We are the directors and staff who go above and beyond to make sure that people are receiving the best services that they can. Throughout the Covid pandemic, we had multiple testing events at our agency to decrease Covid risk on our staff and those supported. You could find me, dressed in full PPE climbing in and out of the vehicles to assist, calm, and hold the hands of the individuals we support while they were getting their Covid test.This is just one example of the small provider flavor I was speaking of. North Dakota needs providers with these qualities and if we face more financial strain there may be many of these providers who can no longer keep their doors open.

I would like to talk briefly about why it is so important that the House remedied the proposed $11 million cuts in the area of developmental disabilities would have on the agencies that provide services and those that receive services in the state of North Dakota. As a whole, developmental disability providers struggle to find a workforce that will bring high-quality care to the people that we support. Direct support professional‘s are the biggest group of staff that we struggle to hire and maintain. Although it is a rewarding job at times, it is also a very physical and stressful job. Cuts in our budget would present us with many more challenges when hiring, training and maintaining these employees. With low paid or not enough direct support professional staff, agencies are unable to provide high-quality care! High quality care is the most important thing. I can tell you right now, I struggle as Ryan’s mother to think about it would be like to put him in a residential facility. My husband and I hope to keep him at home with us as long as we can, and we also hope and pray that the quality of services continues to grow and increase in the years to come.

People with intellectual and developmental disabilities need the highest care possible. They have already experienced so much hardship and struggle in their life and often times don’t even know that they have actually faced those hard times and struggle. This is shown by the love, smiles and happiness that many of the people who receive DD services display every day of their lives. Plain and simple, they deserve the very best from the developmental disabilities industry.

Thank you again for the opportunity to stand before you and give my testimony. I welcome any questions that you may have.

House Appropriations Committee
IN SUPPORT – HB 1012 – DHS Budget – Economic Assistance
March 11, 2021
Janelle Moos, Associate State Director- Advocacy
jmoos@aarp.org
(701) 355-3641

Chairman Holmberg and members of the Senate Appropriations Committee, I am Janelle Moos, Associate State Director of Advocacy at AARP North Dakota.

AARP is a non-profit, non-partisan membership organization with more than 84,000 members in North Dakota. Our mission is to empower people to choose how they live as they age.

We wanted to take a moment to weigh in on a couple of important economic assistance issues.

First, SNAP is an important program that ensures older adults and families get the nutrition needed. We have closely monitored the food crisis more Americans and North Dakotans faced during the pandemic. SNAP benefits are an important tool that addresses this crucial problem. It is an especially important program for Americans over 50 because many face challenges to employment, live on fixed incomes, live alone, and have limited financial resources to pay for necessities like food, housing, and essential medicine. To people struggling to put food on the table, hunger is not a political issue, it is a daily reality. SNAP is a vital lifeline that feeds 23, 840 North Dakota households. 35% of those recipients are either elderly or disabled. Also remember, participants generally spend their SNAP dollars locally, soon after receiving them, boosting local economies. An important benefit in this time.

Also, LIHEAP has served as a lifeline for low-income families. As you may know, AARP believe utility issues and rates are a key pocketbook issue. We have intervened in various cases in front of the North Dakota Public Service Commission on behalf of older adults and consumers and know the struggle of families to afford their utility payments. Having a safety net for families especially in our climate is not only the right thing it is the moral thing to do.

We encourage you to continue to support these programs to ensure no North Dakotan goes hungry or without heating or cooling assistance when they need it.

Again, we appreciate the time to raise issues important to North Dakotans 50+ and would be happy to answer any questions. Thank you.

RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a caregiver of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

I PROVIDE PROGRAM MANAGEMENT SERVICES FOR AN INDIVIDUAL IN SECTION 11. THEY HAVE BEEN RECIEVING THESE SERVICES FOR THE PAST 30 YEARS. IT MAY NOT LOOK LIKE MUCH ON PAPER, BUT IT'S WHAT HAS PROVIDED THEM WITH A SUPPORT SYSTEM TO FUNCTION FROM DAY TO DAY. WITHOUT THESE SERVICES MANY OF THE INDIVIDUALS WOULD BE FACING HOMELESSNESS, GREATER HEALTH ISSUES, JOB LOSS, EARLY NURSING HOME PLACEMENT, OR WORSE, DEATH. ALL OF WHICH WILL COST THE STATE MORE FINANCIALLY IN THE LONG TERM, AS THESE SERVICES ARE CRITICAL FOR THOSE IN THE PROGRAM.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Signature: _____

Printed Name: TAYLOR NELSON

North Dakota address: 2009 30th AVE S
FARGO, ND 58103

RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a caregiver of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

I have worked at Community Living Services for the past 35 years as a Case Manager. I have worked with several individuals through the years under the Section 11 program from the very beginning of when Section 11 funding was initially used to support the individuals we provided services to that "fell through the cracks" at that time. Through the years I have personally witnessed that nothing has changed in that regard, as we continue to still have this group of individuals we serve that direly need supports and continuity in the community. We continue to provide these vital services to individuals who without these supports would be homeless, vagrant, malnourished, mentally and physically ill and worst case scenario wouldn't be here at all or dead. We would like to think that were are humane society and that everyone matters and makes a difference, right? I have knowledge and professional experience in how vital the Section 11 supports are for the individuals we serve, as I have two individuals that I have worked with for almost 30 years. This includes providing services to prevent homelessness and vagrancy, rep payee assistance to establish residency, secure benefits, assistance with paying bills and maintaining their benefits. Other supports include assistance with procuring and maintaining employment, providing referrals, residential supports to maintain them living independently within the community and participating as an active member in society and monitoring and maintaining their health which include supports assisting with doctor appointments and follow through with medical recommendation's so they can remain living independently in their own apartments instead of being housed or institutionalized at the State hospital or in a nursing home, which is blatantly more expensive for the State of North Dakota in the end. CLS has almost half of the Section 11 individuals that are served in the State of North Dakota and unfortunately they will be left without these supports and on their own, as they will not qualify for or be able to transfer to a different program or funding source if this proposal is approved. I beg you to please reconsider. Thank you for your time and attention.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North

Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Signature: Michelle Haugen

Printed Name: Michelle Haugen

North Dakota address: 2671 56th Ave. SE
Fargo, ND
58104

RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a caregiver of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

I have been employed by Community Living Services for over 33 years, providing supports to individuals with disabilities in Fargo. As such, I have had long-standing relationships and understanding of people with disabilities. CLS provides support to 33 of the individuals who would be affected by the elimination of Section 11 services. I can attest to the fact that these individuals definitely require some level of supports in order to live in the community. For example, some the things I assist with include applying for and maintaining benefits, such as Social Security, Housing, Medicaid and SNAP. Without my help, the people I support would like lose their housing and healthcare coverage, and would end up homeless, costing the State and Fargo community even more money. I also serve as Representative Payee for some for their Social Security benefits, which ensures these benefits are used to pay essential bills, such as rent. I often hear from landlords in the area that they wish all of their tenants had such support, as having a payee and a service provider means the rent is paid and they have someone to work with if there are problems. I also assist people to maintain their health. For example, one individual who receives Section 11 was due this summer for her first colonoscopy. She was worried and wanted to complete this, as her mom died from colon cancer, and she understood that her risk of developing colon cancer was higher. However, when she received the instructions for the test prep, she panicked; she did not understand any of it. With my help, she was able to complete the test prep and complete the colonoscopy (she had several polyps removed). Without assistance, she probably would have had to repeat the test several times, costing Medicaid even more money—or possibly the polyps would have been missed and she would have developed cancer. The Section 11 program serves people who have no other options for services, and provides very essential services at a very low cost. The cost to the local community and the State of North Dakota would likely be much higher without these services.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North

Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Signature: Janice Brelje

Printed Name: Janice Brelje

North Dakota address: 69 15th Avenue North
Fargo, ND 58102

8838

RE: HB 1012 – Section 11 Developmental Disability Program

Dear Chairman Holmberg and members of the committee,

As a caregiver of a person receiving Developmental Disability Services, I am writing to express my opposition to eliminating Section 11 funding as outlined in HB 1012. This program serves individuals who would otherwise "fall through the cracks" without the support provided by this program.

I strongly urge you to continue to fund this program and to provide continuity to those receiving Section 11 supports. Thank you for your continued service to the people of North Dakota and for your consideration of continuing this service that supports people with disabilities to be as independent as possible in their communities.

Sincerely,

Signature: Bree Timmerman

Printed Name: Bree Timmerman

North Dakota address: 1731 34th St S, Fargo, ND 58103

8851

Judith Martin
328 North 31st St. Apt. #11
Bismarck, ND 58501
701-516-3923

Testimony House Bill 1012
Senate Appropriations Committee
March 11, 2021

Chairman Holmberg and members of the Senate Appropriations Committee. My name is Judith Martin and I am a consumer of The Dakota Center for Independent Living in Bismarck. I am asking you to please consider full funding for the Dakota Center for Independent Living (DCIL) in HB 1012.

Through the Dakota Center for Independent Living I have learned how to maintain a positive attitude. Staff at the center helped me to learn how to live a more independent lifestyle and assisted in preparing a budget that, in the past, had been completely overruled by others. I did have an idea of what my budget would look like, I just needed some money management skills which were provided by staff. I was shown how to seek out coupon savings for over-the-counter medications. I was able to attend Better Choice, Better Health and Pain Management classes through the center. These classes have helped me to understand and manage physical, healthier choices along with managing my long-term health conditions.

DCIL staff has assisted me in getting subsidized medical insurance for myself and which ones were out there for me. I was told, "Yes, you can. Even you can stand up for yourself!" Through DCIL I have learned to become empowered with confidence in speaking up for myself as a person with a disability.

Again, I would ask that you provide full funding to this government agency, the Dakota Center for Independent Living. Thank you so much for your time.

Sincerely,

Judith Martin

Deland Decoteau
1108 Summit Boulevard #4
Bismarck, ND 58504

Testimony House Bill 1012
Senate Appropriations Committee
March 11, 2021

Chairman Holmberg and members of the Senate Appropriations Committee. My name is Deland DeCoteau and I am a consumer of The Dakota Center for Independent Living in Bismarck.

Before I came to the DCIL I was lost and hopeless. My physical and mental health were at an all-time low and I was frustrated, empty, and afraid. I felt like I had been abandoned by everyone, that I had nothing to look forward to, and I didn't have any reason for living. That all changed when I became a part of the DCIL. They have provided the support, education, direction, and assurance that I needed to regain my physical and mental health. I was treated with warmth, care, and understanding and I met with staff who helped me to examine and find a positive direction for my life.

DCIL provided classes, training, and activities which helped me to address mental health issues and find peace of mind. I regained contact with survival skills, leisure skills, and activities that brought joy into my heart and hope into my life. I also attended groups and classes which helped me to live a healthy lifestyle and to deal with chronic physical issues. The Staff's appreciation and dedication to each consumer along with the support and social interaction provided by the program has been extremely helpful in my recovery.

I thank you for supporting and funding the DCIL and I look forward to a bright future.

Sincerely,

Deland G. DeCoteau

Testimony house Bill HB 1012

March 11, 2021

Senate Appropriate Committee

Senator Ray Holmberg

Senator Holmberg and Committee my name is Denise Kitson and I am asking you to please restore funding in the HB 1012 for Dakota Center for Independent Living and other CIL'S in ND.

I was in a car accident and suffer from a Traumatic Brain Injury and ever since then I have needed assistance with organizing my home, bills and sometimes daily life struggles. DCIL has assisted me in applications for Medicaid, SNAP, Housing and help me to get out and socialize with others. DCIL has monthly TBI support group, cooking classes, crafts and other activities are available to help me get out into the community. DCIL provides me with encouragement and support I need through my ongoing health risks. Without these resources I do not know where I would be now. Please remember the people who cannot help themselves and the people who are willing to help others.

Sincerely,

Denise Kitson

2817 Hawken St. #3

Bismarck, ND. 58503

701-319-2892

kathyt@dakotacil.org

From: Shelly Lanenga <shellylanenga@gmail.com>
Sent: Thursday, March 11, 2021 9:54 AM
To: kathyt@dakotacil.org

Testimony house Bill HB 1012

March 11, 2021

Senate Appropriate Committee

Senator Ray Holmberg

Senator Holmberg and Committee my name is Shelly Lanenga and I am asking you to please restore funding in the HB 1012 for Dakota Center for Independent Living and other CIL'S in ND.

I was in a car accident and suffer from a Traumatic Brain Injury and ever since then I have needed assistance with organizing my home, bills and sometimes daily life struggles. DCIL has assisted me in applications for Medicaid, SNAP, Housing and helped me to get out and socialize with others. DCIL has a monthly TBI support group, cooking classes, crafts and other activities are available to help me get out into the community. DCIL provides me with encouragement and support I need through my ongoing health risks. Without these resources I do not know where I would be now. Please remember the people who cannot help themselves and the people who are willing to help others.

Sincerely,

Shelly Lanenga

Address 703 6th Ave SE, Mandan , ND

Phone # 701-341-0995

kathyt@dakotacil.org

From: Tonia Johnston <10angels75@gmail.com>
Sent: Thursday, March 11, 2021 11:14 AM
To: kathyt@dakotacil.org
Subject: Fwd: HB 1012 Senate

---------- Forwarded message ---------
From: **Tonia Johnston** <10angels75@gmail.com>
Date: Tue, Mar 9, 2021, 12:33 PM
Subject: HB 1012 Senate
To: <ardeenb@dakotacil.org>

HB 1012 March 11, 2021
Senate Appropriations Committee
Senator Ray Holmberg, Chair

Chairman Holmberg and members of the Senate Appropriations Committee. My name is Tonia Johnston and I am writing to support bill HB 1012 for funding Dakota Center for Independent Living. I have been with them for almost 13 years now and without their help I would not be where I am today. I have Bipolar Disorder and when I first started with them I refused to stay on my medications, I was required to have a payee by the VA and I was very angry. My mind was not in a good place. I had tremors in my hands and I was trying to take care of my kids. Life was very difficult. I was not able to keep jobs since I was medically discharged from the Navy. DCIL is all about helping you stay independent. They wanted me to be as involved in my budget as I wanted to be. They go above their job because they also helped me to see that I really needed to help myself too. With their support I slowly was able to seek the help I needed through the VA to get therapy and stay on my medication. My mind became clearer and with that I wanted to be more involved with my money. DCIL supported that little by little I was able to take charge of handling my money. I have become very secure in my life now. I have now become my own payee for my social security account and soon I will take over my VA account. It is only because of DCIL that I was able to do that. They helped me not only with managing my money and learning how to handle that but in learning that I am not my disability. I am more than that. I have learned to be okay with the fact that in order to stay healthy mentally I can not work. DCIL also helped me deal with my anxiety with the different activities they offer to people. You never feel judged and can just be yourself. Thank you for taking the time to read my testimony.

Sincerely,
Tonia Johnston

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/15/2021
Human Services Subcommittee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 2:04 pm.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern.**

Discussion Topics:

- Foster children, DD Waiver
- Fee for Service
- FMAP
- Uniform Payment System
- 1915i

Medicaid Expansion -
Caprice Knapp, Director, Medical Services – testified and answered questions of the sub-committee. She submitted testimony #9314, #9313, #9335.

Krista Fremming, Medical Services Division – testified in favor and answered questions of the sub-committee

Erik Elkins, Medical Services Division – testified in favor and answered questions of the sub-committee.

Brendon Joyce, Medical Services Division – testified in favor and answered questions of the sub-committee.

LeeAnn Thiel, Medical Services Division – testified in favor and answered questions of the sub-committee.

Behavioral Health –
Pam Sagness, Director, Behavioral Health – testified in favor and submitted testimony #9309, #9272, #9278, #9284, #9312, #9334.

Senator Mathern handed out Proposed Changes to HB 1012 – testimony #9270.

Senator Dever closed the hearing at 4:11 pm.

Rose Laning, Committee Clerk

THE FMAP 9314

The Federal Medical Assistance Percentage

WHAT IS THE FMAP?

The Federal Medical Assistance Percentage (FMAP) rates are used in determining the amount of federal matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures.

AT DHS, THESE RATES APPLY TO:

- Traditional Medicaid Services
- Long-Term Care Services*
- Medicaid Wavier Services**
- Child Welfare/ IV-E Foster Care & Subsidized Adoption

**Excluding state programs SPED (Service Payments to Elderly and Disabled) and expanded SPED.*

***Including Home and Community Based Services, Developmental Disabilities Services and 1915(i) Services.*

BY THE NUMBERS

Federal Matching Assistance Percentage (N.D.)

FMAP follows the federal fiscal year from Oct-Sept	Rate
Oct. 1, 2015 - Sept. 30, 2019	50%
Oct. 1, 2019 - Sept. 30, 2020	50.05%
Oct. 1, 2020 - Sept. 30, 2021	52.4%
Oct. 1, 2021 - Sept. 30, 2022	53.59%

COVID FMAP Increase of 6.2% to FMAP	Rate
Jan. 1, 2020 - Sept. 30, 2020	56.25%
Oct. 1, 2020 - June 30, 2021***	58.60%

****This date may change pending extension of public health emergency.*

FEDERAL FISCAL YEAR EFFECTIVE DATES:

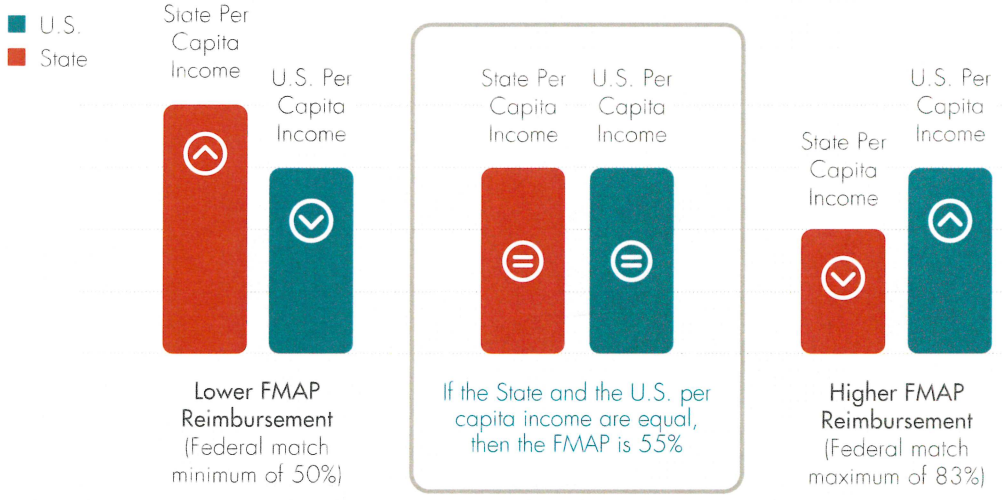
OCT. 1 — SEPT. 30

2020 ⊙ 2021

The FMAP is calculated each federal fiscal year and is effective Oct. 1 through Sept. 30 each year.

HOW FMAP WORKS...

The FMAP formula compares a state's three year average per capita income relative to the U.S. three year average per capita income.



Lower FMAP Reimbursement (Federal match minimum of 50%)

If the State and the U.S. per capita income are equal, then the FMAP is 55%

Higher FMAP Reimbursement (Federal match maximum of 83%)

Jan. 21, 2021

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MEDICAL SERVICES
Medicaid Expansion Quality KPIs

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North Dakota Medicaid Expansion Performance Measurement Scorecard Data for Sanford Health Plan Measurement Year (MY) 2017 – 2019

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Adult Body Mass Index Assessment	93.40	93.33	94.17	♦♦♦
Flu Vaccinations for Adults, Ages 18-64	41.75	38.93	38.60	♦
Breast Cancer Screening	50.35	54.97	54.69	♦
Cervical Cancer Screening	42.61	43.60	44.79	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	37.50	40.52	46.03	♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	77.86	76.86	73.97	♦♦♦
Comprehensive Diabetes Care: Eye Exam	50.09	51.12	49.64	♦
Comprehensive Diabetes Care: HbA1c Control (<8%)	55.01	55.96	60.83	♦♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is better*	30.58	32.12	28.71	♦♦♦
Comprehensive Diabetes Care: HbA1c Testing	92.62	92.57	90.27	♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy	91.21	93.61	89.05	♦
Controlling High Blood Pressure	73.43	68.37	70.00	♦♦♦

MEDICAL SERVICES
Medicaid Expansion Quality KPIs

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Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Asthma Medication Ratio: Ages 19-50	NR	NR	55.00	♦♦
Asthma Medication Ratio: Ages 51-64	NR	NR	51.72	♦
Asthma Medication Ratio: Ages 19-64 (Total)	NR	NR	53.93	♦
PQI 01: Diabetes Short-Term Complications Admission Rate (denominator is total member months x100,00 for ages 18-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.07	40.85	46.53	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (denominator is total member months x100,00 for ages 40-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.26	28.97	48.58	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total member months x100,00 for ages 18-64 and 65+, Rate is numerator events/100,000 member months)* *Lower is better*	23.91	29.07	27.11	♦♦
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 18-39, Rate is numerator events/100,000 member months)* *Lower is better*	8.29	3.47	2.90	♦♦♦

MEDICAL SERVICES
Medicaid Expansion Quality KPIs

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Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Plan All-Cause Readmissions Rate: Ages 18-44* *Lower is better* ^^	NR	NR	1.5441	NC
Plan All-Cause Readmissions Rate: Ages 45-54* *Lower is better* ^^	NR	NR	1.5655	NC
Plan All-Cause Readmissions Rate: Ages 55-64* *Lower is better* ^^	NR	NR	1.1399	NC
Plan All-Cause Readmissions Rate: Total* *Lower is better* ^^	NR	NR	1.4182	♦
Antidepressant Medication Management: Effective Acute Phase Treatment	62.55	64.33	61.85	♦♦♦

^ - Benchmark data source: *Quality Compass 2019 (Measurement Year 2018 data) National Medicaid Average for HMOs*. This is the most current benchmark source at the time of report production

* - Benchmark data source: *Quality of Care for Adults in Medicaid: Findings from the 2018 Adult Core Set Chart, September 2019*, a product of the Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, sponsored by the Centers for Medicare & Medicaid Services. This is the most current benchmark available at the time of report production

^^ - In 2020, the PCR measure reporting is based on the O/E Ratio (Observed Readmissions/Expected Readmissions) and not the Observed Readmission Rate like the previous measurement years

NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate

NC - No Comparison made due to no rate or/and no benchmark available

♦♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile

♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile

♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile

♦ MCO rate is below the NCQA Quality Compass National Average.

↑ Positive trend for three consecutive measurement years

↓ Negative trend for three consecutive measurement years

Optumas
Risk · Strategy · Reform

Memorandum

To: Caprice Knapp, Brendan Joyce, Erik Elkins

CC: Elrycc Berkman
Scott Campbell

From: Tim Doyle, FSA, MAAA

Date: December 18, 2020

Re: Pharmacy Savings Analysis

Background and Scope

Beginning in January 2020, the State of North Dakota carved the pharmacy services out of the managed care program for the Medicaid Expansion population and started to deliver those services in fee-for-service (FFS). **Optumas** was tasked with determining if there were savings that result from the delivery system change. During the review, **Optumas** performed a risk analysis utilizing the UCSD Medicaid Rx tool to normalize any changes in acuity of the underlying data to ensure that potential savings between the two time periods were not distorted.

Data Sources

Detailed Data

As the State's actuary for the development and certification of the Medicaid Expansion Capitation Rates, **Optumas** relied on the latest CY19 Managed Care encounter data that was validated and used during the CY21 rate development. The State additionally provided emerging FFS pharmacy data from January 1, 2020 through November 19, 2020 and the October 2020 State eligibility Roster.

Supplemental Resources

Since costs contained in the Managed Care and FFS data provided by the State included total costs, gross of rebates, the State provided pharmacy rebate information by quarter from CY19 through Q3CY20. **Optumas** relied on this information to benchmark the CY19 encounter data as well as remove all Federal and supplemental rebates in order to ensure that the results reflect the State's final cost.

Results

Since the analysis was done before the end of 2020, **Optumas** relied on comparing the complete first three quarters of data from CY19 and CY20. Because of differences in FMAP for the IHS and 340b providers, **Optumas** limited the review to exclude the IHS/340b providers so that the results were not distorted. In addition, to ensure that the CY19 Q1-3 data was on a comparable time

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period as the CY20 Q1-3 data, **Optumas** used a 7.3% trend as a projection factor. The trend was developed based on a number of years of pharmacy data from the Medicaid Expansion program.

Figure 1 below summarizes the findings from the raw detailed data and trending historical CY19 date to the CY20 time periods. Under this approach, **Optumas** estimates that there is a 13.9% savings switching delivery systems from Managed Care to FFS.

Figure 1. Estimated Savings of Delivery System Change (excluding risk adjustment)

Managed Care CY19 Q1-3				Fee-for-Service CY20 Q1-3		
Raw Data	Federal and Supplemental Rebate Removal	Trend	Trended to CY20 Q1-3	Raw Data	Federal and Supplemental Rebate Removal	Estimated Savings
$132.22	$43.52	7.3%	$46.69	$136.77	$40.20	-13.9%

*Excludes IHS and 340b

Figure 2 below summarizes the findings from the raw detailed data, normalizing the data sets for risk, and trending historical CY19 data to the CY20 time periods. After all appropriate normalization steps, **Optumas** estimates that there is a 13.0% savings switching delivery systems from Managed Care to FFS.

Figure 2. Estimated Savings of Delivery System Change (including risk adjustment)

Managed Care CY19 Q1-3					Fee-for-Service CY20 Q1-3			
Raw Data	Federal and Supplemental Rebate Removal	Medicaid Rx Adjusted	Trend	Trended to CY20 Q1-3	Raw Data	Federal and Supplemental Rebate Removal	Medicaid Rx Adjusted	Estimated Savings
$132.22	$43.52	$43.19	7.3%	$46.34	$136.77	$40.20	$40.30	-13.0%

*Excludes IHS and 340b

Please note that the analyses above only reflect pharmacy claims and do not reflect administration and profit that gets built into the managed care rates. In calendar year 2019, the administrative and profit loads were 3.2% and 1.0%, respectively. If those amounts were included, the savings shown in the tables above would increase even further.

If you have any questions or feedback regarding this memo, please feel free to contact us.

MEDICAL SERVICES
Budget Estimate Comparison

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Differences Between DHS Estimate and OMB Estimate

OMB 12 Month Estimate

		Total Costs	State Share
Admin Estimated Cost (CY 2022 6 months)		$ -	-
Admin Estimated Cost (CY 2023 6 months)		$ -	-

ADMINISTRATIVE COSTS - DHS	Federal Match	Total Costs	State Share
Staff:	50% to 75%	1,860,126	731,147
Contracts:	50% to 75%	(151,160)	(71,270)
Other:	50% to 90%	81,937	40,969
TOTAL DHS Administration Expansion Expenses		1,790,903	$ 700,846

Projected Savings for MCO Admin and HIPF		$ -	$ -
Estimated DHS Administration Expense		$ 1,790,903	$ 700,846
Total Savings from Transferring Expansion from MCO to FFS		$ 1,790,903	$ 700,846

Savings of Expansion Transition from Commercial Rates to Traditional Fee Schedule for 2021 - 2023 Biennium

	Total	Federal	State
Grants	$ (96,421,742)	$ (85,404,552)	$ (11,017,190)
Addition of Dental and Vision	11,697,179	10,527,465	1,169,714
Subtotal Grants	$ (84,724,563)	$ (74,877,087)	$ (9,847,476)
Savings to Transition from MCO Administration to DHS Administration			
MCO Admin	0	0	0
Primary Care Case Management	0	0	0
DHS Admin	1,790,903	1,090,058	700,846
Subtotal for DHS Admin.	$ 1,790,903	$ 1,090,058	$ 700,846
Total Savings			
Total to Move to FFS DHS Admin	$ (82,933,660)	$ (73,787,030)	$ (9,146,631)

DHS 12 Month Estimate

		Total Costs	State Share	State Share Difference Between OMB and DHS
Admin Estimated Cost (CY 2022 6 months)		$ (6,755,533)	(776,886)	
Admin Estimated Cost (CY 2023 6 months)		$ (6,924,317)	(796,296)	-$1,573,182

ADMINISTRATIVE COSTS - DHS	Federal Match	Total Costs	State Share	
Staff:	50% to 75%	1,448,082	568,234	
Contracts:	50% to 75%	252,790	79,520	
Other:	50% to 90%	93,328	46,664	
TOTAL DHS Administration Expansion Expenses		1,794,200	$ 694,418	$6,428

Projected Savings for MCO Admin and HIPF		$ (13,679,850)	$ (1,573,182)	
Estimated DHS Administration Expense		$ 1,794,200	$ 694,418	
Total Savings from Transferring Expansion from MCO to FFS		$ (11,885,650)	$ (878,764)	$1,579,610

Savings of Expansion Transition from Commercial Rates to Traditional Fee Schedule for 2021 - 2023 Biennium

	Total	Federal	State	
Grants	$ (96,421,742)	$ (85,404,552)	$ (11,017,190)	
Addition of Dental and Vision	11,697,179	10,527,465	1,169,714	
Subtotal Grants	$ (84,724,563)	$ (74,877,087)	$ (9,847,476)	
Savings to Transition from MCO Administration to DHS Administration				
MCO Admin	(13,679,850)	(12,106,668)	(1,573,182)	
Primary Care Case Management	0	0	0	
DHS Admin	1,794,200	1,099,782	694,418	
Subtotal for DHS Admin.	$ (11,885,650)	$ (11,006,886)	$ (878,764)	
Total Savings				
Total to Move to FFS DHS Admin	$ (96,610,213)	$ (85,883,973)	$ (10,726,240)	$1,579,610



MEDICAL SERVICES
Medicaid Expansion In-House Strategic Plan

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Overview
The North Dakota Department of Human Services, Medical Services Division, aims to restructure its Medicaid programs to promote better care and quality for members, reduced burden on providers, and continual attention to better stewardship of taxpayer dollars. This document contains detailed information about the goals, objectives, action steps, timelines, and indicators for the restructuring. This is a living document and will be revised and updated as restructuring activities continue to progress.

Vision Statement
All North Dakota Medicaid members have access to the same core services, delivered by health care providers who are incentivized to provide member-centered, comprehensive, high quality care.

Relevant Stakeholders
Because this is a large-scale program redesign effort, progress toward each goal will involve coordination and collaboration between a range of entities whose activities and missions are relevant to that goal. These agencies might include (but are not limited to):

North Dakota Department of Human Services (DHS)
- Behavioral Health Division (BHD)
- Aging Services Division
- Child and Family Services (CFS)
- Developmental Disabilities Division (DD)
- Division of Vocational Rehabilitation
- Field Services Division (FS)

Behavioral health service providers
Community Healthcare Association of the Dakotas (CHAD)
Family Voices of North Dakota
Federally Qualified Health Centers (FQHCs)
Human Service Zones (formerly Social Services)
Indian Health Services
Local Public Health Units
North Dakota Academy of Family Physicians (NDAFP)
Mental Health America of North Dakota
North Dakota Association of Community Providers (NDACP)
North Dakota Brain Injury Network (ND BIN)
North Dakota Chapter of the American Academy of Pediatrics (NDAAP)
North Dakota Dental Association (NDDA)
North Dakota Department of Health (NDDoH)
North Dakota Hospital Association (NDHA)
North Dakota Medical Association (NDMA)
North Dakota Optometric Association (NDOA)
Private health systems
Tribal Nations

Aim #1: Transition Medicaid Expansion from Managed Care to Managed Fee-for-Service.

1.1 Propose changes to state law that will enable DHS to administer the Medicaid Expansion program.

Objective	Action Step	Complete By
1. Develop a budget that outlines the cost savings and benefits that will be achieved through DHS administration of the Medicaid Expansion program.	1.1 Calculate savings that will be achieved through paying Medicaid Expansion providers the same rates as fee-for-service (FFS) Medicaid providers.	July 2020
	1.2 Calculate increases in expenditures for additional services that Medicaid Expansion members will receive once their benefit plan is the same as FFS (dental, vision, long term care, etc.).	July 2020
2. Develop communication materials for legislative session.	2.1 Develop PowerPoint presentation, handouts and talking points to explain the rationale for moving Medicaid Expansion to DHS administration.	December 2020
3. Present information to the Governor, legislature and stakeholders.	3.1 Present information to the Governor.	November 2020
	3.2 Present information to the House Appropriations committee.	January 2021
	3.2 Present information to the Senate Appropriations committee.	March 2021

1.2 Implement a well-defined, timely process that transitions Medicaid Expansion from Managed Care to Managed Fee-For-Service.

Objective	Action Step	Amount of Time Needed
1. Develop a timeline and action steps to transfer administration of Medicaid Expansion to DHS administration.	1.1 Develop timeline and action steps in coordination with the Medicaid Expansion managed care organization.	2 months
	1.2 Hold weekly meetings with managed care organization to ensure completion of timelines and benchmarks.	12 months
2. Provide progress updates to the Governor and interim legislative committees.	2.1 Provide regular progress updates to the Governor and interim legislative committees on the transition of Medicaid Expansion to DHS administration.	18 months

Aim #2 Implement a comprehensive quality strategy for North Dakota Medicaid.

2.1 Develop a primary care value based purchasing program for North Dakota Medicaid members with chronic conditions.

Objective	Action Step	Complete By
1. Develop a timeline and action steps to implement the Medicaid health homes program, as authorized by Section 1945 of the Social Security Act.	1.1 Develop timeline and action steps to implement a health homes program.	6 months
	1.2 Consult with CMS regarding health homes program requirements, including the 90 percent federal match that is available for health homes services for the first eight quarters of the program and the planning funds that may be available to states.	12 months
	1.3 Convene partner workgroups to provide input and direction for health homes program. Solicit input on: • Tiering system for members. • Provider payments. • Attributing members to a health home. • Quality measures and reporting. • How the program should be structured for children as compared to adults.	12 months
	1.4 Develop and submit state plan amendment to CMS for health homes program.	12 months
	1.5 Enroll members and providers with the health homes program and begin services.	6 months

2.2 Develop a hospital value-based payment program.

Objective	Action Step	Complete By
1. Develop a timeline and action steps to implement a value-based payment program for North Dakota hospitals.	1.1 Convene stakeholders to learn about three different value-based payment models that are used by other states.	2 months
	1.2 Convene partner workgroups to provide input and direction for value-based payment program. Input is needed on: • The model that is best suited for North Dakota hospitals. • Payment structure and quality incentives. • Quality measures and reporting.	12 months
	1.3 Develop timeline and action steps to implement a value-based payment program.	6 months

MEDICAL SERVICES
Medicaid Payer Mix

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HOSPITAL NAME	2017	2018		
MEDICAID PAYER MIX			Medicaid Expansion 20% of Medicaid Enrollees	
ST ALEXIUS MEDICAL CENTER	7%	7%	1.4%	
TRINITY HOSPITALS/ST JOES	11%	13%	2.6%	
SANFORD MEDICAL CENTER - FARGO	8%	8%	1.6%	Average for PPS
SANFORD BISMARCK	7%	8%	1.6%	1.8%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	9%	8%	1.6%	
INNOVIS HEALTH	8%	6%	1.2%	
TIOGA MEDICAL CENTER	1%	1%	0.2%	
MOUNTRAIL COUNTY MEDICAL CENTER	3%	3%	0.6%	
MCKENZIE COUNTY HEALTHCARE SYSTEM	5%	4%	0.8%	
GARRISON MEMORIAL HOSPITAL	23%	22%	4.4%	
TURTLE LAKE COMMUNITY HOSPITAL	30%	11%	2.2%	
KENMARE COMMUNITY HOSPITAL	25%	19%	3.8%	
COOPERSTOWN MEDICAL CENTER	3%	6%	1.2%	
ST ANDREWS HEALTH CENTER	14%	17%	3.4%	
NELSON COUNTY HEALTH SYSTEMS-HO	1%	1%	0.2%	
SANFORD MAYVILLE	3%	3%	0.6%	
DAKAKAWEA MEDICAL CENTER	5%	6%	1.2%	
LISBON AREA HEALTH SERVICES	4%	7%	1.4%	
NORTHWOOD DEACONESS HEALTH CENTER	4%	5%	1.0%	
SOUTHWEST HEALTHCARE SERVICES	2%	1%	0.2%	
JACOBSON MEMORIAL HOSPTAL	20%	19%	3.8%	
OAKES COMMUNITY HOSPITAL	2%	8%	1.6%	Average for CAHs
PRESENTATION MEDICAL CENTER	28%	17%	3.4%	1.2%
CARRINTON HEALTH CENTER	2%	2%	0.4%	
PEMBINA COUNTY MEMORIAL HOSPITAL	14%	2%	0.4%	
UNITY MEDICAL CENTER	5%	4%	0.8%	
WISHEK COMMUNITY HOSPITAL	2%	2%	0.4%	
ASHLEY MEDICAL CENTER	2%	2%	0.4%	
CAVALIER COUNTY MEMORIAL HOSPITAL	8%	1%	0.2%	
MERCY HOSPITAL OF VALLEY CITY	4%	1%	0.2%	
ST LUKES HOSPITAL	1%	4%	0.8%	
FIRST CARE HEALTH CENTER	3%	3%	0.6%	
ST ALOISIUS MEDICAL CENTER	5%	4%	0.8%	
LINTON HOSPITAL	3%	4%	0.8%	
SANFORD HILLSBORO	2%	3%	0.6%	
WEST RIVER REGIONAL MEDICAL CENTER	3%	3%	0.6%	
TOWNER COUNTY MEDICAL CENTER	3%	3%	0.6%	
HEART OF AMERICA MEDICAL CENTER	30%	3%	0.6%	
MERCY HOSPITAL OF VALLEY CITY	10%	14%	2.8%	
MERCY MEDICAL CENTER	6%	3%	0.6%	
JAMESTOWN REGIONAL MEDICAL CENTER	13%	7%	1.4%	
ST JOSEPHS HOSPITAL AND HEATLH CENTER	7%	2%	0.4%	

Hospital Medicaid Share of Net Patient Revenues (approx)
Source: Horizon Government Affairs, HCRIS data via RAND Vintage 11-1-2020

MEDICAL SERVICES
Critical Access Hospital Pricing Analysis

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Optumas
Risk • Strategy • Reform

Memorandum

To: Caprice Knapp, Erik Elkins

CC: Elrycc Berkman, ASA, MAAA

From: Tim Doyle, FSA, MAAA

Date: January 7, 2021

Re: Critical Access Hospital (CAH) Pricing Analysis

Background and Scope

Optumas was tasked with reviewing the cost of hospital services at North Dakota Critical Access Hospitals (CAHs) for the State's Medicaid Expansion population. **Optumas** performed a repricing analysis of detailed claims data to price the utilization commensurate with the reimbursement of the State's traditional Medicaid program. The corresponding results show the difference in reimbursement between the actual incurred costs in the Medicaid Expansion program and the costs that otherwise would have been incurred under the State's traditional Medicaid program.

Data Sources

As the State's actuary for the development and certification of the Medicaid Expansion capitation rates, **Optumas** relied on detailed claims and enrollment data for January 1, 2017 – December 31, 2018 (CY17 and CY18) with claims paid dates through June 30, 2019. This data was summarized and validated against reported financials during the development of the CY20 Medicaid Expansion capitation rates. Specifically, for this analysis, the data was limited to inpatient and outpatient claims incurred at any of the 36 CAHs in the State of North Dakota. These facilities are listed in the table below:

State of North Dakota CAHs	
Ashley Medical Center	Nelson County Health System
Carrington Health Center	Northwood Deaconess
Cavalier County Memorial Hospital	Oakes Community Hospital
Community Memorial Hospital	Pembina County Memorial Hospital
Cooperstown Medical Center	Presentation Medical Center
First Care Health Center	Sakakawea Medical Center
Garrison Memorial Hospital	Sanford Hillsboro Medical Center
Heart of America Medical Center	Sanford Mayville
Jacobson Memorial Hospital	Southwest Healthcare Services
Jamestown Hospital	St. Aloisius Hospital
Kenmare Community Hospital	St. Andrew's Health Center
Linton Hospital	St. Joseph's Hospital
Lisbon Area Health Services	St. Luke's Hospital
McKenzie County Medical Center	Tioga Medical Center
Mercy Hospital - Devils Lake	Towner County Medical Center
Mercy Hospital - Valley City	Unity Hospital
Mercy Medical Center	West River Regional Medical Center
Mountrail County Medical Center	Wishek Hospital

MEDICAL SERVICES
Critical Access Hospital Pricing Analysis

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Methodology and Results

Optumas used historical reimbursement information from the State's traditional Medicaid program to reprice each claim in the CY17 and CY18 experience. Inpatient claims were repriced using per diems multiplied by the length of the inpatient stay in days. Outpatient claims were repriced using a cost-to-charge ratio multiplied by the charge amount for the claim. The overall results of the analysis are displayed in the table below:

Calendar Year	Incurred Dollars[1]	Repriced Dollars[2]	Implied % of State Traditional Medicaid Reimbursement
CY17	$22,941,857	$15,859,492	144.7%
CY18	$23,948,522	$16,662,009	143.7%
Two-Year Total	$46,890,379	$32,521,502	144.2%

1 – CAH Medicaid Expansion Program Reimbursement
2 – Repriced using State Traditional Medicaid Reimbursement

The results show, that on average over the two-year period, the CAH incurred dollars reflected reimbursement that was 144.2% times that of the reimbursement of the State's traditional Medicaid program. For CY17 this is a difference of approximately $7.1 million and for CY18 this is a difference of approximately $7.3 million.

Results do vary at the individual hospital level. There are hospitals where the Repriced Dollars are lower than the Incurred dollars. This typically occurs at hospitals that experience a lower volume of overall services. The tables below display the number and portion of hospitals by each year where the Repriced Dollars are Greater than or Less than the Incurred Dollars, and the volume and portion of Incurred Dollars by each of those categories:

	Number of Hospitals		Portion of Hospitals	
	CY17	CY18	CY17	CY18
Repriced Dollars Greater than Incurred Dollars	16	14	44.4%	38.9%
Repriced Dollars Less than Incurred Dollars	20	22	55.6%	61.1%

	Total Incurred Dollars[1]		Portion of Incurred Dollars[1]		Implied % of State Traditional Medicaid Reimbursement	
	CY17	CY18	CY17	CY18	CY17	CY18
Repriced Dollars Greater than Incurred Dollars	$2,479,638	$2,104,588	10.8%	8.8%	79.0%	68.6%
Repriced Dollars Less than Incurred Dollars	$20,462,220	$21,843,934	89.2%	91.2%	160.9%	160.7%
Total	$22,941,857	$23,948,522	100.0%	100.0%	144.7%	143.7%

1 – CAH Medicaid Expansion Program Reimbursement

If you have any questions or feedback regarding this memo, please feel free to contact us.

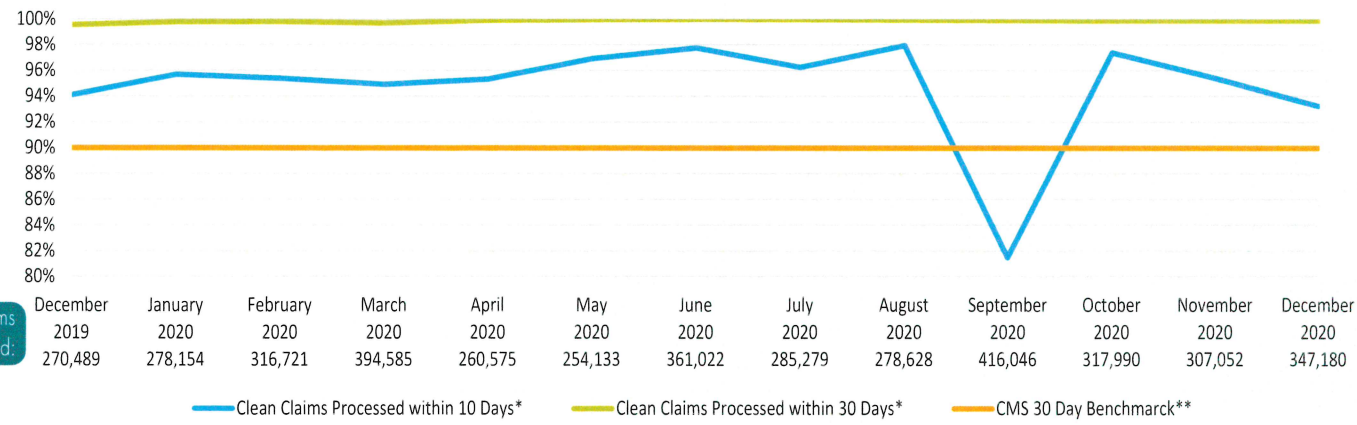
NORTH DAKOTA MEDICAID

Updated 1/20/2021

MONTHLY PAID CLAIMS REPORT

RADITIONAL MEDICAID

30 Day Prompt Pay Results



Clean Claims Processed:	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
	270,489	278,154	316,721	394,585	260,575	254,133	361,022	285,279	278,628	416,046	317,990	307,052	347,180

*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**PER CFR 42 § 447.45 - TIMELY CLAIMS PAYMENT - STATE MUST PAY 90% OF CLEAN CLAIMS WITHIN 30 DAYS AND 99% OF CLEAN CLAIMS WITHIN 90 DAYS

HTTPS://WWW.GOVINFO.GOV/CONTENT/PKG/CFR-2011-TITLE42-VOL4/PDF/CFR-2011-TITLE42-VOL4-SEC447-45.PDF

90 Day Prompt Pay Results



Clean Claims Processed:	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
	270,489	278,154	316,721	394,585	260,575	254,133	361,022	285,279	278,628	416,046	317,990	307,052	347,180

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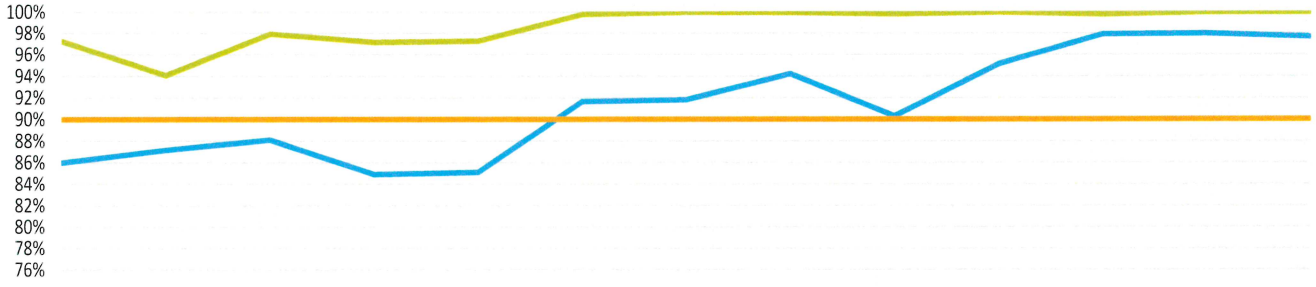
NORTH DAKOTA MEDICAID

Updated 1/20/2021

MONTHLY PAID CLAIMS REPORT

MEDICAID EXPANSION

30 Day Prompt Pay Results



Clean Claims Processed:	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
	33,362	37,721	33,997	38,565	39,139	46,600	33,620	43,584	37,897	49,626	46,765	39,860	49,076

Clean Claims Processed within 10 Days* — Clean Claims Processed within 30 Days* — CMS 30 Day Benchmarck**

*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

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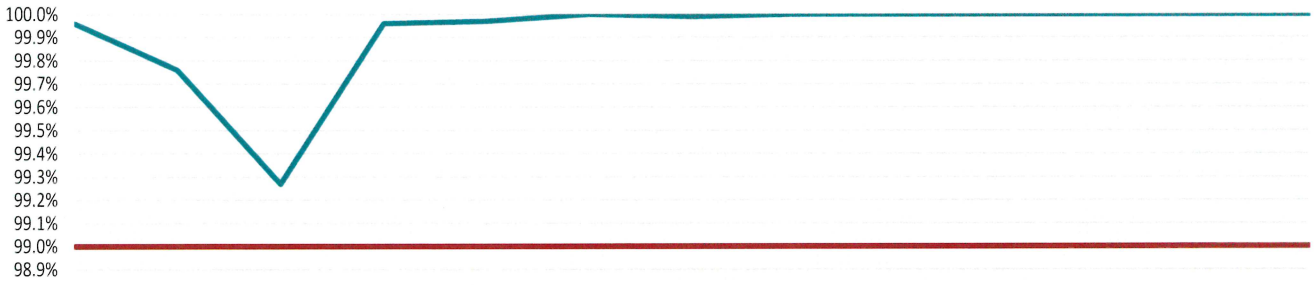
90 Day Prompt Pay Results



Clean Claims Processed:	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
	332,362	37,721	33,997	38,565	39,139	46,600	33,620	43,584	37,897	49,626	46,765	39,860	49,076

Clean Claims Processed within 90 Days* — CMS 90 Day Benchmarck**

*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

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PAPER CLAIMS SUBMISSIONS

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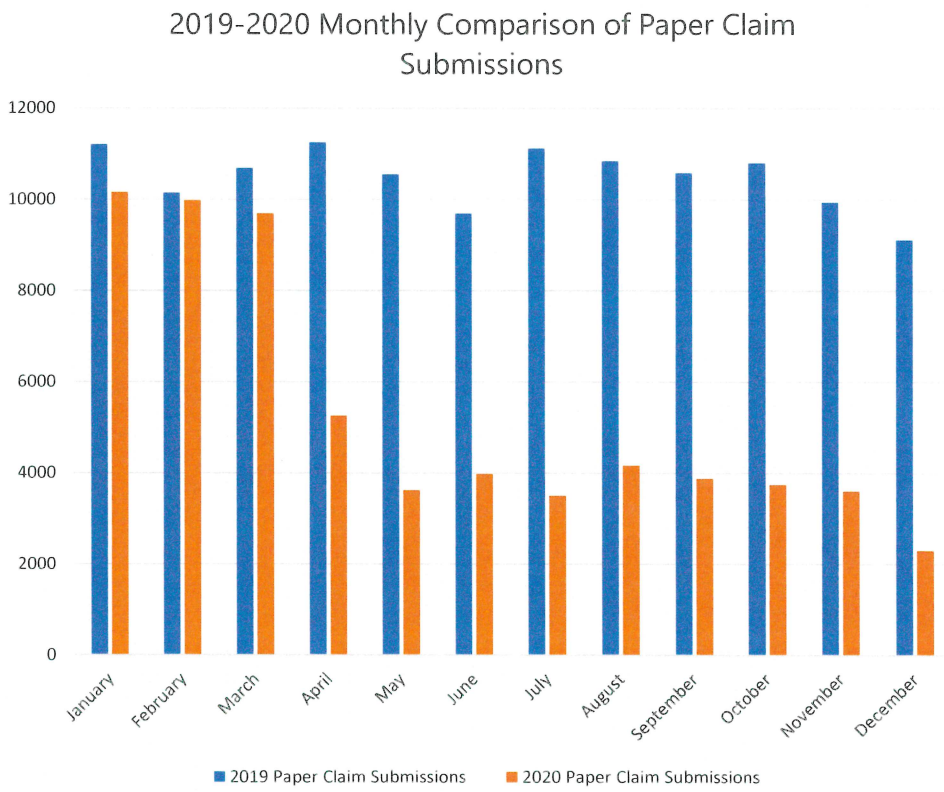
- As of April 15, 2020, paper claims are no longer being accepted by the department unless an exemption had been automatically granted or approved by North Dakota Medicaid.
- Exceptions were given to providers submitting less than 25 claims in a calendar year.
- LTC facilities where Medicaid is not the primary payer or PRTFs.
- Individual QSP providers and those providers that do not bill with an ICD-10 diagnosis code.
- 2019=125,944 paper claims
- 2020=63,829
- Decrease of 50.68%



PAPER CLAIMS SUBMISSIONS

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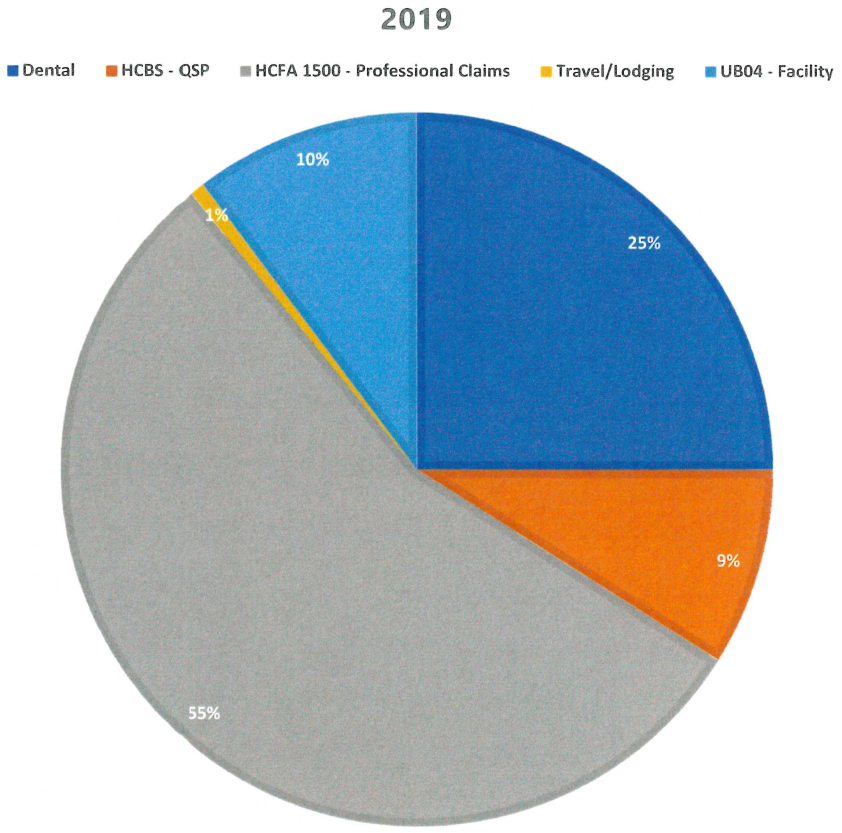

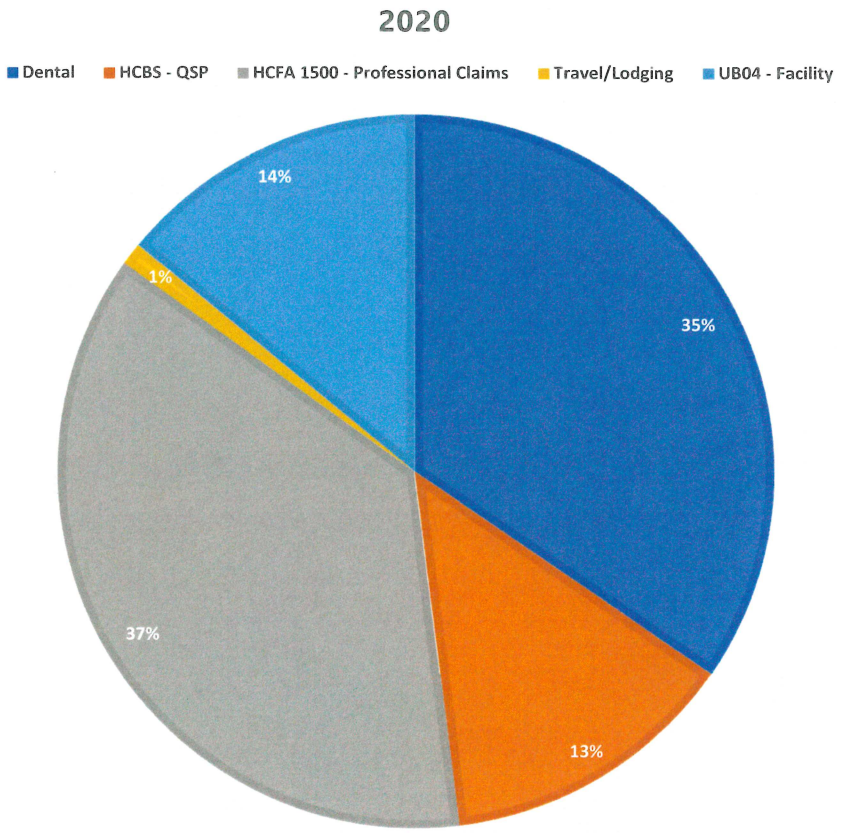

PAPER CLAIMS SUBMISSIONS
2019-2020 Comparison

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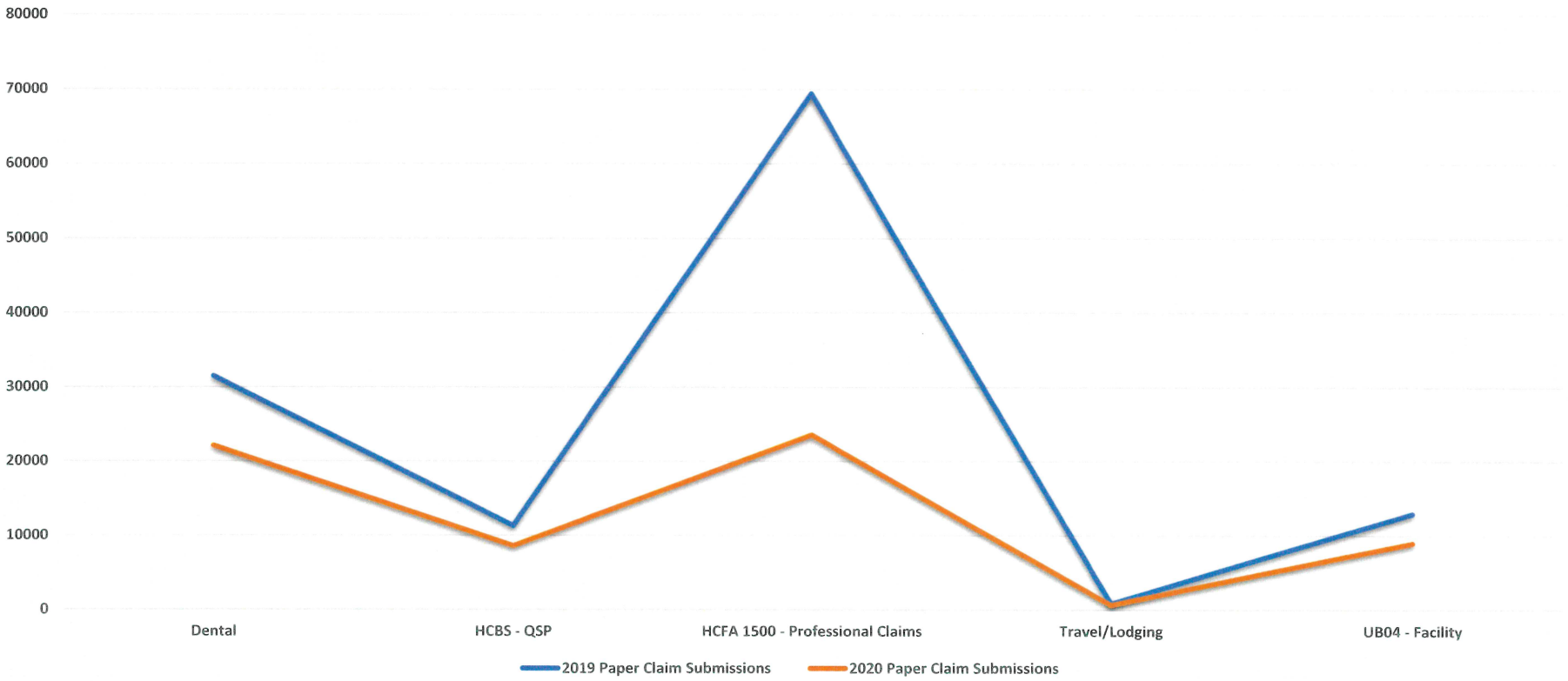

PAPER CLAIMS SUBMISSIONS
Top 15 Providers Submitting Paper Claims in 2019

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Medical Providers

- Altru Health System
- FM Ambulance
- Metro Area Ambulance
- Community Ambulance
- Cass County Social Services
- North Central Human Service Center
- Altru Health Ambulance
- T&K Speech
- Trinity Medical Group(Physicians)

Dental Providers

- Bridging the Dental Gap
- High Plains Dental
- Valley Oral & Facial Surgery
- Bridge City Dentistry
- Pediatric Dentistry LTD
- Joy Dental Design

CLAIMS SUBMISSIONS
Claims Suspense Rate Per Month

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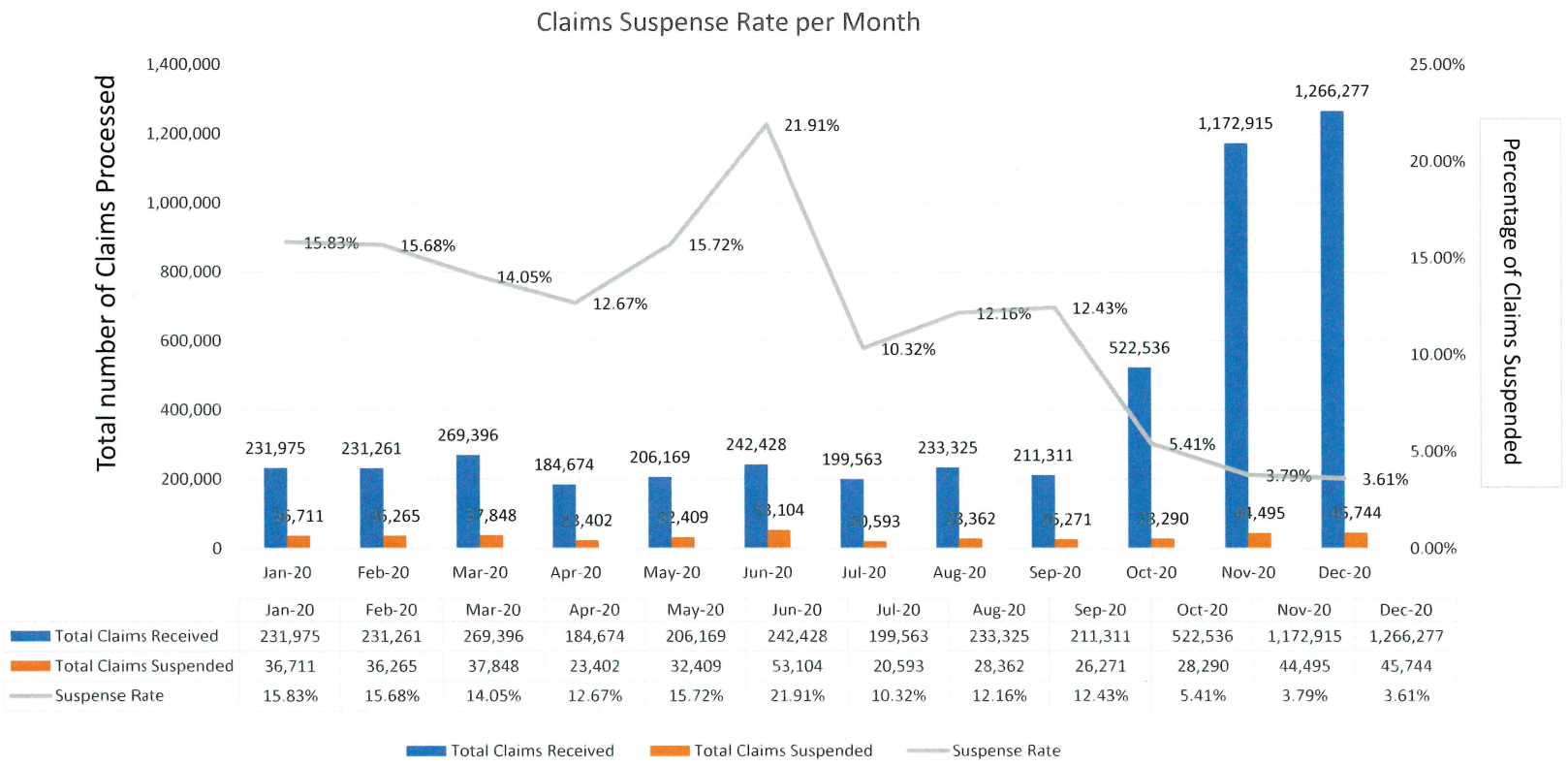

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Total Claims Received	231,975	231,261	269,396	184,674	206,169	242,428	199,563	233,325	211,311	522,536	1,172,915	1,266,277
Total Claims Suspended	36,711	36,265	37,848	23,402	32,409	53,104	20,593	28,362	26,271	28,290	44,495	45,744
Suspense Rate	15.83%	15.68%	14.05%	12.67%	15.72%	21.91%	10.32%	12.16%	12.43%	5.41%	3.79%	3.61%

SUSPENDED CLAIMS & TIMELY FILING

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- Claims that suspend in the MMIS system are monitored and tracked daily.
- Ensures Prompt Pay Requirements are being met.
- Assists providers with the timely filing process as they can view submitted claims via the web portal.
- There are several reasons that cause a claim to suspend for review
  - The recipient has a primary insurance.
  - The diagnosis code billed on the claim needs review by State Coding Staff.
  - The claim is an adjustment of an original claim.
  - Prior Authorization is needed.

DAILY CLAIM SUSPENSE REPORT

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Claim Types	0 - 10 days	11 - 20 days	21 - 30 days	31 - 60 days	61 - 90 days	OVER 90 days	Total Claim Counts	Total Billed Charges	Percent of Total Claim Count
Inpatient	70	0	30	10	0	16	126	$2,810,635.86	4.00%
Lab & Xray	53	15	44	5	0	22	139	$64,638.54	5.00%
MC Cap	4	0	0	0	0	0	4	$19,991.86	0.00%
Lng Trm Cr	20	5	5	4	0	0	34	$299,488.77	1.00%
Outpatient	148	47	92	39	0	8	334	$1,225,755.72	12.00%
Pract/Phy	1173	261	350	307	12	37	2140	$983,604.50	74.00%
Med Sup	52	1	13	2	0	0	68	$86,731.24	2.00%
Transport	29	0	0	0	0	0	29	$1,025,864.75	1.00%
HCBS/DD	10	0	0	0	0	0	10	$57,495.08	1.00%
Totals	1559	329	534	367	12	83	2884	$6,574,206.32	100.00%

TIMELY PAYMENT TO PROVIDERS

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- To increase the timeliness of payments to providers from NDMA is for providers to receive payment via the electronic fund transfer process(EFT).
- Currently 964 providers still receive paper checks
- Top Providers Still Receiving Paper Checks Weekly
  - Dakota Kids Dentistry
  - Valley Oral and Facial Surgery
  - Goebel DDS
  - CVS Pharmacy
  - Heart of America Medical Center-Rugby/Dunseith/Maddock
  - Nelson County Health System
  - Eventide Devils Lake Care Center
  - Alpha Opportunities
  - Sanford Health Care Accessories

CLAIM DENIAL RATE FOR TOP 6 PROVIDERS

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PROVIDER TRAININGS

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- January 2020
  - Training to Hospital billing staff in Minot
- February 2020
  - Training to Hospital billing staff in Jamestown
- March 2020
  - Training/Meeting with CHI
- June 2020
  - Professional Web Portal Training via Teams
- July 2020
  - Dental Web Portal Training via Teams
- August 2020
  - Institutional Web Portal Training via Teams

North Dakota Department of Human Services

ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2020

Family Size	(MAGI Equivalent of Approximately 50% of PL) Parents and Caretakers		Adults age 19 and 20 and Medically Needy for Pregnant Women (90% of PL)		Medically Needy Individuals up to age 21 (92% PL)		Medically Needy Parents, Caretakers and their Spouses (93% PL)		Adult Expansion Group (Ages 19 to 65) & Children (Ages 6 to 19) 138% of the PL		Children (Ages 0 to 6) 152% of the PL		Pregnant Women 162% of the PL	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$517	$6,204	$ 957	$11,484	$ 979	$ 11,739	$ 989	$ 11,867	$ 1,468	$ 17,609	$ 1,617	$ 19,395	$ 1,723	$ 20,671
2	694	8,328	1,293	15,516	1,322	15,861	1,337	16,033	1,983	23,791	2,184	26,205	2,328	27,929
3	871	10,452	1,629	19,548	1,666	19,982	1,684	20,200	2,498	29,974	2,752	33,014	2,933	35,186
4	1,048	12,576	1,965	23,580	2,009	24,104	2,031	24,366	3,013	36,156	3,319	39,824	3,537	42,444
5	1,226	14,712	2,301	27,612	2,353	28,226	2,378	28,532	3,529	42,338	3,887	46,634	4,142	49,702
6	1,403	16,836	2,637	31,644	2,696	32,347	2,725	32,699	4,044	48,521	4,454	53,443	4,747	56,959
7	1,580	18,960	2,973	35,676	3,040	36,469	3,073	36,865	4,559	54,703	5,022	60,253	5,352	64,217
8	1,757	21,084	3,309	39,708	3,383	40,590	3,420	41,032	5,074	60,886	5,589	67,062	5,957	71,474
9	1,934	23,208	3,645	43,740	3,726	44,712	3,767	45,198	5,589	67,068	6,156	73,872	6,561	78,732
10	2,111	25,332	3,981	47,772	4,070	48,834	4,114	49,364	6,105	73,250	6,724	80,682	7,166	85,990
+1	$178	$2,136	$ 336	$ 4,032	$ 344	$ 4,122	348	$ 4,166	$ 516	$ 6,182	$ 568	$ 6,810	$ 605	$ 7,258

Family Size	Optional Targeted Low-Income Children (CHIP) 175% of PL	
	Monthly	Yearly
1	$1,861	$22,330
2	2,515	30,170
3	3,168	38,010
4	3,821	45,850
5	4,475	53,690
6	5,128	61,530
7	5,781	69,370
8	6,435	77,210
9	7,088	85,050
10	7,741	92,890
+1	$ 654	$ 7,840

Maintenance of Effort – Medicaid

Family Size	111% of Federal Poverty Level		133% of Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly
1	$1,181	$14,164	$1,415	$16,971
2	1,595	19,110	1,911	22,929
3	2,010	24,109	2,408	28,888
4	2,424	29,082	2,904	34,846
5	2,838	34,055	3,401	40,804
6	3,253	39,028	3,897	46,763
7	3,667	44,000	4,394	52,721
8	4,082	48,973	4,890	58,680
9	4,496	53,946	5,387	64,638
10	4,910	58,919	5,884	70,596
+1	$ 415	$ 4,973	$ 497	$ 5,958

North Dakota Department of Human Services
NON-ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2020

Family Size	SSI Effective 01-01-2021	Medically Needy 83% of Poverty	QMB 100% of Poverty	SLMB 120% of Poverty	QI-1 135% of Poverty	Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty	Children With Disabilities 250% of Poverty
1	$ 794	$ 883	$ 1,064	$ 1,276	$ 1,436	$ 2,127	$ 2,393	$ 2,659
2	1,191	1,193	1,437	1,724	1,940	2,874	3,233	3,592
3	[redacted]	1,503	1,810	2,172	2,444	3,620	4,073	4,525
4		1,813	2,184	2,620	2,948	4,367	4,913	5,459
5		2,123	2,557	3,068	3,452	5,114	5,753	6,392
6		2,432	2,930	3,516	3,956	5,860	6,593	7,325
7		2,742	3,304	3,964	4,460	6,607	7,433	8,259
8		3,052	3,677	4,412	4,964	7,354	8,273	9,192
9		3,362	4,050	4,860	5,468	8,100	9,113	10,125
10		3,672	4,424	5,308	5,972	8,847	9,953	11,059
+1		$ 310	$ 374	$ 448	$ 504	$ 747	$ 840	$ 934

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/2021)	Community Spouse Maximum Asset Allowance (Effective 01/01/2021)	Community Spouse Income Level (Effective 01/01/16)	Income Level for each Additional Individual
$26,076	$130,380	$2,550	$718 Eff 7/20 $703 Eff. 7/19

Average Cost of Nursing Care

Average Monthly Cost of Care (Effective 01/01/2021)	Average Daily Cost of Care (Effective 01/01/2021)	Nursing Care Income Level (Effective 10/01/2013)	Medicare Premium (Effective 01/2021)	Medicare Savings Program Asset Limit (Effective 01/01/2020)
$9,522.85	$313.08	LTC $65 ICF/IID $100	$148.50 premium for newly Medicare eligible in 2021	1 Person - $7,860 Couple - $11,800



North Dakota's Quality Strategy for Medicaid

Medical Services Division

January 2021

NORTH Dakota | Human Services

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North Dakota's Quality Strategy for Medicaid

I. Introduction and Overview

A. History of North Dakota Medicaid

Medicaid was established in 1965, authorized by Title XIX of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) administers and oversees Medicaid at the federal level. The Department of Human Services administers and oversees Medicaid in North Dakota.

Over the years, CMS and Congress have strengthened and enhanced Medicaid to ensure recipients would have access to cost-effective, high quality health care. Access has been expanded through legislative action. For example, in 1997 the Children's Health Insurance Program (CHIP) was created to provide health insurance and preventive care to millions of uninsured American children whose family's income are slightly higher than the Medicaid income levels. In 2013, North Dakota opted to accept federal funding to expand access under the Patient Protection and Affordable Care Act (ACA), which allowed for coverage to low-income adults without dependent children. In 2014, Medicaid Expansion coverage became effective through a private managed care organization in North Dakota.

Medicaid and CHIP offer health insurance and preventative care to low-income families, pregnant women, people of all ages with disabilities, and people who need long-term care. Table 1 provides historical enrollment information for the total North Dakota Medicaid population.

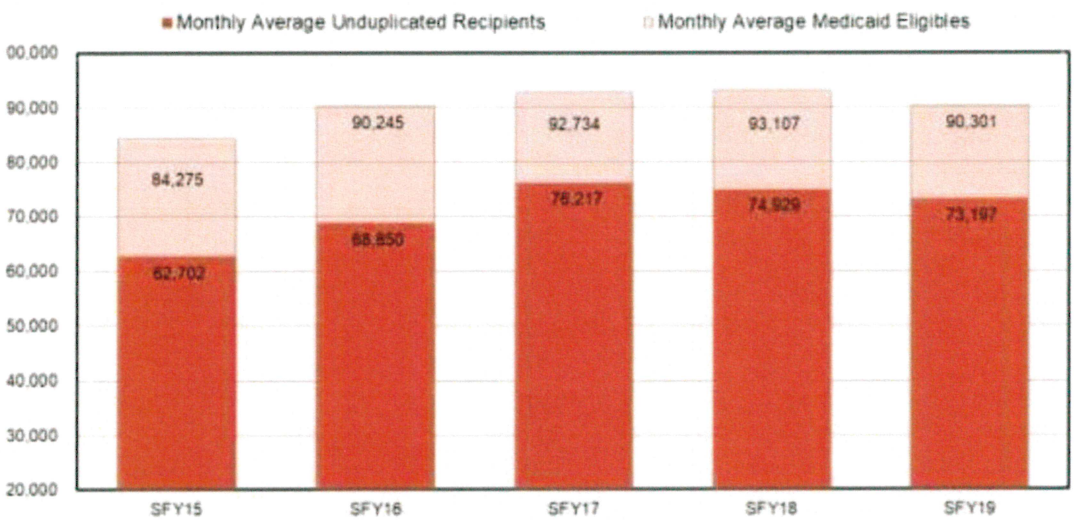


Table 1: *Total Eligible Medicaid Populations for FY 2020*

Funding for Medicaid is shared between states and the federal government. In North Dakota, the funding is approximately equal.

B. History of Medicaid Quality

Although states may have been addressing quality in their Medicaid programs, the first foray to address quality comprehensively at the national level occurred in 2009. The Children's Health Insurance Program Reauthorization Act of 2009 required CMS to develop a core set of children's health care quality measures to monitor the quality of care and health outcomes for children enrolled in Medicaid and CHIP. States were asked to voluntarily report on these measures. By 2010, an initial Child Core Set of measures were developed and published using existing quality of care measures, specifically focusing on:

- availability and effectiveness of preventive services,
- treatment and management of chronic conditions, and
- patient experiences with care.

The ACA required CMS to develop a core set of adult health care quality measures in

Medicaid. States were asked to voluntarily report on these measures. The initial Adult Core Set included quality of care measures that focused on:

- preventative care,
- management of chronic conditions,
- behavioral health treatment, and
- patient experiences with care.

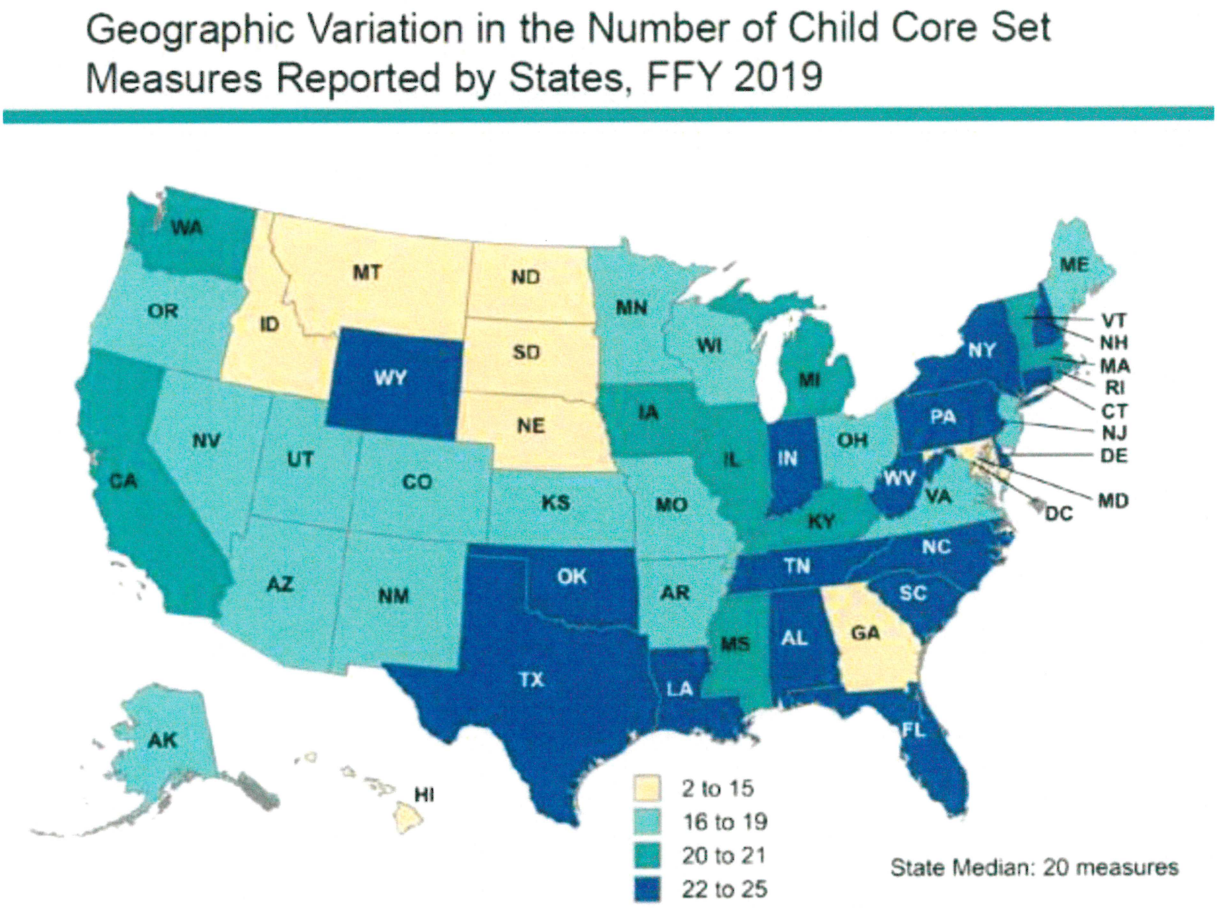
Since 2009 the number of measures, and sometimes the specifications for the measures, have been refined. Currently, for federal fiscal year (FFY) 2020, there are 24 measures in the Child Core Set and 33 measures in the Adult Core Set (Appendix 1). The Child and Adult Core Sets are reviewed and updated annually for reporting feasibility and clinical relevance. The goals of the Child and Adult Core Sets are to facilitate standardized reporting by states on a uniform set of performance measures and encourages states to use results to drive quality improvements. The Child and Adult Core Sets also allow states, the public, and CMS to monitor trends in performance on standardized indicators of quality of care provided to Medicaid and CHIP members under both fee-for-service (FFS) and managed care arrangements and examine performance across states.

As part of the Balanced Budget Act of 2018 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, states will be required to report on all measures in the Child Core Set for children enrolled in Medicaid and CHIP and on all the behavioral health measures in the Adult Core Set for adults enrolled in Medicaid. The behavioral health measures evaluate the quality of substance use disorder treatment services.

In 2018, CMS launched the Medicaid and CHIP Scorecard initiative to provide greater public transparency about the Medicaid and CHIP program administration and quality of care performance. The Scorecard aligns states' and CMS' efforts to drive quality improvements that improve health outcomes for Medicaid and CHIP members using standardized performance measures. The Scorecard is comprised of three pillars: (1)

State Health System Performance, (2) State Administrative Accountability, and (3) Federal Administrative Accountability.[1] Like the Child and Adult Core Sets, the Scorecard measures will continue to evolve over time.

From 2014 to 2018 North Dakota submitted one quality measure: access to preventive dental services for children aged 1 to 20. In 2019, North Dakota submitted 13 Child Core Set measures.



Sources: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020; Form CMS-416 reports for the FFY 2019 reporting cycle as of July 1, 2020, and Centers for Disease Control and Prevention Wide-ranging ONline Data for Epidemiologic Research (CDC WONDER) for calendar year 2018.

Figure 1: *Geographic variation in the number of Child Core Set measures reported by States, FFY 2019*

In 2020, North Dakota reported on 21 Child Core Set measures, 14 Adult Core Set

[1] https://www.medicaid.gov/state-overviews/scorecard/index.html

measures for Traditional Medicaid and 22 Adult Core Set measures for Medicaid Expansion.

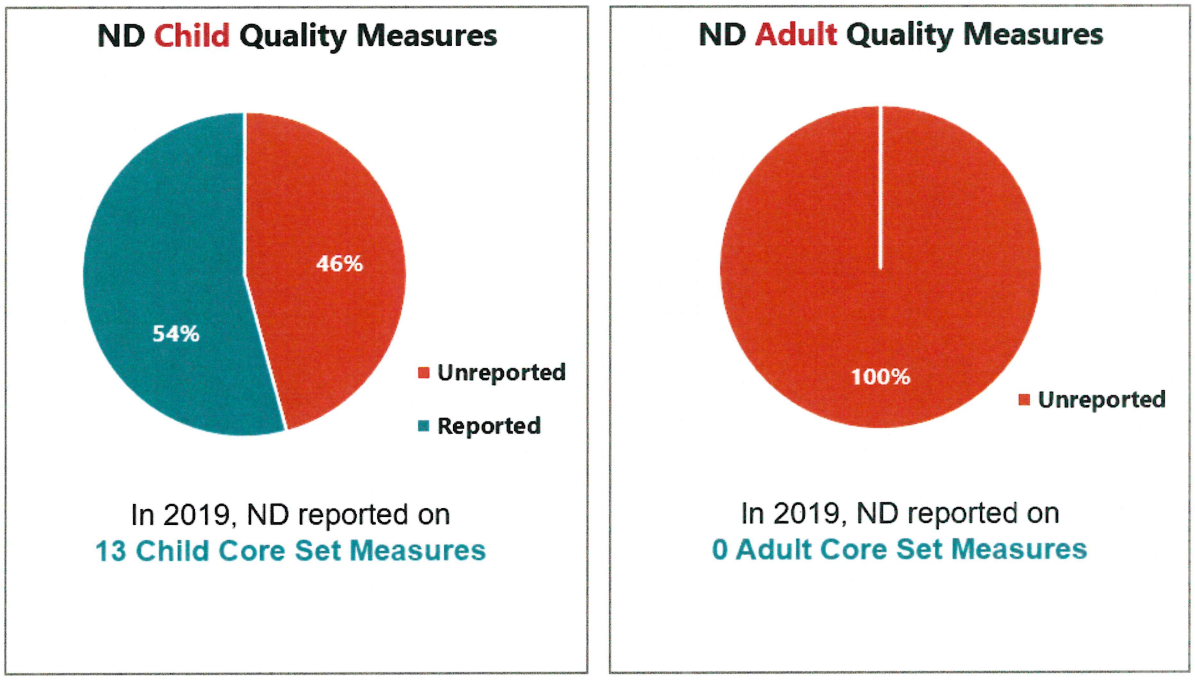


Figure 2: *North Dakota FFY 2019 Reported Measures*

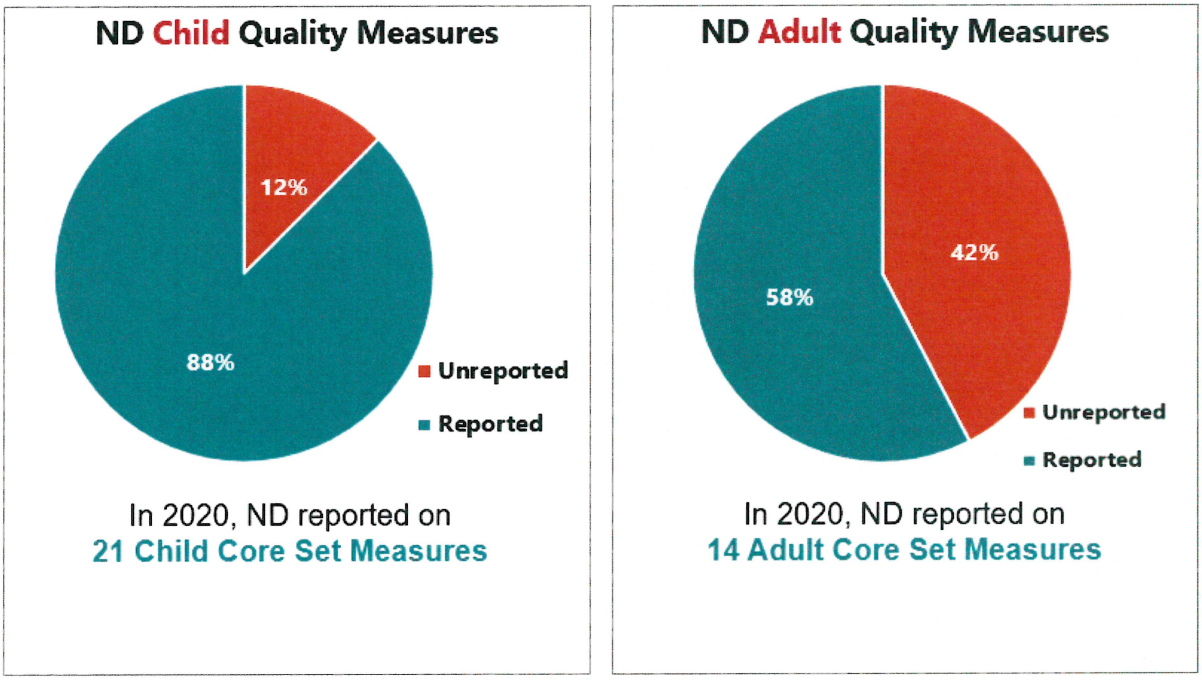


Figure 3: *North Dakota FFY 2020 Reported Measures*

C. North Dakota's Medicaid Quality Strategy

North Dakota's Medicaid Quality Strategy is designed to build healthier communities focusing on the health outcomes of target populations. Medicaid addresses both

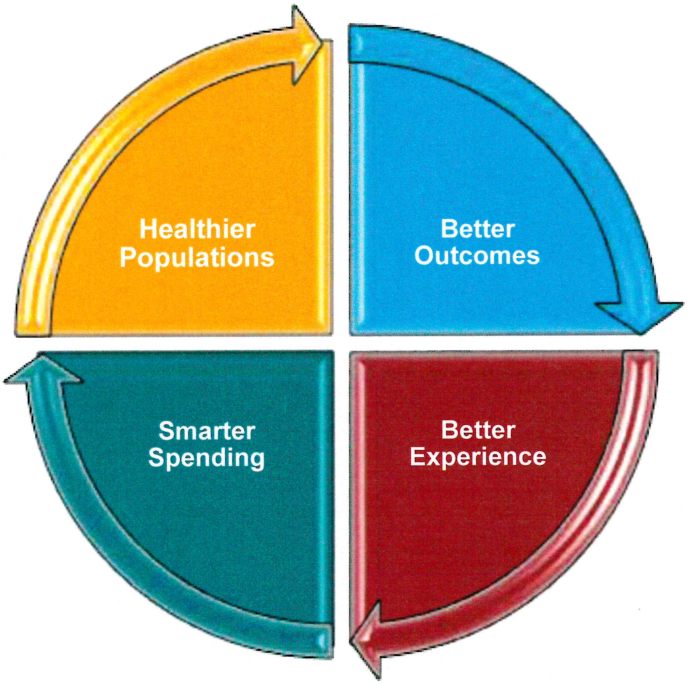


Figure 2: *Quadruple Aim for North Dakota Medicaid*

medical and non-medical health drivers to promote health equality by using the Quadruple Aim: (1) Healthier Populations, (2) Better Outcomes, (3) Smarter Spending, and (4) Better Experience.

Included in each of these four aims is a series of five goals and 10 objectives. As shown in Figure 2, these aims, goals, and objectives create the framework through which North Dakota defines the overall vision for improving quality of care for Medicaid members.

AIMS	GOALS	OBJECTIVES

Healthier Populations	**Goal 1:** **Promote wellness and prevention** **Goal 2:** **Improve Chronic Condition management**	**Objective 1.1:** Promote child health, development, and wellness **Objective 1.2:** Promote maternal health **Objective 2.1:** Improve behavioral health care **Objective 2.2:** Improve asthma management
Better Outcomes	**Goal 3:** **Ensure appropriate access to care**	**Objective 3.1:** Ensure timely access to care **Objective 3.2:** Link patients to appropriate care management services
Smarter Spending	**Goal 4:** **Pay for Value**	**Objective 4.1:** Report Medicaid Quality Measures **Objective 4.2:** Ensure high-value, appropriate care
Better Experience	**Goal 5:** **Enhance experience of care**	**Objective 5.1:** Promote patient engagement in care **Objective 5.2:** Maintain Medicaid provider engagement

Figure 3: *North Dakota's Quality Strategy Aims, Goals, and Objectives*

The development of the Quality Strategy aims, goals, and objectives reflect the opportunity for targeted quality improvement activities for Medicaid members. The Quality Strategy and objectives recognize that significant processes are aligned closely with the quality measures and activities that will drive improvement in the health of Medicaid members.

The objectives aligned with **Goal 1** (promote wellness and preventions) reflect an emphasis on improving the health of children and maternal health.

The objectives aligned with **Goal 2** (improve chronic condition management) focus on chronic conditions that significantly impact the North Dakota Medicaid populations, including asthma and behavioral health.

Many objectives tie to **Goal 3** (ensure appropriate access to care) which recognizes the need to maintain and expand access to appropriate care in a timely manner.

The objectives aligned with **Goal 4** (pay for value) reflect the importance of data transparency with public reporting of the quality measures and recognizes the importance of provider accountability to help drive high quality care to improve population health.

The objectives related to **Goal 5** (enhance experience of care) focus on member engagement in their health care, member satisfaction, provider engagement that drives patient-centered care, and ensuring members are linked to needed care management.

D. North Dakota's Quality Strategy for Medicaid

North Dakota Medicaid's Quality Strategy is based on a framework that can be used to facilitate the transformation of North Dakota's traditional fee-for-service Medicaid program to a value-based purchasing program. The Quality Strategy was designed and refined with stakeholder consideration, involvement, and feedback. The Quality Strategy is grounded in population health, which allows the Medicaid population to be categorized into targeted sub-groups and highlight specific care areas including: (1) prevention, (2) prenatal and postnatal care, (3) behavioral health, and (4) management of chronic conditions. The Quality Strategy is meant to be overarching. Individual

divisions within DHS such as Aging, Developmental Disabilities, and Behavioral Health might develop their own specific goals and objectives that fit into the overarching framework.

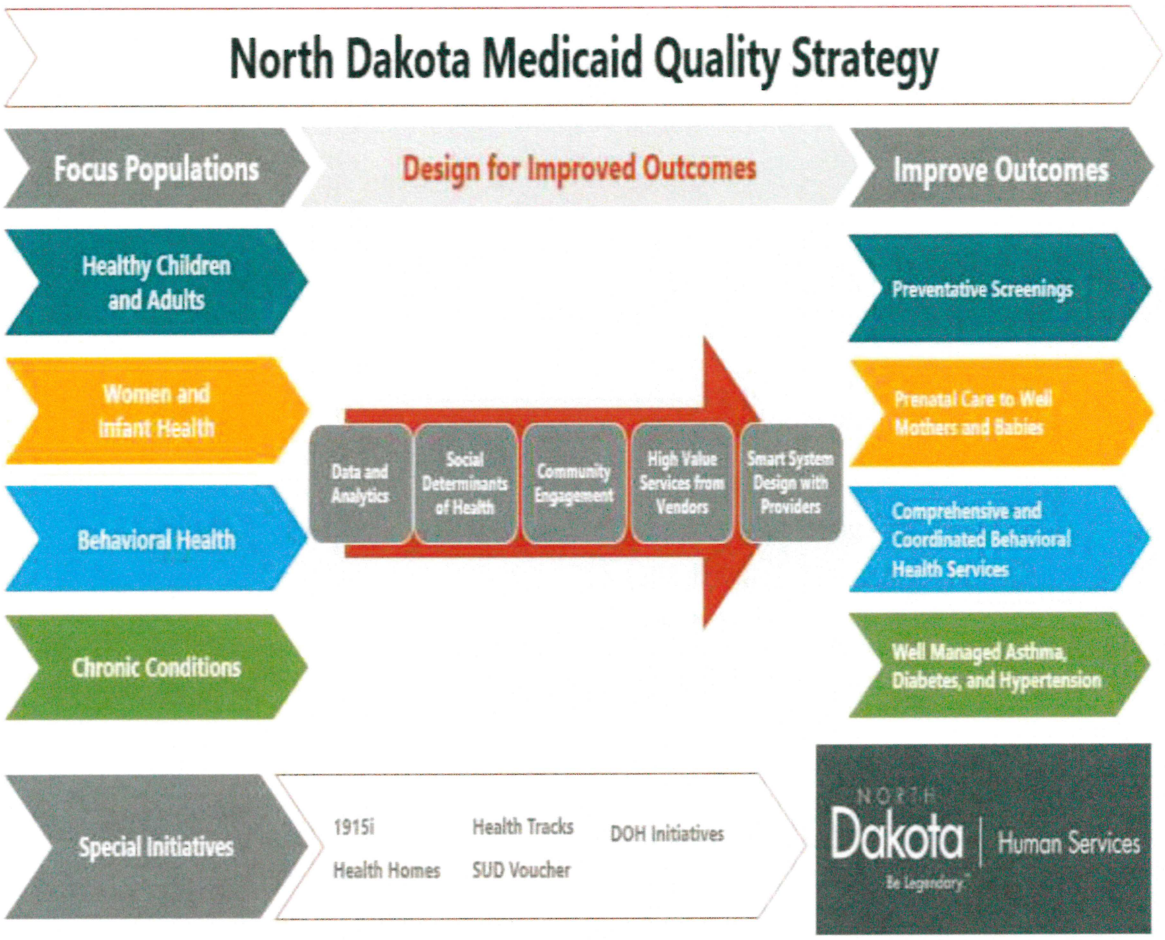


Figure 4: *North Dakota Medicaid Quality Strategy*

Through an emphasis on quality, North Dakota Medicaid aims to improve patient safety, health care outcomes, and add value in all care settings. North Dakota Medicaid aims to accomplish these through a collaborative process in which key stakeholders work together with Medicaid to promote strategies that:

- implement quality measures at the provider level.
- collect, aggregate, and report data in the most transparent way.
- report meaningful information to members, providers, and other stakeholders that can be used to inform decision-making and improve health outcomes.



Figure 5: *Medical Services Division Values*

Medicaid Expansion Quality Strategy

As part of the federal Managed Care Rule, Medicaid managed care organizations are required to have a quality strategy. North Dakota Medicaid has one managed care plan for the Medicaid expansion population. The quality strategy can be found in the Medicaid dashboard at http://www.nd.gov/dhs/services/medicalserv/medicaid/data.html. In addition to a quality strategy, the managed care plan is required to report on quality of care measures annually as well as engage in a performance improvement project. Highlights from the most recent quality of care data show that North Dakota Medicaid performs above the National Median on Child and Adolescent Immunizations.

The North Dakota Medicaid Quality team applied to participate in the Center for Medicaid and CHIP Services (CMCS) Oral Health affinity group. North Dakota Medicaid applied to participate in the Medicaid and CHIP Oral Health Affinity Group CMCS's Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP members. The Medicaid Quality and Health Tracks teams have formed a workgroup that is collaborating with CMCS to develop a performance improvement project that focuses on improving oral health through prevention that will reduce childhood caries. This project is in the development phase, that will focus on improving North Dakota Medicaid's

performance in the following two Child Quality measures: (1) Sealant Receipt on Permanent First Molars and (2) Percentage of Eligibles Who Received Preventive Dental Services.

Other Quality Information: Nursing Facilities

In addition to the Child and Adult Core Sets and the Medicaid expansion quality of care measures, North Dakota Medicaid has other quality of care information. Consumers can compare the quality of care in long-term services and supports or specifically for nursing facilities (NF). For general state comparisons consumers can use the long-term care services and supports scorecard as produced by the SCAN Foundation.[2] Based on the SCAN scorecard, North Dakota ranks 37th in the country on its performance in measures for affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and, effective transitions. The scorecard measures specific to NFs are presented in Table 2 below.

Performance Measures	North Dakota rank out of 50 states **2017**	North Dakota rank out of 50 states **2020**
Median annual nursing home private pay cost as a percentage of median household income age 65+	**48**	**48**
Percent of high-risk nursing home residents with pressure sores	**8**	**1**
Percent of nursing home residents who are receiving antipsychotic medication	**37**	**44**
Percent of nursing home residents with low care needs	**38**	**41**
Percent of long-stay nursing home residents hospitalized within a 6-month period	**17**	**22**
Percent of people with 90+ day nursing home stays successfully transitioned back to community	**50**	**48**

[2] http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/North%20Dakota%20Fact%20Sheet.pdf

Percent of nursing home residents with one or more potentially burdensome transitions at end of life	**9**	**5**

Table 2: *North Dakota's rank on performance measures*

For more NF specific quality of care information consumers can utilize Nursing Home Compare, a website sponsored by Medicare.[3] The website provides information on all Medicare and Medicaid certified NFs and on state survey agencies, ombudsman, and guidance for consumers. ND NFs are rated on a 5-star continuum for overall rating (5 is the highest), health inspections, staffing, and quality measures. Data comes from state surveys conducted by DOH, payroll-based journal, MDS, and Medicare claims. Medicare recently added a new feature to the website to denote facilities that have been cited for potential issues related to abuse.

Nationally, the percentage of NFs with a 5-star rating has increased over time indicating that the program is having a positive impact.[4] Table 3 shows the percentage of 1- and 5-star facilities for ND and surrounding states from 2009 to 2013.[5]

	Percent of 1-star facilities in 2009	Percent of 1-star facilities in 2013	Percent of 5-star facilities in 2009	Percent of 5-star facilities in 2013
North Dakota (n=80)	**8.4%**	**3.7%**	**14.5%**	**33.3%**
South Dakota (n=104)	**14.7%**	**6.4%**	**15.6%**	**24.5%**
Minnesota (n=367)	**14.5%**	**5.0%**	**16.0%**	**29.4%**
Wyoming (n=36)	**20.5%**	**7.9%**	**12.8%**	**31.6%**
Montana (n=70)	**14.3%**	**4.8%**	**15.4%**	**24.1%**

Table 3: *The percentage of 1- and 5-star facilities*

On Nursing Home Compare quality of care is reported separately for short and long stay

[3] https://www.medicare.gov/nursinghomecompare/search.html
[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/NHC-Year-Five-Report.pdf
[5] Ratings for January 2009 and December 2013 by state. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/NHC-Year-Five-Report.pdf

residents. Short stay residents typically have a goal to improve their health and return to their homes whereby long stay residents will likely stay in the facility. Short stay quality measures used to calculate the star rating include:

- Percentage of residents re-hospitalized
- Percent of residents with an outpatient emergency department visit
- Percentage of residents who got an antipsychotic medication
- Percent of residents with new or worsened pressure ulcers
- Percent of residents whose ability to move improved

Long stay quality measures used to calculate the star rating include:

- Number of hospitalizations per 1,000 days
- Number of outpatient emergency department visits per 1,000 days
- Percentage of residents who got an antipsychotic medication
- Percent of residents with 1 or more falls
- Percent of residents with pressure ulcers
- Percent of residents with urinary tract infection
- Percent of residents with a catheter
- Percent of residents whose inability to move worsened
- Percent of residents whose need for help with daily living increased

There are several other quality measures that do not contribute to the star ratings for short- and long-term stays.

Other Quality Information: Hospitals

Hospitals in North Dakota each have an overall star rating on the Hospital Compare website. The Hospital Compare website is a consumer-oriented website that allows consumers to compare hospitals' data on patients' experiences, outcome of care measures, use and overuse of medical procedures, and the volume of Medicare payments. The Overall Hospital Compare Star Rating is a 5-star rating that summarizes hospital performance based on indicators of quality, patient satisfaction survey, and volume of Medicare payments. Table 4 represents the Overall Star Rating for North

Dakota hospitals.

Star Rating	Hospital
★★★★	CHI St. Alexius Health Bismarck
★★★★	Essentia Health Fargo
★★	Altru Hospital Grand Forks
★★	Sanford Medical Center Bismarck
★★	Sanford Medical Center Fargo
★★	Trinity Hospital Minot

*Rating based on current data collection periods from Hospital Compare, last updated on July 22, 2020

Table 4: *Overall Star Rating for North Dakota Hospitals*

Finally, North Dakota Medicaid does collect and report on several quality of care measures for hospitals through a contracted quality improvement organization (QIO) vendor. The QIO's annual report reviewed the volume of Medicaid claims payment per hospital, reported the highest billed Diagnosis-Related Group (DRG) claims for Medicaid, and reviewed prior authorization claims.

II. Value-Based Purchasing Models and Payment Reform

A. Value-Based Purchasing

Developing a quality strategy and documenting quality of care through reporting helps to provide a clearer picture of where the Medicaid program can target areas for improvement. States use different approaches to improve quality of care including

Category 1	•fee-for-service with no link to payment quality
Category 2	•fee-for-service with a link of payment to quality and value
Category 3	•alternative payment models build on a fee-for-service architecture
Category 4	•population-based payment

performance improvement plans, public-private quality collaboratives, and value-based purchasing models. There are several value-based purchasing models Medicaid programs can implement. These are best described in the U.S. Department of Health and Human Services (DHHS) and the Health Care Payment Learning and Action Network (LAN) framework for value-based purchasing. The framework describes Alternative Payment Models (APM) that are meant to align with public and private stakeholders in the shared goal of shifting away from the current Fee-For-Service (FFS), volume-based payment system to a model that pays for value. Figure 6 describes the LAN APM categories. Currently, North Dakota Medicaid is in Category 1.

Figure 6: *LAN APM Model*

A 2018 Health Care Payment LAN APM study revealed the following:

- 39.1% of health care dollars in Category 1
- 25.1% of health care dollars in Category 2
- 35.8% of health care dollars in a composite of Categories 3 & 4

The results highlight a continued movement away from a fee-for-service system that reimburses only on volume, and towards value-based purchasing APMs. In North Dakota, commercial insurers as well as Medicare have made more progress moving to higher categories than Medicaid. For example, Blue Cross Blue Shield of North Dakota has the Blue Alliance program which is a tiered APM system and there are seven areas in the State that participate in a Medicare ACO program.[6]

B. North Dakota Medicaid Current Models

The current delivery of care model for the traditional North Dakota Medicaid population is generally a FFS payment model. The Medicaid agency establishes the FFS reimbursement rates for covered services and pays participating providers directly for each service provided to Medicaid members. In a FFS payment model the providers do not bear any finical risk and they receive full payment for delivering the service regardless of the outcome. In the FFS delivery of care model, there is no organized

[6] http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/North%20Dakota%20Fact%20Sheet.pdf

provider network or coordinating entity.

North Dakota's Medicaid Expansion population receives care though a private managed care organization (MCO). The MCO is a health plan that contracts with the State to provide members with a set of Medicaid benefits for a prospectively set per member per month premium. The MCO is a comprehensive risk-based MCO that has both clinical and financial accountability for covered services provided to its members during their period of enrollment. The flow of funds in a risk based MCO arrangement is the State agency pays the MCO the negotiated per member per month premium times the number of enrollees then the health plan negotiates and pays providers directly through a FFS arrangement or a APM. Currently, the contracted managed care organization pays FFS.

In fall 2020, North Dakota Medicaid along with its stakeholders began exploring different value-based purchasing models. A working group of primary care providers is investigating the Health Homes model for beneficiaries with chronic conditions.

A working group of inpatient providers, including large hospitals and three large critical access hospitals, are investigating the following value-based purchasing delivery of care models through presentations and discussions.

C. Value-Based Purchasing Program for Hospitals

1. Episodes of Care

Episodes of Care is a value-based purchasing model that focuses on the total cost of care related to an episode. Providers or facilities that can deliver an episode below the benchmark cost can share in the realized savings. Providers or facilities that deliver an episode above the benchmark cost may be required to reimburse the State for the loss. Episodes are defined by a triggering event and may include services that are delivered pre and post the triggering event. Examples of triggering events are knee replacement surgery or emergency department visit related to asthma. Episodes are defined by the timeframe and settings. Building on the knee replacement example, the episode could

include post-acute rehabilitation provided by a physical therapist who may or may not be employed by the same health system as the physician financially responsible for the bundle. Clinical expertise is required to define an episode and several state Medicaid programs have their defined bundles available online such as Arkansas and Tennessee.

Benchmarks are needed for each episode so that facilities and providers understand not only what the clinical expectations are, but also the expected total costs. Providers bill the Medicaid program like they normally do under fee-for service. They are not paid in advance for the episode. At the end of the reporting period, typically one year, a reconciliation occurs, and the facility's total costs are compared to the benchmark. If the facility or provider manages the patient's care well and provides full care for less than the benchmark than the facility or provider can share the upside savings. If the cost of care exceeds the benchmark, no additional reimbursement will be received from Medicaid and in some states the facility or provider must pay the state back for the loss. To ensure patient care does not decline in the Episode of Care model, facilities or providers are required to meet specific minimum quality thresholds to ensure cost is not the only consideration while managing members' care.

2. Pay-for-Performance

Pay-for-Performance (P4P) is a delivery of care model that focuses on improving the quality and efficiency of care by incentivizing providers to report on and in some cases improve their performance. The P4P payment model attaches financial incentives and disincentives to provider performance by tying reimbursements to metric-driven outcomes, proven best practice, and patient satisfaction. This allows payers to align payments with outcomes and provider performance. P4P is the most common payment model used to drive quality and add value to health care programs across all types of payers. As a result, providers are often subject to more than one set of performance measures that may or may not conflict with one another. Additionally, P4P programs need to address the social determinant of health by including health equity measures to produce fair provider comparisons and reward providers who performance will among socioeconomically disadvantaged patient populations to offset the additional financial

risk associated with care for these groups.

During value-based discussions with hospitals, Wisconsin Medicaid presented on its P4P program. For instance, the goal for the measurement year 2020, is to reduce FFS Potentially Preventable Readmissions (PPR) in the Wisconsin Medicaid Program by 7.5 percent. A withhold of 3 percent of inpatient, FFS claims will be applied for the Withhold P4P, which will apply to claims with dates of service from 1/1/2020 to 12/31/2020. Withheld funds will be returned to hospitals consistent with the incentive/penalty methodology, and payouts will occur based on 2020 performance.

3. Accountable Care Organizations

An Accountable Care Organization (ACO) is a network of doctors and hospitals that share financial and medical responsibility for the health care delivery and outcomes to a defined attributed population. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency. In an ACO there is a shared risk arrangement that includes both incentives payments based on quality performance, as well as shared savings. The structure of an ACO requires significant time, energy, and resources to develop. For rural areas, providers may need to seek out appropriate partnerships to participate fully in ACO models.

During value-based discussion with hospitals, Caravan Health presented on its ACO program that is operational in seven areas in North Dakota. This program is financed through Medicare.

4. Value-Based Purchasing Models: Pros and Cons

Based on the presentations and a review of literature, the following table describes the pros and cons for each value-based purchasing program that was reviewed.

VBP Programs	Pros	Cons
Episode of Care	▪ Potential to improve coordination among multiple caregivers ▪ Ability to support flexibility in how and where care is delivered ▪ Incentive to efficiently	▪ Need clinical input on episodes ▪ Patient behavior could impede results ▪ Providers may not want to coordinate pre and post trigger care

	manage an episode (reduce treatment/manage costs) ▪ Simplicity from a billing perspective and no provider reporting required ▪ Clear accountability for care for a defined episode ▪ Can be done with small facilities/ populations	
P4P	▪ Potential to improve coordination among multiple caregivers ▪ Ability to support flexibility in how and where care is delivered ▪ Incentive to efficiently manage an episode (reduce treatment/manage costs) ▪ Simplicity from a billing perspective (one bill instead of many) ▪ Clear accountability for care for a defined episode	▪ Difficulty of defining the boundaries of an episode (what care falls within and outside of the episode) ▪ Potential to increase barriers to patients' choice of provider and/or geographic preferences for care accountability for care for a defined episode
ACO	▪ It creates better communication throughout the entire exchange ▪ There are cost advantages to consider when joining an ACO ▪ It provides an opportunity to offer more comprehensive care ▪ Physician-driven treatment ▪ There is already evidence to suggest that the ACO model can be successful It can eliminate extra expenses for the patient ▪ There is full availability of a patient's medical history	▪ The cost of the IT infrastructure can be daunting to medical providers ▪ Sharing everything means that you also concede some decision-making opportunities ▪ There can be challenges with data security for your patients ▪ Medical providers must start to adapt to new ways of doing things ▪ There will be more patients that come through your medical practice ▪ ACOs do not offer a guarantee of success ▪ There is a time element to consider with ACOs ▪ Difficult implementation;

		for organizations that are already using some sort of EMR this task could be easier, but for those who have not then the financial and resource cost could prove to be more than a practice is willing to incur

Table 4: *Pros and Cons Table for VBP Models*

4. Survey Results

North Dakota Medicaid administered a Value-Based Purchasing (VBP) Model Survey to North Dakota Hospital Association (NDHA) members who attended the three VBP presentations that were hosted by North Dakota Medicaid. NDHA members were informed during the presentations that States that incorporate a VBP model into their Medicaid program can increase quality and possibly reduce or maintain costs. DHS administered the survey to understand NDHA member's preferred VBP model. DHS received a total of seven surveys from both Prospective Payment System (PPS) Hospitals and Critical Access Hospitals (CAHs). The six PPS Hospitals that submitted the survey were: Essentia, CHI St. Alexius, Altru, and Trinity. Sanford Bismarck and Sanford Fargo did not complete the survey. The three participating CAHs responded to the survey.

VBP Models	Top Pro	Top Con
Episode of Care	No changes to current billing procedures	If cost is above an acceptable threshold, the provider owes a payment back to the state.
Pay-For-Performance	Simplicity from a billing perspective (one bill instead of many).	Any non-claims based measures will take additional funds to calculate.
Accountable Care Organization	Provides an opportunity to offer more comprehensive care.	Number of patients in the ACO - fewer Medicaid patients can mean more difficulty for providers to manage care and spread risk.

Table 5: *VBP survey results for Top Pros and Top Cons*

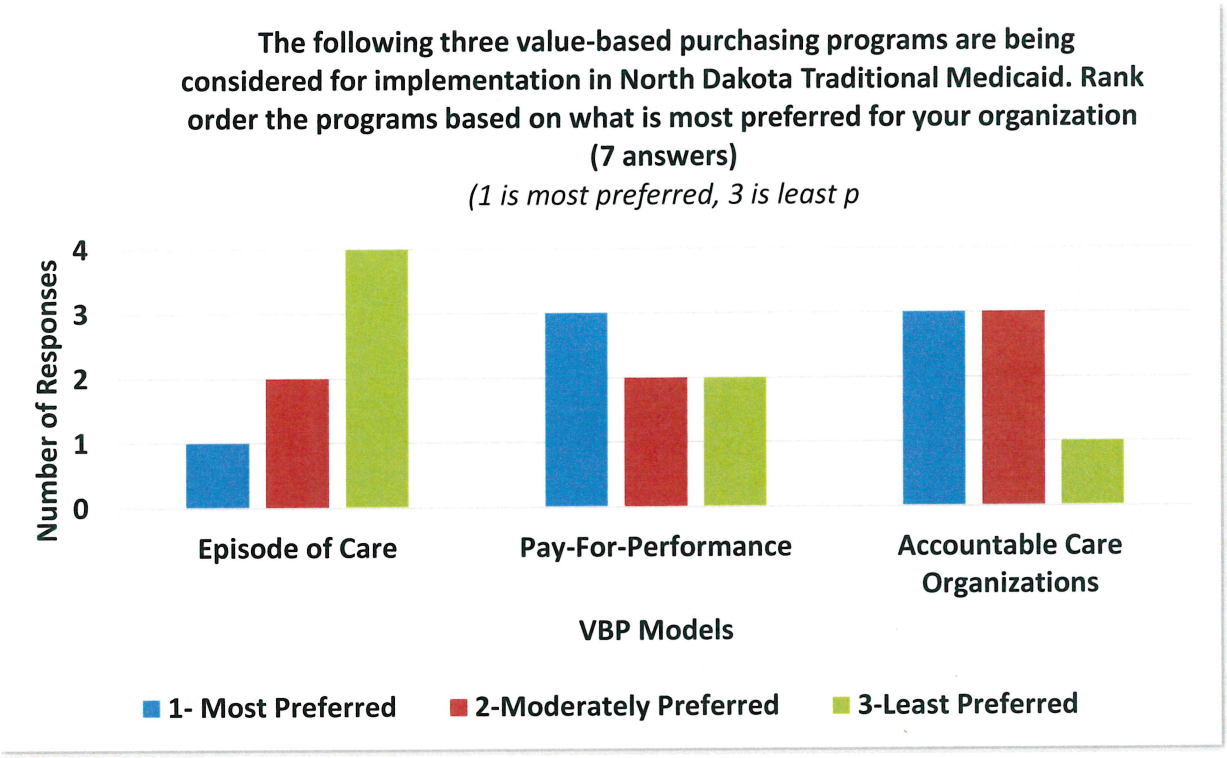


Figure 7: *VBP survey result for Question 1*

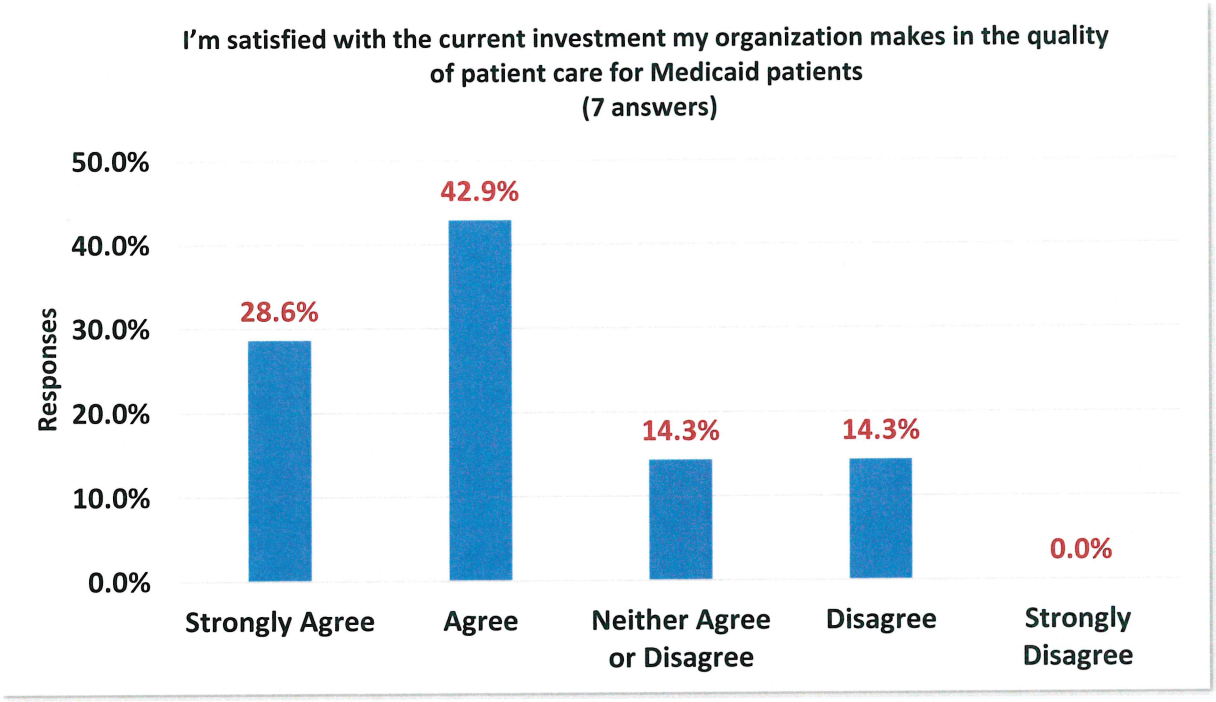


Figure 8: *VBP survey result for Question 10*

D. Value-Based Purchasing Model for Primary Care

The current delivery of care model using for primary care services in North Dakota Medicaid is the Primary Care Case Management (PCCM), which is a managed FFS arrangement with an additional $2 per member per month management fee. The PCCM model requires primary care providers to provide, locate, coordinate and monitor primary care service for Medicaid members.

PCCM requires each traditional Medicaid member to choose a primary care provider, or if they do not, one is chosen for them. Primary care providers must provide referrals and approve acute, non-emergency care in inpatient settings. Although the PCCM program has been in place for some time, there is concern with the $2 incentive, the rules related to attribution, and the lack of effectiveness. In 2020 North Dakota Medicaid hosted presentations from several states on models for primary care other than PCCM. South Dakota, Connecticut, and Alabama presented on their programs and stakeholder feedback indicated that Health Homes which were presented by South Dakota were a model that North Dakota Medicaid should further explore. A working group was established to discuss the model, the parameters that need to be decided, and possible chronic conditions to target.

1. Health Homes

The Health Homes model, authorized in Section 1945 of the Social Security Act, is designed to coordinate healthcare and social services for Medicaid members with chronic conditions, including behavioral health conditions. Health Homes emphasize a whole-person approach for high-risk Medicaid members with chronic conditions through the integration and coordination of primary, acute, behavioral health, and long-term services and support. The Health Home services include: (1) Comprehensive Care Management, (2) Care Coordination, (3) Health Promotion, (4) Comprehensive Transitional Care and Follow-Up, (5) Patient and Family Support, and (6) Referral to Community and Social Support Services. The goals of Health Homes are to reduce the cost of care and improve quality. This is typically accomplished by reducing emergency department use, hospital admissions, and re-admissions of member with chronic conditions through improved disease management. Medicaid members eligible for the

Health Home program are those who: (1) Have two or more chronic conditions, (2) Have one chronic condition and are at risk for a second, and (3) Have one serious and persistent mental health condition. Participation is voluntary for members and providers. Participating providers need to consider their available and/or existing resources to appropriately care for this complex high-risk member population. Providers who are able to provide one of the core services on a routine basis and meet quality benchmarks are eligible to receive a supplemental per member per month payment. The payments usually increase based on the complexity of the member and are paid out quarterly or semi-annually. Evidence from South Dakota shows that the costs avoided to the Medicaid program far outweigh the monthly payments and costs of the health home services. In the first five years of the South Dakota program, there were $7.3 million in avoided costs. Avoided costs were calculated by comparing the expenditures for the health homes group to other Medicaid members who were similar in terms of conditions and demographics but who were not enrolled in the program.

The Health Homes model has a Health Homes Core Set that consist of 12 quality measures that are reported annually to ensure quality performance for this high-risk and high-cost Medicaid population.

2. Health Homes Core Set Cross Walk

Crosswalk Medicaid Quality Measures

Measure	Measure Abbreviation	Health Homes	Adult Core Set	Child Core Set	Blue Alliance	Medicare Shared Savings	Data Collection Method	Measure Steward
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET	X	X		X		Administrative or EHR	NCQA
Controlling High Blood Pressure	CBP	X	X		X	X	Administrative, hybrid, or EHR	NCQA
Screening for Depression and Follow-Up Plan	CDF	X	X	X	X	X	Administrative or EHR	CMS
Follow-Up After Hospitalization for Mental Illness	FUH	X	X	X			Administrative	NCQA
Plan All-Cause Readmissions	PCR	X	X		X*		Administrative	NCQA
Use of Pharmacotherapy for Opiod Use Disorder	OUD	X	X				Administrative	CMS
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	X	X				Administrative	NCQA
Adult Body Mass Index Assessment	ABA	X	X				Administrative or hybrid	NCQA
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite	PQI92	X					Administrative	NCQA
Admission to an Institution from the Community	AIF	X					Adminsitrative	CMS
Ambulatory Care: Embergency Department (ED) Visits	AMB	X			X		Administrative	NCQA
Inpatient Utilization	IU	X					Administrative	CMS

Figure 7: *North Dakota Medicaid's Roadmap to Drive Quality*

E. The Future of Quality in North Dakota Medicaid

The purposes of this document are to outline North Dakota Medicaid's current quality of care, present Medicaid's Quality Strategy, and describe models that can be pursued in the future that will transition the State from fee-for-service to value based purchasing. The figure below depicts this journey to improve the quality of care for Medicaid members and ensure that the State is a good steward of taxpayer dollars by purchasing the highest value care.

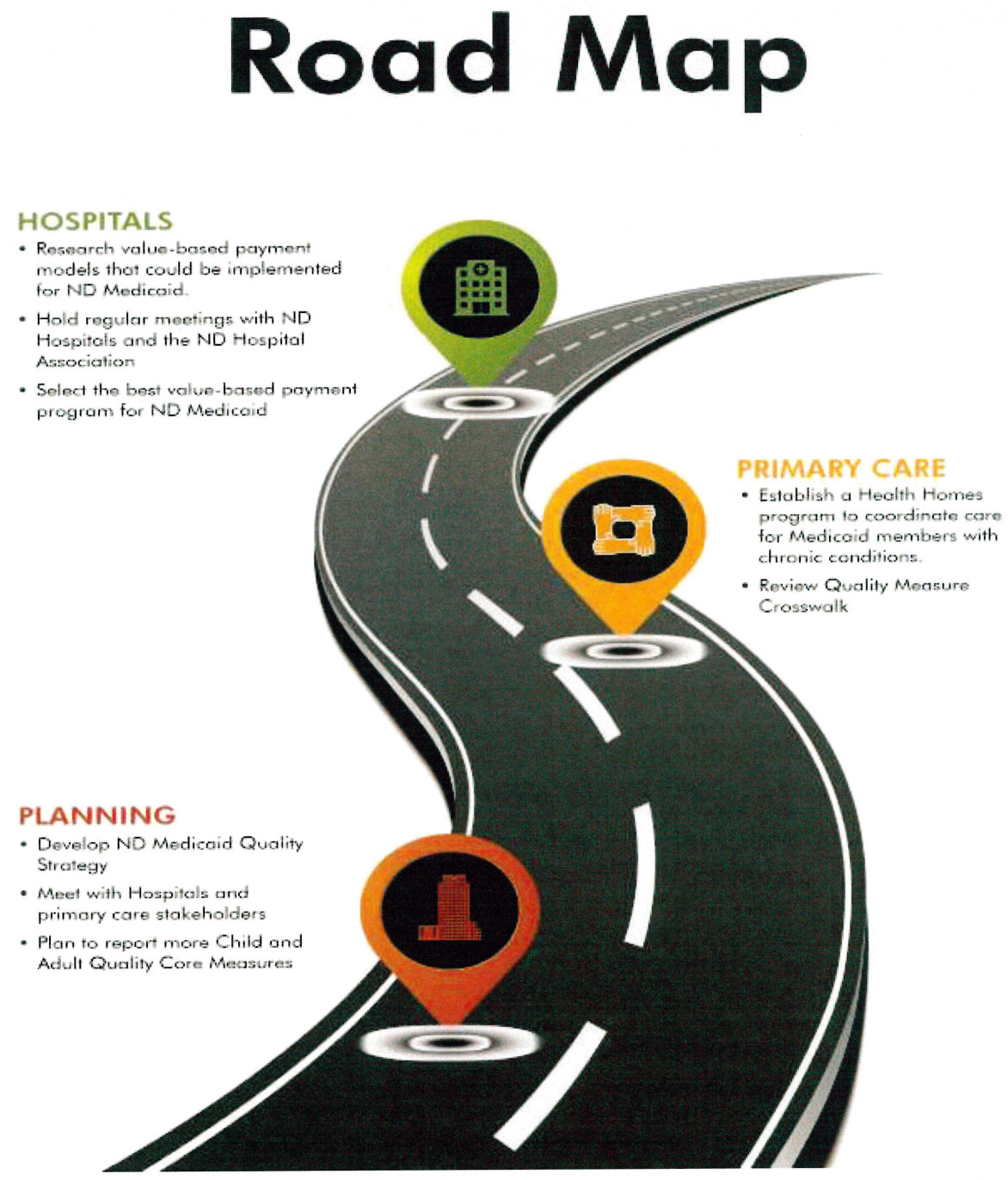


Figure 8: *North Dakota Medicaid's Roadmap to Drive Quality*

III. Conclusion

The North Dakota Quality Strategy is a living document that will continue to evolve as key health care stakeholders, as well as the executive and legislative branches, invest in and insist on high quality of care for Medicaid members. North Dakota can realize high quality for Medicaid members through cross-sector collaboration as multiple agencies and providers serve the same population. This critical collaboration will lead to investments and results that build a comprehensive quality program that will drive better health outcomes and promote a healthier population. North Dakota Medicaid, along with its partners, is committed to the quadruple aims of healthier populations, better outcomes, smarter spending, and better experiences.

Appendix 1: Child and Adult 2020 Core Sets

2020 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)*	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)^	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448**	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	Administrative or hybrid
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	Administrative or hybrid
Maternal and Perinatal Health			
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517**	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)^	Administrative
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)***^	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)^	Administrative
Dental and Oral Health Services			
2508**	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Administrative
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)

NQF #	Measure Steward	Measure Name	Data Collection Method
Experience of Care			
NA****	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

* This measure was modified for the 2020 Core Set. The Counseling for Nutrition and Counseling for Physical Activity indicators were added to this measure for the 2020 Child Core Set. Prior Core Sets included only the Body Mass Index (BMI) Percentile Documentation indicator.

** This measure is no longer endorsed by NQF.

*** This measure was added to the 2020 Child Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

**** The Child Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

^ This measure is part of the Behavioral Health Core Set. The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	Administrative or hybrid
Maternal and Perinatal Health			
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**^	Administrative

NQF #	Measure Steward	Measure Name	Data Collection Method
3488***	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)^	Administrative
3489***	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)^	Administrative
NA****	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)^	Administrative
Experience of Care			
NA*****	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services & Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)**	Survey

* This measure is no longer endorsed by NQF.

** This measure was added to the 2020 Adult Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

*** The NQF number for the FUA-AD and FUM-AD measures was previously listed as 2605. These measures now have separate NQF numbers but are the same measures included in the FFY 2019 Adult Core Set.

**** The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879).

***** The Adult Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

^ This measure is part of the Behavioral Health Core Set. The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

References

History of Quality 2009 didn't have any directive at national level to come up with quality strategy chipper legislations, CHILD and Adult □ Score Card (2009-present)
Link for score card (how many submit) show measures direct them with links
https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

December 31, 2013

Julie Schwab, Director
North Dakota Department of Human Services
600 East Boulevard Avenue Department 325
Bismarck, ND 58505-0250

Dear Ms. Schwab:

This letter is to inform you that the Centers for Medicare and Medicaid Services (CMS) approves Federal Financial Participation (FFP) for the managed care organization (MCO) contract between the North Dakota Department of Human Services and Sanford Health Plan, State contract # 415-09524. This new MCO contract and rates are effective on January 1, 2014 through December 31, 2014. CMS approves this managed care contract with the understanding that additional contract amendments may be warranted based on the final approval of relevant benefit State Plan Amendments (SPAs).

This new MCO contract operates under North Dakota's new 1915(b) Waiver for Managed Care Enrollment of Medicaid Expansion of the New Adult Group, Waiver number ND-04.

CMS found that the submitted contract met the requirements in federal regulations at 42 CFR 438, and that the rates met the requirements at 42 CFR 438.6(c). This approval for the contracted rates is limited to the period for which the rates were actuarially certified, beginning January 1, 2014 and ending December 31, 2014. CMS received an actuarial certification establishing that the rate ranges were developed in accordance with accepted actuarial principles and practices, and were appropriate for the Medicaid populations covered, and Medicaid services included in the contract.

As you know, CMS has been providing technical assistance and consultation to the State since October, 2013. We identified a number of concerns about the State's rate-setting approach, including:

- Original assumptions that an MCO delivery system would cost more than unmanaged fee-for-service – even though national studies show that managed care delivery systems result in cost savings;
- Assumptions of provider payments rates that reflect commercial rates rather than Medicaid fee-for-service rates; and
- Unusually large adjustments for adverse health status of the newly eligible population – one of the largest in the country

Taken together, these assumptions and adjustments are estimated to lead to managed care rates for the newly eligible adults that are roughly twice as large as the fee-for-service costs of current adult enrollees. In response to these concerns, you and your staff have worked with us to address them to the maximum extent possible. Specifically, your actuaries have modified the 'managed care savings' assumptions to reflect a slight savings off current costs, and used Current Population Survey (CPS) data and appropriate benefit costs to modify the acuity assumptions in the capitation rates.

While the rates continue to reflect what you expect your MCO to pay their providers, we have required you to gather actual paid claims, utilization and financial data from your MCO in 2014 so that those assumptions can be tested and revised, as necessary, in the 2015 rates. We have also required you to implement a risk corridor with narrow risk bands to provide protection for all parties involved.

We expect to engage in additional consultations when you are beginning the rate-setting process for 2015. We would like to thank you and your staff for the cooperation we received during the review process. If you have any questions regarding this approval please contract Sophia Hinojosa at Sophia.Hinojosa@cms.hhs.gov or (303) 844-7129.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Cc: Scott Manning, CMS
Robin Preston, CMS
Camille Dobson, CMS
Rebecca Burch Mack, CMS
Maggie Anderson, North Dakota
Cynthia Sheldon, North Dakota

TABLE 3A-10. Medicaid Payments to DSH Hospitals as a Share of Costs, by State, SPRY 2014 T 3A-10

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**44%**	**79%**	**12%**	**13%**	**103%**	**68%**	**10%**	**11%**	**88%**
Alabama	56	73	19	33	**125**	55	14	25	**95**
Alaska	12	110	–	4	**114**	89	–	3	**92**
Arizona	39	44	27	5	**75**	39	24	4	**67**
Arkansas	6	74	18	25	**116**	60	14	20	**95**
California[1]	10	88	6	35	**129**	76	5	30	**112**
Colorado	72	69	30	8	**107**	60	26	7	**93**
Connecticut	15	77	3	4	**84**	75	3	4	**82**
Delaware	8	93	–	26	**119**	78	–	22	**100**
District of Columbia	23	89	0	15	**104**	84	0	15	**99**
Florida	28	91	15	4	**110**	75	13	3	**90**
Georgia	79	92	4	10	**106**	71	3	8	**82**
Idaho	53	99	2	4	**104**	84	1	4	**89**
Illinois[2]	26	77	28	11	**116**	67	24	10	**101**
Indiana	31	97	–	18	**116**	81	–	15	**96**
Iowa	6	84	6	10	**100**	78	6	10	**94**
Kansas	41	77	9	7	**93**	63	7	6	**76**
Kentucky	81	88	6	7	**101**	77	5	6	**89**
Louisiana	31	70	2	63	**134**	51	1	46	**98**
Maryland	13	107	–	12	**119**	89	–	10	**99**
Michigan	71	68	27	5	**100**	63	26	5	**94**
Minnesota[3]	35	85	6	1	**92**	82	6	1	**89**
Mississippi	53	83	19	15	**117**	68	16	12	**97**
Missouri	74	104	–	17	**120**	85	–	14	**99**
Montana	52	80	13	6	**100**	63	11	5	**79**

TABLE 3A-10. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Nebraska	23%	79%	0%	4%	83%	66%	0%	3%	69%
Nevada	42	72	11	9	**91**	56	8	7	**71**
New Jersey	65	84	5	25	**114**	62	4	19	**85**
New Mexico	13	89	13	5	**107**	74	11	4	**89**
New York	91	77	3	14	**94**	72	3	13	**88**
North Carolina	53	71	34	9	**113**	57	27	7	**92**
North Dakota[2]	6	117	–	2	**119**	105	–	2	**107**
Ohio	68	84	6	8	**98**	77	6	7	**90**
Oklahoma	32	76	29	4	**110**	64	24	3	**91**
Oregon	90	98	3	3	**104**	89	3	3	**94**
Pennsylvania	91	59	14	9	**81**	49	11	7	**67**
Rhode Island	80	85	1	14	**100**	79	1	13	**93**
South Carolina	72	90	3	19	**112**	72	2	15	**89**
Tennessee[3]	43	85	24	1	**110**	72	20	1	**93**
Texas	29	80	23	18	**120**	58	16	13	**87**
Utah	69	87	32	4	**123**	68	25	3	**96**
Vermont	81	80	–	10	**90**	76	–	9	**86**
Virginia[3]	22	88	11	10	**108**	69	8	8	**85**
Washington	56	82	(0)	8	**89**	75	-0	7	**82**
Wisconsin	67	75	16	1	**93**	68	15	1	**84**
Wyoming	38	78	12	1	**90**	54	8	0	**63**

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. This analysis includes 44 states and the District of Columbia and excludes Hawaii, Massachusetts, Maine, New Hampshire, South Dakota, and West Virginia. Institutions for mental diseases were also excluded. Base Medicaid payments include fee-for-service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on DSH audits). DSH payments and non-DSH supplemental payments may also be used to offset non-Medicaid costs, such as unpaid costs of care for uninsured patients. Costs for uninsured patients are uncompensated care costs for uninsured patients, net of payments received from them. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not sum due to rounding.

TABLE 3A-10. (continued)

— Dash indicates zero; 0 indicates a non-zero amount less than 0.5 percent.

[1] California public hospitals are eligible to receive DSH payments up to 175 percent of the hospital's Medicaid uninsured costs.

[2] Illinois and North Dakota reported SPRY 2014 DSH payments that exceeded hospital uncompensated care costs for Medicaid and uninsured patients on their as-filed DSH audits. Because DSH payments to an individual hospital cannot exceed hospital uncompensated care costs, some of these payments may be recouped when these states' DSH audits are finalized.

[3] Two DSH hospitals in Minnesota, all DSH hospitals in New Hampshire, three DSH hospitals in Tennessee, one DSH hospital in Virginia, and all DSH hospitals in West Virginia did not include payments from third-party payers when calculating Medicaid shortfall, so they are excluded from this analysis.

Source: MACPAC, 2019, analysis of SPRY 2014 as-filed Medicaid DSH audits.



Institutions for Mental Diseases (IMDs) – Concept and Process Overview

Senate Appropriations

Medical Services Division, Caprice Knapp – Director

March 15, 2021

NORTH Dakota | Human Services

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Background

An institution for mental diseases (IMD) is defined in section 1905(i) of the Social Security Act to mean a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an IMD. There are two exceptions to the IMD exclusion: 1) inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 and older in IMDs (42 CFR § 440.140), and 2) inpatient psychiatric hospital services for individuals under age 21, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility" (PRTF) (42 CFR § 440.160).

IMDs in North Dakota

In North Dakota, the following facilities are classified as IMDs: The State Hospital in Jamestown (140 beds); Prairie St. John's in Fargo (110 beds); ShareHouse in Fargo (87 beds); and Summit Prairie Recovery Center in Raleigh (36 beds).

'Waiving' the Prohibition of Medicaid Payment for IMD Services

Section 1115 of the Social Security Act gives the Secretary of the U.S. Department of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid law to give states additional flexibility to design and improve their programs.

Some states have received approval from CMS for 1115 waivers related to substance abuse disorder (SUD) treatment services provided in IMDs. In November 2018, CMS clarified that they will also approve 1115 waivers for services provided in IMDs that focus primarily on treatment for individuals with serious mental illness (SMI) or serious emotional disturbance (SED)[1]. States may choose to focus their 1115 waivers on SUD treatment, SMI/SED treatment, or both at the same time.

States have the flexibility to design 1115 demonstrations aimed at making significant improvements over the course of a five-year period. Compliance with the following goals and milestones is required.

Required Goals for SUD 1115 waiver:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

- Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
- Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

Required Milestones for SUD 1115 waiver:

- Access to critical levels of care for opioid use disorder (OUD) and other SUDs;
- Widespread use of evidence-based, SUD-specific patient placement criteria;
- Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
- Sufficient provider capacity at each level of care;
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
- Improved care coordination and transitions between levels of care.

Required Goals for SMI/SED 1115 waiver:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Required Milestones for SMI/SED 1115 waiver:

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers);

Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and

psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED;

Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model as well as consideration of a self-direction option for beneficiaries;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, to help determine appropriate level of care and length of stay;

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Other 1115 Waiver Requirements:

- Demonstrations must be "budget neutral" to the Federal government, which means that, during the project, federal Medicaid expenditures will not be more

than federal spending without the demonstration[2]. Calculations are based on per member, per month expenditures pre- and post-implementation for the targeted population [PMPM*Member Months]. Other methodologies may be accepted by CMS.

- Demonstrations must have implementation and evaluation plans approved by CMS.
- 1115 waivers do not allow for room and board payments unless the facility qualifies as an inpatient facility under section 1905(a) of the Social Security Act.
- States are required to have staff and/or contractual resources necessary to conduct independent and robust interim and final evaluations.

Other Considerations:

- Even if ND was approved for an 1115 waiver that would allow Medicaid to reimburse for treatment within an IMD, there would still be limits on the number of days that can be reimbursed (15 days per year for inpatient IMD; 30 days per year for residential IMD[3]). An 1115 waiver would apply only to traditional fee-for-service Medicaid.
- IMD reimbursement for the Medicaid Expansion group, which is currently operated as managed care, would not be included in an 1115 waiver. Federal managed care rules allow capitation payments to be made to a managed care organization (MCO) for a member aged 21 through 64 receiving inpatient treatment in an IMD if it is for psychiatric or SUD crisis residential services and the length of stay is no more than 15 days during the month of the capitation payment[4]. These services must also meet the requirements for 'in lieu of' services, meaning that the state has determined the IMD is medically appropriate and a cost effective substitute, the member is not required by the MCO to choose the IMD setting and the approved in lieu of services are considered in developing the component of the capitation rates that represents the covered services[5].
- There are a targeted number of IMD beds in the state that a waiver would open to Medicaid reimbursement. Also, since Medicaid is the only health care payer with a restriction on paying for IMD services and is the payer of last resort, other payers would pay before Medicaid.
- A waiver for IMDs would not expand eligibility or services. SUD and SMI/SED treatment can already be accessed by Medicaid members in settings not classified as IMDs. The only SUD treatment service that would be offered by an IMD is medically managed detoxification, which is a higher level of SUD treatment than most people need.
- Budget neutrality may be difficult to achieve, given the complex needs of the population who would be eligible for the waiver services, the infrastructure development requirements associated with the required goals and milestones, and the assumptions that are used to generate cost estimates. CMS monitors

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf
[4] https://www.law.cornell.edu/cfr/text/42/438.6
[5] https://www.law.cornell.edu/cfr/text/42/438.3

budget neutrality throughout the demonstration period and performs a formal adjudication at the end of the demonstration period to determine whether a state's actual spending has remained within the specified limit. During demonstration approval, the state must agree to limit their receipt of federal financial participation to the amounts indicated in the budget neutrality test and to return any funds they receive above those limits to CMS[6].

- In two Human Services Research Institute studies pursuit of an IMD waiver was not a recommendation.
- The milestones required to be addressed by states that implement 1115 waivers are broad and would require significant development of the behavioral health continuum.
- The US Government Accountability Office (GAO) found[7] that selected states' evaluations of these demonstrations had widespread, significant limitations that affected their usefulness in informing policy decisions. The limitations included gaps in reported evaluation results for important parts of the demonstrations. CMS is attempting to strengthen evaluation requirements and hold states accountable for meaningful and timely 1115 evaluation requirements.

Examples

Colorado's SUD 1115 waiver

- 2018 started the process, 2021 completed the process
- 2 FTEs allocated; unclear others that contribute to supporting roles.
- ~$500,000 year 1 and year 2; year 1 of implementation $174 million (inpatient and residential treatment)
- Post-implementation $1.58 million for consultants and IT systems (annually)

Virginia's 1115 waiver on Community Engagement, Premiums and Wellness Accounts, Housing and Employment Supports for High Need Enrollees

- 3 FTEs working 100%; 9 total from Compass Division chart (housing analyst, employment analyst, data analyst, wellness accounts analyst, finance analyst, Senior Advisor, Senior Program Analyst, Senior Policy Analyst)
- Manatt as a consultant to write the waiver; cost $3.495 million for Manatt
- Timeline- 2018 to December 2019 but an added 6 months after that to implement. Negotiate with CMS on budget neutrality, implementation plan, and evaluation plan.

[6] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf
[7] https://www.gao.gov/products/GAO-18-220

At the request of Senator Dick Dever - 3-15-2021

Permanent Supportive Housing

	TOTAL CONTRACT 2019-2021	# UNITS
LaGrave on First	$375,000.00	42
Prairie Harvest Mental Health	$2,829,600.00	42
Cooper House	$566,928.00	42
Gerridee's Place	$901,008.00	14
Edwinton	$ -	40
TOTAL	**$ 4,672,536.00**	**180**
$/Unit	**$ 25,958.53**	
$/Unit/Month	**$ 1,081.61**	

Funding Requirements:

- Best practices
- Services are recovery-oriented and person-centered
- Process and outcome measures
- Onsite visits

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Peer Support and 1915i break down of criteria, services and expenditures.

2019-2021 Biennium

These estimates do not expand Medicaid eligibility levels, and assume Expansion is administered as Fee for Service. Must be eligible for Medicaid or Medicaid Expansion to be screened for Peer Support or 1915i services.

Offered to all Eligible individuals that meet qualifying criteria. Such as individuals with SUD, SMI and TBI who need suport to manage their condition. People with SUD, SMI and TBI can be difficult to connect with and reach by traditional health care providers, due to their living arrangements, distrust of traditional health care providers and other factors.

Available to individuals aged 18 and older and diagnosed with a mental health condition and/or substance use disorder and/or brain injury and currently experiencing one or more of the following needs-based criteria:

* Housing instability as demonstrated by homelessness or being at risk of homelessness
* Intensive service needs as demonstrated by past year use of:
  - Behavioral health-related inpatient hospital, State hospital, Behavioral health or brain injury-related long-term care facility/nursing home; Residential treatment services; Repeated (more than one) behavioral health-related emergency department in the past year; or Adults age 18 and older who were in treatment foster care in the past year
* Intensive forensic service needs as identified by criminal justice system involvement:
  - Repeated law enforcement contacts, Parole and probation, Jail and prison;
  - or Adults 18 and older involved in the juvenile justice system in the past year
* Any other significant functional limitations expected to result in homelessness, intensive service need, or justice involvement

The service offered through the **Peer Support** OAR is Peer Support and is not as comprehensive as the 1915i State Plan OAR proposed.

The services offered through the 1915i OAR are **service coordination, employment and education supports, housing supports, peer support, and wraparound supports**.

Peer Support OAR ONLY Funded

	Total	Peer Support for those not eligible for 1915i Services	1915i Peer support "Crossover"
FTE	0.5	0	0.5
General	$ 432,287	$ 152,392	$ 279,895
Federal	$ 563,906	$ 152,392	$ 411,514
Total	$ 996,193	$ 304,784	$ 691,409

1915i State Plan OAR ONLY Funded

	1915i Peer support "Crossover"	Additional Services and Recipients 1915i	Total
FTE	0.5	2.5	3.0
General	$ 279,895	$ 2,553,466	$ 2,833,361
Federal	$ 411,514	$ 3,844,914	$ 4,256,428
Total	$ 691,409	$ 6,398,380	$ 7,089,789

This is the population overlap and consists of the same people

Total Peer	$ 996,193
Total 1915i	$ 7,089,789
Total	$ 8,085,982
Less: Crossover	$ (691,409)
Adjusted Total	$ 7,394,573

Total if both OARs are funded

	Peer Support for those not eligible for 1915i Services	Additional Services and Recipients 1915i	1915i Peer support "Crossover"	Total to Fund Both OARS
FTE	0	2.5	0.5	3
General	$ 152,392	$ 2,553,466	$ 279,895	$ 2,985,753
Federal	$ 152,392	$ 3,844,914	$ 411,514	$ 4,408,820
Total	$ 304,784	$ 6,398,380	$ 691,409	$ 7,394,573

Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Fraser, Ltd.
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Individual Consumers & Families

HB 1012 – Behavioral Health

March 15, 2021

*See attachment dated 3.1.21
** See long sheet from 2019 Session

EPSDT Study

We are requesting an amendment for the North Dakota legislature to conduct a study to determine if North Dakota is fully implementing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under Medicaid, or as it is known in North Dakota, "Health Tracks." EPSDT provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. When EPSDT is fully implemented, it can provide children and families vital services, including access to medically necessary treatment.

Safe Beds

We would like safe beds to return to the Bismarck region. Safe beds are a safe place for a child to deescalate and function as an alternative to costly hospitalization. In the last year, safe beds were no longer available for children with mental health disorders in a mental health crisis. As a result, the only options many families have are: a) do nothing, b) hospitalize their child, c) call law enforcement.

Peer Support**

In the 2019 Session, Maggie Anderson presented information on peer support and the 1915(i) for SB 2012. As passed by the Legislature, the budget included peer support "for those not eligible for 1915(i) services" (a total of $304,784, half federal and half State) as well as separate funds for those 1915(i) eligible. While things are "moving" for the 1915(i), per Caprice Knapp, nothing is happening to implement peer support for those not 1915(i) eligible. When I asked her about this, she said, "I have no staff, no money, and no time". Individuals with mental illness have been advocating for peer support for years. This is a priority for them. Questions for DHS: 1) why has this not happened? 2) where is the money

money that was allocated? 3) what is funded for next biennium for peer support for non-1915(i) eligible individuals? 4) what about Legislative intent?

Family Support*

Contracts were reduced significantly in the executive version of HB 1012 for the Federation of Families for Children's Mental Health and Family Voices of ND. Some funds were restored by the House but these contracts are skimpy to begin with as is one of the Early Intervention programs, "Experienced Parents". This one is in the DD budget and was cut completely. All of these programs should be prioritized for continued full funding into 21-23. Families would be lost without them.

Supported Housing*

In the executive version of HB 1012, DHS decreased funding for Cooper House, LaGrave on First, Prairie Harvest, and Gerridee's. We believe DHS thought the individuals served would be eligible for the 1915(i) and could then draw down a federal match. The House restored some of the money. It has come to light that many, if not most, of these individuals will not be 1915(i) eligible. Without supported housing, many will be at risk and will not be successful living in the community. Full funding should be considered for these programs.

Autism Voucher

DHS put in a bill (SB 2089) to repeal the ASD Voucher with no discussion with the Governor's ASD Task Force. It removed all monies for the Voucher from HB 1012. Senate Human Services turned SB 2089 into a study but replaced the ~ $1.3 million with only $300,000. The Task Force opposes the repeal and submitted amendments to House Human Services to make the Voucher more family-friendly (also shared with Senate Appropriations - testimony by Holly Johnson). The Voucher should be funded at $1.3 million with the amendments from the Task Force. [NOTE: The population at the LSTC is now over 50% adults and youth with a diagnosis of autism.]

Supported Employment

We would like Supported Employment services for people with mental illness to have their budgets restored from the cuts that were slated under "1915(i) Savings." Supported Employment (SEP) services assist individuals to obtain and keep competitive employment at or above the minimum wage. Ongoing follow-along support is available for an indefinite period as needed by the individual to maintain their paid

competitive employment position. Individuals with serious mental illness rely on supported employment services so that they can maintain employment and can maintain living in the community. The proposed budget made significant cuts to those program areas, with some initial requests to eliminate entire programs. While some has been discussed to be restored to allow providers time to become Medicaid providers, it does not account for the fact that some of those individuals with serious mental illness will not meet the eligibility requirements of the 1915(i). We also want to make sure that individuals who receive supported employment services under the 1915(i) continue to receive ongoing and continuous SEP services as they earn and maintain their employment wages.

Voluntary Placement Dollars

We would like a restoration of the dollars allocated to the Voluntary Treatment program. The Governor's proposed budget cuts the voluntary treatment program from its previous budget of $533,440 to a proposed 2021-2023 budget of $453,424. With the creation of the voluntary treatment program, parents were no longer required to relinquish custody of their children in order to receive treatment that would be provided in that residential treatment facility. During the last legislative session, the voluntary treatment program was given the flexibility to provide services to children in order to prevent an out-of-home placement. The voluntary treatment program is essential in families being able to maintain custody of their children and provide linkages to community-based services.

State Hospital

As Dr. Etherington has shared, many studies have already been completed regarding building of a new State Hospital (see binder she gave Sen. Appropriations). All advocacy organizations that have taken a position on this matter are supporting the building of a new State Hospital in conjunction with 8-10 new behavioral health beds in the western part of the State. Dr. Etherington has shared a funding plan that does not require new monies for this however, if a new facility is not built, there will be significant monies needed for repair and maintenance of existing buildings. Action is recommended to move forward with authorization of a new State Hospital.

1915(i) – Legis. intent language re WHODAS score (future)

We would like there to be legislative intent raised regarding the WHODAS score that is used to determine eligibility for services under the 1915(i) State Plan Amendment. We would like that the legislature direct the Department of Human Services to conduct multi-stakeholder

meetings (that include consumers and family members) to evaluate the WHODAS score threshold used to determine eligibility for services under the 1915(i) and lower the score, if necessary, to ensure individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) are not losing the invaluable services to meet their needs. This would also serve to benefit North Dakota as it seeks to maximize federal dollars in providing services to those in need.

Definition of Serious Emotional Disturbance (SED):

> A diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

-Approximate number of North Dakotans with SED (2019): 18,125.

Definition of Serious Mental Illness (SMI):

> Someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

-Approximate number of North Dakotans with SMI (2019): 30,258

-North Dakota 1915(i) Application set eligibility at a WHODAS score of 50 or above. With those parameters, the Department of Human Services anticipated that the number served between SUD, SED, SMI, TBI was 11,150.

Brain Injury Network*

Brain injury services and programs were cut significantly in the executive budget, some related to expected federal matches through the 1915(i). The House restored some of the funds noting the 1915(i) may not provide funding for many of the individuals. Still, ND has little in the way of services for individuals with a brain injury – any reductions will mean even less for supports. Relevant are the NDBIN, pre-vocational program, and the return to work program with a total reduction, after HB 1012 was passed by the House, of over a $¼ million. Consideration is requested to restore all of the funds cut for brain injury services and support.

It is suggested that, while giving DHS flexibility with funding items, there is also accountability for Legislative intent. Examples include the ASD Voucher; ASD training funds (the ASD Task Force did not know

there was $90,000+ for this); and peer support. Where has the money gone that was authorized for these things?

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Pam Sagness
As passed by the House

Department of Human Services
1915I Contracts reduced in the Executive Budget Request
2021-2023 Biennium

Division	Description	Executive Budget Request Savings	Notes	Remaining Contract Total for Provider	Actual House Restoration	Total Reduction by contract with House Changes
Behavioral Health	Reduce Parent to Parent - 1915i Realignment	(11,250)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	69,375	5,625	(5,625)
Behavioral Health	Reduce Brain Injury - Resource Facilitation (NDBIN) - 1915i realignment	(279,247)	Not direct services - 15% reduction of total contract for efficiencies	474,719	195,472	(83,775)
Behavioral Health	Reduce Brain Injury - Pre-voc program (Skillsmart) - 1915i realignment	(168,750)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	253,125	84,375	(84,375)
Behavioral Health	Reduce Brain Injury - Return to work (Workstart) - 1915i realignment	(174,277)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	261,416	87,139	(87,138)
Behavioral Health	Reduce peer support certification	(13,590)	no change	0		(13,590)
Behavioral Health	Reduce Peer support pilot	(15,000)	no change	0		(15,000)
Subtotal Behavioral Health		**(662,113)**		**1,058,634**	**372,611**	**(289,502)**
Children and Family Services	**Reduce Family Peer Support (Family Health Info & Ed Ctr) - 1915i re-alignment**	**(100,000)**	**Not direct services - 15% reduction of total contract for efficiencies**	**148,750**	**73,750**	**(26,250)**
Human Service Center	Reduce LaGrave contract - 1915i re-alignment	(187,500)	All tenants pay rent; NEHSC gives services; remaining $ support until 1915i efficient	281,250	93,750	(93,750)
Human Service Center	Reduce Prairie Harvest Mental Health contract - 1915i re-alignment	(1,414,800)	All tenants pay rent; NEHSC gives services; remaining $ support until 1915i efficient	1,644,260	353,700	(1,061,100)
Human Service Center	Reduce Cooper House contract - 1915i re-alignment	(283,464)	All tenants pay rent; SEHSC gives services; remaining $ support until 1915i efficient	425,196	141,732	(141,732)
Human Service Center	Reduce Supportive Employment contract - 1915i re-alignment	(583,226)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	291,613	291,613	(291,613)
Human Service Center	Eliminate Gerridee's Place contract for long-term residential - 1915i re-alignment	(901,008)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021). All clients quality under 1915i and contract	450,504	450,504	(450,504)
Human Service Center	Reduce Supportive Employment contract - 1915i re-alignment	(62,000)	Added back 25% of reduction for 6 months of biennium (through December 30, 2021)	31,000	31,000	(31,000)
Subtotal Human Service Centers		**(3,431,998)**		**3,123,823**	**1,362,299**	**(2,069,699)**
Total DHS Savings Plan		**(4,856,224)**		**5,389,841**	**2,181,271**	**(2,674,953)**

SUD Voucher

Proposed Total Budget: $12,000,000

130% GROWTH (each year)					
RESIDENTIAL			NON-RESIDENTIAL		
% Cap	Amount	# Months to Expend Based on Estimate*	Remaining Amount		# Months to Expend Based on Estimate**
20%	$2,400,000.00	7.16	80%	$9,600,000.00	26.43
25%	$3,000,000.00	8.95	75%	$9,000,000.00	24.77
30%	$3,600,000.00	10.74	70%	$8,400,000.00	23.12
35%	$4,200,000.00	12.53	65%	$7,800,000.00	21.47
40%	$4,800,000.00	14.31	60%	$7,200,000.00	19.82
45%	$5,200,000.00	16.10	55%	$6,600,000.00	18.17
50%	$6,000,000.00	17.89	50%	$6,000,000.00	16.52

Proposed Total Budget: $14,000,000

130% GROWTH (each year)					
RESIDENTIAL			NON-RESIDENTIAL		
% Cap	Amount	# Months to Expend Based on Estimate*	Remaining Amount		# Months to Expend Based on Estimate**
20%	$2,800,000.00	8.35	80%	$11,200,000.00	30.83
25%	$3,500,000.00	10.44	75%	$10,500,000.00	28.90
30%	$4,200,000.00	12.53	70%	$9,800,000.00	26.98
35%	$4,900,000.00	14.61	65%	$9,100,000.00	25.05
40%	$5,600,000.00	16.70	60%	$8,400,000.00	23.12
45%	$6,300,000.00	18.79	55%	$7,700,000.00	21.20
50%	$7,000,000.00	20.88	50%	$7,000,000.00	19.27

Proposed Total Budget: $17,000,000

130% GROWTH (each year)					
RESIDENTIAL			NON-RESIDENTIAL		
% Cap	Amount	# Months to Expend Based on Estimate*	Remaining Amount		# Months to Expend Based on Estimate**
20%	$3,400,000.00	10.14	80%	$13,600,000.00	37.44
25%	$4,250,000.00	12.67	75%	$12,750,000.00	35.10
30%	$5,100,000.00	15.21	70%	$11,900,000.00	32.76
35%	$5,950,000.00	17.74	65%	$11,050,000.00	30.42
40%	$6,800,000.00	20.28	60%	$10,200,000.00	28.08
45%	$7,650,000.00	22.81	55%	$9,350,000.00	25.74
50%	$8,500,000.00	25.35	50%	$8,500,000.00	23.40

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The Arc North Dakota

HOUSE 1012-DHS BUDGET PUBLIC TESTIMONY FUNDING REQUESTS

HOUSE BILL 1012 – 67TH LEGISLATIVE ASSEMBLY OF NORTH DAKOTA

The information provided below was given during public testimony.

The Arc of North Dakota: The Arc of ND is asking for funding for the state hospital. Restore the 11 million for section 11 and continue the Life Skills and Transition Center's downsizing. Contact: Kirsten Dvorak –k.dvorak@thearcofbismarck.org

Designer Genes: Asked for the following Restore $260,000 ($100,000 State General Funds and $160,000 from Federal Part C grant) for Experienced Parent Program. Contact: Roxane Romanick- romanick@bis.midco.net

Family Voices of North Dakota (family Support): Restore the 15% (26,250) to $175,000 funding. Reinstate experience parent funding, do not move the autism voucher money to the autism waiver. Keep the independent living center funding as it passed in the house. In addition to restoring the North Dakota Federation of Families for Children's Mental Health to $11,250. Contact Donene Feist- fvnd@drtel.net

North Dakota Association of Community Providers (NDACP):

•Maintenance of the House's restoration of approximately eleven million dollars ($11,000,000) to provider rates for residential habilitation and intermediate care facilities for people with intellectual and developmental disabilities (ICFID), but also,

• Maintenance of the Governor's proposed two million, four hundred thousand dollar increase ($2,400,000) today support services such as individual employment, group employment, and prevocational services, with a matching reduction to Intermediate Care Facilities for People with Intellectual Disabilities (ICFID) and residential habilitation;

•Restoration of $240,000 in funding for mandated DD provider accreditation with the Council on Quality and Leadership (CQL);

•Inflationary increases to DD providers of 3% each year of the 2022 - 2023 biennium, especially due to economic and wage pressures in various communities;

•Maintaining the House's appropriation of up to $250,000 to NDDHS to financially stabilize DD providers disproportionately affected by the COVID-19 emergency — especially In-Home Support providers who suffered the most significant losses;

•Restoration of all cuts to Section 11 State General Fund services to people with DD who don't qualify for the DD Medicaid Waiver;

•Fully fund the 1915(i) Medicaid Amendment with special attention paid to ensure it remains accessible to people with DD/ID, and review of the proposed World Health Organization Disability Assessment Schedule threshold score of 50 — a very severe score;

•Fully fund reforms and behavioral health initiatives from the Life Skills and Transition Center;

•Retention of a substantial state tax credit to employers who hire North Dakotans with developmental disabilities and mental illness, in HB 1405 (2021). HB 1405 received a unanimous do-pass recommendation from Senate Finance and Taxation Committee on March 9, 2021.

Many members also support the restoration of funding for recreation and leisure centers with consideration of serving additional communities; a close review of the infant development and Part C budgets to ensure timely services can be brought to bear to minimize developmental delays; and strengthening of rates in related home and community-based services to North Dakotans with other kinds of disabilities — QSP services under Aging Services and for brain injury, as well as 1915(i) Medicaid Amendment behavioral health services.

NDACP is persuaded that building a new State Hospital as proposed in HB 1012 makes sense to move more mental health services to the community. It is challenging to move beyond brick and mortar legacies built by generations past, but it is probably time. NDACP Contact Bruce Murry-brucemurry@ndacp.org

Prepared by the Legislative Council staff
for Senator Mathern
March 12, 2021

ENGROSSED HOUSE BILL NO. 1012
LISTING OF PROPOSED CHANGES TO BILL REGARDING SUBSTANCE USE

Department of Human Services

Proposed funding changes:

	Description	FTE	General Fund	Special Funds	Total
* 1	Increase funding for substance use disorder programs from $15 million to $17 million as provided in the executive budget recommendation		$2,000,000		$2,000,000
	Total proposed funding changes		$2,000,000	$0	$2,000,000

Other proposed changes:

2 Create a DHS working group that includes substance use disorder providers to develop a program to establish residential substance use disorder programs utilizing up to $3 million of legacy fund earnings for substance use disorder residential programs in regions 1 and 8 which are eligible to utilize traditional Medicaid and Medicaid Expansion funding.

* 3 Provide for DHS to seek approval from the Centers for Medicare and Medicaid Services to allow substance use disorder programs to serve as qualified entities for the purpose of Medicaid presumptive eligibility under the traditional Medicaid and Medicaid Expansion programs. Require DHS to provide a report to the Legislative Management regarding the status of the approval and the adoption of administrative rules relating to the change.

* 4 Provide for community-based providers of ASAM level 2.5 services be increased to the same rate as hospital-based ASAM level 2.5 service providers within the Medicaid Expansion program.

5 Establish a moratorium for the 2021-23 biennium on residential substance use disorder providers that are not currently licensed in the state or have not been approved for voucher residential services.

* 6 Require DHS to apply for a Medicaid waiver to allow individuals between 21 and 65 years of age to be served in an institution for mental disease and be eligible for Medicaid funding. This may permit Medicaid payments for patients that receive treatment at the State Hospital.

7 Remove provisions added by the House to limit the amount of funding that may be distributed to residential substance use disorder service providers.

* 8 Declare items 2, 3, 5, and 6 to be an emergency measure.

* Items of agreement with providers that offer full range.

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/25/2021
Department of Human Service Sub-Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 3:59 PM.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern.**

Discussion Topics:

- Public Private Partnerships (P3)
- Contracts for State Hospital
- Life Skills Transition Center management

Rosalie Etherington, Superintendent, North Dakota State Hospital – testified in favor and submitted testimony # 10777 and #10776.

Jake Terzo – JCI – testified in favor on Public Private Partnerships.

Sue Foerster, Director, Life Skills Transition Center – testified in favor.

Senator Dever closed the hearing at 5:06 PM.

Rose Laning, Committee Clerk

10777



NEW TREATMENT CAMPUS

SENATE APPROPRIATIONS SUB-COMMITTEE

SENATOR DEVER, CHAIRMAN

NORTH DAKOTA STATE HOSPITAL

Rosalie Etherington, NDSH Superintendent

NORTH Dakota | Human Services

Be Legendary.™

PATHWAY TO A NEW TREATMENT CAMPUS

- Completed comprehensive asset assessment
- Identified deferred maintenance backlog costs
- Identified square footage requirements for new campus
- Identified financing options

STATE HOSPITAL DOWNSIZING

- 1950s – State Hospital size begins to reduce
- 1990s – Strategic measures to reduce state hospital size
- 1997 – 4 buildings transferred to prison
- 2001 – 4 buildings and function transferred to prison
- 2015 – 1 building and function transferred to prison
- 2019 – 1 building and function transferred to prison

COMPREHENSIVE BUILDING ASSESSMENTS

- 2017 – Unesco Facility Conditions Assessment
- 2019 – Prairie Engineering MEPS Replacement Costs
- 2020 – Sitelogiq Facilities Condition Update

ARCHITECTURAL ASSESSMENTS

- 2019 – BWBR Architect New Hospital Cost Estimates
- 2020 – BWBR Architect New Hospital Cost Estimates

MAINTENANCE COSTS EXCEED BENEFIT

- $148M deferred maintenance backlog for at-risk systems
- $38M immediate deferred maintenance for failing systems

PUBLIC/PRIVATE PARTNERSHIP

- P3 provides more staff savings
- P3 provides guaranteed building maintenance
- P3 reduces time between design, bid, and build
- P3 provides penalties for non-performance


NORTH
Dakota | Human Services
Be Legendary.™


JRCC Buildings
NDSH Buildings in use
Vacant/Abandoned Buildings
JRCC

North Dakota State Hospital Top Issues

Below is a list of assets that are at, or past, their useful life and are in need of replacement.

This list, although not comprehensive, highlights the majority of assets in **Alarm** conditions.

LaHaug Building

- Chiller, Cooling Tower, and Chilled Water pumps
- (11) Air Handling Units, original to 1982, serving the majority of the facility
- Electrical Distribution in the entire facility
- Security cameras throughout entire facility
- Carpet tiles and VCT flooring through most of the facility

GM Building

- Steam and condensate piping throughout entire facility
- Multiple Air Handling Units original to 1965
- Multiple Unit Ventilators original to 1965
- Temperature controls through entire facility
- Electrical Distribution in the entire facility
- Security cameras throughout entire facility

New Horizons Building

- Steam and condensate piping throughout entire facility
- Chiller, Cooling Tower, and Chilled Water pumps
- Domestic hot water heaters
- All Air Handling Units original to 1971, 1985, and 1987
- All Unit Ventilators original to 1968, 1971, and 1985
- Temperature controls through entire facility
- Electrical Distribution in the entire facility
- Exterior doors and windows for entire facility
- Interior carpet in hallways and offices
- Security cameras throughout entire facility

Learning Resource Center

- Temperature controls in rooms
- Exterior Doors
- Exterior bricks and mortar for the entire facility
- Security cameras throughout entire facility
- Carpet tiles and VCT flooring through most of the facility
- Interior doors through most of the facility

North Dakota State Hospital Issues (Caution)

Below is a list of assets nearing the end of their useful life and soon needing replacement.

This list, although not comprehensive, highlights the majority of assets in **Caution** conditions.

LaHaug Building

- (4) Air Handling Units, original to 1994 and 1997, serving isolation suites and basement
- Exterior doors, window, exterior bricks, and exterior concrete
- Roofs on the majority of the facility
- Interior carpet, doors and ceilings throughout entire facility
- Security cameras throughout entire facility

GM Building

- Hot water pumps and distribution piping
- Chilled water piping through entire facility
- Exterior doors, window, exterior bricks, and exterior concrete
- Fire alarm system serving the entire facility

New Horizons Building

- Chilled water piping through entire facility
- Roofs on the majority of the facility
- Exterior bricks, and exterior concrete
- Fire alarm system serving the entire facility
- Security cameras throughout entire facility

Learning Resource Center

- (2) Air Handling Units, original to 1991, serving 3rd floor
- Hot water pumps and distribution piping
- Steam distribution piping
- Chilled water piping through entire facility
- Electrical Distribution in the entire facility
- Roofs on the majority of the facility
- Exterior windows, and exterior concreate
- Fire alarm system serving the entire facility

The State Conducted Six Infrastructure Studies During the 2019-2021 Biennium for the North Dakota State Hospital

Key findings and take away are as follows:

The current State Hospital campus has disintegrated and surpassed maintenance efforts

$148 MILLION There is $148M of deferred maintenance backlog

Some buildings are condemned, and many are beyond repair

Current deferred maintenance funds are insufficient to keep up with demand

Three patient care buildings are old and inefficient and not designed for state-of-the-art care

Underground tunnels are crumbling and require demolition

A new treatment campus designed to modern, healing standards improves patient safety and outcomes

Speed healing and shorten hospital stays

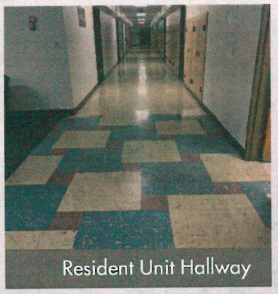
Reduce physical barriers and improve safety technology for patients and team members

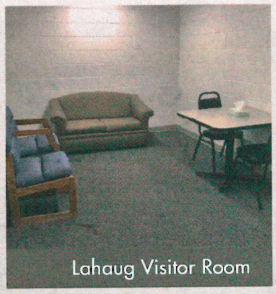
Provide for a more peaceful, tranquil setting and increase satisfaction for patients and team members

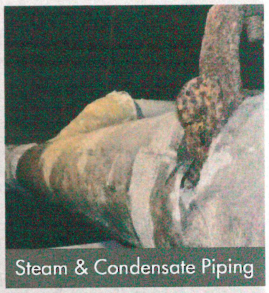
Create a one-building hospital, reducing total staff needed and improving energy efficiencies

The ND State Hospital
EST. 1885

ND Statehood
EST. 1889


Resident Unit Hallway


Lahaug Visitor Room


Steam & Condensate Piping

The State Hospital plays a singular role in patient care as the only facility in North Dakota to serve as a:

- Psychiatric hospital
  - Serving jail inmates
  - Providing forensic assessment for court competency and criminal responsibility
  - Providing care to individuals found Not Guilty by Reason of Insanity
- Residential treatment facility for Sexually Dangerous Individuals
- Psychiatric hospital and residential facility providing court-ordered services as condition of bond or in lieu of prison
- Acute psychiatric hospital for the Jamestown and Devils Lake regions

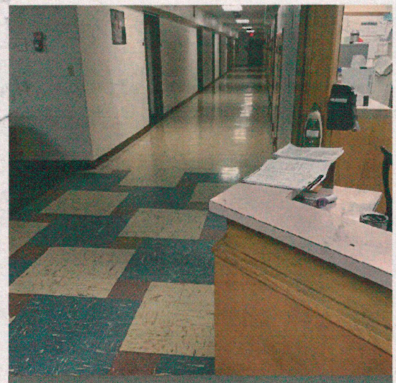
The DOCR is interested in taking ownership of LaHaug. Collaboration with DOCR (Department of Corrections and Rehabilitation) is underway to conduct an architectural analysis of Lahaug for repurpose to a prison.

DID YOU KNOW?

The state hospital also serves as the secondary hospital for six ND regions, accepting patients from other hospitals for specialized treatment response.

NORTH Dakota Be Legendary. | State Hospital HUMAN SERVICES


Chapel Roof Footings


Nurses Station

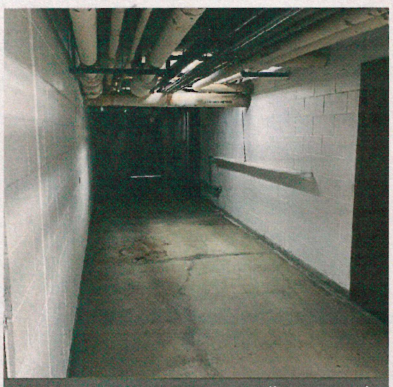

Shop Ceiling

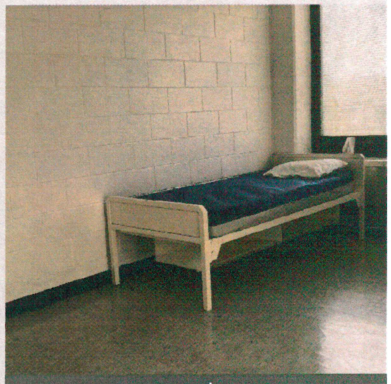

Therapeutic Pool Building


Unit Ventilators

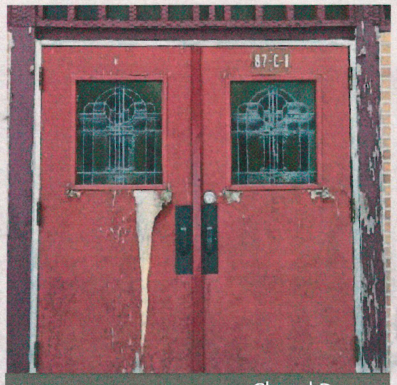


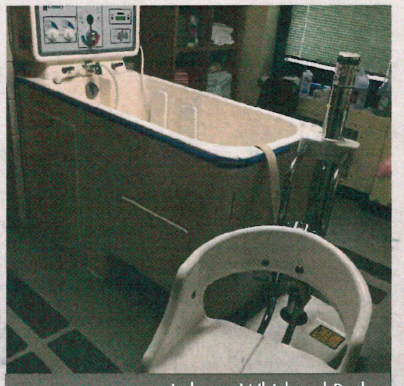
Grounds Shop

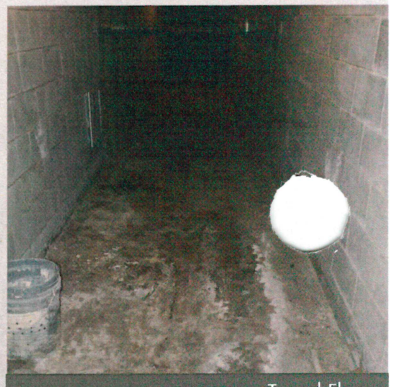

Walking Tunnel


Lahaug Patient Room


Patient Gym


Chapel Doors


Lahaug Whirlpool Bath


Tunnel Floor

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
3/31/2021
Department of Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 10:38 AM.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern**.

Discussion Topics:

- One-year extension on resolution – CFS
- Foster Care
- Target Case Management – Maintenance rates
- Eligibility for services

Blair Thoreson, representing Nexus-PATH – testified in favor.

Clete Winkelmann, Executive Director, Nexus-PATH – testified in favor.

Rachel Allison, Foster Parent – Nexus-PATH – testified in favor and submitted testimony #11182.

Jodi – Nexus-PATH director – testified in favor.

Arnie Strebe, CFO, DHS – introduced Caprice Knapp.

LeeAnn Thiel, Medicaid Payment and Reimbursement Services Division, Medical Services, DHS – testified in favor.

Cory Peterson, Children and Family Services, DHS – testified in favor.

Senator Dever submitted testimony #11194.

Trina Gress, Vice President, Community Options, Bismarck – testified in favor.

Rosalie Etherington, Superintendent, ND State Hospital – testified in favor and answered sub-committee questions.

Senator Dever closed the hearing at 11:53 AM.

Rose Laning, Committee Clerk

Testimony
House Bill 1012
Senate Appropriations Subcommittee
Senator Dick Dever, Chairman
March 31, 2021

Chairman Dever, members of the Senate Appropriations Subcommittee, I am Rachel Allison, a Foster Parent with Nexus-PATH in Minot, ND. Nexus-PATH is a member of Nexus Family Healing, providing child welfare and behavioral health services in ND. I am providing this testimony on HB 1012, and asking for delayed implementation of equalized Targeted Case Management (TCM) rates. This will ensure uninterrupted services for some of the most vulnerable children in our state.

I have been a foster parent with Nexus-PATH for the last 5 years. Over that time, I have worked with many children and their families. I have experienced the changing treatment needs of these children as well. We are being informed as the child welfare system changes and progresses in the state of North Dakota and we are working hard to provide our services where they are needed.

When a youth is placed in foster care with Nexus-PATH, there are many supports we as foster parents require due to the treatment needs the kids present. As foster parents, we rely heavily on our Nexus-PATH case managers for these supports. Not only do they help with the placement of the youth in our home, but they are aiding in the placement of this youth in a community. The case managers are often working to connect these youth with school districts, to connect them with medical and mental health services, to arrange family reunification activities such as visits, and to make sure they are receiving any and all services necessary for their treatment. The case managers are also providing support to us as foster parents by being available 24/7 for any emergency situations, helping us to arrange respite care so that we are able to attend trainings or just rejuvenate so we

can continue with our important work, as well as helping us stay current with all foster parent licensing requirements.

I understand that in mid-December of 2020, our agency received notification from DHS Medical Services Division that an equalization of rates was included in the Department's budget as submitted, and that equalizing all rates might have an impact on services we provide. I am here to tell you that the economic impact our agency would have would significantly impact the types of services I as a foster parent could provide. Our case managers would not be able to provide the level of services we have grown accustomed to if they were to be stretched thinner due to more demands, such as higher caseloads, which could be what Nexus-PATH has to do to respond to the lower TCM rate.

In addition, this comes at a time when the child welfare system is asking us to provide more intensive services in foster care, which isn't possible at a lower cost. As foster parents, we are always aware of the many youth awaiting placement in a Nexus-PATH home. Many of us look at foster parent recruitment as part of our calling, as we know more of us are always needed. I fear that if the support starts to look different, we could risk the retention of the homes we already have, meaning the youth would wait even longer for the services they need.

I am here to support the request of Nexus-PATH that your committee consider an amendment to HB1012 to delay implementation of the new lowered rate for a one-year period, to allow Nexus-PATH the opportunity to adjust its services in a way that will not negatively affect the services we provide or the retention of foster parents and staff.

Thank you for consideration of this request.

Treatment Foster Care

CURRENT STATE

Nexus-PATH
FAMILY HEALING

MAINTENANCE RATE
$7.8 MILLION



TCM $3.4 MILLION

$11.2 MILLION

2020 • 291 monthly average number of foster homes • 324 youth served

Treatment Foster Care

PROPOSED

Nexus-PATH
FAMILY HEALING



MAINTENANCE RATE
$7.8 MILLION

46% decrease

TCM $1.2 MILLION

$9,055,898

IMPACT

- Increase in the number of children our case workers are assigned to serve.
- Fewer supervisors to support social workers.
- Less resources to recruit new foster parents.
- Less resources to train and support current foster parents.

The foster parents below provided permission to list their name, address, email, and telephone number in support of this testimony and welcome questions you may have regarding their needs in order to maintain their service provision.

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At the request of Senator Dick Dever per Doreen Eichele, Dacotah Foundation - 3-30-2021

Permanent Supportive Housing

Proposed Funding:

	Current$	Beds	Funds Requested	Sub-Committee$	Alternative
Prairie Harvest (75%)	2,829,600	42	2,829,600	1,090,258.26	2,122,200
Gerridee's Place (75%)	901,008	14	901,008	363,419.42	675,756
	3,730,608				
Edwinton (40 X 629.90/mth X24)	0	40	640,000	1,038,341.20	604,704
LaGrave (42 X 629.90/mth X24)	375,000	42	515,000	1,090,258.26	634,939
Cooper House (42 X 629.90/mth X24)	566,928	42	570,000	1,090,258.26	634,939
	941,928				
Total Funding	4,672,536		5,455,608	4,672,535	4,672,538

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
4/1/2021
Department of Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 2:49 PM.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern**.

Discussion Topics:

- Providers/Provider rates
- Moratorium
- ASAM Level
- Sunset clause on Medicaid expansion
- Presumptive Eligibility

Senator Dever presented the committee with testimony #11307 and #11305.

Pam Sagness, Director, Mental Health Division, Dept. of Human Services – testified in favor and answered questions of the sub-committee.

Senator Mathern presented amendment [LC 21.0271.02010] - #11308.

Caprice Knapp, Director, Medical Services, Dept. of Human Services – testified in favor and answered sub-committee questions.

Senator Mathern presented testimony #11311.

Jonathan Alm, Legal Advisor, Dept. of Human Services – testified neutrally and presented testimony #11314 and #11313.

Senator Dever closed the hearing at 4:32 PM.

Rose Laning, Committee Clerk

SB 2012 – 2021-23 Budget for

Department of Human Services

Issues for discussion

1. Therapeutic Foster Care –
2. Permanent Supportive Housing
3. Supported Employment
4. Dementia Services
5. Provider Rates
6. Experienced Parent
7. Autism Voucher – SB 2089
8. Early Childhood Education – HB 1416 & 1466
9. Senior Nutrition Funding
10. Section 11 Funding – Residential & Vocational Supports
11. Accreditation costs for DD Licensure – Council on Quality Leadership
12. Brain Injury – Pre-Voc & Return to Work
13. Corporate Guardianship – 10 additional slots
14. Decreased census at LSTC – Need for additional transition funding?
15. COVID – 19 Emergency Funds for DD providers
16. Simle Middle School Pilot Project
17. ASAM Level 2.5 Services reimbursement
18. Moratorium on new SUD Providers
19. SUD Voucher funding
20. Funding for new SUD providers in rural areas
21. Sunset Clause on SUD Vouchers
22. ASO Study
23. Presumptive Eligibility
24. State Hospital
25. Transfer of land at LSTC for Fire Training Center
26. Recreation and Leisure Center funding restoration
27. Funding for Psychiatrist for LSTC
28. Child Support – funding & FTE's

29. Interpreter Services for Medicaid Providers
30. Additional FTE for Behavioral Health
31. Centers for Independent Living.
32. Zone reserve funds
33. Zone employee compensation
34.

Dever, Dick D.

From: Sagness, Pamela T.
Sent: Tuesday, March 30, 2021 5:26 PM
To: Dever, Dick D.
Subject: SUD Voucher Notes

SUD Voucher:

SUD Voucher total $17 million

- $2 million CARES Funds (expires Dec 2021)
- $4 million American Rescue Funds (expires 2024?)
- $11 million general fund (increase of $3 million from 19-21 biennium)

SUD Grants to expand service in underserved areas

- $3 million CARES funds to expand non-IMD services in underserved areas (expires Dec 2021)

SUD Voucher – other considerations

- Moratorium on new IMD residential providers and beds
- Cap on SUD Voucher IMD residential payments (House 30% on $12 million, DHS provided numbers for $17 million – 50% cap to cover 24 months)

These are the notes discussed in the meeting today. If you need any further numbers for consideration please let me know.

Pam

Pamela Sagness
Executive Policy Director, Behavioral Health
Department of Human Services

NORTH Dakota | Behavioral Health
Be Legendary.™ HUMAN SERVICES

701.328.8824 • psagness@nd.gov • behavioralhealth.nd.gov

21.0271.02010
Title.

Prepared by the Legislative Council staff for
Senator Mathern
March 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, remove "; to create and enact a new section to chapter 50-06 of the North Dakota"

Page 1, line 3, remove "Century Code, relating to substance use disorder treatment voucher system grants"

Page 1, line 4, replace "sections 50-06-42 and" with "section"

Page 1, line 5, remove "the substance use disorder voucher program and"

Page 1, line 9, remove the third "; to provide an"

Page 1, line 10, remove "expiration date"

Page 2, replace line 11 with:

"Grants	452,041,904	11,311,450	463,353,354"

Page 2, replace lines 13 through 15 with:

"Total all funds	$3,414,166,080	$350,409,491	$3,764,575,571
Less estimated income	2,232,568,138	238,823,355	2,471,391,493
Total general fund	$1,181,597,942	$111,586,136	$1,293,184,078"

Page 3, replace lines 7 through 9 with:

"Grand total general fund	$1,461,150,884	$108,204,660	$1,569,355,544
Grant total special funds	2,623,604,181	290,500,058	2,914,104,239
Grant total all funds	$4,084,755,065	$398,704,718	$4,483,459,783"

Page 7, remove lines 20 through 29

Page 8, remove lines 1 through 31

Page 9, remove lines 1 through 13

Page 11, after line 6, insert:

"**SECTION 17. SUBSTANCE USE DISORDER PROGRAM GRANTS - REPORT TO LEGISLATIVE MANAGEMENT.** Subdivision 2 of section 1 of this Act includes the sum of $3,000,000 for substance use disorder treatment grants. The department of human services shall develop an implementation plan for the distribution of the grant funding. The executive director of the department of human services shall appoint a committee that includes substance use disorder providers to advise the department on the development of the implementation plan. The implementation plan shall provide for the following:

1. A licensed substance abuse treatment program may apply for a competitive substance use disorder treatment voucher system grant.

2. To receive a grant, a licensed substance abuse treatment program must:

a. Submit an application in the form and manner prescribed by the department;

b. Enter a grant agreement with the department;

c. Use grant funds for a licensed substance abuse treatment program with fewer than seventeen beds in an underserved area, as determined by the department, in the state's substance abuse treatment system;

d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

e. Provide and disclose information needed to comply with the department's data collection requirements; and

f. Operate in compliance with grant requirements.

3. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

4. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program.

Before January 1, 2022, the department shall report to the legislative management regarding the plan to distribute substance use disorder treatment grants."

Page 14, line 7, replace "17" with "15"

Page 14, remove lines 9 and 10

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment:

- Increases funding for the substance use disorder program from $15 million to $17 million.
- Adjusts the funding source for the program to provide that $14 million is from the general fund and $3 million is from federal funds.
- Provides for $3 million of program funding to be used for substance use disorder treatment grants.
- Provides for the department to appoint a committee that includes substance use disorder providers to advise the department on the distribution of substance use disorder treatment grants.
- Removes sections added by the House relating to substance use disorder voucher treatment grants and the amount of substance use disorder voucher funding that may be used for residential services.

NORTH DAKOTA NDATPC ADDICTION TREATMENT PROVIDERS COALITION

NDATPC
3201 Fiechtner Dr. S
Fargo, ND 58103
ndatpcboard@gmail.com

Presumptive Eligibility & Medicaid Expansion PHP Rates

Chairman Dever & Members of the Committee,

On the behalf of non-hospital based providers in North Dakota, we are seeking parity with patient access and financial reimbursement in regards to presumptive eligibility and Medicaid Expansion 2.5/PHP Rates.

First, there are numerous providers throughout the state whom experience unnecessary 3-4 month wait times for enrollment in Medicaid and Medicaid Expansion. For example, providers like Heartview Foundation estimate that if all Medicaid and Medicaid Expansion eligible patients were enrolled immediately upon entering services, they would reduce their utilization of the SUD Voucher by $650,000 per year. Meanwhile Community Medical Services, the opioid treatment program in Minot and Fargo conservatively estimates they would reduce utilization of the SUD Voucher by $720,000 per year. By identifying the Opioid Treatment Providers as qualified entities for the process of presumptive eligibility, these entities are then capable of making enrollment determinations based on an individual's household income and other requirements. Presumptive eligibility serves a dual purpose of providing immediate access to needed health care services while putting people on a path to ongoing coverage.

Second, we ask for the Medicaid Expansion Amendment from the 2019 Legislative Session be enforced when it comes to consistent reimbursement rates across SUD providers. This was set to happen in 2019, but at the last minute the Department of Human Services subjectively adjusted the payment methodology and provided community based Partial Hospitalization Program/ASAM 2.5 with a different rate. Given there is no difference between hospital-based and community-based PHP programs in the North Dakota Medicaid Fee Structure, we would ask all community based programs be paid at the same rate as the hospital based programs within Medicaid Expansion.

We understand the Senate Appropriations Committee has many items to discuss, but these two simple changes have the opportunity to make a significant impact throughout the SUD industry.

Thank you for your time,

Ty Hegland
President/CEO, ShareHouse
Volunteer Chair, NDATPC

SHAREHOUSE
Summit Recovery Center
FIRST STEP RECOVERY
GOOD ROAD RECOVERY CENTER
Heart River
DRAKE COUNSELING SERVICES, INC
Growing Together Minot, ND
A.D.A.P.T. Inc. Changing Lifestyles
Agassiz Associates Live Life Intentionally
Community
Advance In Recovery Carrington, ND

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 3, after "grants" insert "; to create and enact a new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to North Dakota early childhood council membership"

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"Capital projects – human service centers 0 724,000"

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Page 5, remove lines 4 and 5

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A special education director;"

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SECTION 38. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates or reductions made in estimated reimbursement during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

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1. The department of human services is authorized to contract for the construction of a new treatment campus on the property owned by the state of North Dakota, in Stutsman County, through a public-private partnership only if:
   a. The department of human services utilizes chapter 48-02.1 and have a private operator to build, transfer, and operate the facility through a development agreement on property owned by the state of North Dakota;
   b. It does not result in an identified net budget increase based on the appropriated amount received during the 2019-21 biennium for the state hospital and south central regional human service center;
   c. The department of human services retains the cottages for students and staff housing;
   d. The state of North Dakota retains the title to the buildings and real estate under the development agreement; and
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2. The treatment campus must include space for the operation of the south central regional human service center."

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1. Methods of reimbursement for basic care facility cost categories including direct care, indirect care, room and board, and property; and
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Before October 1, 2022, the department shall present the report to the assigned interim committee. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

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Page 14, line 11, replace "Section" with "Sections"

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Page 14, line 11, replace "is" with "and section 22 of Senate Bill No. 2086, as approved by the sixty-seventh legislative assembly, are"

Renumber accordingly

DHS Engrossed HB 1012 - 2021/23 Budget Unresolved Items

Update: 3/31/21

Further Review	Division	Item	FTE Positions	General Fund	Other Funds	Total	Comments
Yes	New	Refugee Services (formerly at LSS)	4.00	-	4,337,408	4,337,408	Proposed 21/23 budget includes $1.75M
Yes	CFS	Child Care Services (formerly at LSS)	33.00	1,601,096	150,000	1,751,096	Proposed 21/23 budget includes $6.4M
No	BHD	Authority for Litigation Funds to pass from AG funds to DHS			2,000,000	2,000,000	Opioid Settelement Authority
No	SEHSC	Capital Projects for SEHSC		724,000		724,000	Originally included in the legacy bill and removed, includes heat pump replacement 455k and carpet replacement 269k
Yes	Management	Reduce funding for operating - Management		8,405,193		8,405,193	Restore House operating cut
No	LSTC	Fund shift adaptive equipment			306,701	306,701	Allow for LSTC to find outside funding for Adaptive equipment program
No	LSTC	Fund Psychiatrist		83,040		83,040	House added $100k need additional $83k
Yes	Child Support	Transition duties from ND Courts to DHS	3.50	308,126	209,662	517,788	SB 2002
No	HSC	Restore rent for NEHSC		168,736		168,736	Restore reduction of rent
No	Developmental Disabilities	Adjust Error for DD Crisis Beds		(30,156)	116,556	86,400	Budget Error
No	Medical	HB 1288 Glucose monitoring		479,585	1,297,885	1,777,470	Will need appropriation in bill or HB 1012
No	Medical	HB 1407 Tribal Care Coordination			7,181,628	7,181,628	Will need appropriation in bill or HB 1012
No	Medical	SB 2224 Metabolic supplements		9,300	10,700	20,000	Bill is enrolled with no appropriation
No	Long Term Care	Correct DOJ estimate for Personal Care		(619,550)	(712,824)	(1,332,374)	Correct error in estimate amounts overstated
No	Aging	DOJ rental assistance of $300,000 reclassify from Salaries to Operating		-		-	Net zero transaction, move funds to another budget line
No	Zones	Change in Salary Package			(163,558)	(163,558)	Change in cost for 1.5%/2% with $100 Minimum Yr 1
No	CFS	Change in funding for HB 1466 Policy		(3,958,910)	3,958,910	-	Four year old program utilize ESSER Funding from DPI
No	Medical	Hyperbaric oxygen therapy		335,000		335,000	Carryover authority needed
No	NDSH	Roof replacement project			572,000	572,000	Carryover of SIIF funds to complete project
No	BHD	Community Based Behavioral Health		3,000,000			Carryover authority needed
No	BHD	Mental Health Promotion & Mental Illness		109,000		109,000	Carryover authority needed
No	BHD	Suicide Prevention		750,000		750,000	Carryover authority needed
		Total	40.50	$ 7,170,460	$ 18,693,068	$ 25,863,528	

Legend
New
Reconsideration
Adjustments
Carryover

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
4/5/2021
Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 9:03 AM.

Senators present: **Dever, Erbele, Hogue, Oehlke, and Mathern.**

Discussion Topics:

- Unresolved amendment requests
- Carry over funds
- Zone operations
- Refugee support services
- Care Coordination agreements

Jonathan Alm, Legal Services, Dept. of Human Services – testified in favor and submitted testimony #11313 and #11314.

Sara Stolt – COO – Dept. of Human Services –testified in favor and submitted testimony #8458.

Terry Traynor, Executive Director, ND Association of Counties – testified in favor.

Arnie Strebe, CEO, Dept. of Human Services – testified in favor and continued with testimony #11313.

Jaimie Wilke, Assistant CFO, Dept. of Human Services – testified in favor.

Sue Foerster, Life Skills and Transition Center – testified in favor.

Tina Bay – Dept. of Human Services – testified in favor.

LeeAnn Thiel – Dept. of Human Services – testified in favor.

Eric Elkins – Dept. of Human Services – testified in favor.

Senator Dever closed the hearing at 10:50 AM.

Rose Laning, Committee Clerk

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Renumber accordingly



House Bill 1012

Senate Appropriations Committee

Senator Ray Holmberg, Chairman

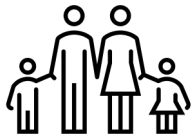
Human Service Zones

Local + State Partnerships For Effective and Efficient Service Delivery

NORTH Dakota | Human Services

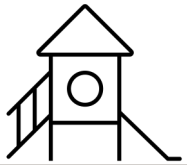
Be Legendary.™

DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment



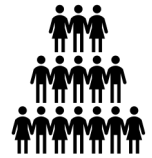
Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services



Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



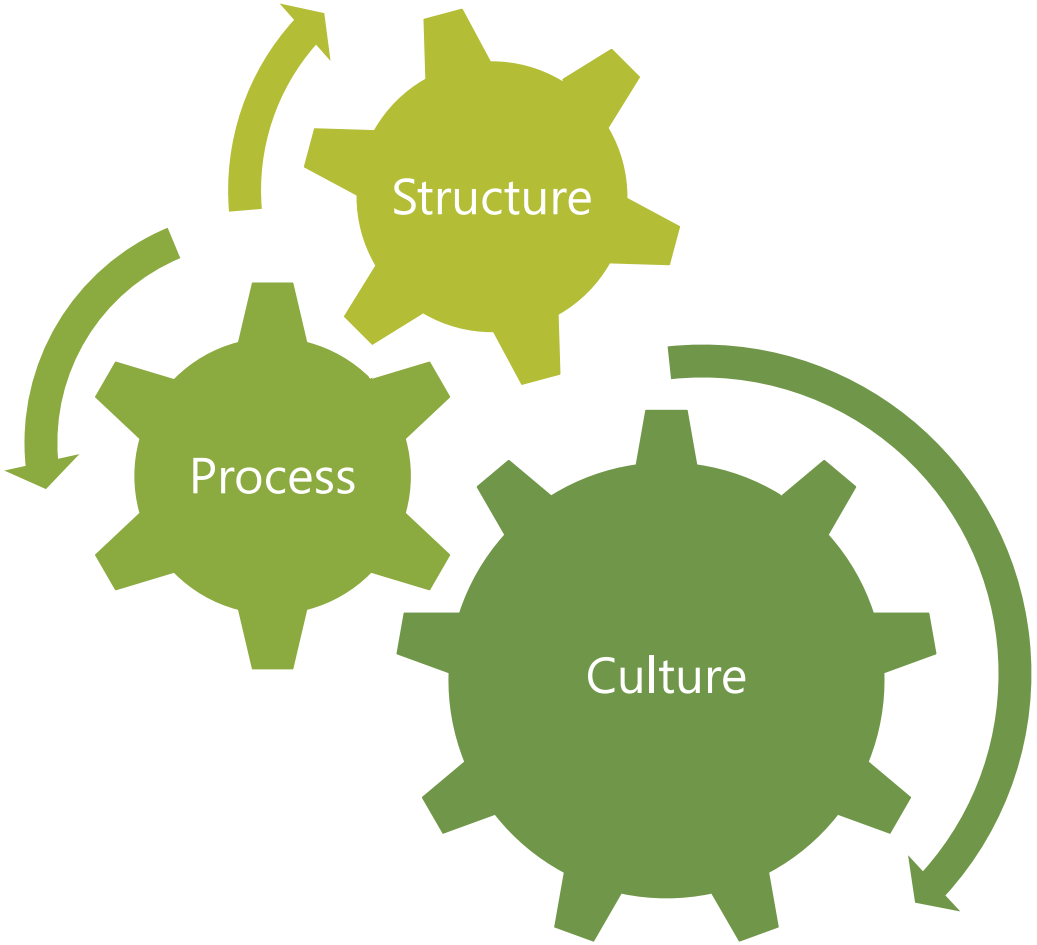
High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

IMPROVING PROGRAMS IS MORE THAN LOOKING AT STRUCTURE: Process and Cultural Change Must Accompany Structural Change



- 3 Core Areas
  - Process
  - Structure
  - Culture
- Focus is on service delivery to the client in the most effective and efficient way possible
- Seek to remove geographic, political and cultural boundaries to deliver smart, efficient and compassionate human services
- Primary Stakeholders
  - Individuals & Families
  - Taxpayers
  - Employees



HUMAN SERVICE ZONES



Gateway for Human Services

- Child Welfare
- Economic Assistance
- Indigent burials
- General Assistance
- County Supported HCBS
- Locally provided programs



Access Points Across ND

- Formerly known as County Social Services
- 19 Human Service Zones
- 46 Offices



Effectiveness + Efficiency

- Person-Centered
- Timeliness
- Quality

HUMAN SERVICES ZONES-MILESTONES

Zone Formation

- Formation of zone boards
- Zones formed 1/1/20
- Zone directors hired by 3/31/20
- Draft zone plans 6/1/20
- Final zone plans 12/1/20

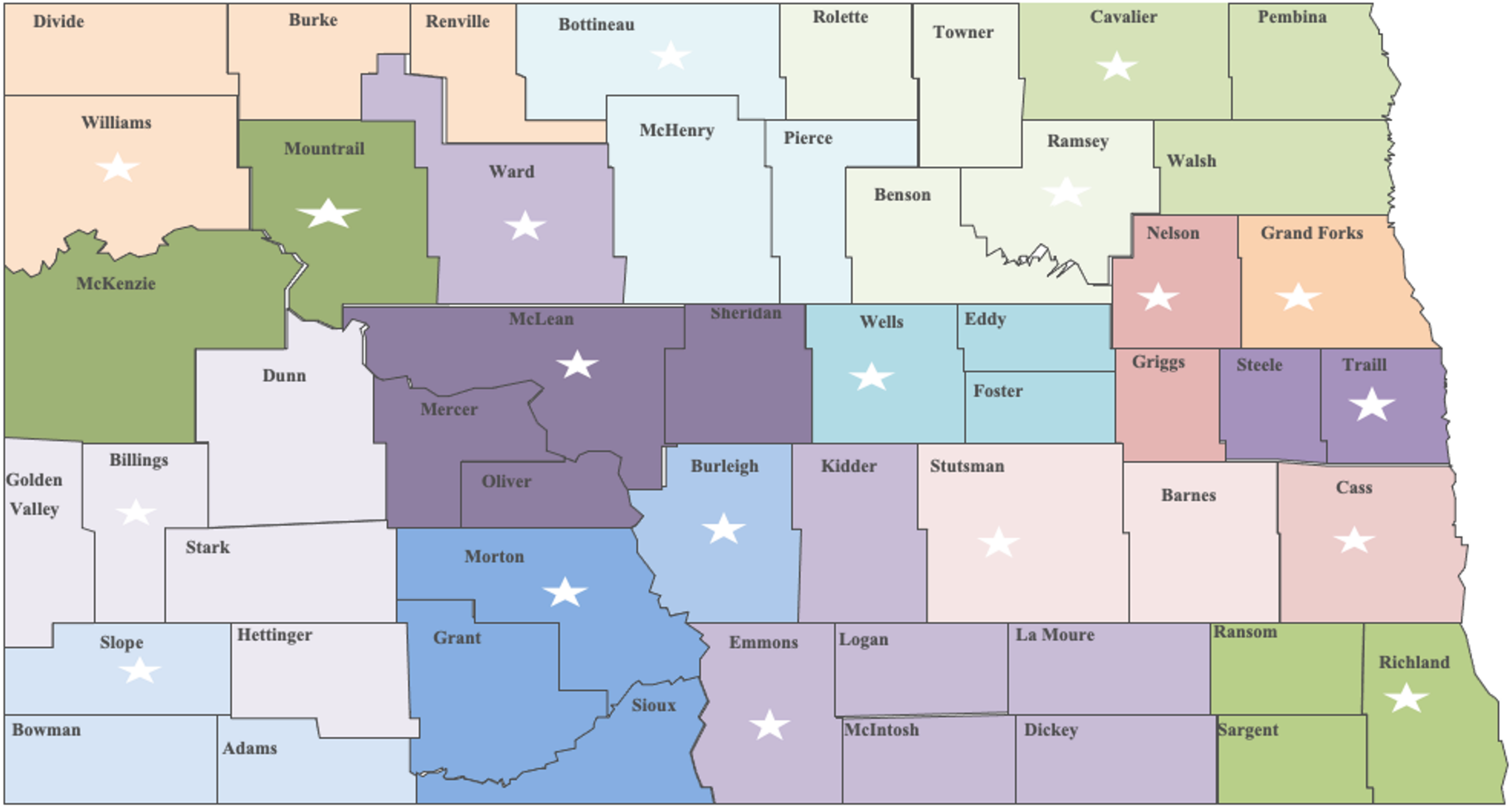
Zone Operations

- Unified and consistent human resources policy and process manual 1/1/21
- Zone director performance appraisal process
- Consistent Chart of Accounts
- Indirect Costs*
- Equity Study*

Program Operations

- Consistent General Assistance policy and process*
- Consistent Indigent Burial Criteria*
- Opt In – State Study*
- Multiple Redesign
  - Child Welfare
  - Eligibility*
  - Central Background Check
  - Institutional CPS
  - Foster Eligibility*
  - Sub Adopt Negotiations*
  - ADRL
  - QSP Enrollment*

*These projects are currently in process.


Divide
Burke
Renville
Bottineau
Rolette
Towner
Cavalier
Pembina
Williams
Mountrail
Ward
McHenry
Pierce
Ramsey
Walsh
Benson
Nelson
Grand Forks
McKenzie
McLean
Sheridan
Wells
Eddy
Griggs
Steele
Traill
Dunn
Mercer
Foster
Billings
Golden Valley
Oliver
Burleigh
Kidder
Stutsman
Barnes
Cass
Stark
Morton
Slope
Hettinger
Grant
Emmons
Logan
La Moure
Ransom
Richland
Sioux
Bowman
Adams
McIntosh
Dickey
Sargent

Total Full Time Equivalents



Counties were authorized 1,207 FTE



DHS budgeted for 985 FTEs in the zones



222 positions under reevaluation

ZONE DIRECTORS



Social Service Directors 2019

37

17+2



Human Service Zone Directors

18



Program + Direct Service Staff

HUMAN SERVICE ZONE ADMINISTRATION

Executive Policy

Leads Family Stability and Community Inclusion strategy and policy to guide service delivery in zones.

Chief Operating Officer

Leads DHS and zone operations and program redesign efforts for the zones.



Dir Zone Operations

Works to guide zones, build collaboration and lead zone operations.

Project Manager

Leads the DHS Office of Transformation supporting redesign projects, change management and process improvement across DHS and Human Service Zones.

FTE TRANSITIONS FROM COUNTY TO STATE



HCBS CASE MANAGERS

- Provide case management for older adults & individuals with physical disabilities receiving state and federally funded home and community-based services and basic care
- Became state employees 1/1/2020

Major Initiatives

- Specialized role of HCBS Case Manager
- Standardized training required for position
- Implemented a statewide centralized intake system for HCBS referrals and informed choice visits to ensure consumers understand their long-term service and support options
- 64 FTE provide support to 3057 unduplicated individuals
- Average 283 referrals and 54 new cases per month

CFS QUALITY ASSURANCE UNIT

SUPERVISOR: LEANNE MILLER



Continuous Quality Improvement Efforts (TBD in 2021)



Facility Licensure Visits



Case Record Reviews



Child & Family Service Reviews

Safety, Permanency, and Well-Being

EARLY CHILDHOOD SERVICES UNIT



2020 Big Wins

- Childcare Licensors are now state employees
- Made progress on the Early Childhood Services (ECS) online application system

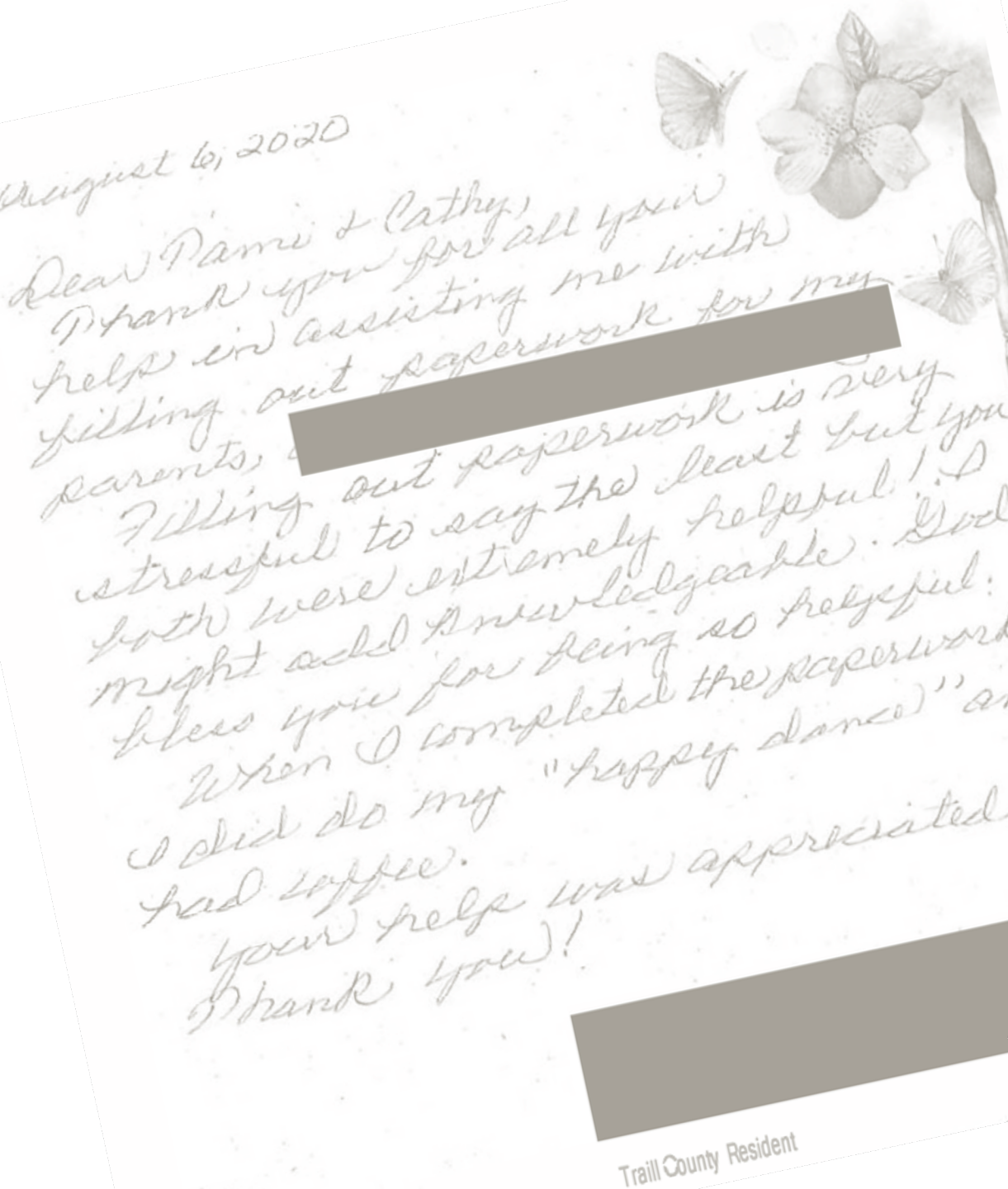


Goals for 2021

- Successfully complete the Child Care and Development Fund (CCDF) Monitoring Visit in Spring 2021
- Continue to work towards completion of the Early Childhood Services (ECS) online application system

MEDICAID LONG TERM CARE ELIGIBILITY UNIT

- Processed and maintain LTC Medicaid applications according to federal timeliness standards
- 16 FTE transferred from Human Service Zones
- Established Q1 2020
- Went live May 11, 2020



August 6, 2020

Dear Pami & Cathy,

Thank you for all your help in assisting me with filling out paperwork for my parents, [redacted]

Filling out paperwork is very stressful to say the least but you both were extremely helpful! I might add knowledgeable. God bless you for being so helpful: When I completed the paperwork, I did do my "happy dance" and had coffee.

Your help was appreciated.

Thank you!

[redacted]

Traill County Resident

12-11-20

Dear Ms. Brevik

This is just a quick note to say THANK YOU for your compassionate demeanor in handling our case.

It was a much needed emphatic ear you gave me on the phone at a time of my peak stress over this unexpected "review" matter. Such an attitude is very rare in my experience.

Happy Holidays

Sincerely

Pierce County Resident

FOSTER ELIGIBILITY + SUB ADOPT

- Authorized for 14 FTE to transfer from the HSZ to the State for a specialty foster eligibility unit
- Authorized for 2 FTE to transfer from the HSZ to the state to support subsidized adoption negotiation
- Unit launches in March 2021
- Will process all foster eligibility, Medicaid determinations for all foster and adopted children and negotiate subsidy for special needs adoptions

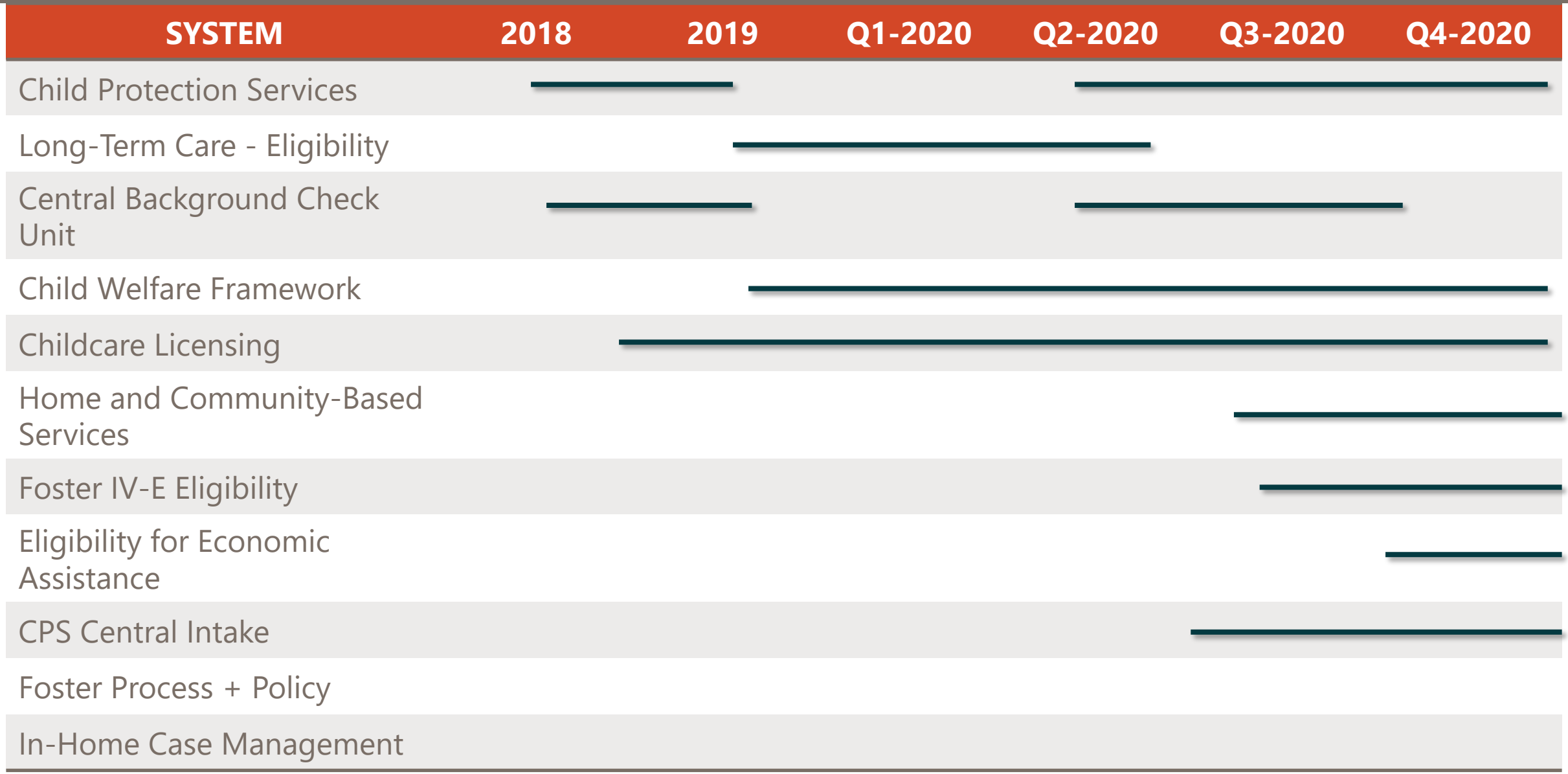
FOSTER CARE LICENSING

- SB2086 Request for up to 16 FTE to for a specialized foster care licensing unit to provide foster care licensing and renewals to foster homes in ND
- Create consistency and a leveled approach to managing foster licenses

IN PROGRESS

- Request for 16 FTE to transfer from the county to state to form a specialty foster care licensing team
- Consistent indigent burial criteria
- Consistent General Assistance policies, criteria and appeals process
- Study for zones to opt into State employment

SYSTEM REDESIGN TIMELINE



EQUITY ADJUSTMENTS

Zone Directors	Compensation equity to align all zone directors within the range
Zone Employee Benefits	Employees shifting to host county benefits which were often more robust
Zone Transfers to State Team	140 FTE that transferred to state were made whole if moving to state caused them to go backwards in salary and benefits

HUMAN SERVICE ZONES
Overview of Budget Changes

Description	2019-2021 Budget	Increase/ (Decrease)	2021-2023 Executive Budget	Increase/ (Decrease)	2021 - 2023 budget to Senate
Salaries and Benefits	24,186,262	2,934,739	27,121,001	(72,545)	27,048,456
Operating	4,621,302	(432,412)	4,188,890	-	4,188,890
Grants	144,892,436	956,411	145,848,847	13,065,322	158,914,169
Total	173,700,000	3,458,738	177,158,738	12,992,777	190,151,515
General Fund	-	1,323,223	1,323,223	(11,499)	1,311,724
Federal Funds	-	1,176,874	1,176,874	-	1,176,874
Other Funds	173,700,000	958,641	174,658,641	13,004,276	187,662,917
Total	173,700,000	3,458,738	177,158,738	12,992,777	190,151,515
Full Time Equivalent (FTE)	140.00	0.00	143.00	0.00	143.00

ZONE FUND BALANCES

- Fund balances are reported in January of each year.
- Anything above the fund balance limitation is reduced in the June payment of the following year. Note there were no fund balance reduction in CY 2020.
- If the payment provided to the HSZ to defray costs to provide Human Services, the HSZ would then utilize fund balances.
- HSZ must utilized the full balance of their human service zone human services fund before requesting additional dollars from the Department.
- It is anticipated fund balances will be exhausted in 21-23.

Estimated Fund Balances	In Millions
CY 2020 Beginning Balances Report by HSZ	$10.30
Estimated Beginning Fund Balances Ending CY 2020	$15.02
Less: Estimated Fund Balance Reduction CY 21	$8.85
Remaining Fund Balance CY 21	$6.18

	19-21	21-23
Expenditures > $2,000,000	$500,000	$500,000
Expenditures < $2,000,000	$100,000	$250,000



Contact Information

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3rd Floor, Judicial Wing
Bismarck, ND 58505

Phone: 701-328-1891
E-mail: sarastolt@nd.gov



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2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
4/6/2021
Department of Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 9:28 AM.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern**.

Discussion Topics:

- Experience Parent program
- Section 11 funding
- Corporate Guardianship
- Crisis beds in Region 7

Arnie Strebe, Chief Administrative Officer, Dept. of Human Services – testified in favor and handed out #11396.

Brady Larson, Legislative Council – testified neutrally and submitted #11395.

Jessica Thomasson, Executive Policy Director, ND Dept. of Human Services – testified in favor.

Tina Bay, Director, Developmental Disabilities Division; Dept. of Human Services – testified in favor.

Bruce Murray, Executive Director, ND Association of Community Providers – testified in favor.

Rosalie Etherington, Superintendent, ND State Hospital – testified in favor.

Carlotta McCleary, Executive Director, ND Federation of Families for Children's Mental Health – testified in favor.

Cory Pederson, Children and Family Services, Dept. of Human Services – testified in favor.

Krista Fremming, Deputy Director, Medical Services, Dept. of Human Services – testified in favor.

Kirsten Dvorak, Executive Director, The Arc of ND – testified in favor.

Pam Sagness, Director, Behavioral Health, Dept. of Human Services – testified in favor.

Senator Dever closed the hearing at 11:03 AM.

Rose Laning, Committee Clerk

	Topic	Division	Has Sub-committee had discussion?	Follow-up provided (as of 4-5-21)	Further Sub-Committee action needed?	Notes
4	Dementia Services	Aging			Comm preference	DHS requires no further discussion; nothing further has been provided
9	Senior Nutrition Funding	Aging			Comm preference	Watch for overlap with HB1395
6	Experienced Parent	DD			Comm preference	DHS requires no further discussion; nothing further has been provided
10	Section 11 Funding – Residential & Vocational Supports	DD			Comm preference	
11	Accreditation costs for DD Licensure – Council on Quality Leadership	DD			Comm preference	
13	Corporate Guardianship – 10 additional slots	DD			Comm preference	
26	Recreation and Leisure Center funding restoration	DD			Comm preference	
15	COVID – 19 Emergency Funds for DD providers	DD			DHS follow up needed	Jess/Tina will follow up with a summary of this issue
35	Crisis beds in Region 7	HSC			DHS follow up needed	Rosalie gathering info re safe beds (utilization, options)
7	Autism Voucher – SB 2089	Med Svc	x		DHS follow up needed	Need to provide Brady with info on how to reflect in budget; Still need $300,000 reflected on the appropriation line for the voucher as all the money is in the waiver
5	Provider Rates	Med Svc			DHS follow up needed	Still need to provide Brady with numbers based on 1.5% and 2%; Ready to send to Brady
19	SUD Voucher Funding	BHD	x		Need direction from committee	
12	Brain Injury – Pre-Voc & Return to Work	BHD / HSC	x		Need direction from committee	
34	Family voices	CFS			Need direction from committee	Previous testimony restored to 85% (contract)
29	Interpreter Services for Medicaid Providers	Med Svc			Need direction from committee	SB 2205 failed to pass, cost would have been 249,600 general funds and 249,600 other funds
30	Additional FTE for Behavioral Health	Med Svc / BHD / EA			Need direction from committee	External request for BHD grant writer; DHS will provide estimate

	Topic	Division	Has Sub-committee had discussion?	Follow-up provided (as of 4-5-21)	Further Sub-Committee action needed?	Notes
16	Simle Middle School Pilot Project	BHD	x		No action needed / Done	
18	Moratorium on new SUD Providers	BHD	x	amendment provided to Brady	Ready for Vote	
20	Funding for new SUD providers in rural areas	BHD	x		Ready for Vote	
21	Sunset clause on SUD Vouchers (Medicaid Expansion)	BHD	x		Ready for Vote	Completed, there is no sunset clause. Committee removed sunset clause on Medicaid expansion
8	Early Childhood Education – HB 1416 & 1466	CFS	x		Ready for Vote	
28	Child Support – funding & FTE's	CS	x		Ready for Vote	
32	Zone reserve funds	HSZ	x		Ready for Vote	
33	Zone employee compensation	HSZ	x		Ready for Vote	
14	Decreased census at LSTC – Need for additional transition funding?	LSTC	x		Ready for Vote	
25	Transfer of land at LSTC for Fire Training Center	LSTC	x		Ready for Vote	DHS reviewed language in amendment; language is appropriate
27	Funding for Psychiatrist for LSTC	LSTC	x		Ready for Vote	
22	ASO Study	Med Svc	x		Ready for Vote	Removed section from EHB 1012
17	ASAM Level 2.5 Services reimbursement	Med Svc / BHD	x	amendment provided to Brady	Ready for Vote	
23	Presumptive Eligibility	Med Svc / BHD / EA	x	DHS provided est to add FTE	Ready for Vote	
1	Therapeutic Foster Care TCM Rates	Med Svc / CFS	x	DHS provided est of delayed rate adj	Ready for Vote	
24	State Hospital	SH	x		Ready for Vote	Have info needed in the Amendment
3	Supported Employment	HSC	x		Tues/Thurs (preferred)	Rosalie has further analysis on funding sources; working on mtg with CommOpt (Mon?)
2	Permanent Supportive Housing	BHD / HSC	x	DHS provided requirement language to Brady	Tuesday	Requested conversation from Rosalie on Gerridee/Prairie Harvest; considering two funding formulas
31	Centers for Independent Living	VR			No action needed / Done	No further information from DHS; funds were restored in House

DHS - Management - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

Prepared for Senator Dever
4/5/2021

	House Version				Senate Version				Senate Changes to House Version Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	107.95	$64,690,274	$90,021,088	$154,711,362	107.95	$64,690,274	$90,021,088	$154,711,362	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)	(18.10)	($838,781)	($3,553,654)	($4,392,435)				$0
Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554				0
Salary increase		370,808	77,346	448,154		376,748	79,044	455,792		5,940	1,698	7,638
Retirement contribution increase				0				0				0
Health insurance increase		3,903	830	4,733		3,903	830	4,733				0
Reduce funding for operating		(8,405,193)		(8,405,193)		0		0		8,405,193		8,405,193
Administration												
Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121				0
Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426				0
Capitol complex rent model change				0				0				0
Information Technology Services												
Data processing costs and other program changes		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715				0
Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)				0
Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886				0
Early childhood data system		500,000		500,000		500,000		500,000				0
Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394				0
Other funds reprioritization			2,324,362	2,324,362			2,324,362	2,324,362				0
Total ongoing funding changes	(10.10)	$6,532,881	$2,302,324	$8,835,205	(10.10)	$14,944,014	$2,304,022	$17,248,036	0.00	$8,411,133	$1,698	$8,412,831
One-time funding items												
Upgrade MMIS system		$4,326,686	$30,673,314	$35,000,000		$4,326,686	$30,673,314	$35,000,000				$0
Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000				0
Data automation		98,186	98,186	196,372		98,186	98,186	196,372				0
MMIS tech stack		600,000	1,800,000	2,400,000		600,000	1,800,000	2,400,000				0
Quality measures services		11,344	34,031	45,375		11,344	34,031	45,375				0
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$0	$0	$0
Total Changes to Base Level Funding	(10.10)	$26,569,097	$49,907,855	$76,476,952	(10.10)	$34,980,230	$49,909,553	$84,889,783	0.00	$8,411,133	$1,698	$8,412,831
2021-23 Total Funding	97.85	$91,259,371	$139,928,943	$231,188,314	97.85	$99,670,504	$139,930,641	$239,601,145	0.00	$8,411,133	$1,698	$8,412,831
Total ongoing changes as a percentage of base level	*(9.4%)*	*10.1%*	*2.6%*	*5.7%*	*(9.4%)*	*23.1%*	*2.6%*	*11.1%*				
Total changes as a percentage of base level	*(9.4%)*	*41.1%*	*55.4%*	*49.4%*	*(9.4%)*	*54.1%*	*55.4%*	*54.9%*				

DHS - County Social Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

Prepared for Senator Dever
04/05/21

	House Version				Senate Version				Senate Changes to House Version Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	0.00	$0	$173,700,000	$173,700,000	0.00	$0	$173,700,000	$173,700,000	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
Base payroll changes			$1,653,466	$1,653,466			$1,653,466	$1,653,466				$0
Salary increase		412,248	291,785	704,033		340,915	292,547	633,462		(71,333)	762	(70,571)
Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024				0
Retirement contribution increase				0				0				0
Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997				0
Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673				0
Zone employee salary increase			3,975,941	3,975,941			3,812,383	3,812,383			(163,558)	(163,558)
Additional zone operations funding			9,089,381	9,089,381			9,089,381	9,089,381				0
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
One-time funding items												
No one-time funding items				$0				$0				$0
Total one-time funding changes	0.00	$0	$0	$0	0.00	$0	$0	$0	0.00	$0	$0	$0
Total Changes to Base Level Funding	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
2021-23 Total Funding	3.00	$1,311,724	$188,839,791	$190,151,515	3.00	$1,240,391	$188,676,995	$189,917,386	0.00	($71,333)	($162,796)	($234,129)
Total ongoing changes as a percentage of base level			*8.7%*	*9.5%*			*8.6%*	*9.3%*				
Total changes as a percentage of base level			*8.7%*	*9.5%*			*8.6%*	*9.3%*				

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
4/8/2021
Department of Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Dever opened the hearing at 9:08 AM.

Senators present: **Dever, Erbele, Hogue, Oehlke and Mathern**.

Discussion Topics:

- Overview of the Legislative Council Amendments
- Demolishing Buildings
- Developmental Disabilities Waivers
- Firetruck at State Hospital

Senator Dever gave an overview of the bill.

Brady Larson, Legislative Council – handed out a Listing of Proposed Changes to Engrossed Bill HB 1012 - #11446 and #11448.

Senator Mathern presented testimony #11447. He also presented and explained amendment LC 21. 0271.02020 - #11453.

Rosalie Etherington, Superintendent, ND State Hospital – answered sub-committee questions.

Tina Bay, Medical Services, DHS – answered sub-committee questions and submitted #11459.

Jonathan Alm, Legal Services, DHS – providing neutral testimony

Caprice Knapp, Director, Medical Services, DHS – answered sub-committee questions and submitted testimony #11460.

Bruce Murry, Executive Director, ND Association of Community Providers – answered sub-committee questions.

Theresa Larsen, Director, Protection and Advocacy Project – answered sub-committee questions.

Arnie Strebe, Chief Administrative Officer, DHS – answering sub-committee questions.

Senator Dever closed the hearing at 11:24 AM.

Rose Laning, Committee Clerk

The suggestion would be to replace Section 22 with:

SECTION 22. EMERGENCY STABILIZATION GRANTS – DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015 or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.
2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

Fire Truck Amendment

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a ~~political subdivision for the state share of costs relating to the purchase of a fire truck~~city that is located in a county of less than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services ~~shall discontinue any agreement with a political subdivision for fire protection services and~~ may not enter any future agreement with a political subdivision for fire protection services.

11448 & 11447

Prepared by the Legislative Council staff
for the HB 1012 Subcommittee
April 6, 2021

HOUSE BILL NO. 1012
LISTING OF PROPOSED CHANGES TO ENGROSSED BILL

Department of Human Services

Proposed funding changes:

	Description	FTE	General Fund	Special Funds	Total
1	Restore funding for supportive housing services to current funding levels and add a section for DHS to develop a method to distribute grants		$1,747,086		$1,747,086
2	Delay the adjustment of reimbursement rates of targeted case management in foster care		549,585	632,319	1,181,904
3	Remove funding and Section 33 of the bill for a study of the use of an Administrative Services Organization for Medicaid Expansion behavioral health services		(150,000)	(150,000)	(300,000)
4	Increase funding for SUD vouchers from $12 to $17 million and provide for $3 million of SUD grants to be distributed through RFP process		5,000,000		5,000,000
5	Provide for Medicaid presumptive eligibility	1.00	43,639	130,917	174,556
6	Add funding for refugee resettlement services	4.00		4,337,408	4,337,408
7	Add funding for child care services	33.00	1,601,096	150,000	1,751,096
8	Restore funding removed by the House for operating expenses		8,405,193		8,405,193
9	Increase funding for dementia services grants to provide total funding of $1.3 million		268,000		268,000
10	Add funding for the experienced parent program		260,000		260,000
11	Restore funding for Section 11 supported housing and employment services		373,261		373,261
12	Restore a portion of funding for developmental disability provider accreditation costs to provide a total of $100,000		75,000		75,000
13	Add 10 corporate guardianship slots for developmental disabilities		98,311		98,311

14	Restore funding for developmental disability recreational and leisure services		150,000		150,000
15	Adjust funding to move $300,000 from autism waivers to autism vouchers		0		0
16	Increase provider inflation rates to 1.5% and 2.0% during the 2021-23 biennium		9,333,240	9,704,409	19,037,649
17	Restore funding for parent-to-parent support organizations		31,875		31,875
18	Add a statutory section and funding for Medicaid reimbursement for interpreter services		249,600	249,600	499,200
19	Add 1 FTE grants and funding behavioral health position	1.00	171,455		171,455
20	Add positions related to the transition of duties from the courts to child support	3.50	308,126	209,662	517,788
21	Increase funding for psychiatrist transition costs at the Life Skills and Transition Center		83,040		83,040
22	Add one-time funding for capital projects at the Southeast Human Service Center		724,000		724,000
	Total proposed funding changes	42.50	$29,322,507	$15,264,315	$44,586,822

Other proposed changes:

23 Provide for a DHS study of early and periodic screening, diagnostic, and treatment services.

24 Amend Sections 16 and 17 of the bill to remove the sunset clause on Medicaid Expansion program and adjust language regarding provider reimbursement rates being an open record.

25 Provide for a moratorium on residential SUD providers, amend Section 15 of the bill to increase the amount of funding that may be used for SUD residential services to 50 percent, and reimburse all providers of ASAM Level 2.5 services at the same rate.

26 Add a section to authorize the conveyance of land from the Life Skills and Transition Center to the Grafton Fire Department.

21.0271.02020
Title.

Prepared by the Legislative Council staff for
Senator Mathern
April 7, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health"

Page 3, after line 30, insert:

"**SECTION 3. APPROPRIATION - STATE DEPARTMENT OF HEALTH.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 23, replace "4" with "5"

Page 12, line 3, replace "4" with "5"

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Page 14, line 11, replace "3" with "4"

Renumber accordingly

Senate Appropriations
April 8, 2021

Cost of Services for People with Intellectual and Developmental Disabilities

The North Dakota Department of Human Services pays for a continuum of services for individuals with intellectual and developmental disabilities. Costs reflect the statewide average cost of the continuum of care, from institutional level of care at the Life Skills and Transition Center (LSTC), which serves people whose needs exceed community capacity, to community-based services.

Life Skills and Transition Center (LSTC)

The LSTC is a service provider in the North Dakota Developmental Disabilities Provider continuum of services.

- LSTC Services include: Traditional (ICF) Services, Home and Community-Based Services and Statewide Crisis and Support Services.
- All other community living options are explored prior to an admission to the LSTC.
- The future role of the LSTC is to be the crisis and stabilization center for people with DD/ID.

Current Daily Cost: $1,123.78/day

Costs include:

- Room
- Board
- Therapies provided on-site by staff (physical therapy, occupational therapy, speech/language therapy)
- Psychiatric services
- Clinical psychology and Applied Behavior Analysis services
- Pharmacy
- Lab and x-ray
- Medical services on site provided by a medical provider
- Dental services
- Nutrition services
- Recreational therapy
- Adaptive equipment
- Day activities
- Transportation
- Vocational activities
- Clothing and incidentals
- Staff supervision and direct support services

DEVELOPMENTAL DISABILITIES SERVICES IN THE COMMUNITY

The following services are provided by private licensed developmental disability service providers.

Intermediate Care Facility ICF/IID

- Highest level of services provided outside of the state institution and is still considered an institutional setting.
- Provides comprehensive and individualized health care and rehabilitation services to participants to promote their functional status and independence. This is for people who need 24-hour care.

Current average daily rate:

- Adult: $605.19/day
- Child: $713.99/day

Costs include:

- Room
- Board
- Day programs (day supports or employment services), and some medical items
- Therapies provided on-site by staff (occupational therapy, speech/language therapy)
- Staff time to provide supervision and habilitative care
  - NOTE: Rate does NOT include direct health-related costs (i.e. dental, pharmacy…)

Residential Services (waiver program)

- Designed to assist participants with socialization, self-help and adaptive skills that improve the participants ability to independently reside and participate in an integrated community.

Current average daily rate: $298.64/day

Cost include:

- Staff time to provide supervision and habilitative care

Cost DOES NOT INCLUDE:

- Room
- Board
- Day programs (day supports or extended services) and medical items
- Direct health-related costs (i.e. dental, pharmacy…)

In-Home Supports (waiver program)

- Designed to assist participants with activities of daily living, supervision and provide support to the primary caregiver while living in their family home.

Current rate: $36.41/hour

Cost include:

- Staff time to provide supervision and habilitative care

Cost <u>DOES NOT</u> INCLUDE:

- Room
- Board
- Day programs (day supports or extended services) and medical items
- Direct health-related costs (i.e. dental, pharmacy…)

Day Services (waiver program)

- Provides formalized training and staff support in a non-residential setting to promote skill development. Services should facilitate and foster community participation as identified in the participants plan.

Current average rate: $23.80/hour

Cost include:

- Staff time to provide supervision and habilitative care

DHS Administration – Medicaid Expansion
Ages 19 and 20

GRANTS	TOTAL COST	STATE SHARE	FEDERAL MATCH	OTHER
19-20 DHS Administered	$ (12,610,533)	$ (5,863,898)	$ (6,746,635)	
Premium Adjustment for 21-44 Cohort	$ 12,857,823	$ 1,285,780	$ 11,572,043	
Cost/(Savings)	**$ 247,290**	**$ (4,578,118)**	**$ 4,825,408**	

ADMIN	TOTAL COST	STATE SHARE	FEDERAL MATCH	OTHER
EPSDT (5 per year) and PCCM (4 per year) Notices (1,096 EPSDT and 1,096 PCCM)	$ 7,398	$ 3,699	$ 3,699	
Claims Processing Staff (.5) FTE	$ 69,246	$ 17,312	$ 51,934	
Cost/(Savings)	**$ 76,644**	**$ 21,011**	**$ 55,633**	

TOTAL	TOTAL COST	STATE SHARE	FEDERAL MATCH	OTHER
Cost/(Savings)	**$ 323,934**	**$ (4,557,107)**	**$ 4,881,041**	

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1012
4/9/2021
Department of Human Services Sub-committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services.

Senator Holmberg opened the committee work at 8:33 AM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- Explanation of the amendment
- Building new State Hospital
- Application of Federal match for IMD dollars

Senator Dever presented and moved amendment LC 21.0271.02001 - #11478.
Senator Oehlke second.

Brady Larson, Legislative Council – providing neutral testimony.

Senators			*Senators*	
Senator Holmberg	Y		*Senator Hogue*	Y
Senator Krebsbach	Y		*Senator Oehlke*	Y
Senator Wanzek	Y		*Senator Poolman*	Y
Senator Bekkedahl	Y		*Senator Rust*	Y
Senator Davison	Y		*Senator Sorvaag*	Y
Senator Dever	Y		*Senator Heckaman*	Y
Senator Erbele	Y		*Senator Mathern*	Y

Roll Call vote 14-0-0. Motion passed.

Senator Dever moved Do Pass as Amended on HB 1012.
Senator Mathern second.

Senators			*Senators*	
Senator Holmberg	Y		*Senator Hogue*	Y
Senator Krebsbach	Y		*Senator Oehlke*	Y
Senator Wanzek	Y		*Senator Poolman*	Y
Senator Bekkedahl	Y		*Senator Rust*	Y
Senator Davison	Y		*Senator Sorvaag*	Y
Senator Dever	Y		*Senator Heckaman*	Y
Senator Erbele	Y		*Senator Mathern*	Y

Roll Call vote 14-0-0. Motion passed.

Senator Holmberg closed the committee work at 9:23 AM.
Rose Laning, Committee Clerk

SK 1/8/18 41

21.0271.02001
Title.03000
Fiscal No. 1

Prepared by the Legislative Council staff for
Senator Dever
April 8, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health"

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 2, after "50-06" insert "and a new section to chapter 50-24.1"

Page 1, line 3, after "grants" insert ", a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership"

Page 1, line 4, after "50-06-42" insert ", 50-11.1-14,"

Page 1, line 5, after "program" insert ", the early childhood workforce development fees,"

Page 1, line 9, after "application" insert "; to provide for retroactive application"

Page 1, remove lines 22 through 24

Page 2, remove lines 1 through 30

Page 3, replace lines 1 through 10 with:

"Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	85,747,426	220,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$84,889,783	$239,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$34,980,230	$99,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$57,782,440	$126,777,313
Operating expenses	150,961,583	19,170,338	170,131,921
Capital assets	10,000	0	10,000
Grants	452,041,904	13,963,488	466,005,392
Grants - medical assistance	2,742,157,720	315,028,658	3,057,186,378
Total all funds	$3,414,166,080	$405,944,924	$3,820,111,004
Less estimated income	2,232,568,138	274,026,185	2,506,594,323
Total general fund	$1,181,597,942	$131,918,739	$1,313,516,681

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,812,628)	$169,888,515
Institutions	137,476,480	(3,942,407)	133,534,073
Total all funds	$342,177,623	($38,755,035)	$303,422,588
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($25,713,375)	$189,149,293

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$142,425,985	$1,603,576,869
Grant total special funds	2,623,604,181	325,871,073	2,949,475,254
Grant total all funds	$4,084,755,065	$468,297,058	$4,553,052,123
Full-time equivalent positions	2,230.23	44.10	2,274.33"

Page 3, after line 18, insert:

"Capital projects - southeast human service center	0	724,000
Life skills and transition center transition costs	0	5,200,000
Developmental disabilities provider stabilization grants	0	125,000"

Page 3, replace lines 21 and 22 with:

"State hospital study	200,000	3,000,000"

Page 3, replace lines 24 through 26 with:

"Total all funds	$22,068,926	$83,890,747
Less estimated income	20,556,323	56,657,531
Total general fund	$1,512,603	$27,233,216"

Page 4, line 5, remove "political subdivision"

Page 4, line 6, replace "for the state share of costs relating to the purchase of a fire truck" with "city located in a county of fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital"

Page 4, line 10, remove "shall discontinue any agreement with a political subdivision for fire protection"

Page 4, line 11, remove "services and"

Page 4, after line 12, insert:

"**SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 1, after "**SERVICES**" insert "**- LEGISLATIVE INTENT**"

Page 5, line 5, after the period insert "It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement."

Page 5, line 7, replace "$187,385,888" with "$187,223,092"

Page 5, line 20, remove "**STATE HOSPITAL -**"

Page 5, line 22, after "chapel" insert ", administrative building,"

Page 5, line 23, replace "4" with "5"

Page 5, after line 29, insert:

"**SECTION 13. PERMANENT SUPPORTIVE HOUSING GRANTS.** Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 14. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 15. REFUGEE RESETTLEMENT SERVICES. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services shall establish and implement a plan that resettles at least twenty-five percent of new refugees in locations in the state outside of the three most populous counties. If the department, in consultation with applicable federal and private placement agencies, determines the goal of resettling at least twenty-five percent of refugees outside the three most populous counties is not achievable, the department shall discontinue the resettlement process for refugees and the federal funds identified in this section may not be expended for any purpose.

SECTION 16. TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. Subdivision 2 of section 1 of this Act includes the sum of $5,200,000 from federal or other funds made available to the department for the transition of individuals from the life skills and transition center to community-based providers. To be eligible to receive funding under this section, a provider must accept an individual who has a regular admission to the life skills and transition center and is being discharged, must ensure that all service needs are met including vocational services, and must implement a policy to not decline to provide services in the future to any individual being served under this section."

Page 7, replace lines 15 through 19 with:

"SECTION 18. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the

addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization shall reimburse all North Dakota substance use providers of American society of addiction medicine level 2.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care."

Page 8, remove lines 19 through 31

Page 9, replace lines 1 through 13 with:

"**SECTION 20. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular

emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

SECTION 21. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than fifty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 22. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 23. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 24. A new paragraph to subdivision I of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;"

Page 9, line 16, overstrike "**Effective through**"

Page 9, line 17, overstrike "**July 31,**"

Page 9, line 17, remove "**2023**"

Page 9, line 17, overstrike the first boldfaced hyphen

Page 11, line 1, remove the overstrike over "5. Provider reimbursement rate information received by the department under this"

Page 11, line 2, remove the overstrike over "~~section is~~"

Page 11, line 4, after "~~section~~" insert "an open record"

Page 11, line 4, remove the overstrike over the period and insert immediately thereafter:

"**SECTION 27.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section."

Page 11, after line 13, insert:

"**SECTION 30. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Page 11, remove lines 23 through 28

Page 12, line 3, replace "4" with "5"

Page 13, replace lines 13 through 18 with:

"**SECTION 41. EXEMPTION.** The sum of $750,000 from the general fund appropriated to the department of human services for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 42. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department of human services for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 43. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department of human services for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 44. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department of human services for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement

project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 45. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates or nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090 during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 47. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management."

Page 13, line 22, remove "conduct a study and"

Page 13, line 22, remove ". The report must provide"

Page 13, remove line 23

Page 13, line 24, replace "closing the state hospital, renovating the state hospital, or building" with ", including an architectural review and cost estimate to construct"

Page 13, line 26, replace "a" with "the"

Page 13, line 26, remove "regarding the results of the study"

Page 13, line 27, replace "$300,000" with "$3,000,000"

Page 13, line 28, replace "the report and recommendation" with "preparing the report and to develop detailed design plans for the construction of a new treatment campus"

Page 13, remove lines 29 through 31

Page 14, replace lines 1 through 6 with:

"**SECTION 49. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES.** The department of human services shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 50. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021-22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 51. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 52. RETROACTIVE APPLICATION. Section 20 of this Act applies retroactively to July 1, 2020."

Page 14, line 7, replace "Section 17" with "Sections 18 and 26"

Page 14, line 7, replace "becomes" with "become"

Page 14, line 9, replace "14" with "19"

Page 14, line 11, replace "is" with "and section 22 of Senate Bill No. 2086, as approved by the sixty-seventh legislative assembly, are"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
State Department of Health				
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00
DHS - Management				

Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85
DHS - Program/Policy				
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323
General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17
DHS - County Social Services Financing				
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00
DHS - Field Services				
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31
Bill total				
Total all funds	$4,084,755,065	$4,481,459,783	$72,155,770	$4,553,615,553
Less estimated income	2,623,604,181	2,911,104,239	38,652,730	2,949,756,969
General fund	$1,461,150,884	$1,570,355,544	$33,503,040	$1,603,858,584
FTE	2,230.23	2,231.83	42.50	2,274.33

House Bill No. 1012 - State Department of Health - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Grants			$563,430	$563,430
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00

Department 301 - State Department of Health - Detail of Senate Changes

	Adds Funding for Task Force[1]	Total Senate Changes
Grants	$563,430	$563,430
Total all funds	$563,430	$563,430
Less estimated income	281,715	281,715
General fund	$281,715	$281,715
FTE	0.00	0.00

[1] Funding is added to provide a grant to the Task Force on the Prevention of Sexual Abuse of Children for staff and programming materials focused on primary prevention activities.

12/18

House Bill No. 1012 - DHS - Management - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$20,222,500	$19,332,219	$7,638	$19,339,857
Operating expenses	134,438,862	211,781,095	8,405,193	220,186,288
Capital assets	50,000	75,000		75,000
Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85

Department 326 - DHS - Management - Detail of Senate Changes

	Adjusts Funding for Management[1]	Total Senate Changes
Salaries and wages	$7,638	$7,638
Operating expenses	8,405,193	8,405,193
Capital assets		
Total all funds	$8,412,831	$8,412,831
Less estimated income	1,698	1,698
General fund	$8,411,133	$8,411,133
FTE	0.00	0.00

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		$5,940	$1,698	$7,638
Restores funding removed by the House for operating expenses.		8,405,193		8,405,193
Total ongoing funding changes	0.00	$8,411,133	$1,698	$8,412,831

House Bill No. 1012 - DHS - Program/Policy - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$68,994,873	$119,359,007	$7,418,306	$126,777,313
Operating expenses	150,961,583	166,664,510	3,467,411	170,131,921
Capital assets	10,000	10,000		10,000
Grants	452,041,904	461,353,354	4,652,038	466,005,392
Grants - Medical assistance	2,742,157,720	3,015,188,700	41,997,678	3,057,186,378
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323
General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17

Department 328 - DHS - Program/Policy - Detail of Senate Changes

	Adjusts Funding for Program and Policy[1]	Total Senate Changes
Salaries and wages	$7,418,306	$7,418,306
Operating expenses	3,467,411	3,467,411
Capital assets		
Grants	4,652,038	4,652,038
Grants - Medical assistance	41,997,678	41,997,678
Total all funds	$57,535,433	$57,535,433
Less estimated income	38,202,830	38,202,830
General fund	$19,332,603	$19,332,603
FTE	42.50	42.50

[1] Funding for Program and Policy is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($3,512)	($24,341)	($27,853)
Adjusts provider inflation funding to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		9,060,898	9,704,410	18,765,308
Adds federal funding and FTE positions for refugee resettlement services.	4.00		4,337,408	4,337,408
Economic Assistance				
Adds 1 FTE specialty eligibility position	1.00	43,639	130,917	174,556
Child Support				
Adds FTE positions and funding for duties being transferred from the judicial branch	3.50	308,126	209,662	517,788
Medical Services				
Adds funding to allow interpreter services to be covered by Medicaid		249,600	249,600	499,200
Adds funding for the costs to provide Medicaid coverage for continuous glucose monitoring devices as provided in House Bill No. 1288		479,585	1,297,885	1,777,470
Adjusts funding based on changes to the tribal health care coordination fund in House Bill No. 1407			7,181,628	7,181,628
Adds funding for costs to provide Medicaid coverage of metabolic supplements as provided in Senate Bill No. 2224		9,300	10,700	20,000
Long-Term Care				
Adjusts funding based on updated estimates regarding funding needed to provide services resulting from a federal Department of Justice lawsuit settlement agreement		(619,550)	(712,824)	(1,332,374)
Transfers $300,000 of funding from the autism waiver program to the autism voucher program				0
Aging Services				
Increases funding for dementia services grants to provide a total of $1.3 million		268,000		268,000

Children and Family Services				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		26,250		26,250
Adjusts funding for a new early childhood program to provide a portion of funding from federal funds available from the Department of Public Instruction		(3,958,910)	3,958,910	0
Delays the realignment of therapeutic foster care targeted case management rates		549,585	632,319	1,181,904
Adds funding for child care and early childhood programs	33.00	1,601,096	150,000	1,751,096
Behavioral Health Division				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		5,625		5,625
Increases funding for substance use disorder vouchers to $17 million. The House increased funding for the vouchers from $8 million to $12 million.		5,000,000		5,000,000
Adds 1 FTE grants and funding position	1.00	171,455		171,455
Developmental Disabilities				
Restores a portion of funding for small agency accreditation costs removed in the agency savings plan to provide a total of $100,000. The House restored $25,000 of funding.		75,000		75,000
Adds funding for the experienced parent program		260,000		260,000
Restores funding removed in agency savings plan for Section 11 supported housing and employment		373,261		373,261
Increases corporate guardianship slots by 10 to provide for total slots of 499		98,311		98,311
Restores a portion of funding removed in agency savings plan for recreational and leisure services grants		150,000		150,000
Adjusts funding for crisis beds to reflect updated budget estimates		(30,156)	116,556	86,400
Restores funding reduced in the agency savings plan for adjustments to provider rates		5,240,000	5,910,000	11,150,000
Total ongoing funding changes	42.50	$19,357,603	$33,152,830	$52,510,433
One-Time Funding Items				
Removes funding added by the House for a study of the use of an Administrative Services Organization for Medicaid Expansion behavioral health services		($150,000)	($150,000)	($300,000)

Adds one-time funding from federal or other funds to transition individuals from the Life Skills and Transition Center to private developmental disability providers			5,200,000	5,200,000
Adds one-time funding to provide emergency stabilization grants to developmental disability providers		125,000		125,000
Total one-time funding items		($25,000)	$5,050,000	$5,025,000
Total changes to House	42.50	$19,332,603	$38,202,830	$57,535,433

House Bill No. 1012 - DHS - County Social Services Financing - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
County social services	$173,700,000	$190,151,515	($234,129)	$189,917,386
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of Senate Changes

	Adjusts Funding for Salaries and Wages[1]	Total Senate Changes
County social services	($234,129)	($234,129)
Total all funds	($234,129)	($234,129)
Less estimated income	(162,796)	(162,796)
General fund	($71,333)	($71,333)
FTE	0.00	0.00

[1] Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250. The adjustments are made as follows:

	General Fund	Other Funds	Total
DHS employees	($71,333)	$762	($70,571)
County employees		(163,558)	(163,558)
Total	($71,333)	($162,796)	($234,129)

House Bill No. 1012 - DHS - Field Services - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Human service centers	$204,701,143	$166,926,620	$2,961,895	$169,888,515
Institutions	137,476,480	130,617,763	2,916,310	133,534,073
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31

Department 349 - DHS - Field Services - Detail of Senate Changes

	Adjusts Funding for Field Services[1]	Total Senate Changes
Human service centers	$2,961,895	$2,961,895
Institutions	2,916,310	2,916,310
Total all funds	$5,878,205	$5,878,205
Less estimated income	329,283	329,283
General fund	$5,548,922	$5,548,922
FTE	0.00	0.00

[1] Funding is adjusted for Field Services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($146,283)	$22,582	($123,701)
Funding for provider inflation is adjusted to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		272,343		272,343
Human Service Centers				
Funding for supportive housing grants reduced as part of the 1915i realignment is restored		1,747,086		1,747,086
Rent expenses removed in the agency savings plan for the Northeast Human Service Center are restored		168,736		168,736
Institutions				
Funding for psychiatrist transition costs at the Life Skills and Transition Center are increased to $183,040. The House provided funding of $100,000 for transition costs.		83,040		83,040
Funding is adjusted to allow for the purchase of adaptive equipment using other funds at the Life Skills and Transition Center			306,701	306,701
Total ongoing funding changes	0.00	$2,124,922	$329,283	$2,454,205
One-Time Funding Changes				
Funding for a State Hospital study is increased from $300,000 to $3 million to provide for architectural reviews and the development of detailed plans for the construction of a new State Hospital		$2,700,000		$2,700,000

One-time funding is added for heat pump and carpet replacement projects at the Southeast Human Service Center		724,000		724,000
Total one-time funding changes	0.00	$3,424,000	$0	$3,424,000
Total changes to base level funding	0.00	$5,548,922	$329,283	$5,878,205

House Bill No. 1012 - Other Changes - Senate Action

This amendment also:

- Adjusts the amount of funding being provided from the human service finance fund for the county social and human services program.
- Provides that DHS develop a funding methodology to distribute permanent supportive housing grants.
- Adds a section to provide for an emergency grant allocation program for developmental disabilities providers and removes a section relating to DHS applying for an Appendix K waiver.
- Provides for DHS to settle a certain number of refugees outside of the three most populous counties.
- Provides funding and requirements to transfer individuals from the Life Skills and Transition Center to community providers.
- Provides legislative intent regarding future appropriations for the federal Department of Justice lawsuit settlement.
- Provides for certain substance use disorder providers to be reimbursed at similar levels, provides for a moratorium on new substance use disorder residential providers, and provides for no more than 50 percent of substance use disorder vouchers be allocated for residential substance use disorder services administered by programs with more than 16 beds.
- Adds a section to authorize DHS to collect fees for early childhood services training and development courses.
- Removes the sunset clause on the Medicaid Expansion program and adjusts language regarding provider reimbursement rates being open records.
- Adds a section to provide for interpreter services to be covered under the Medicaid program.
- Provides for DHS to establish a behavioral health bed management system.
- Authorizes the conveyance of land at the Life Skills and Transition Center to the Grafton Fire Department.
- Authorizes exemptions to continue appropriation authority into the 2021-23 biennium. The exemptions will reduce general fund turnback by $4,085,000.
- Provides for DHS to conduct a study of the Early and Periodic Screening, Diagnostic, and Treatment Program.
- Removes a section providing for a DHS study of using an Administrative Services Organization for behavioral health services in the Medicaid Expansion program.
- Provides for DHS to develop a new payment methodology for basic care facilities.
- Provides for a DHS report to the Legislative Management regarding the early childhood four-year old grant program.
- Authorizes positions for child care licensing to be used for other purposes.

REPORT OF STANDING COMMITTEE

HB 1012, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1012 was placed on the Sixth order on the calendar.

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health"

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 2, after "50-06" insert "and a new section to chapter 50-24.1"

Page 1, line 3, after "grants" insert ", a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership"

Page 1, line 4, after "50-06-42" insert ", 50-11.1-14,"

Page 1, line 5, after "program" insert ", the early childhood workforce development fees,"

Page 1, line 9, after "application" insert "; to provide for retroactive application"

Page 1, remove lines 22 through 24

Page 2, remove lines 1 through 30

Page 3, replace lines 1 through 10 with:

"Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	85,747,426	220,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$84,889,783	$239,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$34,980,230	$99,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$57,782,440	$126,777,313
Operating expenses	150,961,583	19,170,338	170,131,921
Capital assets	10,000	0	10,000
Grants	452,041,904	13,963,488	466,005,392
Grants - medical assistance	2,742,157,720	315,028,658	3,057,186,378
Total all funds	$3,414,166,080	$405,944,924	$3,820,111,004
Less estimated income	2,232,568,138	274,026,185	2,506,594,323
Total general fund	$1,181,597,942	$131,918,739	$1,313,516,681

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,812,628)	$169,888,515
Institutions	137,476,480	(3,942,407)	133,534,073
Total all funds	$342,177,623	($38,755,035)	$303,422,588
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($25,713,375)	$189,149,293

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$142,425,985	$1,603,576,869
Grant total special funds	2,623,604,181	325,871,073	2,949,475,254
Grant total all funds	$4,084,755,065	$468,297,058	$4,553,052,123
Full-time equivalent positions	2,230.23	44.10	2,274.33"

Page 3, after line 18, insert:

"Capital projects - southeast human service center	0	724,000
Life skills and transition center transition costs	0	5,200,000
Developmental disabilities provider stabilization grants	0	125,000"

Page 3, replace lines 21 and 22 with:

"State hospital study	200,000	3,000,000"

Page 3, replace lines 24 through 26 with:

"Total all funds	$22,068,926	$83,890,747
Less estimated income	20,556,323	56,657,531
Total general fund	$1,512,603	$27,233,216"

Page 4, line 5, remove "political subdivision"

Page 4, line 6, replace "for the state share of costs relating to the purchase of a fire truck" with "city located in a county of fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital"

Page 4, line 10, remove "shall discontinue any agreement with a political subdivision for fire protection"

Page 4, line 11, remove "services and"

Page 4, after line 12, insert:

"**SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH.**
There is appropriated out of any moneys in the general fund in the state treasury, not

otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 1, after "**SERVICES**" insert "**- LEGISLATIVE INTENT**"

Page 5, line 5, after the period insert "It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement."

Page 5, line 7, replace "$187,385,888" with "$187,223,092"

Page 5, line 20, remove "**STATE HOSPITAL -**"

Page 5, line 22, after "chapel" insert ", administrative building,"

Page 5, line 23, replace "4" with "5"

Page 5, after line 29, insert:

"**SECTION 13. PERMANENT SUPPORTIVE HOUSING GRANTS.** Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 14. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 15. REFUGEE RESETTLEMENT SERVICES. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services shall establish and implement a plan that resettles at least twenty-five percent of new refugees in locations in the state outside of the three most populous counties. If the department, in consultation with applicable federal and private placement agencies, determines the goal of resettling at least twenty-five percent of refugees outside the three most populous counties is not achievable, the department shall discontinue the

resettlement process for refugees and the federal funds identified in this section may not be expended for any purpose.

SECTION 16. TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. Subdivision 2 of section 1 of this Act includes the sum of $5,200,000 from federal or other funds made available to the department for the transition of individuals from the life skills and transition center to community-based providers. To be eligible to receive funding under this section, a provider must accept an individual who has a regular admission to the life skills and transition center and is being discharged, must ensure that all service needs are met including vocational services, and must implement a policy to not decline to provide services in the future to any individual being served under this section."

Page 7, replace lines 15 through 19 with:

"**SECTION 18. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.**

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization shall reimburse all North Dakota substance use providers of American society of addiction medicine level 2.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care."

Page 8, remove lines 19 through 31

Page 9, replace lines 1 through 13 with:

"**SECTION 20. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

SECTION 21. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical

management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than fifty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 22. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 23. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 24. A new paragraph to subdivision I of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;"

Page 9, line 16, overstrike "**Effective through**"

Page 9, line 17, overstrike "**July 31,**"

Page 9, line 17, remove "**2023**"

Page 9, line 17, overstrike the first boldfaced hyphen

Page 11, line 1, remove the overstrike over "5. Provider reimbursement rate information received by the department under this"

Page 11, line 2, remove the overstrike over "~~section is~~"

Page 11, line 4, after "~~section~~" insert "an open record"

Page 11, line 4, remove the overstrike over the period and insert immediately thereafter:

"**SECTION 27.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section."

Page 11, after line 13, insert:

"**SECTION 30. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Page 11, remove lines 23 through 28

Page 12, line 3, replace "4" with "5"

Page 13, replace lines 13 through 18 with:

"**SECTION 41. EXEMPTION.** The sum of $750,000 from the general fund appropriated to the department of human services for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 42. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department of human services for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 43. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department of human services for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 44. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department of human services for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 45. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates or nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090 during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 47. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management."

Page 13, line 22, remove "conduct a study and"

Page 13, line 22, remove ". The report must provide"

Page 13, remove line 23

Page 13, line 24, replace "closing the state hospital, renovating the state hospital, or building" with ", including an architectural review and cost estimate to construct"

Page 13, line 26, replace "a" with "the"

Page 13, line 26, remove "regarding the results of the study"

Page 13, line 27, replace "$300,000" with "$3,000,000"

Page 13, line 28, replace "the report and recommendation" with "preparing the report and to develop detailed design plans for the construction of a new treatment campus"

Page 13, remove lines 29 through 31

Page 14, replace lines 1 through 6 with:

"**SECTION 49. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES.** The department of human services shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 50. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021-22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 51. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 52. RETROACTIVE APPLICATION. Section 20 of this Act applies retroactively to July 1, 2020."

Page 14, line 7, replace "Section 17" with "Sections 18 and 26"

Page 14, line 7, replace "becomes" with "become"

Page 14, line 9, replace "14" with "19"

Page 14, line 11, replace "is" with "and section 22 of Senate Bill No. 2086, as approved by the sixty-seventh legislative assembly, are"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
State Department of Health				
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00
DHS - Management				
Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85
DHS - Program/Policy				
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323
General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17
DHS - County Social Services Financing				
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00
DHS - Field Services				
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31
Bill total				
Total all funds	$4,084,755,065	$4,481,459,783	$72,155,770	$4,553,615,553
Less estimated income	2,623,604,181	2,911,104,239	38,652,730	2,949,756,969
General fund	$1,461,150,884	$1,570,355,544	$33,503,040	$1,603,858,584
FTE	2,230.23	2,231.83	42.50	2,274.33

House Bill No. 1012 - State Department of Health - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Grants			$563,430	$563,430
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00

Department 301 - State Department of Health - Detail of Senate Changes

	Adds Funding for Task Force[1]	Total Senate Changes
Grants	$563,430	$563,430
Total all funds	$563,430	$563,430
Less estimated income	281,715	281,715
General fund	$281,715	$281,715
FTE	0.00	0.00

[1] Funding is added to provide a grant to the Task Force on the Prevention of Sexual Abuse of Children for staff and programming materials focused on primary prevention activities.

House Bill No. 1012 - DHS - Management - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$20,222,500	$19,332,219	$7,638	$19,339,857
Operating expenses	134,438,862	211,781,095	8,405,193	220,186,288
Capital assets	50,000	75,000		75,000
Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85

Department 326 - DHS - Management - Detail of Senate Changes

	Adjusts Funding for Management[1]	Total Senate Changes
Salaries and wages	$7,638	$7,638
Operating expenses	8,405,193	8,405,193
Capital assets		
Total all funds	$8,412,831	$8,412,831
Less estimated income	1,698	1,698
General fund	$8,411,133	$8,411,133
FTE	0.00	0.00

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		$5,940	$1,698	$7,638
Restores funding removed by the House for operating expenses.		8,405,193		8,405,193
Total ongoing funding changes	0.00	$8,411,133	$1,698	$8,412,831

House Bill No. 1012 - DHS - Program/Policy - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$68,994,873	$119,359,007	$7,418,306	$126,777,313
Operating expenses	150,961,583	166,664,510	3,467,411	170,131,921
Capital assets	10,000	10,000		10,000
Grants	452,041,904	461,353,354	4,652,038	466,005,392
Grants - Medical assistance	2,742,157,720	3,015,188,700	41,997,678	3,057,186,378
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323
General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17

Department 328 - DHS - Program/Policy - Detail of Senate Changes

	Adjusts Funding for Program and Policy[1]	Total Senate Changes
Salaries and wages	$7,418,306	$7,418,306
Operating expenses	3,467,411	3,467,411
Capital assets		
Grants	4,652,038	4,652,038
Grants - Medical assistance	41,997,678	41,997,678
Total all funds	$57,535,433	$57,535,433
Less estimated income	38,202,830	38,202,830
General fund	$19,332,603	$19,332,603
FTE	42.50	42.50

[1] Funding for Program and Policy is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($3,512)	($24,341)	($27,853)
Adjusts provider inflation funding to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		9,060,898	9,704,410	18,765,308
Adds federal funding and FTE positions for refugee resettlement services.	4.00		4,337,408	4,337,408
Economic Assistance				
Adds 1 FTE specialty eligibility position	1.00	43,639	130,917	174,556
Child Support				
Adds FTE positions and funding for duties being transferred from the judicial branch	3.50	308,126	209,662	517,788
Medical Services				
Adds funding to allow interpreter services to be covered by Medicaid		249,600	249,600	499,200
Adds funding for the costs to provide Medicaid coverage for continuous glucose monitoring devices as provided in House Bill No. 1288		479,585	1,297,885	1,777,470
Adjusts funding based on changes to the tribal health care coordination fund in House Bill No. 1407			7,181,628	7,181,628
Adds funding for costs to provide Medicaid coverage of metabolic supplements as provided in Senate Bill No. 2224		9,300	10,700	20,000
Long-Term Care				
Adjusts funding based on updated estimates regarding funding needed to provide services resulting from a federal Department of Justice lawsuit settlement agreement		(619,550)	(712,824)	(1,332,374)
Transfers $300,000 of funding from the autism waiver program to the autism voucher program				0
Aging Services				
Increases funding for dementia services grants to provide a total of $1.3 million		268,000		268,000
Children and Family Services				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		26,250		26,250
Adjusts funding for a new early childhood program to provide a portion of funding from federal funds available from the Department of Public Instruction		(3,958,910)	3,958,910	0

Delays the realignment of therapeutic foster care targeted case management rates		549,585	632,319	1,181,904
Adds funding for child care and early childhood programs	33.00	1,601,096	150,000	1,751,096
Behavioral Health Division				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		5,625		5,625
Increases funding for substance use disorder vouchers to $17 million. The House increased funding for the vouchers from $8 million to $12 million.		5,000,000		5,000,000
Adds 1 FTE grants and funding position	1.00	171,455		171,455
Developmental Disabilities				
Restores a portion of funding for small agency accreditation costs removed in the agency savings plan to provide a total of $100,000. The House restored $25,000 of funding.		75,000		75,000
Adds funding for the experienced parent program		260,000		260,000
Restores funding removed in agency savings plan for Section 11 supported housing and employment		373,261		373,261
Increases corporate guardianship slots by 10 to provide for total slots of 499		98,311		98,311
Restores a portion of funding removed in agency savings plan for recreational and leisure services grants		150,000		150,000
Adjusts funding for crisis beds to reflect updated budget estimates		(30,156)	116,556	86,400
Restores funding reduced in the agency savings plan for adjustments to provider rates		5,240,000	5,910,000	11,150,000
Total ongoing funding changes	42.50	$19,357,603	$33,152,830	$52,510,433
One-Time Funding Items				
Removes funding added by the House for a study of the use of an Administrative Services Organization for Medicaid Expansion behavioral health services		($150,000)	($150,000)	($300,000)
Adds one-time funding from federal or other funds to transition individuals from the Life Skills and Transition Center to private developmental disability providers			5,200,000	5,200,000
Adds one-time funding to provide emergency stabilization grants to developmental disability providers		125,000		125,000
Total one-time funding items		($25,000)	$5,050,000	$5,025,000
Total changes to House	42.50	$19,332,603	$38,202,830	$57,535,433

House Bill No. 1012 - DHS - County Social Services Financing - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
County social services	$173,700,000	$190,151,515	($234,129)	$189,917,386
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of Senate Changes

	Adjusts Funding for Salaries and Wages[1]	Total Senate Changes
County social services	($234,129)	($234,129)
Total all funds	($234,129)	($234,129)
Less estimated income	(162,796)	(162,796)
General fund	($71,333)	($71,333)
FTE	0.00	0.00

[1] Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250. The adjustments are made as follows:

	General Fund	Other Funds	Total
DHS employees	($71,333)	$762	($70,571)
County employees		(163,558)	(163,558)
Total	($71,333)	($162,796)	($234,129)

House Bill No. 1012 - DHS - Field Services - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Human service centers	$204,701,143	$166,926,620	$2,961,895	$169,888,515
Institutions	137,476,480	130,617,763	2,916,310	133,534,073
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31

Department 349 - DHS - Field Services - Detail of Senate Changes

	Adjusts Funding for Field Services[1]	Total Senate Changes
Human service centers	$2,961,895	$2,961,895
Institutions	2,916,310	2,916,310
Total all funds	$5,878,205	$5,878,205
Less estimated income	329,283	329,283
General fund	$5,548,922	$5,548,922
FTE	0.00	0.00

[1] Funding is adjusted for Field Services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of		($146,283)	$22,582	($123,701)

1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.				
Funding for provider inflation is adjusted to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		272,343		272,343
Human Service Centers				
Funding for supportive housing grants reduced as part of the 1915i realignment is restored		1,747,086		1,747,086
Rent expenses removed in the agency savings plan for the Northeast Human Service Center are restored		168,736		168,736
Institutions				
Funding for psychiatrist transition costs at the Life Skills and Transition Center are increased to $183,040. The House provided funding of $100,000 for transition costs.		83,040		83,040
Funding is adjusted to allow for the purchase of adaptive equipment using other funds at the Life Skills and Transition Center			306,701	306,701
Total ongoing funding changes	0.00	$2,124,922	$329,283	$2,454,205
One-Time Funding Changes				
Funding for a State Hospital study is increased from $300,000 to $3 million to provide for architectural reviews and the development of detailed plans for the construction of a new State Hospital		$2,700,000		$2,700,000
One-time funding is added for heat pump and carpet replacement projects at the Southeast Human Service Center		724,000		724,000
Total one-time funding changes	0.00	$3,424,000	$0	$3,424,000
Total changes to base level funding	0.00	$5,548,922	$329,283	$5,878,205

House Bill No. 1012 - Other Changes - Senate Action

This amendment also:

- Adjusts the amount of funding being provided from the human service finance fund for the county social and human services program.
- Provides that DHS develop a funding methodology to distribute permanent supportive housing grants.
- Adds a section to provide for an emergency grant allocation program for developmental disabilities providers and removes a section relating to DHS applying for an Appendix K waiver.
- Provides for DHS to settle a certain number of refugees outside of the three most populous counties.
- Provides funding and requirements to transfer individuals from the Life Skills and Transition Center to community providers.
- Provides legislative intent regarding future appropriations for the federal Department of Justice lawsuit settlement.
- Provides for certain substance use disorder providers to be reimbursed at similar levels, provides for a moratorium on new substance use disorder residential providers, and provides for no more than 50 percent of substance use disorder

vouchers be allocated for residential substance use disorder services administered by programs with more than 16 beds.

- Adds a section to authorize DHS to collect fees for early childhood services training and development courses.
- Removes the sunset clause on the Medicaid Expansion program and adjusts language regarding provider reimbursement rates being open records.
- Adds a section to provide for interpreter services to be covered under the Medicaid program.
- Provides for DHS to establish a behavioral health bed management system.
- Authorizes the conveyance of land at the Life Skills and Transition Center to the Grafton Fire Department.
- Authorizes exemptions to continue appropriation authority into the 2021-23 biennium. The exemptions will reduce general fund turnback by $4,085,000.
- Provides for DHS to conduct a study of the Early and Periodic Screening, Diagnostic, and Treatment Program.
- Removes a section providing for a DHS study of using an Administrative Services Organization for behavioral health services in the Medicaid Expansion program.
- Provides for DHS to develop a new payment methodology for basic care facilities.
- Provides for a DHS report to the Legislative Management regarding the early childhood four-year old grant program.
- Authorizes positions for child care licensing to be used for other purposes.

21.0271.02001
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
Senator Dever
April 8, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health"

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 2, after "50-06" insert "and a new section to chapter 50-24.1"

Page 1, line 3, after "grants" insert ", a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership"

Page 1, line 4, after "50-06-42" insert ", 50-11.1-14,"

Page 1, line 5, after "program" insert ", the early childhood workforce development fees,"

Page 1, line 9, after "application" insert "; to provide for retroactive application"

Page 1, remove lines 22 through 24

Page 2, remove lines 1 through 30

Page 3, replace lines 1 through 10 with:

"Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	85,747,426	220,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$84,889,783	$239,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$34,980,230	$99,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$57,782,440	$126,777,313
Operating expenses	150,961,583	19,170,338	170,131,921
Capital assets	10,000	0	10,000
Grants	452,041,904	13,963,488	466,005,392
Grants - medical assistance	2,742,157,720	315,028,658	3,057,186,378
Total all funds	$3,414,166,080	$405,944,924	$3,820,111,004
Less estimated income	2,232,568,138	274,026,185	2,506,594,323
Total general fund	$1,181,597,942	$131,918,739	$1,313,516,681

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,812,628)	$169,888,515
Institutions	137,476,480	(3,942,407)	133,534,073
Total all funds	$342,177,623	($38,755,035)	$303,422,588
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($25,713,375)	$189,149,293

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$142,425,985	$1,603,576,869
Grant total special funds	2,623,604,181	325,871,073	2,949,475,254
Grant total all funds	$4,084,755,065	$468,297,058	$4,553,052,123
Full-time equivalent positions	2,230.23	44.10	2,274.33"

Page 3, after line 18, insert:

"Capital projects - southeast human service center	0	724,000
Life skills and transition center transition costs	0	5,200,000
Developmental disabilities provider stabilization grants	0	125,000"

Page 3, replace lines 21 and 22 with:

"State hospital study	200,000	3,000,000"

Page 3, replace lines 24 through 26 with:

"Total all funds	$22,068,926	$83,890,747
Less estimated income	20,556,323	56,657,531
Total general fund	$1,512,603	$27,233,216"

Page 4, line 5, remove "political subdivision"

Page 4, line 6, replace "for the state share of costs relating to the purchase of a fire truck" with "city located in a county of fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital"

Page 4, line 10, remove "shall discontinue any agreement with a political subdivision for fire protection"

Page 4, line 11, remove "services and"

Page 4, after line 12, insert:

"**SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 1, after "**SERVICES**" insert "**- LEGISLATIVE INTENT**"

Page 5, line 5, after the period insert "It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement."

Page 5, line 7, replace "$187,385,888" with "$187,223,092"

Page 5, line 20, remove "**STATE HOSPITAL -**"

Page 5, line 22, after "chapel" insert ", administrative building,"

Page 5, line 23, replace "4" with "5"

Page 5, after line 29, insert:

"**SECTION 13. PERMANENT SUPPORTIVE HOUSING GRANTS.** Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 14. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 15. REFUGEE RESETTLEMENT SERVICES. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services must establish and implement a plan that resettles at least twenty-five percent of new refugees in locations in the state outside of the three most populous counties. If the department, in consultation with applicable federal and private placement agencies, determines the goal of resettling at least twenty-five percent of refugees outside the three most populous counties is not achievable, the department shall discontinue the resettlement process for refugees and the federal funds identified in this section may not be expended for any purpose.

SECTION 16. TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. Subdivision 2 of section 1 of this Act includes the sum of $5,200,000 from federal or other funds made available to the department for the transition of individuals from the life skills and transition center to community-based providers. To be eligible to receive funding under this section, a provider must accept an individual who has a regular admission to the life skills and transition center and is being discharged, must ensure that all service needs are met including vocational services, and must implement a policy to not decline to provide services in the future to any individual being served under this section."

Page 7, replace lines 15 through 19 with:

"SECTION 18. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the

addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization shall reimburse all North Dakota substance use providers of American society of additional medicine Level II.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care."

Page 8, remove lines 19 through 31

Page 9, replace lines 1 through 13 with:

"**SECTION 20. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular

emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

SECTION 21. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than fifty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 22. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 23. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 24. A new subparagraph to subdivision I of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;"

Page 9, line 16, overstrike "**Effective through**"

Page 9, line 17, overstrike "**July 31,**"

Page 9, line 17, remove "**2023**"

Page 11, remove the overstrike over line 1

Page 11, line 2, remove the overstrike over "~~section is~~"

Page 11, line 4, after "~~section~~" insert "an open record"

Page 11, line 4, remove the overstrike over "~~the period~~"

SECTION 27. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid Expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited

English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section."

Page 11, after line 13, insert:

"**SECTION 30. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Page 11, remove lines 23 through 28

Page 12, line 3, replace "4" with "5"

Page 13, replace lines 13 through 18 with:

"**SECTION 41. EXEMPTION.** The sum of $750,000 from the general fund appropriated to the department for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 42. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 43. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 44. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 45. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21

biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates or nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090 during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 47. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management."

Page 13, line 22, remove "conduct a study and"

Page 13, line 22, remove ". The report must provide"

Page 13, remove line 23

Page 13, line 24, replace "closing the state hospital, renovating the state hospital, or building" with ", including an architectural review and cost estimate to construct"

Page 13, line 26, replace "a" with "the"

Page 13, line 26, remove "regarding the results of the study"

Page 13, line 27, replace "$300,000" with "$3,000,000"

Page 13, line 28, replace "the report and recommendation" with "preparing the report and to develop detailed design plans for the construction of a new treatment campus"

Page 13, remove lines 29 through 31

Page 14, replace lines 1 through 6 with:

"**SECTION 49. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES.** The department of human services shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 50. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021-22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 51. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 52. RETROACTIVE APPLICATION. Section 20 of this Act applies retroactively to July 1, 2020."

Page 14, line 7, replace "Section 17" with "Sections 18 and 26"

Page 14, line 7, replace "becomes" with "become"

Page 14, line 9, replace "14" with "19"

Page 14, line 11, replace "is" with "and section 22 of Senate Bill No. 2086, as approved by the sixty-seventh legislative assembly, are"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
State Department of Health				
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00
DHS - Management				
Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85
DHS - Program/Policy				
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323

General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17
DHS - County Social Services Financing				
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00
DHS - Field Services				
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31
Bill total				
Total all funds	$4,084,755,065	$4,481,459,783	$72,155,770	$4,553,615,553
Less estimated income	2,623,604,181	2,911,104,239	38,652,730	2,949,756,969
General fund	$1,461,150,884	$1,570,355,544	$33,503,040	$1,603,858,584
FTE	2,230.23	2,231.83	42.50	2,274.33

House Bill No. 1012 - State Department of Health - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Grants			$563,430	$563,430
Total all funds	$0	$0	$563,430	$563,430
Less estimated income	0	0	281,715	281,715
General fund	$0	$0	$281,715	$281,715
FTE	0.00	0.00	0.00	0.00

Department 301 - State Department of Health - Detail of Senate Changes

	Adds Funding for Task Force[1]	Total Senate Changes
Grants	$563,430	$563,430
Total all funds	$563,430	$563,430
Less estimated income	281,715	281,715
General fund	$281,715	$281,715
FTE	0.00	0.00

[1] Funding is added to provide a grant to the Task Force on the Prevention of Sexual Abuse of Children for staff and programming materials focused on primary prevention activities.

House Bill No. 1012 - DHS - Management - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$20,222,500	$19,332,219	$7,638	$19,339,857
Operating expenses	134,438,862	211,781,095	8,405,193	220,186,288
Capital assets	50,000	75,000		75,000
Total all funds	$154,711,362	$231,188,314	$8,412,831	$239,601,145
Less estimated income	90,021,088	139,928,943	1,698	139,930,641
General fund	$64,690,274	$91,259,371	$8,411,133	$99,670,504
FTE	107.95	97.85	0.00	97.85

Department 326 - DHS - Management - Detail of Senate Changes

	Adjusts Funding for Management[1]	Total Senate Changes
Salaries and wages	$7,638	$7,638
Operating expenses	8,405,193	8,405,193
Capital assets		
Total all funds	$8,412,831	$8,412,831
Less estimated income	1,698	1,698
General fund	$8,411,133	$8,411,133
FTE	0.00	0.00

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		$5,940	$1,698	$7,638
Restores funding removed by the House for operating expenses.		8,405,193		8,405,193
Total ongoing funding changes	0.00	$8,411,133	$1,698	$8,412,831

House Bill No. 1012 - DHS - Program/Policy - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Salaries and wages	$68,994,873	$119,359,007	$7,418,306	$126,777,313
Operating expenses	150,961,583	166,664,510	3,467,411	170,131,921
Capital assets	10,000	10,000		10,000
Grants	452,041,904	461,353,354	4,652,038	466,005,392
Grants - Medical assistance	2,742,157,720	3,015,188,700	41,997,678	3,057,186,378
Total all funds	$3,414,166,080	$3,762,575,571	$57,535,433	$3,820,111,004
Less estimated income	2,232,568,138	2,468,391,493	38,202,830	2,506,594,323
General fund	$1,181,597,942	$1,294,184,078	$19,332,603	$1,313,516,681
FTE	383.25	648.67	42.50	691.17

Department 328 - DHS - Program/Policy - Detail of Senate Changes

	Adjusts Funding for Program and Policy[1]	Total Senate Changes
Salaries and wages	$7,418,306	$7,418,306
Operating expenses	3,467,411	3,467,411
Capital assets		
Grants	4,652,038	4,652,038
Grants - Medical assistance	41,997,678	41,997,678
Total all funds	$57,535,433	$57,535,433
Less estimated income	38,202,830	38,202,830
General fund	$19,332,603	$19,332,603
FTE	42.50	42.50

[1] Funding for Program and Policy is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($3,512)	($24,341)	($27,853)
Adjusts provider inflation funding to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		9,060,898	9,704,410	18,765,308
Adds federal funding and FTE positions for refugee resettlement services.	4.00		4,337,408	4,337,408
Economic Assistance				
Adds 1 FTE specialty eligibility position	1.00	43,639	130,917	174,556
Child Support				
Adds FTE positions and funding for duties being transferred from the judicial branch	3.50	308,126	209,662	517,788
Medical Services				
Adds funding to allow interpreter services to be covered by Medicaid		249,600	249,600	499,200
Adds funding for the costs to provide Medicaid coverage for continuous glucose monitoring devices as provided in House Bill No. 1288		479,585	1,297,885	1,777,470
Adjusts funding based on changes to the tribal health care coordination fund in House Bill No. 1407			7,181,628	7,181,628
Adds funding for costs to provide Medicaid coverage of metabolic supplements as provided in Senate Bill No. 2224		9,300	10,700	20,000
Long-Term Care				
Adjusts funding based on updated estimates regarding funding needed to provide services resulting from a federal Department of Justice lawsuit settlement agreement		(619,550)	(712,824)	(1,332,374)
Transfers $300,000 of funding from the autism waiver program to the autism voucher program				0
Aging Services				
Increases funding for dementia services grants to provide a total of $1.3 million		268,000		268,000

Children and Family Services				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		26,250		26,250
Adjusts funding for a new early childhood program to provide a portion of funding from federal funds available from the Department of Public Instruction		(3,958,910)	3,958,910	0
Delays the realignment of therapeutic foster care targeted case management rates		549,585	632,319	1,181,904
Adds funding for child care and early childhood programs	33.00	1,601,096	150,000	1,751,096
Behavioral Health Division				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment		5,625		5,625
Increases funding for substance use disorder vouchers to $17 million. The House increased funding for the vouchers from $8 million to $12 million.		5,000,000		5,000,000
Adds 1 FTE grants and funding position	1.00	171,455		171,455
Developmental Disabilities				
Restores a portion of funding for small agency accreditation costs removed in the agency savings plan to provide a total of $100,000. The House restored $25,000 of funding.		75,000		75,000
Adds funding for the experienced parent program		260,000		260,000
Restores funding removed in agency savings plan for Section 11 supported housing and employment		373,261		373,261
Increases corporate guardianship slots by 10 to provide for total slots of 499		98,311		98,311
Restores a portion of funding removed in agency savings plan for recreational and leisure services grants		150,000		150,000
Adjusts funding for crisis beds to reflect updated budget estimates		(30,156)	116,556	86,400
Restores funding reduced in the agency savings plan for adjustments to provider rates		5,240,000	5,910,000	11,150,000
Total ongoing funding changes	42.50	$19,357,603	$33,152,830	$52,510,433
One-Time Funding Items				
Removes funding added by the House for a study of the use of an Administrative Services Organization for Medicaid Expansion behavioral health services		($150,000)	($150,000)	($300,000)

Adds one-time funding from federal or other funds to transition individuals from the Life Skills and Transition Center to private developmental disability providers			5,200,000	5,200,000
Adds one-time funding to provide emergency stabilization grants to developmental disability providers		125,000		125,000
Total one-time funding items		($25,000)	$5,050,000	$5,025,000
Total changes to House	42.50	$19,332,603	$38,202,830	$57,535,433

House Bill No. 1012 - DHS - County Social Services Financing - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
County social services	$173,700,000	$190,151,515	($234,129)	$189,917,386
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995
General fund	$0	$1,311,724	($71,333)	$1,240,391
FTE	140.00	143.00	0.00	143.00

Department 333 - DHS - County Social Services Financing - Detail of Senate Changes

	Adjusts Funding for Salaries and Wages[1]	Total Senate Changes
County social services	($234,129)	($234,129)
Total all funds	($234,129)	($234,129)
Less estimated income	(162,796)	(162,796)
General fund	($71,333)	($71,333)
FTE	0.00	0.00

[1] Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250. The adjustments are made as follows:

	General Fund	Other Funds	Total
DHS employees	($71,333)	$762	($70,571)
County employees		(163,558)	(163,558)
Total	($71,333)	($162,796)	($234,129)

House Bill No. 1012 - DHS - Field Services - Senate Action

	Base Budget	House Version	Senate Changes	Senate Version
Human service centers	$204,701,143	$166,926,620	$2,961,895	$169,888,515
Institutions	137,476,480	130,617,763	2,916,310	133,534,073
Total all funds	$342,177,623	$297,544,383	$5,878,205	$303,422,588
Less estimated income	127,314,955	113,944,012	329,283	114,273,295
General fund	$214,862,668	$183,600,371	$5,548,922	$189,149,293
FTE	1,599.03	1,342.31	0.00	1,342.31

Department 349 - DHS - Field Services - Detail of Senate Changes

	Adjusts Funding for Field Services[1]	Total Senate Changes
Human service centers	$2,961,895	$2,961,895
Institutions	2,916,310	2,916,310
Total all funds	$5,878,205	$5,878,205
Less estimated income	329,283	329,283
General fund	$5,548,922	$5,548,922
FTE	0.00	0.00

[1] Funding is adjusted for Field Services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($146,283)	$22,582	($123,701)
Funding for provider inflation is adjusted to provide a 1.5 percent increase the 1st year of the biennium and 2.0 percent the 2nd year of the biennium. The House provided 1 percent annual inflationary increases.		272,343		272,343
Human Service Centers				
Funding for supportive housing grants reduced as part of the 1915i realignment is restored		1,747,086		1,747,086
Rent expenses removed in the agency savings plan for the Northeast Human Service Center are restored		168,736		168,736
Institutions				
Funding for psychiatrist transition costs at the Life Skills and Transition Center are increased to $183,040. The House provided funding of $100,000 for transition costs.		83,040		83,040
Funding is adjusted to allow for the purchase of adaptive equipment using other funds at the Life Skills and Transition Center			306,701	306,701
Total ongoing funding changes	0.00	$2,124,922	$329,283	$2,454,205
One-Time Funding Changes				
Funding for a State Hospital study is increased from $300,000 to $3 million to provide for architectural reviews and the development of detailed plans for the construction of a new State Hospital		$2,700,000		$2,700,000

One-time funding is added for heat pump and carpet replacement projects at the Southeast Human Service Center		724,000		724,000
Total one-time funding changes	0.00	$3,424,000	$0	$3,424,000
Total changes to base level funding	0.00	$5,548,922	$329,283	$5,878,205

House Bill No. 1012 - Other Changes - Senate Action

This amendment also:

- Adjusts the amount of funding being provided from the human service finance fund for the county social and human services program.
- Provides that DHS develop a funding methodology to distribute permanent supportive housing grants.
- Adds a section to provide for an emergency grant allocation program for developmental disabilities providers and removes a section relating to DHS applying for an Appendix K waiver.
- Provides for DHS to settle a certain number of refugees outside of the three most populous counties.
- Provides funding and requirements to transfer individuals from the Life Skills and Transition Center to community providers.
- Provides legislative intent regarding future appropriations for the federal Department of Justice lawsuit settlement.
- Provides for certain substance use disorder providers to be reimbursed at similar levels, provides for a moratorium on new substance use disorder residential providers, and provides for no more than 50 percent of substance use disorder vouchers be allocated for residential substance use disorder services administered by programs with more than 16 beds.
- Adds a section to authorize DHS to collect fees for early childhood services training and development courses.
- Removes the sunset clause on the Medicaid Expansion program and adjusts language regarding provider reimbursement rates being open records.
- Adds a section to provide for interpreter services to be covered under the Medicaid program.
- Provides for DHS to establish a behavioral health bed management system.
- Authorizes the conveyance of land at the Life Skills and Transition Center to the Grafton Fire Department.
- Authorizes exemptions to continue appropriation authority into the 2021-23 biennium. The exemptions will reduce general fund turnback by $4,085,000.
- Provides for DHS to conduct a study of the Early and Periodic Screening, Diagnostic, and Treatment Program.
- Removes a section providing for a DHS study of using an Administrative Services Organization for behavioral health services in the Medicaid Expansion program.
- Provides for DHS to develop a new payment methodology for basic care facilities.
- Provides for a DHS report to the Legislative Management regarding the early childhood four-year old grant program.
- Authorizes positions for child care licensing to be used for other purposes.

21.0271.02001

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1012

Introduced by

Appropriations Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an appropriation to the state department of health; to create and enact ~~a~~two new ~~section~~sections to chapter 50-06 and a new section to chapter 50-24.1 of the North Dakota Century Code, relating to substance use disorder treatment voucher system grants, a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership; to amend and reenact sections 50-06-42, 50-11.1-14, and 50-24.1-37 of the North Dakota Century Code, relating to the substance use disorder voucher program, the early childhood workforce development fees, and the Medicaid expansion program; to repeal section 50-24.1-18.1 of the North Dakota Century Code, relating to consumer-directed health maintenance services; to provide an exemption; to provide a statement of legislative intent; to provide for a report; to provide for a study; to provide for a transfer; to provide for the conveyance of land; to provide an application; to provide for retroactive application; to provide an effective date; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from special funds derived from federal funds and other income, to the department of human services for the purpose of defraying the expenses of its various divisions, for the biennium beginning July 1, 2021, and ending June 30, 2023, as follows:

Subdivision 1.

MANAGEMENT

	Base Level	Adjustments or Enhancements	Appropriation
~~Salaries and wages~~	~~$20,222,500~~	~~($890,281)~~	~~$19,332,219~~
~~Operating expenses~~	~~134,438,862~~	~~77,342,233~~	~~211,781,095~~
~~Capital assets~~	~~50,000~~	~~25,000~~	~~75,000~~
~~Total all funds~~	~~$154,711,362~~	~~$76,476,952~~	~~$231,188,314~~
~~Less estimated income~~	~~90,021,088~~	~~49,907,855~~	~~139,928,943~~
~~Total general fund~~	~~$64,690,274~~	~~$26,569,097~~	~~$91,259,371~~

~~Subdivision 2.~~

~~PROGRAM AND POLICY~~

	Base Level	Adjustments or Enhancements	Appropriation
~~Salaries and wages~~	~~$68,994,873~~	~~$50,364,134~~	~~$119,359,007~~
~~Operating expenses~~	~~150,961,583~~	~~15,702,927~~	~~166,664,510~~
~~Capital assets~~	~~10,000~~	~~0~~	~~10,000~~
~~Grants~~	~~452,041,904~~	~~9,311,450~~	~~461,353,354~~
~~Grants - medical assistance~~	~~2,742,157,720~~	~~273,030,980~~	~~3,015,188,700~~
~~Total all funds~~	~~$3,414,166,080~~	~~$348,409,491~~	~~$3,762,575,571~~
~~Less estimated income~~	~~2,232,568,138~~	~~235,823,355~~	~~2,468,391,493~~
~~Total general fund~~	~~$1,181,597,942~~	~~$112,586,136~~	~~$1,294,184,078~~

~~Subdivision 3.~~

~~FIELD SERVICES~~

	Base Level	Adjustments or Enhancements	Appropriation
~~Human service centers~~	~~$204,701,143~~	~~($37,774,523)~~	~~$166,926,620~~
~~Institutions~~	~~137,476,480~~	~~(6,858,717)~~	~~130,617,763~~
~~Total all funds~~	~~$342,177,623~~	~~($44,633,240)~~	~~$297,544,383~~
~~Less estimated income~~	~~127,314,955~~	~~(13,370,943)~~	~~113,944,012~~
~~Total general fund~~	~~$214,862,668~~	~~($31,262,297)~~	~~$183,600,371~~

~~Subdivision 4.~~

~~COUNTY SOCIAL SERVICE FINANCING~~

	Base Level	Adjustments or Enhancements	Appropriation
~~County social services~~	~~$173,700,000~~	~~$16,451,515~~	~~$190,151,515~~
~~Total all funds~~	~~$173,700,000~~	~~$16,451,515~~	~~$190,151,515~~
~~Less estimated income~~	~~173,700,000~~	~~15,139,791~~	~~188,839,791~~
~~Total general fund~~	~~$0~~	~~$1,311,724~~	~~$1,311,724~~

~~Subdivision 5.~~

~~TOTAL - SECTION 1~~

	Base Level	Adjustments or Enhancements	Appropriation
~~Grand total general fund~~	~~$1,461,150,884~~	~~$109,204,660~~	~~$1,570,355,544~~
~~Grant total special funds~~	~~2,623,604,181~~	~~287,500,058~~	~~2,911,104,239~~
~~Grant total all funds~~	~~$4,084,755,065~~	~~$396,704,718~~	~~$4,481,459,783~~
~~Full-time equivalent positions~~	~~2,230.23~~	~~1.60~~	~~2,231.83~~
Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	85,747,426	220,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$84,889,783	$239,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$34,980,230	$99,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$57,782,440	$126,777,313
Operating expenses	150,961,583	19,170,338	170,131,921
Capital assets	10,000	0	10,000
Grants	452,041,904	13,963,488	466,005,392
Grants - medical assistance	2,742,157,720	315,028,658	3,057,186,378

Total all funds	$3,414,166,080	$405,944,924	$3,820,111,004
Less estimated income	2,232,568,138	274,026,185	2,506,594,323
Total general fund	$1,181,597,942	$131,918,739	$1,313,516,681

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,812,628)	$169,888,515
Institutions	137,476,480	(3,942,407)	133,534,073
Total all funds	$342,177,623	($38,755,035)	$303,422,588
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($25,713,375)	$189,149,293

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$142,425,985	$1,603,576,869
Grant total special funds	2,623,604,181	325,871,073	2,949,475,254
Grant total all funds	$4,084,755,065	$468,297,058	$4,553,052,123
Full-time equivalent positions	2,230.23	44.10	2,274.33

SECTION 2. ONE-TIME FUNDING - EFFECT ON BASE BUDGET - REPORT TO SIXTY-EIGHTH LEGISLATIVE ASSEMBLY. The following amounts reflect the one-time funding items

approved by the sixty-sixth legislative assembly for the 2019-21 biennium and the one-time funding items included in the appropriation in section 1 of this Act:

One-Time Funding Description	2019-21	2021-23
Technology projects	$13,785,658	$67,641,747
Capital projects - life skills and transition center	4,277,165	0
Capital projects - state hospital	2,493,500	0
Capital projects - southeast human service center	0	724,000
Life skills and transition center transition costs	0	5,200,000
Developmental disabilities provider stabilization grants	0	125,000
Medically complex children provider funding	977,603	0
Hyperbaric oxygen therapy grant	335,000	0
~~State hospital study~~	~~200,000~~	~~300,000~~
~~Medicaid system consultant~~	~~0~~	~~300,000~~
State hospital study	200,000	3,000,000
Nursing facility payment methodology	0	7,200,000
~~Total all funds~~	~~$22,068,926~~	~~$75,441,747~~
~~Less estimated income~~	~~20,556,323~~	~~51,607,531~~
~~Total general fund~~	~~$1,512,603~~	~~$23,834,216~~
Total all funds	$22,068,926	$83,890,747
Less estimated income	20,556,323	56,657,531
Total general fund	$1,512,603	$27,233,216

The 2021-23 biennium one-time funding amounts are not a part of the entity's base budget for the 2023-25 biennium. The department of human services shall report to the appropriations committees of the sixty-eighth legislative assembly on the use of this one-time funding for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 3. APPROPRIATION - 2019-21 BIENNIUM - DEPARTMENT OF HUMAN SERVICES - FIRE PROTECTION AGREEMENTS - EXEMPTION. There is appropriated out of any moneys in the department of human services operating fund in the state treasury, not otherwise appropriated, the sum of $333,333, or so much of the sum as may be necessary, to the department of human services for the purpose of providing a grant to a ~~political subdivision for the state share of costs relating to the purchase of a fire truck~~city located in a county of

fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital, for the period beginning with the effective date of this Act and ending June 30, 2021. The funding appropriated in this section is a one-time funding item. The requirements of chapter 54-44.4 do not apply to the selection of a grant recipient, the grant award, or payments made under this section. The department of human services ~~shall discontinue any agreement with a political subdivision for fire protection services and~~ may not enter any future agreement with a political subdivision for fire protection services.

SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 5. FUNDING TRANSFERS - EXEMPTION - AUTHORIZATION - REPORT. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022, any transfer made in excess of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 6. FUNDING TRANSFERS - EXEMPTION - AUTHORIZATION - REPORT. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer appropriation authority from line items within subdivisions 1, 2, and 3 of section 1 of this Act to subdivision 4 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department of human services shall notify the legislative council of any transfer made pursuant to this section. The department shall report to the budget section after June 30, 2022, any transfer made in excess

of $50,000 and to the appropriations committees of the sixty-eighth legislative assembly regarding any transfers made pursuant to this section.

SECTION 7. FULL-TIME EQUIVALENT POSITION - AGING SERVICES - LEGISLATIVE INTENT. Section 1 of this Act includes one full-time equivalent position for the administration of services resulting from a federal department of justice lawsuit settlement. This position is authorized only for the biennium beginning July 1, 2021, and ending June 30, 2023, and may not be included in the department's base budget for the biennium beginning July 1, 2023, and ending June 30, 2025. It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement.

SECTION 8. ESTIMATED INCOME - HUMAN SERVICE FINANCE FUND. The estimated income line item in subdivision 4 of section 1 of this Act includes the sum of ~~$187,385,888~~$187,223,092 from the human service finance fund for state-paid economic assistance and social and human services.

SECTION 9. ESTIMATED INCOME - COMMUNITY HEALTH TRUST FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $24,000,000 from the community health trust fund for defraying expenses in the medical services division.

SECTION 10. ESTIMATED INCOME - HEALTH CARE TRUST FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $1,000,000 from the health care trust fund and $1,150,538 from federal funds for nursing facility operating margin adjustments.

SECTION 11. CAPITAL PAYMENTS. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to expend funds for the payment of special assessments at the state hospital and life skills and transition center.

SECTION 12. CAPITAL PROJECTS - ~~STATE HOSPITAL -~~ EMERGENCY COMMISSION APPROVAL. During the biennium beginning July 1, 2021, and ending June 30, 2023, the department of human services is authorized to proceed with the demolition of the chapel, administrative building, and employee building and associated tunnels at the state hospital. Pursuant to section ~~45~~ of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act. The department may transfer funds for the demolition of the identified buildings and

associated tunnels and for emergency capital projects. Notwithstanding section 54-27-12, the department of human services may spend up to $5,000,000 for emergency projects under this section and may seek emergency commission approval to spend more than $5,000,000 under this section.

SECTION 13. PERMANENT SUPPORTIVE HOUSING GRANTS. Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 14. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.
2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 15. REFUGEE RESETTLEMENT SERVICES. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services must establish and implement a plan that resettles at least twenty-five percent of new refugees in locations in the state outside of the three most populous counties. If the department, in consultation with applicable federal and private placement

agencies, determines the goal of resettling at least twenty-five percent of refugees outside the three most populous counties is not achievable, the department shall discontinue the resettlement process for refugees and the federal funds identified in this section may not be expended for any purpose.

SECTION 16. TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. Subdivision 2 of section 1 of this Act includes the sum of $5,200,000 from federal or other funds made available to the department for the transition of individuals from the life skills and transition center to community-based providers. To be eligible to receive funding under this section, a provider must accept an individual who has a regular admission to the life skills and transition center and is being discharged, must ensure that all service needs are met including vocational services, and must implement a policy to not decline to provide services in the future to any individual being served under this section.

SECTION 17. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:
   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.
   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.
   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid

program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

6. The department of human services and the Medicaid expansion managed care organization shall ensure the appropriate contract amendment is adopted for coverage through December 31, 2021. The contract amendment shall stay within the appropriation and the requirements of chapter 54-44.4 do not apply.

~~**SECTION 16. EXPENDITURES MAY NOT EXCEED APPROPRIATION - NURSING HOME RATES.** Subdivision 2 of section 1 of this Act includes the sum of $621,362,568, of which $288,313,216 is from the general fund, for nursing home payments for the biennium beginning~~

~~July 1, 2021, and ending June 30, 2023. The expenditures for nursing homes may not exceed this amount.~~

SECTION 18. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:
   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.
   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.
   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.
2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915i state plan.
3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care

organization shall reimburse all North Dakota substance use providers of American society of additional medicine Level II.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

SECTION 19. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Substance use disorder treatment voucher system grants.

1. A licensed substance abuse treatment program, excluding regional human service centers and hospital or medical clinic-based programs for medical management of withdrawal, may apply for a competitive substance use disorder treatment voucher system grant. A licensed substance abuse treatment program is eligible for a one-time grant award. To receive a grant, a licensed substance abuse treatment program shall:
   a. Submit an application in the form and manner prescribed by the department;
   b. Enter a grant agreement with the department;
   c. Use grant funds for a licensed substance abuse treatment program with fewer than seventeen beds in an underserved area, as determined by the department, in the state's substance abuse treatment system;
   d. Use the grant funds to support the provision of substance use disorder treatment in underserved areas of the state's substance abuse treatment system;

e. Provide and disclose information needed to comply with the department's data collection requirements; and

f. Operate in compliance with grant requirements.

2. The department, within legislative appropriations, may distribute up to three grants under this section to licensed substance abuse treatment programs.

3. The department may recapture grant funds distributed to a licensed program found by the department to be out of compliance with the requirements established by the grant program, including ending or reducing the operation of the substance use disorder treatment services in the underserved area.

4. The department may not collect property, equipment, or supplies purchased with grant funds from the licensed substance abuse treatment program after successful completion of the terms of the grant.

5. The grant term must be for five years.

~~**SECTION 17. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:~~

~~**50-06-42. Substance use disorder treatment voucher system.**~~

~~1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, and hospital- or medical clinic-based programs for medical management of withdrawal. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.~~

~~2. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:~~

~~a. No more than thirty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.~~

~~b. The remaining appropriation must be allocated for nonresidential outpatient and ancillary substance use disorder services administered by licensed substance abuse treatment programs.~~

SECTION 20. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.
2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.
3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting

vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

SECTION 21. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2
2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.
3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.
4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:
   a. No more than fifty percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 22. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 23. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.
2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 24. A new subparagraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;

SECTION 25. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (~~Effective through July 31, 2021~~2023 - Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.
2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. Except for pharmacy services, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.
4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.
5. Provider reimbursement rate information received by the department under this section is confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section.

SECTION 26. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. Medicaid expansion - Legislative management report. (Contingent repeal - See note)

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010

[Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department shall inform new enrollees in the medical assistance expansion program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. Except for pharmacy services and coverages for individuals ages nineteen and twenty, the department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange.

4. The contract between the department and the private carrier must provide the department with full access to provider reimbursement rates. The department shall consider provider reimbursement rate information in selecting a private carrier under this section. Before August first of each even-numbered year, the department shall submit a report to the legislative management regarding provider reimbursement rates under the medical assistance expansion program. ~~This report may provide cumulative data and trend data but may not disclose identifiable provider reimbursement rates.~~

5. Provider reimbursement rate information received by the department under this section is ~~confidential, except the department may use the reimbursement rate information to prepare the report to the legislative management as required under this section~~an open record.

SECTION 27. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid Expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section.

SECTION 28. REPEAL. Section 50-24.1-18.1 of the North Dakota Century Code is repealed.

SECTION 29. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may

convey real property associated with the life skills and transition center in Grafton to the Grafton parks and recreation department. The department of human services may convey a portion of two parcels of land commonly referred to as "the bowl" on the terms and conditions determined appropriate by the department and the attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 30. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER. The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance.

SECTION 31. LEASE OF LAND - STATE HOSPITAL. The department of human services and national guard may enter an agreement to lease up to twenty acres of real property associated with the state hospital for the national guard to construct a new training and storage facility.

SECTION 32. PROVIDER PROCESS AND OUTCOME MEASURES. Providers that receive funding from the department of human services shall submit process and outcome measures, as required by the department, to the department of human services for programs and services supported by state funding during the biennium beginning July 1, 2021, and ending June 30, 2023.

~~**SECTION 29. IN-HOME SUPPORT SERVICES - DEVELOPMENTAL DISABILITIES WAIVER.** The department of human services shall add in-home support services to the appendix K application submitted by the department to the centers for Medicare and Medicaid services for the developmental disability services waiver for the COVID-19 emergency. Funding for in-home support services under the appendix K application may not exceed $250,000 during the COVID-19 emergency.~~

SECTION 33. QUALIFIED RESIDENTIAL TREATMENT PROVIDERS. The department of human services shall adopt rules, on or before October 1, 2021, establishing a new ratesetting

process and requirements for foster care maintenance rates for qualified residential treatment providers based on the appropriation approved by the sixty-seventh legislative assembly.

SECTION 34. COMMUNITY BEHAVIORAL HEALTH PROGRAM. Pursuant to section 45 of this Act, the director of the office of management and budget may transfer appropriation authority between line items within subdivisions 1, 2, and 3 of section 1 of this Act for the biennium beginning July 1, 2021, and ending June 30, 2023, as requested by the department of human services. The department may transfer funds for the continuation of the community behavioral health program pursuant to subsection 2 of section 54-23.3-10.

SECTION 35. EXEMPTION. The amount appropriated for the Medicaid management information system technology stack upgrade in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the Medicaid management information system technology stack upgrade during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 36. EXEMPTION. The amount appropriated for the modification of the department of human services' eligibility systems in chapter 578 of the 2011 Special Session Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2013-15 biennium, then the 2015-17 biennium, then the 2017-19 biennium, and then the 2019-21 biennium are available for the completion of the modification of the eligibility systems project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 37. EXEMPTION. The amount appropriated for the development of the child care licensing and data system in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the child care licensing and data system during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 38. EXEMPTION. The amount appropriated for the development of the health information network in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the

health information network during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 39. EXEMPTION. The sum of $200,000 from the general fund appropriated for the department's operating expenses for the school behavioral health program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the school behavioral health pilot projects during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 40. EXEMPTION. The sum of $150,000 from the general fund appropriated for the department's operating expenses for behavioral health recovery home grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation may be used for behavioral health recovery home grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

~~**SECTION 35. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITY RATES.** The appropriation in section 1 of this Act includes adjustments to reimbursement rates for developmental disability service providers. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly if funding provided for developmental disability provider payments is not sufficient to pay actual expenses.~~

SECTION 41. EXEMPTION. The sum of $750,000 from the general fund appropriated to the department for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 42. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 43. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 44. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 45. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates or nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090 during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 47. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving

screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management.

SECTION 48. STATE HOSPITAL TREATMENT CAMPUS - REPORT TO LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall ~~conduct a study and~~ prepare a report~~. The report must provide a cost-benefit analysis and available options and address the feasibility and desirability of closing the state hospital, renovating the state hospital, or building~~, including an architectural review and cost estimate to construct a new treatment campus to meet the health care needs of the state. Before October 1, 2022, the department of human services shall provide a~~the report to the legislative management~~ regarding the results of the study~~. Subdivision 3 of section 1 of this Act includes the sum of ~~$300,000~~$3,000,000 for the purpose of contracting with a consultant to assist in ~~the report and recommendation~~preparing the report and to develop detailed design plans for the construction of a new treatment campus.

~~**SECTION 35. BEHAVIORAL HEALTH SERVICES - REPORT TO LEGISLATIVE MANAGEMENT.** During the 2021-22 interim, the department of human services shall study the feasibility and desirability of implementing behavioral health services for the medical assistance expansion program through an administrative services organization. Subdivision 2 of section 1 of this Act includes the sum of $300,000 for the purpose of contracting with a consultant to assist in the study and to develop a plan to implement behavioral health services for the medical assistance expansion program through an administrative services organization. The~~

~~department of human services shall provide reports to the legislative management regarding the status and results of the study.~~

SECTION 49. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES. The department of human services shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and
2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 50. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021-22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 51. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 52. RETROACTIVE APPLICATION. Section 20 of this Act applies retroactively to July 1, 2020.

SECTION 53. EFFECTIVE DATE. ~~Section 17~~Sections 18 and 26 of this Act ~~becomes~~become effective January 1, 2022.

SECTION 54. EXPIRATION DATE. Section ~~14~~19 of this Act is effective through July 1, 2027, and after that date is ineffective.

SECTION 55. EMERGENCY. Section 3 of this Act ~~is~~and section 22 of Senate Bill No. 2086, as approved by the sixty-seventh legislative assembly, are declared to be an emergency measure.

2021 CONFERENCE COMMITTEE

HB 1012

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/19/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 10:00 a.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Changes to the House Version**

Chairman Nelson (10:01 am) introduced the bill

Senator Dever (10:02 am) went through the senate changes #11558

Representative Kreidt (10:05 am) explained the house changes

Senator Mathern (10:07 am) testified

Chair Nelson closed the meeting at 10:35 a.m.

Cole Fleck, Committee Clerk

Department of Human Services - Budget No. 325
House Bill No. 1012

2021-23 House Version	FTE	General Fund	Other Funds	Total
Management	97.85	$91,259,371	$139,928,943	$231,188,314
Program and Policy	648.67	1,294,184,078	2,468,391,493	3,762,575,571
Field Services	1,342.31	183,600,371	113,944,012	297,544,383
County Social Services	143.00	1,311,724	188,839,791	190,151,515
Total 2021-23 House Version	2,231.83	$1,570,355,544	$2,911,104,239	$4,481,459,783

2021-23 Senate Version	FTE	General Fund	Other Funds	Total
Management	97.85	$99,670,504	$139,930,641	$239,601,145
Program and Policy	691.17	1,313,516,681	2,506,594,323	3,820,111,004
Field Services	1,342.31	189,149,293	114,273,295	303,422,588
County Social Services	143.00	1,240,391	188,676,995	189,917,386
Total 2019-21 Senate Version	2,274.33	$1,603,576,869	$2,949,475,254	$4,553,052,123

Senate Changes to House Version	FTE	General Fund	Other Funds	Total
Management	0.00	$8,411,133	$1,698	$8,412,831
Program and Policy	42.50	19,332,603	38,202,830	57,535,433
Field Services	0.00	5,548,922	329,283	5,878,205
County Social Services	0.00	(71,333)	(162,796)	(234,129)
Total Changes	42.50	$33,221,325	$38,371,015	$71,592,340

Department of Human Services - House Bill No. 1012 Other Sections

	House Version	Senate Version
Deficiency appropriation	Section 3 appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.	Section 3 appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.
State Department of Health appropriation	Not included	Section 4 appropriates $281,715 from the general fund and $281,715 from other funds to the State Department of Health for a grant to the Task Force on Prevention of Sexual Abuse of Children.
Line item transfers	Section 4 allows DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 5 allows DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.	Section 5 allows DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 6 allows DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.
Aging Services FTE position	Section 6 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.	Section 7 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.
Human service finance fund	Section 7 identifies $187,385,888 of the appropriation for the county social and human service project is from the human service finance fund.	Section 8 identifies $187,223,092 of the appropriation for the county social and human service project is from the human service finance fund.
Community health trust fund	Section 8 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.	Section 9 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.
Health care trust fund	Section 9 identifies $1 million of the appropriation for long-term care is from the health care trust fund for nursing facility operating margin adjustments.	Section 10 identifies $1 million of the appropriation for long-term care is from the health care trust fund for nursing facility operating margin adjustments.
Capital projects and payments	Section 10 authorizes the payment of special assessments at the State Hospital and Life Skills and Transition Center. Section 11 authorizes the demolition of the chapel and employee building at the State Hospital. The section also allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.	Section 11 authorizes the payment of special assessments at the State Hospital and Life Skills and Transition Center. Section 12 authorizes the demolition of the chapel, administrative building, and employee building at the State Hospital. The section also allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.
Permanent supportive housing grants	Not included	Section 13 identifies funding to be provided for permanent supportive housing grants and requires DHS to develop a funding methodology to distribute the funds.
Emergency stabilization grants	Not included	Section 14 identifies $125,000 from the general fund to be used for emergency stabilization grants for newly licensed developmental disability providers.
Refugee resettlement	Not included	Section 15 identifies funding to be used for refugee resettlement and provides for at least 25 percent of new refugees to be resettled in areas of the state outside of the three most populous counties.
Life Skills and Transition Center transition of individuals	Not included	Section 16 identifies funding from federal or other sources that is to be used to assist in the transition of individuals from the Life Skills and Transition Center to private providers.

Legislative intent - Provider rates	Section 31 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if developmental disability provider funding is not sufficient to pay actual expenses.	Section 46 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if provider funding is not sufficient to pay actual expenses.
Early and Periodic Screening, Diagnostic, and Treatment Program	Not included	Section 47 provides for DHS to study the Early and Periodic Screening, Diagnostic, and Treatment Program.
State Hospital complex study	Section 32 provides for DHS to conduct a study of the State Hospital complex and to provide a report to the Legislative Management regarding the results of the study.	Section 48 provides for DHS to conduct a study of the State Hospital complex and to develop detailed design plans for a new State Hospital.
Medicaid Expansion behavioral health services	Section 33 provides for DHS to conduct a study of the feasibility and desirability of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.	Not included
Basic care facility rates	Not included	Section 49 requires DHS to develop a new payment methodology for basic care payment rates.
Four-year old program	Not included	Section 50 provides for DHS to report to the Legislative Management regarding the status of the implementation of the new four-year old program.
Transfer of employees	Not included	Section 51 authorizes DHS to utilize child care licensing employees for other duties.
Human services zone funds	Not included	Section 55 declares Section 22 of Senate Bill No. 2086, relating to human service zone fund balances, to be an emergency measure.

DHS - Management - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	107.95	$64,690,274	$90,021,088	$154,711,362	107.95	$64,690,274	$90,021,088	$154,711,362	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)	(18.10)	($838,781)	($3,553,654)	($4,392,435)				$0
Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554				0
Salary increase		370,808	77,346	448,154		376,748	79,044	455,792		5,940	1,698	7,638
Retirement contribution increase				0				0				0
Health insurance increase		3,903	830	4,733		3,903	830	4,733				0
Reduce funding for operating		(8,405,193)		(8,405,193)		0		0		8,405,193		8,405,193
Administration												
Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121				0
Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426				0
Capitol complex rent model change				0				0				0
Information Technology Services												
Data processing costs and other program change:		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715				0
Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)				0
Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886				0
Early childhood data system		500,000		500,000		500,000		500,000				0
Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394				0
Other funds reprioritization			2,324,362	2,324,362			2,324,362	2,324,362				0
Total ongoing funding changes	(10.10)	$6,532,881	$2,302,324	$8,835,205	(10.10)	$14,944,014	$2,304,022	$17,248,036	0.00	$8,411,133	$1,698	$8,412,831
One-time funding items												
Upgrade MMIS system		$4,326,686	$30,673,314	$35,000,000		$4,326,686	$30,673,314	$35,000,000				$0
Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000				0
Data automation		98,186	98,186	196,372		98,186	98,186	196,372				0
MMIS tech stack		600,000	1,800,000	2,400,000		600,000	1,800,000	2,400,000				0
Quality measures services		11,344	34,031	45,375		11,344	34,031	45,375				0
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$0	$0	$0
Total Changes to Base Level Funding	(10.10)	$26,569,097	$49,907,855	$76,476,952	(10.10)	$34,980,230	$49,909,553	$84,889,783	0.00	$8,411,133	$1,698	$8,412,831
2021-23 Total Funding	97.85	$91,259,371	$139,928,943	$231,188,314	97.85	$99,670,504	$139,930,641	$239,601,145	0.00	$8,411,133	$1,698	$8,412,831
Total ongoing changes as a percentage of base level	*(9.4%)*	*10.1%*	*2.6%*	*5.7%*	*(9.4%)*	*23.1%*	*2.6%*	*11.1%*				
Total changes as a percentage of base level	*(9.4%)*	*41.1%*	*55.4%*	*49.4%*	*(9.4%)*	*54.1%*	*55.4%*	*54.9%*				

DHS - Program and Policy - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	257.22	$22,005,318	$23,196,444	$45,201,762	257.22	$22,005,318	$23,196,444	$45,201,762				$0
Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141				0
Salary increase		1,501,257	1,359,427	2,860,684		1,497,745	1,335,086	2,832,831		(3,512)	(24,341)	(27,853)
Retirement contribution increase				0				0				0
Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816				0
Provider inflation increases		13,478,022	14,417,097	27,895,119		22,538,920	24,121,507	46,660,427		9,060,898	9,704,410	18,765,308
Federal medical assistance percentage changes		(45,779,364)	45,779,364	0		(45,779,364)	45,779,364	0				0
Refugee resettlement services				0	4.00		4,337,408	4,337,408	4.00		4,337,408	4,337,408
Economic Assistance												
Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354				0
Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242				0
Speciality eligibility worker					1.00	43,639	130,917	174,556	1.00	43,639	130,917	174,556
								0				0
Child Support												
Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)				0
Agency savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)				0
Transition of duties from Courts				0	3.50	308,126	209,662	517,788	3.50	308,126	209,662	517,788
Medical Services												
Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036				0
Agency savings plan, excluding adjustments to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746		(999,112)	5,250,858	4,251,746				0
Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845				0
Other funds reprioritization			(40,000)	(40,000)			(40,000)	(40,000)				0
Funding source change - Community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	0		14,400,000	(14,400,000)	0				0
Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)				0
Medicaid COVID-19 vaccine		1,581,000	1,819,000	3,400,000		1,581,000	1,819,000	3,400,000				0
DOJ settlement services		66,465	199,395	265,860		66,465	199,395	265,860				0
Medicaid Expansion - 19 and 20 year olds to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)	0.50	(2,413,379)	(2,745,227)	(5,158,606)				0
Adjust estimated utilization rates		(176,553)	(202,213)	(378,766)		(176,553)	(202,213)	(378,766)				0
Restore per member per month payment		769,869	882,371	1,652,240		769,869	882,371	1,652,240				0
Medicaid interpreter services				0		249,600	249,600	499,200		249,600	249,600	499,200
Medicaid glucose monitoring				0		479,585	1,297,885	1,777,470		479,585	1,297,885	1,777,470
Tribal health care coordination				0			7,181,628	7,181,628			7,181,628	7,181,628
Medicaid metabolic supplements				0		9,300	10,700	20,000		9,300	10,700	20,000
Long-Term Care												
Agency savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)				0
Restore funding for basic care program		5,300,000		5,300,000		5,300,000		5,300,000				0
Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712				0
Other funds reprioritization			(2,284,362)	(2,284,362)			(2,284,362)	(2,284,362)				0

Funding source change - Health care trust fund		1,000,000	(1,000,000)	0		1,000,000	(1,000,000)	0				0
Adjustment for utilization rates		(9,395,558)	(9,429,807)	(18,825,365)		(9,395,558)	(9,429,807)	(18,825,365)				0
Provide funding from health care trust fund			2,150,538	2,150,538			2,150,538	2,150,538				0
DOJ settlement services		2,197,552	2,309,196	4,506,748		1,578,002	1,596,372	3,174,374		(619,550)	(712,824)	(1,332,374)
Autism funding adjustment				0				0				0
DD Council												
Continued program changes			124,949	124,949			124,949	124,949				0
Aging Services												
Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548				0
Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)				0
DOJ settlement agreement	1.00	300,000	150,000	450,000	1.00	300,000	150,000	450,000				0
Senior community employment grant			889,285	889,285			889,285	889,285				0
Dementia services grant				0		268,000		268,000		268,000		268,000
Children and Family Services												
Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905				0
Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)				0
Restore portion of 1915i realignment		73,750		73,750		100,000		100,000		26,250		26,250
Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)				0
Transfer early childhood program	3.00	300,000	400,000	700,000	3.00	300,000	400,000	700,000				0
Early childhood grant program	3.70	5,458,910		5,458,910	3.70	1,500,000	3,958,910	5,458,910		(3,958,910)	3,958,910	0
Therapeutic foster care TCM realignment				0		549,585	632,319	1,181,904		549,585	632,319	1,181,904
Child care services				0	33.00	1,601,096	150,000	1,751,096	33.00	1,601,096	150,000	1,751,096
Behavioral Health Division												
Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)				0
Agency savings plan		(832,173)		(832,173)		(832,173)		(832,173)				0
Restore portion of 1915i realignment		372,611		372,611		378,236		378,236		5,625		5,625
Grant cost and caseload changes		5,427,067		5,427,067		5,427,067		5,427,067				0
Expand substance use disorder voucher		7,000,000		7,000,000		12,000,000		12,000,000		5,000,000		5,000,000
Grants and funding FTE position				0	1.00	171,455		171,455	1.00	171,455		171,455
Vocational Rehabilitation												
Continued program changes		(416,293)	(381,081)	(797,374)		(416,293)	(381,081)	(797,374)				0
Agency savings plan		(1,803,954)	(91,000)	(1,894,954)		(1,803,954)	(91,000)	(1,894,954)				0
Restore CIL and ski park funds		1,803,954	91,000	1,894,954		1,803,954	91,000	1,894,954				0
Developmental Disabilities												
Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196				0
Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)				0
Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021				0
Small agency accreditation costs		25,000		25,000		100,000		100,000		75,000		75,000
Experienced Parent Program				0		260,000		260,000		260,000		260,000
Section 11 supported housing and employment				0		373,261		373,261		373,261		373,261
Corporate guardianship slots				0		98,311		98,311		98,311		98,311
Recreational and leisure services				0		150,000		150,000		150,000		150,000
Adjust crisis bed funding				0		(30,156)	116,556	86,400		(30,156)	116,556	86,400
Restore provider rate reductions				0		5,240,000	5,910,000	11,150,000		5,240,000	5,910,000	11,150,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491	307.92	$128,445,739	$264,974,185	$393,419,924	42.50	$19,357,603	$33,152,830	$52,510,433

One-time funding items:												
Nursing facility payment methodology change		$3,348,000	$3,852,000	$7,200,000		$3,348,000	$3,852,000	$7,200,000				$0
Nursing facility bed buyback program				0				0				0
ASO management consultant		150,000	150,000	300,000		0	0	0		(150,000)	(150,000)	(300,000)
LSTC transition costs				0			5,200,000	5,200,000			5,200,000	5,200,000
Developmental disabilities stabilization grants				0		125,000		125,000		125,000		125,000
Total one-time funding changes	0.00	$3,498,000	$4,002,000	$7,500,000	0.00	$3,473,000	$9,052,000	$12,525,000		($25,000)	$5,050,000	$5,025,000
								0				
Total Changes to Base Level Funding	265.42	$112,586,136	$235,823,355	$348,409,491	307.92	$131,918,739	$274,026,185	$405,944,924	42.50	$19,332,603	$38,202,830	$57,535,433
2021-23 Total Funding	648.67	$1,294,184,078	$2,468,391,493	$3,762,575,571	691.17	$1,313,516,681	$2,506,594,323	$3,820,111,004	42.50	$19,332,603	$38,202,830	$57,535,433
Total ongoing changes as a percentage of base level	*69.3%*	*9.2%*	*10.4%*	*10.0%*	*80.3%*	*10.9%*	*11.9%*	*11.5%*				
Total changes as a percentage of base level	*69.3%*	*9.5%*	*10.6%*	*10.2%*	*80.3%*	*11.2%*	*12.3%*	*11.9%*				

DHS - Field Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Position	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	1,599.03	$214,862,668	$127,314,955	$342,177,623	1,599.03	$214,862,668	$127,314,955	$342,177,623	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)				$0
Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758				0
Salary increase		5,572,943	489,043	6,061,986		5,426,660	511,625	5,938,285		(146,283)	22,582	(123,701)
Retirement contribution increase				0				0				0
Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577				0
Provider inflationary increases		405,815		405,815		678,158		678,158		272,343		272,343
								0				0
Human Service Centers								0				0
Continued program changes		3,116,890	(2,911,912)	204,978		3,116,890	(2,911,912)	204,978				0
Cost and caseload changes		2,624,029		2,624,029		2,624,029		2,624,029				0
Civil sex offender treatment contract		917,004		917,004		917,004		917,004				0
Agency savings plan		(6,414,994)		(6,414,994)		(6,414,994)		(6,414,994)				0
Restore 1915i realignment reductions		1,362,299		1,362,299		3,109,385		3,109,385		1,747,086		1,747,086
Restore Northeast Human Service Center rent				0		168,736		168,736		168,736		168,736
								0				0
Institutions												
Continued program changes		(4,250,920)	3,154,778	(1,096,142)		(4,250,920)	3,154,778	(1,096,142)				0
Agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)				0
Restore State Hospital beds	14.00	1,775,792	345,100	2,120,892	14.00	1,775,792	345,100	2,120,892				0
LSTC psychiatrist		100,000		100,000		183,040		183,040		83,040		83,040
Adjust funding for LSTC adaptive equipment				0			306,701	306,701			306,701	306,701
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)	(256.72)	($29,437,375)	($13,041,660)	($42,479,035)	0.00	$2,124,922	$329,283	$2,454,205
One-time funding items												
State Hospital complex study		$300,000		$300,000		$3,000,000		$3,000,000		$2,700,000		$2,700,000
Southeast Human Service Center projects				0		$724,000		724,000		$724,000		724,000
Total one-time funding changes	0.00	$300,000	$0	$300,000	0.00	$3,724,000	$0	$3,724,000	0.00	$3,424,000	$0	$3,424,000
Total Changes to Base Level Funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)	(256.72)	($25,713,375)	($13,041,660)	($38,755,035)	0.00	$5,548,922	$329,283	$5,878,205
2021-23 Total Funding	1,342.31	$183,600,371	$113,944,012	$297,544,383	1,342.31	$189,149,293	$114,273,295	$303,422,588	0.00	$5,548,922	$329,283	$5,878,205
Total ongoing changes as a percentage of base level	*(16.1%)*	*(14.7%)*	*(10.5%)*	*(13.1%)*	*(16.1%)*	*(13.7%)*	*(10.2%)*	*(12.4%)*				
Total changes as a percentage of base level	*(16.1%)*	*(14.5%)*	*(10.5%)*	*(13.0%)*	*(16.1%)*	*(12.0%)*	*(10.2%)*	*(11.3%)*				

DHS - County Social Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	140.00	$0	$173,700,000	$173,700,000	140.00	$0	$173,700,000	$173,700,000	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
Base payroll changes			$1,653,466	$1,653,466			$1,653,466	$1,653,466				$0
Salary increase		412,248	291,785	704,033		340,915	292,547	633,462		(71,333)	762	(70,571)
Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024				0
Retirement contribution increase				0				0				0
Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997				0
Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673				0
Zone employee salary increase			3,975,941	3,975,941			3,812,383	3,812,383			(163,558)	(163,558)
Additional zone operations funding			9,089,381	9,089,381			9,089,381	9,089,381				0
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
One-time funding items												
No one-time funding items				$0				$0				$0
Total one-time funding changes	0.00	$0	$0	$0	0.00	$0	$0	$0	0.00	$0	$0	$0
Total Changes to Base Level Funding	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
2021-23 Total Funding	143.00	$1,311,724	$188,839,791	$190,151,515	143.00	$1,240,391	$188,676,995	$189,917,386	0.00	($71,333)	($162,796)	($234,129)
Total ongoing changes as a percentage of base level	*2.1%*		*8.7%*	*9.5%*	*2.1%*		*8.6%*	*9.3%*				
Total changes as a percentage of base level	*2.1%*		*8.7%*	*9.5%*	*2.1%*		*8.6%*	*9.3%*				

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/20/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:28 a.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Brain Injuries**
- **Supportive Housing**
- **Refuge Resettlement**
- **State Hospital Study**

Senator Mathern (9:30 am) testified #11575

Senator Dever (9:34 am) testified #11558

Additional Written Testimony: #11574

Chair Nelson closed the meeting at 10:02 a.m.

Cole Fleck, Committee Clerk

#11575

Prepared by the Legislative Council staff
for Senator Mathern
April 14, 2021

HOUSE BILL NO. 1012
LISTING OF PROPOSED CHANGES TO ENGROSSED BILL

1. Brain Injury - Mathern

Department of Human Services

Proposed funding changes:

	Description	FTE	General Fund	Special Funds	Total
1	Restore full funding removed in agency savings plan for brain injury services for 1915i realignment (The House restored $366,986 of the $622,274 reduction for brain injury services)		$255,288		$255,288
	Total proposed funding changes		$255,288	$0	$255,288

Other proposed changes: Add elimination of Sunset

2 Adjust a section added by the Senate relating to permanent supportive housing grants as detailed in Appendix A.

2. Housing – Mathern

SECTION 13. PERMANENT SUPPORTIVE HOUSING GRANTS.

Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall ~~develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations~~ distribute the funding with an equalizing per unit per month rate to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

3. Refugee - Mathern

SECTION 15. REFUGEE RESETTLEMENT SERVICES. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services shall work with the federal partners to explore adding more resettlement locations to the state with a goal of resettling 25% of refugees outside of the existing resettlement locations.

4. State Hospital - Mathern

21.0271.02024
Title.

Prepared by the Legislative Council staff for
Senator Mathern
April 19, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, replace lines 19 through 28 with:

"**SECTION 32. REPORT TO LEGISLATIVE MANAGEMENT - STATEWIDE ACUTE PSYCHIATRIC AND RESIDENTIAL CARE NEEDS.** During the 2021-22 interim, the department of human services, with the assistance of the state hospital's governing body, stakeholders, members of the legislative assembly, and consultants, shall review the acute psychiatric and residential needs of the state and prepare a report. The report must include a fifty-year plan for acute psychiatric and residential care in the state that includes options to contract with private acute care facilities to provide services in at least the four largest cities in the state and options to replace the existing state hospital facility with a new sixteen-bed treatment campus focused on forensic psychiatric evaluation and treatment. Before October 1, 2022, the department of human services shall present the report to the legislative management. Subdivision 3 of section 1 of this Act includes the sum of $300,000 to develop architectural plans and for other planning costs for the construction of a new sixteen-bed state hospital treatment campus. The department of human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services provided in institutions for mental diseases to Medicaid beneficiaries between the ages of twenty-one and sixty-four."

Renumber accordingly

Department of Human Services - Budget No. 325
House Bill No. 1012

2021-23 House Version	FTE	General Fund	Other Funds	Total
Management	97.85	$91,259,371	$139,928,943	$231,188,314
Program and Policy	648.67	1,294,184,078	2,468,391,493	3,762,575,571
Field Services	1,342.31	183,600,371	113,944,012	297,544,383
County Social Services	143.00	1,311,724	188,839,791	190,151,515
Total 2021-23 House Version	2,231.83	$1,570,355,544	$2,911,104,239	$4,481,459,783

2021-23 Senate Version	FTE	General Fund	Other Funds	Total
Management	97.85	$99,670,504	$139,930,641	$239,601,145
Program and Policy	691.17	1,313,516,681	2,506,594,323	3,820,111,004
Field Services	1,342.31	189,149,293	114,273,295	303,422,588
County Social Services	143.00	1,240,391	188,676,995	189,917,386
Total 2019-21 Senate Version	2,274.33	$1,603,576,869	$2,949,475,254	$4,553,052,123

Senate Changes to House Version	FTE	General Fund	Other Funds	Total
Management	0.00	$8,411,133	$1,698	$8,412,831
Program and Policy	42.50	19,332,603	38,202,830	57,535,433
Field Services	0.00	5,548,922	329,283	5,878,205
County Social Services	0.00	(71,333)	(162,796)	(234,129)
Total Changes	42.50	$33,221,325	$38,371,015	$71,592,340

Department of Human Services - House Bill No. 1012 Other Sections

	House Version	Senate Version
Deficiency appropriation	Section 3 appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.	Section 3 appropriates $333,333 from the DHS operating fund during the 2019-21 biennium for a grant to a political subdivision for a portion of the cost of purchasing a firetruck.
State Department of Health appropriation	Not included	Section 4 appropriates $281,715 from the general fund and $281,715 from other funds to the State Department of Health for a grant to the Task Force on Prevention of Sexual Abuse of Children.
Line item transfers	Section 4 allows DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 5 allows DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.	Section 5 allows DHS to transfer appropriation authority between line items within subdivisions 1 through 3 of Section 1. Section 6 allows DHS to transfer appropriation authority from line items within subdivisions 1 through 3 of Section 1 to subdivision 4 of Section 1.
Aging Services FTE position	Section 6 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.	Section 7 identifies 1 FTE position in the Aging Services program is for the administration of services resulting from a federal Department of Justice lawsuit settlement and the position is authorized only for the 2021-23 biennium.
Human service finance fund	Section 7 identifies $187,385,888 of the appropriation for the county social and human service project is from the human service finance fund.	Section 8 identifies $187,223,092 of the appropriation for the county social and human service project is from the human service finance fund.
Community health trust fund	Section 8 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.	Section 9 identifies $24 million of the appropriation for the Medical Services Division is from the community health trust fund.
Health care trust fund	Section 9 identifies $1 million of the appropriation for long-term care is from the health care trust fund for nursing facility operating margin adjustments.	Section 10 identifies $1 million of the appropriation for long-term care is from the health care trust fund for nursing facility operating margin adjustments.
Capital projects and payments	Section 10 authorizes the payment of special assessments at the State Hospital and Life Skills and Transition Center. Section 11 authorizes the demolition of the chapel and employee building at the State Hospital. The section also allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.	Section 11 authorizes the payment of special assessments at the State Hospital and Life Skills and Transition Center. Section 12 authorizes the demolition of the chapel, administrative building, and employee building at the State Hospital. The section also allows DHS to transfer funds from other line items to pay for the demolition of the buildings and other emergency capital projects.
Permanent supportive housing grants	Not included	Section 13 identifies funding to be provided for permanent supportive housing grants and requires DHS to develop a funding methodology to distribute the funds.
Emergency stabilization grants	Not included	Section 14 identifies $125,000 from the general fund to be used for emergency stabilization grants for newly licensed developmental disability providers.
Refugee resettlement	Not included	Section 15 identifies funding to be used for refugee resettlement and provides for at least 25 percent of new refugees to be resettled in areas of the state outside of the three most populous counties.
Life Skills and Transition Center transition of individuals	Not included	Section 16 identifies funding from federal or other sources that is to be used to assist in the transition of individuals from the Life Skills and Transition Center to private providers.

Legislative intent - Provider rates	Section 31 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if developmental disability provider funding is not sufficient to pay actual expenses.	Section 46 provides legislative intent that DHS seek a deficiency appropriation from the 68th Legislative Assembly if provider funding is not sufficient to pay actual expenses.
Early and Periodic Screening, Diagnostic, and Treatment Program	Not included	Section 47 provides for DHS to study the Early and Periodic Screening, Diagnostic, and Treatment Program.
State Hospital complex study	Section 32 provides for DHS to conduct a study of the State Hospital complex and to provide a report to the Legislative Management regarding the results of the study.	Section 48 provides for DHS to conduct a study of the State Hospital complex and to develop detailed design plans for a new State Hospital.
Medicaid Expansion behavioral health services	Section 33 provides for DHS to conduct a study of the feasibility and desirability of implementing behavioral health services for the Medicaid Expansion program through an administrative services organization.	Not included
Basic care facility rates	Not included	Section 49 requires DHS to develop a new payment methodology for basic care payment rates.
Four-year old program	Not included	Section 50 provides for DHS to report to the Legislative Management regarding the status of the implementation of the new four-year old program.
Transfer of employees	Not included	Section 51 authorizes DHS to utilize child care licensing employees for other duties.
Human services zone funds	Not included	Section 55 declares Section 22 of Senate Bill No. 2086, relating to human service zone fund balances, to be an emergency measure.

DHS - Management - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	107.95	$64,690,274	$90,021,088	$154,711,362	107.95	$64,690,274	$90,021,088	$154,711,362	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	(18.10)	($838,781)	($3,553,654)	($4,392,435)	(18.10)	($838,781)	($3,553,654)	($4,392,435)				$0
Base payroll changes		(508,525)	732,079	223,554		(508,525)	732,079	223,554				0
Salary increase		370,808	77,346	448,154		376,748	79,044	455,792		5,940	1,698	7,638
Retirement contribution increase				0				0				0
Health insurance increase		3,903	830	4,733		3,903	830	4,733				0
Reduce funding for operating		(8,405,193)		(8,405,193)		0		0		8,405,193		8,405,193
Administration												
Continued program changes		341,831	841,290	1,183,121		341,831	841,290	1,183,121				0
Savings plan	8.00	431,068	440,358	871,426	8.00	431,068	440,358	871,426				0
Capitol complex rent model change				0				0				0
Information Technology Services												
Data processing costs and other program change:		14,822,924	4,401,791	19,224,715		14,822,924	4,401,791	19,224,715				0
Savings plan		(4,396,355)	(3,012,157)	(7,408,512)		(4,396,355)	(3,012,157)	(7,408,512)				0
Technology contractual services and repairs		4,010,886		4,010,886		4,010,886		4,010,886				0
Early childhood data system		500,000		500,000		500,000		500,000				0
Microsoft Office 365		200,315	50,079	250,394		200,315	50,079	250,394				0
Other funds reprioritization			2,324,362	2,324,362			2,324,362	2,324,362				0
Total ongoing funding changes	(10.10)	$6,532,881	$2,302,324	$8,835,205	(10.10)	$14,944,014	$2,304,022	$17,248,036	0.00	$8,411,133	$1,698	$8,412,831
One-time funding items												
Upgrade MMIS system		$4,326,686	$30,673,314	$35,000,000		$4,326,686	$30,673,314	$35,000,000				$0
Child welfare technology project		15,000,000	15,000,000	30,000,000		15,000,000	15,000,000	30,000,000				0
Data automation		98,186	98,186	196,372		98,186	98,186	196,372				0
MMIS tech stack		600,000	1,800,000	2,400,000		600,000	1,800,000	2,400,000				0
Quality measures services		11,344	34,031	45,375		11,344	34,031	45,375				0
Total one-time funding changes	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$20,036,216	$47,605,531	$67,641,747	0.00	$0	$0	$0
Total Changes to Base Level Funding	(10.10)	$26,569,097	$49,907,855	$76,476,952	(10.10)	$34,980,230	$49,909,553	$84,889,783	0.00	$8,411,133	$1,698	$8,412,831
2021-23 Total Funding	97.85	$91,259,371	$139,928,943	$231,188,314	97.85	$99,670,504	$139,930,641	$239,601,145	0.00	$8,411,133	$1,698	$8,412,831
Total ongoing changes as a percentage of base level	*(9.4%)*	*10.1%*	*2.6%*	*5.7%*	*(9.4%)*	*23.1%*	*2.6%*	*11.1%*				
Total changes as a percentage of base level	*(9.4%)*	*41.1%*	*55.4%*	*49.4%*	*(9.4%)*	*54.1%*	*55.4%*	*54.9%*				

DHS - Program and Policy - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080	383.25	$1,181,597,942	$2,232,568,138	$3,414,166,080	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	257.22	$22,005,318	$23,196,444	$45,201,762	257.22	$22,005,318	$23,196,444	$45,201,762				$0
Base payroll changes		2,029,128	624,013	2,653,141		2,029,128	624,013	2,653,141				0
Salary increase		1,501,257	1,359,427	2,860,684		1,497,745	1,335,086	2,832,831		(3,512)	(24,341)	(27,853)
Retirement contribution increase				0				0				0
Health insurance increase		17,084	14,732	31,816		17,084	14,732	31,816				0
Provider inflation increases		13,478,022	14,417,097	27,895,119		22,538,920	24,121,507	46,660,427		9,060,898	9,704,410	18,765,308
Federal medical assistance percentage changes		(45,779,364)	45,779,364	0		(45,779,364)	45,779,364	0				0
Refugee resettlement services				0	4.00		4,337,408	4,337,408	4.00		4,337,408	4,337,408
Economic Assistance												
Continued program changes		(210,585)	3,276,939	3,066,354		(210,585)	3,276,939	3,066,354				0
Grant cost and caseload changes		2,952,453	8,382,789	11,335,242		2,952,453	8,382,789	11,335,242				0
Speciality eligibility worker					1.00	43,639	130,917	174,556	1.00	43,639	130,917	174,556
								0				0
Child Support												
Continued program changes		36,397	(91,785)	(55,388)		36,397	(91,785)	(55,388)				0
Agency savings plan		(103,906)	(357,788)	(461,694)		(103,906)	(357,788)	(461,694)				0
Transition of duties from Courts				0	3.50	308,126	209,662	517,788	3.50	308,126	209,662	517,788
Medical Services												
Continued program changes		2,493,060	5,504,976	7,998,036		2,493,060	5,504,976	7,998,036				0
Agency savings plan, excluding adjustments to Medicaid Expansion administration and rates		(999,112)	5,250,858	4,251,746		(999,112)	5,250,858	4,251,746				0
Grant cost and caseload changes		55,976,251	100,813,594	156,789,845		55,976,251	100,813,594	156,789,845				0
Other funds reprioritization			(40,000)	(40,000)			(40,000)	(40,000)				0
Funding source change - Community health and tobacco prevention and control trust funds		14,400,000	(14,400,000)	0		14,400,000	(14,400,000)	0				0
Underfund Medicaid grants		(9,580,913)	(9,955,925)	(19,536,838)		(9,580,913)	(9,955,925)	(19,536,838)				0
Medicaid COVID-19 vaccine		1,581,000	1,819,000	3,400,000		1,581,000	1,819,000	3,400,000				0
DOJ settlement services		66,465	199,395	265,860		66,465	199,395	265,860				0
Medicaid Expansion - 19 and 20 year olds to fee for service	0.50	(2,413,379)	(2,745,227)	(5,158,606)	0.50	(2,413,379)	(2,745,227)	(5,158,606)				0
Adjust estimated utilization rates		(176,553)	(202,213)	(378,766)		(176,553)	(202,213)	(378,766)				0
Restore per member per month payment		769,869	882,371	1,652,240		769,869	882,371	1,652,240				0
Medicaid interpreter services				0		249,600	249,600	499,200		249,600	249,600	499,200
Medicaid glucose monitoring				0		479,585	1,297,885	1,777,470		479,585	1,297,885	1,777,470
Tribal health care coordination				0			7,181,628	7,181,628			7,181,628	7,181,628
Medicaid metabolic supplements				0		9,300	10,700	20,000		9,300	10,700	20,000
Long-Term Care												
Agency savings plan		(7,871,872)	(960,285)	(8,832,157)		(7,871,872)	(960,285)	(8,832,157)				0
Restore funding for basic care program		5,300,000		5,300,000		5,300,000		5,300,000				0
Grant cost and caseload changes		40,219,972	37,478,740	77,698,712		40,219,972	37,478,740	77,698,712				0
Other funds reprioritization			(2,284,362)	(2,284,362)			(2,284,362)	(2,284,362)				0

Funding source change - Health care trust fund		1,000,000	(1,000,000)	0		1,000,000	(1,000,000)	0				0
Adjustment for utilization rates		(9,395,558)	(9,429,807)	(18,825,365)		(9,395,558)	(9,429,807)	(18,825,365)				0
Provide funding from health care trust fund			2,150,538	2,150,538			2,150,538	2,150,538				0
DOJ settlement services		2,197,552	2,309,196	4,506,748		1,578,002	1,596,372	3,174,374		(619,550)	(712,824)	(1,332,374)
Autism funding adjustment				0				0				0
DD Council												
Continued program changes			124,949	124,949			124,949	124,949				0
Aging Services												
Continued program changes		126,302	2,384,246	2,510,548		126,302	2,384,246	2,510,548				0
Agency savings plan		(248,240)	(163,425)	(411,665)		(248,240)	(163,425)	(411,665)				0
DOJ settlement agreement	1.00	300,000	150,000	450,000	1.00	300,000	150,000	450,000				0
Senior community employment grant			889,285	889,285			889,285	889,285				0
Dementia services grant				0		268,000		268,000		268,000		268,000
Children and Family Services												
Continued program changes		3,172,228	(394,323)	2,777,905		3,172,228	(394,323)	2,777,905				0
Agency savings plan		(12,191,335)	(7,728,080)	(19,919,415)		(12,191,335)	(7,728,080)	(19,919,415)				0
Restore portion of 1915i realignment		73,750		73,750		100,000		100,000		26,250		26,250
Grant cost and caseload changes		(6,187,819)	6,025,058	(162,761)		(6,187,819)	6,025,058	(162,761)				0
Transfer early childhood program	3.00	300,000	400,000	700,000	3.00	300,000	400,000	700,000				0
Early childhood grant program	3.70	5,458,910		5,458,910	3.70	1,500,000	3,958,910	5,458,910		(3,958,910)	3,958,910	0
Therapeutic foster care TCM realignment				0		549,585	632,319	1,181,904		549,585	632,319	1,181,904
Child care services				0	33.00	1,601,096	150,000	1,751,096	33.00	1,601,096	150,000	1,751,096
Behavioral Health Division												
Continued program changes		156,645	(1,957,536)	(1,800,891)		156,645	(1,957,536)	(1,800,891)				0
Agency savings plan		(832,173)		(832,173)		(832,173)		(832,173)				0
Restore portion of 1915i realignment		372,611		372,611		378,236		378,236		5,625		5,625
Grant cost and caseload changes		5,427,067		5,427,067		5,427,067		5,427,067				0
Expand substance use disorder voucher		7,000,000		7,000,000		12,000,000		12,000,000		5,000,000		5,000,000
Grants and funding FTE position				0	1.00	171,455		171,455	1.00	171,455		171,455
Vocational Rehabilitation												
Continued program changes		(416,293)	(381,081)	(797,374)		(416,293)	(381,081)	(797,374)				0
Agency savings plan		(1,803,954)	(91,000)	(1,894,954)		(1,803,954)	(91,000)	(1,894,954)				0
Restore CIL and ski park funds		1,803,954	91,000	1,894,954		1,803,954	91,000	1,894,954				0
Developmental Disabilities												
Continued program changes		(11,821)	163,017	151,196		(11,821)	163,017	151,196				0
Agency savings plan		(2,252,289)	(1,926,850)	(4,179,139)		(2,252,289)	(1,926,850)	(4,179,139)				0
Grant cost and caseload changes		19,323,007	22,244,014	41,567,021		19,323,007	22,244,014	41,567,021				0
Small agency accreditation costs		25,000		25,000		100,000		100,000		75,000		75,000
Experienced Parent Program				0		260,000		260,000		260,000		260,000
Section 11 supported housing and employment				0		373,261		373,261		373,261		373,261
Corporate guardianship slots				0		98,311		98,311		98,311		98,311
Recreational and leisure services				0		150,000		150,000		150,000		150,000
Adjust crisis bed funding				0		(30,156)	116,556	86,400		(30,156)	116,556	86,400
Restore provider rate reductions				0		5,240,000	5,910,000	11,150,000		5,240,000	5,910,000	11,150,000
Total ongoing funding changes	265.42	$109,088,136	$231,821,355	$340,909,491	307.92	$128,445,739	$264,974,185	$393,419,924	42.50	$19,357,603	$33,152,830	$52,510,433

One-time funding items:												
Nursing facility payment methodology change		$3,348,000	$3,852,000	$7,200,000		$3,348,000	$3,852,000	$7,200,000				$0
Nursing facility bed buyback program				0				0				0
ASO management consultant		150,000	150,000	300,000		0	0	0		(150,000)	(150,000)	(300,000)
LSTC transition costs				0			5,200,000	5,200,000			5,200,000	5,200,000
Developmental disabilities stabilization grants				0		125,000		125,000		125,000		125,000
Total one-time funding changes	0.00	$3,498,000	$4,002,000	$7,500,000	0.00	$3,473,000	$9,052,000	$12,525,000		($25,000)	$5,050,000	$5,025,000
								0				
Total Changes to Base Level Funding	265.42	$112,586,136	$235,823,355	$348,409,491	307.92	$131,918,739	$274,026,185	$405,944,924	42.50	$19,332,603	$38,202,830	$57,535,433
2021-23 Total Funding	648.67	$1,294,184,078	$2,468,391,493	$3,762,575,571	691.17	$1,313,516,681	$2,506,594,323	$3,820,111,004	42.50	$19,332,603	$38,202,830	$57,535,433
Total ongoing changes as a percentage of base level	*69.3%*	*9.2%*	*10.4%*	*10.0%*	*80.3%*	*10.9%*	*11.9%*	*11.5%*				
Total changes as a percentage of base level	*69.3%*	*9.5%*	*10.6%*	*10.2%*	*80.3%*	*11.2%*	*12.3%*	*11.9%*				

DHS - Field Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Position	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	1,599.03	$214,862,668	$127,314,955	$342,177,623	1,599.03	$214,862,668	$127,314,955	$342,177,623	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
2019-21 transfers and adjustments	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)	(239.12)	($21,166,537)	($19,642,790)	($40,809,327)				$0
Base payroll changes		(7,659,868)	12,248,626	4,588,758		(7,659,868)	12,248,626	4,588,758				0
Salary increase		5,572,943	489,043	6,061,986		5,426,660	511,625	5,938,285		(146,283)	22,582	(123,701)
Retirement contribution increase				0				0				0
Health insurance increase		59,867	5,710	65,577		59,867	5,710	65,577				0
Provider inflationary increases		405,815		405,815		678,158		678,158		272,343		272,343
								0				0
Human Service Centers								0				0
Continued program changes		3,116,890	(2,911,912)	204,978		3,116,890	(2,911,912)	204,978				0
Cost and caseload changes		2,624,029		2,624,029		2,624,029		2,624,029				0
Civil sex offender treatment contract		917,004		917,004		917,004		917,004				0
Agency savings plan		(6,414,994)		(6,414,994)		(6,414,994)		(6,414,994)				0
Restore 1915i realignment reductions		1,362,299		1,362,299		3,109,385		3,109,385		1,747,086		1,747,086
Restore Northeast Human Service Center rent				0		168,736		168,736		168,736		168,736
								0				0
Institutions												
Continued program changes		(4,250,920)	3,154,778	(1,096,142)		(4,250,920)	3,154,778	(1,096,142)				0
Agency savings plan	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)	(31.60)	(8,004,617)	(7,059,498)	(15,064,115)				0
Restore State Hospital beds	14.00	1,775,792	345,100	2,120,892	14.00	1,775,792	345,100	2,120,892				0
LSTC psychiatrist		100,000		100,000		183,040		183,040		83,040		83,040
Adjust funding for LSTC adaptive equipment				0			306,701	306,701			306,701	306,701
Total ongoing funding changes	(256.72)	($31,562,297)	($13,370,943)	($44,933,240)	(256.72)	($29,437,375)	($13,041,660)	($42,479,035)	0.00	$2,124,922	$329,283	$2,454,205
One-time funding items												
State Hospital complex study		$300,000		$300,000		$3,000,000		$3,000,000		$2,700,000		$2,700,000
Southeast Human Service Center projects				0		$724,000		724,000		$724,000		724,000
Total one-time funding changes	0.00	$300,000	$0	$300,000	0.00	$3,724,000	$0	$3,724,000	0.00	$3,424,000	$0	$3,424,000
Total Changes to Base Level Funding	(256.72)	($31,262,297)	($13,370,943)	($44,633,240)	(256.72)	($25,713,375)	($13,041,660)	($38,755,035)	0.00	$5,548,922	$329,283	$5,878,205
2021-23 Total Funding	1,342.31	$183,600,371	$113,944,012	$297,544,383	1,342.31	$189,149,293	$114,273,295	$303,422,588	0.00	$5,548,922	$329,283	$5,878,205
Total ongoing changes as a percentage of base level	*(16.1%)*	*(14.7%)*	*(10.5%)*	*(13.1%)*	*(16.1%)*	*(13.7%)*	*(10.2%)*	*(12.4%)*				
Total changes as a percentage of base level	*(16.1%)*	*(14.5%)*	*(10.5%)*	*(13.0%)*	*(16.1%)*	*(12.0%)*	*(10.2%)*	*(11.3%)*				

DHS - County Social Services - Budget No. 325
House Bill No. 1012
Base Level Funding Changes

	House Version				Senate Version				Senate Changes to House Version			
									Increase (Decrease) - House Version			
	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total	FTE Positions	General Fund	Other Funds	Total
2021-23 Biennium Base Level	140.00	$0	$173,700,000	$173,700,000	140.00	$0	$173,700,000	$173,700,000	0.00	$0	$0	$0
2021-23 Ongoing Funding Changes												
Base payroll changes			$1,653,466	$1,653,466			$1,653,466	$1,653,466				$0
Salary increase		412,248	291,785	704,033		340,915	292,547	633,462		(71,333)	762	(70,571)
Health insurance increase		3,287	2,737	6,024		3,287	2,737	6,024				0
Retirement contribution increase				0				0				0
Continued program changes		896,189	(372,192)	523,997		896,189	(372,192)	523,997				0
Home- and community-based services staff	3.00		498,673	498,673	3.00		498,673	498,673				0
Zone employee salary increase			3,975,941	3,975,941			3,812,383	3,812,383			(163,558)	(163,558)
Additional zone operations funding			9,089,381	9,089,381			9,089,381	9,089,381				0
Total ongoing funding changes	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
One-time funding items												
No one-time funding items				$0				$0				$0
Total one-time funding changes	0.00	$0	$0	$0	0.00	$0	$0	$0	0.00	$0	$0	$0
Total Changes to Base Level Funding	3.00	$1,311,724	$15,139,791	$16,451,515	3.00	$1,240,391	$14,976,995	$16,217,386	0.00	($71,333)	($162,796)	($234,129)
2021-23 Total Funding	143.00	$1,311,724	$188,839,791	$190,151,515	143.00	$1,240,391	$188,676,995	$189,917,386	0.00	($71,333)	($162,796)	($234,129)
Total ongoing changes as a percentage of base level	*2.1%*		*8.7%*	*9.5%*	*2.1%*		*8.6%*	*9.3%*				
Total changes as a percentage of base level	*2.1%*		*8.7%*	*9.5%*	*2.1%*		*8.6%*	*9.3%*				

Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

HB 1012 – Behavioral Health
April 20, 2021

EPSDT Study

We are requesting an amendment for the North Dakota legislature to conduct a study to determine if North Dakota is fully implementing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit under Medicaid, or as it is known in North Dakota, "Health Tracks." EPSDT provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. When EPSDT is fully implemented, it can provide children and families vital services, including access to medically necessary treatment.

Safe Beds

We would like safe beds to return to the Bismarck region. Safe beds are a safe place for a child to deescalate and function as an alternative to costly hospitalization. In the last year, safe beds were no longer available for children with mental health disorders in a mental health crisis. As a result, the only options many families have are: a) do nothing, b) hospitalize their child, c) call law enforcement.

Children and Family Services has agreed to take on the responsibility for providing safe bed services through the use of shelter beds throughout the state.

Peer Support

In the 2019 Session, Maggie Anderson presented information on peer support and the 1915(i) for SB 2012. As passed by the Legislature, the budget included peer support "for those not eligible for 1915(i) services" (a total of $304,784, half federal and half State) as well as separate funds for those 1915(i) eligible. While things are "moving" for the 1915(i), per Caprice Knapp, nothing is happening to implement peer support for those not 1915(i) eligible. When I asked her about this, she said, "I have no

staff, no money, and no time". Individuals with mental illness have been advocating for peer support for years. This is a priority for them. Questions for DHS: 1) why has this not happened? 2) where is the money that was allocated? 3) what is funded for next biennium for peer support for non-1915(i) eligible individuals? 4) what about Legislative intent?

The Department recently agreed they were funded for non-1915(i) peer supports in Medicaid and that they will move forward with this activity this biennium (2019-2021).

Family Support

Contracts were reduced significantly in the executive version of HB 1012 for the Federation of Families for Children's Mental Health and Family Voices of ND. Some funds were restored by the House but these contracts are skimpy to begin with as is one of the Early Intervention programs, "Experienced Parents". This one is in the DD budget and was cut completely. All of these programs should be prioritized for continued full funding into 21-23. Families would be lost without them.

Supported Housing

In the executive version of HB 1012, DHS decreased funding for Cooper House, LaGrave on First, Prairie Harvest, and Gerridee's. We believe DHS thought the individuals served would be eligible for the 1915(i) and could then draw down a federal match. The House restored some of the money. It has come to light that many, if not most, of these individuals will not be 1915(i) eligible. Without supported housing, many will be at risk and will not be successful living in the community. Full funding should be considered for these programs.

Autism Voucher

DHS put in a bill (SB 2089) to repeal the ASD Voucher with no discussion with the Governor's ASD Task Force. It removed all monies for the Voucher from HB 1012. Senate Human Services turned SB 2089 into a study but replaced the ~ $1.3 million with only $300,000. The Task Force opposes the repeal and submitted amendments to House Human Services to make the Voucher more family-friendly (also shared with Senate Appropriations - testimony by Holly Johnson). The Voucher should be funded at $1.3 million with the amendments from the Task Force. [NOTE: The population at the LSTC is now over 50% adults and youth with a diagnosis of autism.]

Supported Employment
We would like Supported Employment services for people with mental illness to have their budgets restored from the cuts that were slated under "1915(i) Savings." Supported Employment (SEP) services assist individuals to obtain and keep competitive employment at or above the minimum wage. Ongoing follow-along support is available for an indefinite period as needed by the individual to maintain their paid competitive employment position. Individuals with serious mental illness rely on supported employment services so that they can maintain employment and can maintain living in the community. The proposed budget made significant cuts to those program areas, with some initial requests to eliminate entire programs. While some has been discussed to be restored to allow providers time to become Medicaid providers, it does not account for the fact that some of those individuals with serious mental illness will not meet the eligibility requirements of the 1915(i). We also want to make sure that individuals who receive supported employment services under the 1915(i) continue to receive ongoing and continuous SEP services as they earn and maintain their employment wages.

Voluntary Placement Dollars
We would like a restoration of the dollars allocated to the Voluntary Treatment program. The Governor's proposed budget cuts the voluntary treatment program from its previous budget of $533,440 to a proposed 2021-2023 budget of $453,424. With the creation of the voluntary treatment program, parents were no longer required to relinquish custody of their children in order to receive treatment that would be provided in that residential treatment facility. During the last legislative session, the voluntary treatment program was given the flexibility to provide services to children in order to prevent an out-of-home placement. The voluntary treatment program is essential in families being able to maintain custody of their children and provide linkages to community-based services.

Maintenance of this program is in keeping with an *Olmstead*-savvy behavioral health system in North Dakota.

State Hospital
As Dr. Etherington has shared, many studies have already been completed regarding building of a new State Hospital (see binder she gave Sen. Appropriations). All advocacy organizations that have taken a position on this matter are supporting the building of a new State Hospital in conjunction with 8-10 new behavioral health beds in the western part of the State. Dr. Etherington has shared a funding plan

that does not require new monies for this however, if a new facility is not built, there will be significant monies needed for repair and maintenance of existing buildings. Action is recommended to move forward with authorization of a new State Hospital.

1915(i) – Legis. intent language re WHODAS score (future)
We would like there to be legislative intent raised regarding the WHODAS score that is used to determine eligibility for services under the 1915(i) State Plan Amendment. We would like that the legislature direct the Department of Human Services to conduct multi-stakeholder meetings (that include consumers and family members) to evaluate the WHODAS score threshold used to determine eligibility for services under the 1915(i) and lower the score, if necessary, to ensure individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) are not losing the invaluable services to meet their needs. This would also serve to benefit North Dakota as it seeks to maximize federal dollars in providing services to those in need.

Definition of Serious Emotional Disturbance (SED):

> A diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

-Approximate number of North Dakotans with SED (2019): 18,125.

Definition of Serious Mental Illness (SMI):

> Someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

-Approximate number of North Dakotans with SMI (2019): 30,258

-North Dakota 1915(i) Application set eligibility at a WHODAS score of 50 or above. With those parameters, the Department of Human Services anticipated that the number served between SUD, SED, SMI, TBI was 11,150.

Brain Injury Network
Brain injury services and programs were cut significantly in the executive budget, some related to expected federal matches through the 1915(i). The House restored some of the funds noting the 1915(i) may not provide funding for many of the individuals. Still, ND has

little in the way of services for individuals with a brain injury – any reductions will mean even less for supports. Relevant are the NDBIN, pre-vocational program, and the return to work program with a total reduction, after HB 1012 was passed by the House, of over a $¼ million. Consideration is requested to restore all of the funds cut for brain injury services and support.

It is suggested that, while giving DHS flexibility with funding items, there is also accountability for Legislative intent. Examples include the ASD Voucher; ASD training funds (the ASD Task Force did not know there was $90,000+ for this); and peer support. Where has the money gone that was authorized for these things?

IMD Exclusion Waiver

MHAN stands opposed to any attempts to move forward with an IMD Exclusion Waiver for behavioral health services. Since the Goodrick, Daniels, and Goodrick report of 1988, the state of North Dakota has been repeatedly advised by its own consultants to reduce our reliance on institutional placements to provide mental health services to the citizens of North Dakota. North Dakota has had a consistent record of spending most of its mental health dollars on institutional settings instead of providing community-based services.

As institutional facilities are far more expensive than community-based programs, funding that goes to institutional placements is ultimately funding that inhibits the creation and maintenance of a functioning community-based service delivery system.

After the 1999 *Olmstead* decision, states have been required to give citizens access to community-based services before requiring that they seek only institutional care. The Schulte Report of 2014 and the HSRI Report of 2018 have warned that North Dakota is not meeting federal requirements in providing community-based mental health services under *Olmstead* and the Americans with Disabilities Act.

In 1976, the state of North Dakota said that its vision for mental health services was that every citizen of North Dakota have access to the right services, at the right time, and nearest their home as possible. The citizens of North Dakota agree with that vision, and that vision is also required under the Americans with Disabilities Act. As we continue to advocate for the state of North Dakota to meet its

requirements under federal law, we also strenuously object to any effort to further incentivize institutionalization.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/20/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 3:07 p.m.

Representative/ Senators	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Changes to the Bill**

Senator Dever (3:09 pm) testified

Shelly Peterson (3:34 pm) testified

Caprice Knapp (3:36 pm) testified

Chair Nelson closed the meeting at 3:57 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/22/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:35 a.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Section 22**
- **Life Skills and Transition center**
- **Oxygen Therapy Program**
- **Nursing home rates**

Senator Dever (9:38 am) testified

Chair Nelson closed the meeting at 10:28 a.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/22/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 2:32 p.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**
- **DD Budget**
- **SUD Voucher**

Senator Dever (2:32 pm) testified

Chair Nelson closed the meeting at 3:34 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/23/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:31 a.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Representative Nelson (9:32 am) testified

Senator Mathern moved to adopt amendment of the language of section 46 that clarifies the issue of going back to the deficiency budget to cover utilization and rate adjustment and appropriate $5,575,000. (testimony #11721)

Rep Mitskog seconded

Roll Call Vote: 2-4-0 motion failed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson					x		Senator Dever					x
Representative Kreidt					x		Senator Hogue					x
Representative Mitskog				x			Senator Mathern				x	
Total Rep. Vote				1	2		Total Senate Vote				1	2

Rep Kreidt moved to adopt section 46 and add 2 million in general fund and 2.2 million federal funds to the DD provider line.

Senator Hogue seconded

Roll Call Vote: 4-2-0 motion carried

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				x			Senator Dever				x	
Representative Kreidt				x			Senator Hogue				x	
Representative Mitskog					x		Senator Mathern					x
Total Rep. Vote				2	1		Total Senate Vote				2	1

Representative Mitskog Proposed an amendment 21.02071.02027 (testimony #11722)

Chair Nelson closed the meeting at 10:35

Cole Fleck, Committee Clerk

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates ~~or~~, nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090, or developmental disability provider reimbursement rate adjustments, during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 46. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates ~~or~~, nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090, or developmental disability provider reimbursement rate adjustments, during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

21.0271.02027
Title.

Prepared by the Legislative Council staff for
Representative Mitskog
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 14, after line 6, insert:

"**SECTION 34. SUBSTANCE USE DISORDER TREATMENT VOUCHERS - REPORT TO LEGISLATIVE MANAGEMENT.** Quarterly during the 2021-23 biennium, the department of human services behavioral health division shall submit a report to the legislative management on the status of the substance use disorder treatment voucher system program, including data on the utilization of the program, data on program expenditures, and an estimate of the number of months of funding remaining in the program."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/23/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 2:32 p.m.

Representative / Senator	Present	Absent
Nelson	P	
Kreidt	P	
Mitskog	P	
Dever	P	
Hogue	P	
Mathern	P	

Discussion Topics:

- **Amendment Review**

Rep Weisz (2:33 pm) testified Amendment 210271.02026

Rep Kreidt move to adopt amendment

Rep Mitskog seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				x			Senator Dever				x	
Representative Kreidt				x			Senator Hogue				x	
Representative Mitskog				x			Senator Mathern				x	
Total Rep. Vote				3			Total Senate Vote				3	

Rep Kreidt (2:49) move to amend; proposed budget of 15 million and 2 million in grants

Senator Dever seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Rep Mitskog move to adopt amendment 210271.02027

Senator Mathern seconded

Roll Call Vote: (2:55) **6-0-0 motion passed**

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Rep Kreidt (3:22) move to amend to reduce operation costs by 4 million dollars

Rep Mitskog seconded

Roll Call Vote: 3-3-0 motion failed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever					X
Representative Kreidt				X			Senator Hogue					X
Representative Mitskog				X			Senator Mathern					X
Total Rep. Vote				3			Total Senate Vote					3

Senator Dever (3:23) move to amend with a 1.4-million-dollar reduction

Senator Hogue seconded

Roll Call Vote: 2-4-0 motion failed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson					X		Senator Dever				X	
Representative Kreidt					X		Senator Hogue				X	
Representative Mitskog					x		Senator Mathern					X
Total Rep. Vote					3		Total Senate Vote				2	1

Rep Kreidt move to amend with 2-million-dollar reduction

Rep Mitskog seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				x	
Total Rep. Vote				3			Total Senate Vote				3	

Chair Nelson closed the meeting at 3:27 p.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Representative Weisz
April 22, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 1, line 4, replace the second "and" with ", 50-24.1-02.7, 50-24.1-31, and"

Page 1, line 5, replace "and" with a comma

Page 1, line 5, after the second "program" insert ", and Medicaid coverage for workers with disability coverage and families of children with disabilities"

Page 9, after line 13, insert:

"**SECTION 16. AMENDMENT.** Section 50-24.1-02.7 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.7. Workers with disabilities coverage.

The department shall establish and implement a buyin program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program must:

1. Be made available to an individual with a disability who is a member of a household with a net income less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget applicable to the household size;

2. Allow up to an additional ten thousand dollars in assets;

3. Require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;

4. Include a one-time program enrollment fee of one hundred dollars; ~~and~~

5. Provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program; and

6. Not require the payment of a premium or enrollment fee or disenroll an individual for failure to pay a premium or enrollment fee for workers with disabilities coverage during a federally declared emergency if collection of the premium or enrollment fee may impact the receipt of federal funds.

SECTION 17. AMENDMENT. Section 50-24.1-31 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-31. Optional medical assistance for families of children with disabilities.

1. The department shall establish and implement a buyin program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred fifty percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium for families of children with disabilities coverage during a federal declared emergency if collection of the premium may impact the receipt of federal funds."

Page 14, line 11, replace "Section" with "Sections"

Page 14, line 11, after "3" insert ", 16, and 17"

Page 14, line 11, replace "is" with "are"

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Mitskog
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 14, after line 6, insert:

"**SECTION 34. SUBSTANCE USE DISORDER TREATMENT VOUCHERS - REPORT TO LEGISLATIVE MANAGEMENT.** Quarterly during the 2021-23 biennium, the department of human services behavioral health division shall submit a report to the legislative management on the status of the substance use disorder treatment voucher system program, including data on the utilization of the program, data on program expenditures, and an estimate of the number of months of funding remaining in the program."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/26/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:32 a.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Bruce Murry (9:33 am) testified

Sen Dever move to adopt amendment 21.0271.02029

Rep Kreidt seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Mathern Introduces amendment 21.0271.02030 (testimony #11727)

Sen Mathern (10:16) move the amendment **Representative Mitskog** Second

Sen Mathern Withdraws Motion **Representative Mitskog** Withdraws her second

Chair Nelson closed the meeting at 10:30 a.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Senator Dever

April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the House accede to the Senate amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be further amended as follows:

Page 13, after line 18 insert:

"**SECTION 47. LEGISLATIVE INTENT - STATE FISCAL RECOVERY FUND - TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER.** It is the intent of the sixty-seventh legislative assembly that the department of human services seek an appropriation during any special session of the sixty-seventh legislative assembly from the state fiscal recovery fund received through H.R. 1319 of the 117th Congress, also known as the federal American Rescue Plan Act, for the purpose of transitioning individuals from the life skills and transition center to community-based providers."

Renumber accordingly

21.0271.02030
Title.

Prepared by the Legislative Council staff for
Senator Mathern
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, replace lines 19 through 28 with:

"SECTION 32. APPROPRIATION - LEGISLATIVE MANAGEMENT STUDY - STATEWIDE ACUTE PSYCHIATRIC AND RESIDENTIAL CARE NEEDS.

1. During the 2021-22 interim, the legislative management shall study the acute psychiatric hospitalization and related step down residential treatment and support needs of individuals with mental illness. As part of the study, the legislative management shall gather input from stakeholders and other groups, including private hospitals, the department of human services, and mental health advocates. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

2. The study must review options for a long-term plan for acute psychiatric hospitalization and related step down residential treatment and support needs in the state and short-term options during the next two bienniums to contract with private provider acute psychiatric care facilities to provide treatment services in four or more cities in the state, workforce needs of such specific locations, and options to replace the existing state hospital facility with one or more sixteen-bed treatment facilities focused on forensic psychiatric evaluation and treatment in a manner that the facility be exempt from the federal institutions for mental diseases exclusion.

3. The legislative management may obtain consulting services to develop recommendations for private provider contracts, treatment requirements and outcome measures, locations in the state including private and public facilities, disposition and changes of the present state hospital, draft architectural plans and planning costs for the construction of one new sixteen-bed state hospital forensic evaluation treatment facility, and narrative description of a future facility should the need for one be projected.

4. The department of human services shall provide to the consultants and a legislative management committee a complete description of other outpatient and inpatient private and public behavioral health services, including substance use disorder facilities, existing in the state to prevent acute behavioral health hospitalization and to support patients following discharge from psychiatric hospitalization and related residential care.

5. The department of human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services

provided in institutions for mental diseases to Medicaid beneficiaries between the ages of twenty-one and sixty-four.

6. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $200,000, or so much of the sum as may be necessary, to the legislative management for consulting services for the study identified in this section, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/26/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 1:32 p.m.

Representative / Senator	Present	Absent
Nelson	P	
Kreidt	P	
Mitskog	P	
Dever	P	
Hogue	P	
Mathern	P	

Discussion Topics:

- **Amendment Review**

Chairman Nelson (1:35 pm) testified

Rep Kreidt move amendment 21.0271.02032

Sen Dever seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Rep Kreidt move to amend the 1 and 1% inflator

Rep Mitskog seconded

Roll Call Vote: (1:57) **4-2-0 motion failed**

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue					X
Representative Mitskog				X			Senator Mathern					X
Total Rep. Vote				3			Total Senate Vote				1	2

Sen Mathern move amendment 21.0271.02033

Rep Kreidt seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Senator Mathern (2:14) introduces language for refugee resettlement services

Chair Nelson closed the meeting at 2:30 p.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Representative J. Nelson
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, replace lines 13 through 18 with:

"**SECTION 31. DEVELOPMENTAL DISABILITY PROVIDER RATES.** Before July 1, 2021, the department of human services, in consultation with the developmental disabilities payment steering committee, shall identify $6,950,000 in reductions to be made to payment rates for intermediate care facilities and residential services for individuals with developmental disabilities, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 14, line 11, replace "Section" with "Sections"

Page 14, line 11, after "3" insert "and 31"

Page 14, line 11, replace "is" with "are"

Renumber accordingly

Prepared by the Legislative Council staff for
Senator Mathern
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, replace lines 19 through 28 with:

"SECTION 32. APPROPRIATION - LEGISLATIVE MANAGEMENT STUDY - STATEWIDE ACUTE PSYCHIATRIC AND RESIDENTIAL CARE NEEDS.

1. During the 2021-22 interim, the legislative management shall study the acute psychiatric hospitalization and related step down residential treatment and support needs of individuals with mental illness. The legislative management shall create an acute psychiatric treatment committee consisting of six members to conduct the study. The legislative management chairman shall designate the committee chairman and vice chairman and the legislative council shall provide staff services for the committee.

2. As part of the study, the committee shall gather input from stakeholders and other groups, including private hospitals, the department of human services, and mental health advocates.

3. The study must review options for a long-term plan for acute psychiatric hospitalization and related step down residential treatment and support needs in the state and short-term options during the next two bienniums to contract with private provider acute psychiatric care facilities to provide treatment services in four or more cities in the state, workforce needs of such specific locations, and options to replace the existing state hospital facility with one or more treatment facilities focused on forensic psychiatric evaluation.

4. The committee, with the approval of the legislative management, may obtain consulting services to determine the total number of acute care beds needed in the state and to develop recommendations for private provider contracts, treatment requirements and outcome measures, locations in the state, including private and public facilities, and the future use of facilities at the state hospital campus. The consulting services may also develop conceptual drawings for recommendations for a new state hospital treatment campus.

5. The department of human services shall provide to the consultants and the committee a complete description of other outpatient and inpatient private and public behavioral health services, including substance use disorder facilities, existing in the state to prevent acute behavioral health hospitalization and to support patients following discharge from psychiatric hospitalization and related residential care.

6. The department of human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services provided in institutions for mental diseases to Medicaid beneficiaries between the ages of twenty-one and sixty-four.

7. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

8. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $250,000, or so much of the sum as may be necessary, to the legislative management for consulting services for the study identified in this section, for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 14, line 11, replace "Section" with "Sections"

Page 14, line 11, after "3" insert "and 32"

Page 14, line 11, replace "is" with "are"

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/26/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 4:31 p.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Sen Hogue move amendment langue for refugee resettlement

Sen Mathern seconded

Roll Call Vote: 6-0-0 motion carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Mathern (4:37) introduces amendment 21.0271.02028 for Childcare Aware (testimony #11723 & # 11724)

Sen Mathern (5:10) Makes motion to adopt amendment

Rep Mitskog seconded

Roll Call Vote: 6-0-0 motion carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Hogue (5:20) move amendment for professional language (testimony #11726)

Rep Kreidt seconded

Roll Call Vote: 6-0-0 motion carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Rep Kreidt (5:21) move amendment 21.0271.02031 (testimony #11725)

Rep Mitskog seconded

Roll Call Vote: 6-0-0 motion carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Chairman Nelson closed the meeting at 5:26 pm

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Senator Davison
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 3, after line 30, insert:

"**SECTION 3. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - EARLY CHILDHOOD PROGRAMS.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $339,600, or so much of the sum as may be necessary, to the department of human services for early childhood program regulatory duties, for the biennium beginning July 1, 2021, and ending June 30, 2023. The department of human services is authorized seven full-time equivalent positions for regulatory duties of early childhood programs. The department of human services shall contract with a private entity for the delivery of the child care aware program."

Page 12, line 3, replace "4" with "5"

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Page 14, line 11, replace "3" with "4"

Renumber accordingly

PROPOSED AMENDMENTS TO SENATE BILL NO. 2146

Page 1, line 2, after "grounds" insert "; to create and enact a new section to chapter 01-02 of the North Dakota Century Code, relating to first-person language; to provide an effective date"

Page 1, after line 16, insert:

"**SECTION 2.** A new section to chapter 1-02 of the North Dakota Century Code is created and enacted as follows:

Person-first language.

The provisions of this code, unless the context otherwise requires, must be construed in person-first language and any new enactments of this code must be written in person-first language.

SECTION 3. EFFECTIVE DATE. Section 2 of this Act becomes effective on January 1, 2022."

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Kreidt
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, after line 18, insert:

"**SECTION 32. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES.** The department of human services, in collaboration with basic care providers and other representatives of the basic care industry, shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly."

Renumber accordingly

Information Supplement to Childcare Aware, Bright & Early and Growing Futures

The purpose of the document is to provide supplementary informant to the discussion on adding 33 full-time FTE's to the state payroll. These employees are currently temporary employees contracted through Human Services. They were previously employed by Lutheran Social Services in Fargo, until their bankruptcy/reorganization.

As you move forward in the decision there are three additional pieces to the puzzle which are important:

1) **HB 1416 (passed & signed)** – allows for the following:
    a. A school board / district to set-up a four-year old program that is approved by the department of human services.
    b. Defines four-year old program approval process
    c. Eliminates current early childhood education program in Dept. of Commerce
    d. Makes changes in early childhood council
2) **HB 1466 (passed & signed)** – allows for the following:
    a. Allows for the submission of an application for **"best in class four-year old experience"** grant.
    b. The annual award for grant is $120,000 per approved group size (14) and there is a $20,000 matching component for this grant.
    c. It requires the department to assign a program support coach to each approved program.
    d. Allows for any program including church, business or organization that operates a four-year-old program.
    e. Fiscal not provides for the following:
        i. 4.8 million for 20 programs at $120,000 (3.3 million from DPI fed funds and 1.5 million from the Commerce department)
        ii. Provides $120,000 for evaluation or data and outcome analysis
        iii. .2 FTE for administration of grant funding ($28,000)
        iv. 3 FTE to support approved 4-year old program ($510,00)
3) **SB 2018 (In House with changes)** allows for the following:
    a. The current 1.5 million moves from Commerce to the Department of Human Services

Full-time Employee summary from LSS to DHS

There are two components to these 33 FTE's which DHS would like to make permanent.

Regulatory four-year old program:

The first component is **regulatory**. The **4 staff** from **Bright and Early** are the individuals who will do the accreditation for the $120,000 in "best in class 4-year old experiences" grant.

In addition to the Bright and Early **regulatory component** is the **Growing Futures database/registry**. This group manages the workforce registry that tracks training and qualifications of childcare providers, as a component of licensing.

Technical Supports to Childcare Providers (Coaching, Training and various Supports)

Childcare Aware has 26 temporary positions and currently 24 are filled. The two vacant positions are CCA positions. There are a variety of positions including coaches, inclusion specialists that serve providers and families. This could include a variety of health and safety resources.

Questions to be asked:

Why should the Regulatory organization (DHS) do the technical support for these agencies too?

In HB 1466 there is an allocation for $510,000 and 3 FTE to support approved four-year old programs. Isn't that what Bright & Early (4 FTE) and the Growing Futures (3 FTE) would do? According the Dept. of Public Instruction, that's what Bright & Early does is the accreditation. They would continue to do that for the best-in class 4-year old grant.

There is between $600,000 -$800,000 left over from previous 4 year old program? How is that added back into budget at DHS?

How do all the administration fees, office rental etc... Tie into current budget submitted to DHS?

I could ask about 10 more questions.... But will wait until after I visit with the both of you...

21.0271.02028
Title.

Prepared by the Legislative Council staff for
Senator Davison
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 3, after line 30, insert:

"**SECTION 3. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - EARLY CHILDHOOD PROGRAMS.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $339,600, or so much of the sum as may be necessary, to the department of human services for early childhood program regulatory duties, for the biennium beginning July 1, 2021, and ending June 30, 2023. The department of human services is authorized seven full-time equivalent positions for regulatory duties of early childhood programs. The department of human services shall contract with a private entity for the delivery of the child care aware program."

Page 12, line 3, replace "4" with "5"

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Page 14, line 11, replace "3" with "4"

Renumber accordingly

PROPOSED AMENDMENTS TO SENATE BILL NO. 2146

Page 1, line 2, after "grounds" insert "; to create and enact a new section to chapter 01-02 of the North Dakota Century Code, relating to first-person language; to provide an effective date"

Page 1, after line 16, insert:

"**SECTION 2.** A new section to chapter 1-02 of the North Dakota Century Code is created and enacted as follows:

Person-first language.

The provisions of this code, unless the context otherwise requires, must be construed in person-first language and any new enactments of this code must be written in person-first language.

SECTION 3. EFFECTIVE DATE. Section 2 of this Act becomes effective on January 1, 2022."

Renumber accordingly

21.0271.02031
Title.

Prepared by the Legislative Council staff for
Representative Kreidt
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, after line 18, insert:

"**SECTION 32. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES.** The department of human services, in collaboration with basic care providers and other representatives of the basic care industry, shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/27/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:00 a.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Tim Blasl (9:02 am) testified

Sen Dever motioned to remove senate amendments

Rep Kreidt seconded

Roll Call Vote: 3-3-0 motion failed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				x	
Representative Kreidt				X			Senator Hogue					X
Representative Mitskog					X		Senator Mathern					X
Total Rep. Vote				2	1		Total Senate Vote				1	2

Rep Kreidt move the amount of 4,276,380 for federal coronavirus relief be added; 1.1 million to community behavior health program, remaining 2 million is for senior nutrition services, 1 million is to offset general funds and is declared an emergency

Rep Mitskog seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Mathern (9:34) Introduces amendment 21.0271.02034 Childcare Aware (testimony #11740)

Sen. Mathern moved amendment LC # 21.0271.02034

Representative Kreidt Second

10:18 Sen. Mathern withdrew his motion. Rep. Kreidt withdrew his second.

Chair Nelson closed the meeting at 10:20 a.m.

Cole Fleck, Committee Clerk

21.0271.02034
Title.

Prepared by the Legislative Council staff for
Senator Mathern
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 3, after line 30, insert:

"**SECTION 3. APPROPRIATION - DEPARTMENT OF HUMAN SERVICES - EARLY CHILDHOOD PROGRAMS.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $430,000, or so much of the sum as may be necessary, to the department of human services for early childhood program regulatory duties and increases in contract costs, for the biennium beginning July 1, 2021, and ending June 30, 2023. The department of human services is authorized eight full-time equivalent positions for regulatory duties of early childhood programs. The department of human services shall contract with a private entity for the delivery of the child care aware program."

Page 12, line 3, replace "4" with "5"

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Page 14, line 11, replace "3" with "4"

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/27/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 1:31 p.m.

Representative / Senator	Present	Absent
Nelson	P	
Kreidt	P	
Mitskog	P	
Dever	P	
Hogue	P	
Mathern	P	

Discussion Topics:

- **Amendment Review**

Sen Dever move the amendment 21.0271.02016

Rep Kreidt seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Mathern (2:21) move to take out Dec 31st 2021 date that is in the bill; and add langue to encourage prover to use 1915 I weaver whenever possible and we add the wording for the entire biennium

Sen Dever seconded

Roll Call Vote: 6-0-0 motion passed

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Senator Dever				X	
Representative Kreidt				X			Senator Hogue				X	
Representative Mitskog				X			Senator Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Chair Nelson closed the meeting at 2:36 p.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Senator Dever

April 7, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 5, after line 5, insert:

"**SECTION 7. SPENDING RESTRICTION - 2021-23 BIENNIUM - FEDERAL MEDICAL ASSISTANCE PERCENTAGE.** The department of human services may not spend any general fund savings resulting from federal enhancements or adjustments that cause the federal medical assistance percentage to exceed the rates used by the sixty-seventh legislative assembly for budgeting purposes for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/28/2021 am
Conference committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:32 a.m.

Representative / Senator	Present	Absent
Nelson	P	
Kreidt	P	
Mitskog	P	
Dever	P	
Hogue	P	
Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Merger of DOH**

Rep Weisz (9:35 am) introduced amendments 21.0271.02035 and 21.0271.02023 (testimony #11674 & #11673)

Sen Dever motioned to adopt amendment 21.0271.02023

Rep Kreidt seconded the motion

Roll Call Vote: (9:52) 5-1-0 motion carries

Representatives				*Yes*	*No*		*Senators*				*Yes*	*No*
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue				X	
Rep Mitskog				X			Sen Mathern					x
Total Rep. Vote				3			*Total Senate Vote*				2	1

Rep Kreidt (10:09) motioned to adopt amendment 21.0271.02035, cleaning up the language

Sen Dever seconded the motion

Roll Call Vote: 6-0-0 motion carries

Representatives				*Yes*	*No*		*Senators*				*Yes*	*No*
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				3			*Total Senate Vote*				3	

Kurt Snyder, Exec Dir, Heart view Foundation (10:14 am) testified

Caprice Knapp, Department of Human Services (10:18 am) testified

Sen Dever (10:33) motioned to amend effective dates for section 18 of the bill.

Rep Kreidt seconded the motion

Roll Call Vote: 4-2-0 motion fails

Representatives				*Yes*	*No*		*Senators*				*Yes*	*No*
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				x			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			*Total Senate Vote*				1	2

Cory Pederson, Dir of Children and Family services (11:03 am) testified

Additional written testimony: #11675

Chair Nelson closed the meeting at 11:18 a.m.

Cole Fleck, Committee Clerk

Prepared by the Legislative Council staff for
Representative Weisz
April 20, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 5, after line 5, insert:

"**SECTION 7. TRANSFER OF APPROPRIATION AUTHORITY.** Section 1 of this Act includes appropriation authority for the department of human services for the biennium beginning July 1, 2021, and ending June 30, 2023. On September 1, 2022, in accordance with provisions of House Bill No. 1247, as approved by the sixty-seventh legislative assembly, the office of management and budget shall transfer remaining appropriation authority contained in section 1 of this Act, and any remaining appropriation authority for the department of human services in other bills approved by the sixty-seventh legislative assembly, to the department of health and human services. The appropriation authority in section 1 of this Act and appropriation authority for the department of human services from any other bill that is transferred to the department of health and human services must be maintained and reported separately from other appropriation authority transferred to the department of health and human services."

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Weisz
April 27, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, after line 18, insert:

"**SECTION 32. LEGISLATIVE INTENT - CONSULTANT.** It is the intent of the sixty-seventh legislative assembly that the department of human services utilize federal funds available to the department to obtain the services of a consultant to facilitate the merger of the department of human services and state department of health as provided for in House Bill No. 1247 as approved by the sixty-seventh legislative assembly for the biennium beginning July 1, 2021, and ending June 30, 2023."

Renumber accordingly

21.0271.02023
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 20, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 5, after line 5, insert:

"**SECTION 7. TRANSFER OF APPROPRIATION AUTHORITY.** Section 1 of this Act includes appropriation authority for the department of human services for the biennium beginning July 1, 2021, and ending June 30, 2023. On September 1, 2022, in accordance with provisions of House Bill No. 1247, as approved by the sixty-seventh legislative assembly, the office of management and budget shall transfer remaining appropriation authority contained in section 1 of this Act, and any remaining appropriation authority for the department of human services in other bills approved by the sixty-seventh legislative assembly, to the department of health and human services. The appropriation authority in section 1 of this Act and appropriation authority for the department of human services from any other bill that is transferred to the department of health and human services must be maintained and reported separately from other appropriation authority transferred to the department of health and human services."

Page 14, line 7, replace "17" with "18"

Page 14, line 9, replace "14" with "15"

Renumber accordingly

21.0271.02035
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 27, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

That the Senate recede from its amendments as printed on pages 1650-1665 of the House Journal and pages 1375-1390 of the Senate Journal and that Engrossed House Bill No. 1012 be amended as follows:

Page 13, after line 18, insert:

"**SECTION 32. LEGISLATIVE INTENT - CONSULTANT.** It is the intent of the sixty-seventh legislative assembly that the department of human services utilize federal funds available to the department to obtain the services of a consultant to facilitate the merger of the department of human services and state department of health as provided for in House Bill No. 1247 as approved by the sixty-seventh legislative assembly for the biennium beginning July 1, 2021, and ending June 30, 2023."

Renumber accordingly

Prepared by the Legislative Council staff
for HB 1012 Conference Committee
4/27/2021 4:00 p.m.

ENGROSSED HOUSE BILL NO. 1012
APPROVED CONFERENCE COMMITTEE CHANGES TO SENATE VERSION

Department of Human Services

Approved changes to Senate version:

	Description	FTE	General Fund	Special Funds	Total
1	Reduce the amount restored for developmental disability provider rates to $4.2 million, of which $4 million is from the general fund.		($3,240,000)	($3,710,000)	($6,950,000)
2	Adjust SUD voucher funding to provide a total of $15 million and reduce SUD grant funding to $2 million.		(3,000,000)		(3,000,000)
3	Reduce operating expenses by $2 million rather than $8.4 million as provided in the House version.		(2,000,000)		(2,000,000)
4	Remove other funds authority added by the Senate for costs to transition individuals from the Life Skills and Transition Center. Replace Section 16 with a section of legislative intent that DHS seek an appropriation from any available funds at a future special legislative session for transition costs.			(5,200,000)	(5,200,000)
5	Reduce funding for the State Hospital study to $500,000 and provide for the study to be a Legislative Management study.		(2,500,000)		(2,500,000)
6	Appropriate funding from the capitol building fund to the Office of Management and Budget for an Americans with Disabilities Act consultant.			25,000	25,000
7	Add funding from coronavirus relief fund for community behavioral health ($1,750,000) and senior nutrition services ($2,457,638) including a general fund offset of $1 million.		(1,000,000)	4,207,638	3,207,638
	Total approved funding changes		($11,740,000)	($4,677,362)	($16,417,362)

Other approved changes:

8 Adjust section 46 to provide for DHS to seek a deficiency appropriation if funding for developmental disability provider payments is not sufficient under the new payment system.

9 Amend section 21 to adjust the amount of SUD voucher payments that may be allocated to residential providers to forty-five percent and adjust section 19 to reduce the number of SUD grants from 3 to 2.

10 Add a section for quarterly Budget Section reports regarding SUD vouchers.

11 Amend two sections of statute to provide that an individual may not be disenrolled from specific programs during a federal emergency. Declare the sections to be an emergency measure.

12 Add a section to provide for DHS to reduce developmental disability provider reimbursement rates for the 2021-23 biennium by $6.95 million.

13 Add a section to provide for person-first language to be used in legislative drafting.

14 Adjust language added by the Senate relating to refugee resettlement services.

15 Adjust language added by the Senate relating to the development of a revised payment methodology for basic care to include representatives of the basic care industry.

16 Add a section to restrict DHS from spending any general fund savings resulting from any enhancements to the federal medical assistance percentage during the 2021-23 biennium.

17 Add a section that supported employment funding is to be used during the 2021-23 biennium to continue contracts with existing evidence based supported employment providers and that any available 1915(i) funding is to be utilized before general fund appropriations.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/28/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 1:31 p.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Inflators**
- **Impact from Covid-19**

Sen Dever (1:33 pm) testified

Sen Dever (1:38) motioned to adopt the amendment for Inflators for 2% the first year and 0% the second year for all providers

Rep Kreidt seconded

Roll Call Vote: 4-2-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			Total Senate Vote				1	2

Sen Hogue (1:42) motioned to amend inflators with 2% the first year and ½% the second year. General fund obligation of 6,872,391.

Sen Mathern seconded

Roll Call Vote: 4-2-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson					X		Sen Dever				X	
Rep Kreidt					X		Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				1	2		Total Senate Vote				3	

Chair Nelson closed the meeting at 1:45 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/28/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 6:08 p.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Funding for Inflation**
- **Child care funding**
- **Housing grants**

Sen Dever (6:13) moved an amendment for funding for inflation 2% and ½% the second year, reduce child care to $430,000, funding for housing grants reduced to 1 million dollars and funding of $7.5 million form community health trust fund to replace general fund appropriations. (#11683)

Sen Hogue Seconded

Roll Call Vote: 3-3-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson					X		Sen Dever				X	
Rep Kreidt					X		Sen Hogue				X	
Rep Mitskog					X		Sen Mathern				X	
Total Rep. Vote					3		Total Senate Vote				3	

Rep Kreidt moved to amend with 2% the first year and 0% the second year.

Rep Mitskog Seconded

Roll Call Vote: 3-3-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever					X
Rep Kreidt				X			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			Total Senate Vote					3

Chair Nelson (6:20) closed the meeting at 6:20 PM

Cole Fleck, Committee Clerk

I move that Engrossed House Bill No. 1012 with Senate amendments be adjusted as follows:

- Funding for inflation is adjusted to provide a 2 percent increase the first year of the biennium and a 0.5 percent increase the second year of the biennium;
- Funding from the general fund for child care aware be reduced to $430,000 and 8 FTE positions are provided for regulatory duties;
- Funding for supportive housing grants is reduced by $1 million; and
- Funding of $7.5 million from the community health trust fund be used to replace general fund appropriations in the medical services division.

I move that Engrossed House Bill No. 1012 with Senate amendments be adjusted as follows:

- Funding for inflation is adjusted to provide a 2 percent increase the first year of the biennium and a 0.5 percent increase the second year of the biennium;
- Funding from the general fund for child care aware be reduced to $430,000 and 8 FTE positions are provided for regulatory duties;
- Funding for supportive housing grants is reduced by $1 million; and
- Funding of $7.5 million from the community health trust fund be used to replace general fund appropriations in the medical services division.

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/29/2021 am
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 9:03 a.m.

Representative / Senator	Present	Absent
Rep Nelson	P	
Rep Kreidt	P	
Rep Mitskog	P	
Sen Dever	P	
Sen Hogue	P	
Sen Mathern	P	

Discussion Topics:

- **Amendment Review**

Sen Dever (9:06 am) testified

Tim Blasl, Hospital Association (9:42 am) testified

Sen Mathern (10:24) moved to amend with inflator of 2% the first year and 1/2 % the second year with the contingency of the F map being in place for the first quarter of the next biennium

Sen Dever Seconded

Roll Call Vote: 4-2-0

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson					X		Sen Dever				X	
Rep Kreidt					X		Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				1	2		Total Senate Vote				3	

Chair Nelson closed the meeting at 10:31 a.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/29/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 1:22 p.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Rep Kreidt (1:28) moved to amend Inflators 2% fir year and 0% the second year of the biennium and the langue that is in version 2.

Rep Mitskog seconded

Roll Call Vote: 3-3-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever					X
Rep Kreidt				X			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			Total Senate Vote					3

Sen Mathern (1:31) move to amend section 1; inflation 2% first year ½% second year and review the wording for the hospitals making it continues for all providers.

Sen Dever Seconded

Roll Call Vote: 3-3-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson					X		Sen Dever				X	
Rep Kreidt					X		Sen Hogue				X	
Rep Mitskog					X		Sen Mathern				X	
Total Rep. Vote					3		Total Senate Vote				3	

Chair Nelson closed the meeting at 2:09 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/29/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 4:33 p.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**
- **Inflators for Hospitals**

Rep Mitskog moved to amend with 2% for the first year and 1/2% the second year for all the providers except the hospitals

Rep Kreidt Seconded

Roll Call Vote: 4-2-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			Total Senate Vote				1	2

Rep Mitskog (5:03) moved to amend with 2% the first year and ½% the second year for all providers except the hospitals and with the intent langue for the future special session

Rep Kreidt seconded

Roll Call Vote: 4-2-0 motion fails

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue					X
Rep Mitskog				X			Sen Mathern					X
Total Rep. Vote				3			Total Senate Vote				1	2

Chair Nelson closed the meeting at 5:10 p.m.

Cole Fleck, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1012
4/29/2021 pm
Conference Committee

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; and to provide for a report.

Chair Nelson Opened the meeting at 7:50 p.m.

Representative / Senator	Present	Absent
Representative Nelson	P	
Representative Kreidt	P	
Representative Mitskog	P	
Senator Dever	P	
Senator Hogue	P	
Senator Mathern	P	

Discussion Topics:

- **Amendment Review**

Arnie Strebe, CEO/CFO, Department of Human Services (7:58 pm) testified

Sen Mathern moved to amend with inflators and langue of intent for future special sessions

Sen Hogue seconded

Roll Call Vote: 6-0-0 Motion Carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Dever (8:08) moved an amendment for supportive housing

Rep Kreidt seconded

Roll Call Vote: 6-0-0 Motion Carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Sen Dever (8:16) moved to amend moving funds from health care trust fund to general fund

Rep Mitskog seconded

Roll Call Vote: 6-0-0 Motion Carries

Representatives				Yes	No		Senators				Yes	No
Chairman Nelson				X			Sen Dever				X	
Rep Kreidt				X			Sen Hogue				X	
Rep Mitskog				X			Sen Mathern				X	
Total Rep. Vote				3			Total Senate Vote				3	

Senator Mathern moved that Senate recede from its amendments and further amend with LC# 21.0271.02036

Rep. Kreidt. Seconded

Roll Call Vote taken. 6-0-0 motion carried.

Chairman Nelson: Adjourned at 8:25 PM

Cole Fleck, Committee Clerk

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Fiscal No. 1

Prepared by the Legislative Council staff for
Conference Committee
April 29, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1012

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health; to provide an appropriation to the legislative council; to provide an appropriation to the office of management and budget"

Page 1, line 2, after "a" insert "new section to chapter 1-02, two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 2, after "50-06" insert ", and a new section to chapter 50-24.1"

Page 1, line 3, after the first "to" insert "person-first language,"

Page 1, line 3, after "grants" insert ", a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new paragraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership"

Page 1, line 4, after "50-06-42" insert ", 50-11.1-14, 50-24.1-02.7, 50-24.1-31,"

Page 1, line 5, after "program" insert ", early childhood workforce development fees, Medicaid coverage for workers with disability coverage and families of children with disabilities,"

Page 1, line 9, after "application" insert "; to provide for retroactive application"

Page 1, remove lines 22 through 24

Page 2, remove lines 1 through 30

Page 3, replace lines 1 through 10 with:

"Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	83,747,426	218,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$82,889,783	$237,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$32,980,230	$97,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$53,731,256	$122,726,129
Operating expenses	150,961,583	20,314,902	171,276,485
Capital assets	10,000	0	10,000
Grants	452,041,904	15,404,936	467,446,840
Grants - medical assistance	2,742,157,720	295,998,870	3,038,156,590
Total all funds	$3,414,166,080	$385,449,964	$3,799,616,044

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Less estimated income	2,232,568,138	274,982,735	2,505,550,873
Total general fund	$1,181,597,942	$112,467,229	$1,294,065,171

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,917,117)	$169,784,026
Institutions	137,476,480	(6,942,407)	130,534,073
Total all funds	$342,177,623	($41,859,524)	$300,318,099
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($28,817,864)	$186,044,804

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$117,869,986	$1,579,020,870
Grant total special funds	2,623,604,181	324,827,623	2,948,431,804
Grant total all funds	$4,084,755,065	$442,697,609	$4,527,542,674
Full-time equivalent positions	2,230.23	19.10	2,249.33"

Page 3, after line 18, insert:

"Capital projects - southeast human service center	0	724,000
Developmental disabilities provider stabilization grants	0	125,000"

Page 3, replace lines 21 and 22 with:

"State hospital study	200,000	0"

Page 3, replace lines 24 through 26 with:

"Total all funds	$22,068,926	$75,690,747
Less estimated income	20,556,323	51,457,531
Total general fund	$1,512,603	$24,233,216"

Page 4, line 5, remove "political subdivision "

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Page 4, line 6, replace "for the state share of costs relating to the purchase of a fire truck" with "city located in a county of fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital"

Page 4, line 10, remove "shall discontinue any agreement with a political subdivision for fire protection"

Page 4, line 11, remove "services and"

Page 4, after line 12, insert:

"**SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 5. APPROPRIATION - LEGISLATIVE MANAGEMENT STUDY - STATEWIDE ACUTE PSYCHIATRIC AND RESIDENTIAL CARE NEEDS.

1. During the 2021-22 interim, the legislative management shall study the acute psychiatric hospitalization and related step down residential treatment and support needs of individuals with mental illness. The legislative management shall create an acute psychiatric treatment committee consisting of eight members to conduct the study. The legislative management chairman shall designate the committee chairman and vice chairman and the legislative council shall provide staff services for the committee. The committee must complete the study by October 1, 2022.

2. As part of the study, the committee shall gather input from stakeholders and other groups, including private hospitals, the department of human services, and mental health advocates.

3. The study must review options for a long-term plan for acute psychiatric hospitalization and related step down residential treatment and support needs in the state and short-term options during the next two bienniums to contract with private provider acute psychiatric care facilities to provide treatment services in four or more cities in the state, workforce needs of such specific locations, and options to replace the existing state hospital facility with one or more treatment facilities focused on forensic psychiatric evaluation and treatment.

4. The committee, with the approval of the legislative management, may obtain consulting services to determine the total number of acute care beds needed in the state and to develop recommendations for private provider contracts, treatment requirements and outcome measures, locations in the state, including private and public facilities, the future use of facilities at the state hospital campus including the LaHaug building, and other items identified in subsection 3. The consulting services may also develop conceptual drawings for recommendations for a new state hospital.

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5. The department of human services shall provide to the consultants and the committee a complete description of other outpatient and inpatient private and public behavioral health services, including substance use disorder facilities, existing in the state to prevent acute behavioral health hospitalization and to support patients following discharge from psychiatric hospitalization and related residential care.

6. The department of human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services provided in institutions for mental diseases to Medicaid beneficiaries between the ages of twenty-one and sixty-four.

7. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

8. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $500,000, or so much of the sum as may be necessary, to the legislative council for consulting services for the study identified in this section, for the period beginning with the effective date of this section, and ending June 30, 2023. The funding appropriated in the section is considered a one-time funding item.

SECTION 6. APPROPRIATION - OFFICE OF MANAGEMENT AND BUDGET - CAPITOL BUILDING FUND. There is appropriated out of any moneys in the capitol building fund in the state treasury, not otherwise appropriated, the sum of $25,000, or so much of the sum as may be necessary, to the office of management and budget for the purpose of utilizing a consultant to determine the compliance of the capitol building with 2010 Americans with Disabilities Act standards, for the biennium beginning July 1, 2021, and ending June 30, 2023. The funding appropriated in this section is considered a one-time funding item.

SECTION 7. SPENDING RESTRICTION - 2021-23 BIENNIUM - FEDERAL MEDICAL ASSISTANCE PERCENTAGE. The department of human services may not spend any general fund savings resulting from federal enhancements or adjustments that cause the federal medical assistance percentage to exceed the rates used by the sixty-seventh legislative assembly for budgeting purposes for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 1, after "**SERVICES**" insert "**- LEGISLATIVE INTENT**"

Page 5, line 5, after the period insert "It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement.

SECTION 11. TRANSFER OF APPROPRIATION AUTHORITY. Section 1 of this Act includes appropriation authority for the department of human services for the biennium beginning July 1, 2021, and ending June 30, 2023. On September 1, 2022, in accordance with provisions of House Bill No. 1247, as approved by the sixty-seventh legislative assembly, the office of management and budget shall transfer remaining appropriation authority contained in section 1 of this Act, and any remaining appropriation authority for the department of human services in other bills approved by the sixty-seventh legislative assembly, to the department of health and human services. The appropriation authority in section 1 of this Act and appropriation authority for the

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department of human services from any other bill that is transferred to the department of health and human services must be maintained and reported separately from other appropriation authority transferred to the department of health and human services.

SECTION 12. ESTIMATED INCOME - FEDERAL CORONAVIRUS RELIEF FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $2,457,638 from the federal coronavirus relief fund for senior nutrition services and the sum of $1,750,000 from the federal coronavirus relief fund for the community behavioral health program."

Page 5, line 7, replace "$187,385,888" with "$187,223,092"

Page 5, line 11, replace "$24,000,000" with "$31,500,000"

Page 5, line 20, remove "**STATE HOSPITAL -**"

Page 5, line 22, after "chapel" insert ", administrative building,"

Page 5, line 23, replace "4" with "8"

Page 5, after line 29, insert:

"**SECTION 18. PERMANENT SUPPORTIVE HOUSING GRANTS.** Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 19. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 20. REFUGEE RESETTLEMENT SERVICES - LEGISLATIVE MANAGEMENT REPORT. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services shall collaborate with applicable federal and private placement agencies to develop a plan to resettle refugees in at least five geographically diverse communities in the state outside of the existing resettlement communities with a goal of resettling twenty-five percent of new refugees outside of existing resettlement

communities. During the 2021-22 interim, the department of human services shall provide a report to the legislative management regarding refugee resettlement services."

Page 7, replace lines 15 through 19 with:

"SECTION 22. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

   a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

   b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

   c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915(i) state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization shall reimburse all North Dakota substance use providers of American society of addiction medicine level 2.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers,

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federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

SECTION 23. A new section to chapter 1-02 of the North Dakota Century Code is created and enacted as follows:

Person-first language

The provisions of this code, unless the context otherwise requires, must be construed in person-first language and any new enactments of this code must be written in person-first language."

Page 8, line 9, replace "three" with "two"

Page 8, remove lines 19 through 31

Page 9, replace lines 1 through 13 with:

"**SECTION 25. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal~~.~~, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting

vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

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SECTION 26. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than forty-five percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 27. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 28. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 29. A new paragraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code, as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;

SECTION 30. AMENDMENT. Section 50-24.1-02.7 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.7. Workers with disabilities coverage.

The department shall establish and implement a buyin program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program ~~must~~:

1. ~~Be~~Must be made available to an individual with a disability who is a member of a household with a net income less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget applicable to the household size;

2. ~~Allow~~Must allow up to an additional ten thousand dollars in assets;

3. ~~Require~~Must require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;

4. ~~Include~~Must include a one-time program enrollment fee of one hundred dollars; ~~and~~

5. ~~Provide~~Must provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program; and

6. May not require the payment of a premium or enrollment fee or disenroll an individual for failure to pay a premium or enrollment fee for workers with disabilities coverage during a federally declared emergency if collection of the premium or enrollment fee may impact the receipt of federal funds.

SECTION 31. AMENDMENT. Section 50-24.1-31 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-31. Optional medical assistance for families of children with disabilities.

1. The department shall establish and implement a buyin program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred fifty percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium for families of children with disabilities coverage during a federally declared emergency if collection of the premium may impact the receipt of federal funds."

Page 9, line 16, overstrike "**Effective through**"

Page 9, line 17, overstrike "**July 31,**"

Page 9, line 17, remove "**2023**"

Page 9, line 17, overstrike "**-**"

Page 11, remove the overstrike over line 1

Page 11, line 2, remove the overstrike over "~~section is~~"

Page 11, line 4, after "~~section~~" insert "an open record"

Page 11, line 4, remove the overstrike over the overstruck period

Page 11, after line 4, insert:

"**SECTION 34.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited

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English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section."

Page 11, after line 13, insert:

"**SECTION 37. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Page 11, remove lines 23 through 28

Page 12, line 3, replace "4" with "8"

Page 13, remove lines 13 through 31

Page 14, replace lines 1 through 6 with:

SECTION 48. EXEMPTION. The sum of $750,000 from the general fund appropriated to the department of human services for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 49. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department of human services for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 50. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department of human services for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 51. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department of human services for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 52. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject

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to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 53. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates, nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090, or developmental disability provider reimbursement rate adjustments, during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 54. DEVELOPMENTAL DISABILITY PROVIDER RATES. By July 1, 2021, the department of human services, in consultation with the developmental disabilities payment steering committee, shall identify $6,950,000 in reductions to be made to payment rates for intermediate care facilities and residential services for individuals with developmental disabilities, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 55. LEGISLATIVE INTENT - STATE FISCAL RECOVERY FUND OR OTHER FUNDS - TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. It is the intent of the sixty-seventh legislative assembly that the department of human services seek an appropriation during any special session of the sixty-seventh legislative assembly from the state fiscal recovery fund received through H.R. 1319 of the 117th Congress, also known as the federal American Rescue Plan Act, or from any eligible federal or other funds made available to the department, for the purpose of transitioning individuals from the life skills and transition center to community-based providers.

SECTION 56. LEGISLATIVE INTENT - SUPPORTED EMPLOYMENT FUNDING. It is the intent of the sixty-seventh legislative assembly that funding appropriated from the general fund for supported employment in section 1 of this Act be used to continue contracts with existing evidence-based supported employment providers during the biennium beginning July 1, 2021, and ending June 30, 2023, and that any funding available through the federal Medicaid 1915(i) state plan amendment be utilized before funding appropriated from the general fund.

SECTION 57. LEGISLATIVE INTENT - CONSULTANTS. It is the intent of the sixty-seventh legislative assembly that the department of human services and state department of health utilize federal funds available to the departments to obtain consulting services to facilitate the merger of the department of human services and state department of health as provided for in House Bill No. 1247 as approved by the sixty-seventh legislative assembly for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 58. LEGISLATIVE INTENT - PROVIDER RATE INCREASE. Section 1 of this Act includes funding for human service provider inflation increases of two percent the first year and one-quarter of one percent the second year of the biennium beginning July 1, 2021, and ending June 30, 2023. It is the intent of the sixty-seventh legislative assembly that future special sessions of the sixty-seventh legislative assembly consider an additional second year inflationary increase during the 2021-23 biennium based on any extensions of the enhanced federal Medicaid assistance

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percentage and a review of budget needs of all areas of the department of human services.

SECTION 59. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management.

SECTION 60. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES. The department of human services, in collaboration with basic care providers and other representatives of the basic care industry, shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 61. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021 22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 62. SUBSTANCE USE DISORDER TREATMENT VOUCHERS - REPORT TO BUDGET SECTION. During the 2021-22 interim, the department of human services behavioral health division shall submit quarterly reports to the budget section on the status of the substance use disorder treatment voucher system program, including data on the utilization of the program, data on program

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expenditures, and an estimate of the number of months of funding remaining in the program.

SECTION 63. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 64. RETROACTIVE APPLICATION. Section 25 of this Act applies retroactively to July 1, 2020.

Page 14, line 7, replace "Section 17" with "Sections 22 and 33"

Page 14, line 7, replace "becomes" with "become"

Page 14, line 9, replace "14" with "24"

Page 14, line 11, replace "Section" with "The sum of $2,457,638 from the federal coronavirus relief fund included in subdivision 2 of section 1 for senior nutrition services, sections"

Page 14, line 11, after "3" insert ", 5, 30, 31, and 54"

Page 14, line 11, replace "is" with ", and section 22 of Senate Bill No. 2086, as approved by the sixty seventh legislative assembly, are"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:
STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Office of Management and Budget						
Total all funds	$0	$0	$25,000	$25,000	$0	$25,000
Less estimated income	0	0	25,000	25,000	0	25,000
General fund	$0	$0	$0	$0	$0	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00
Legislative Council						
Total all funds	$0	$0	$500,000	$500,000	$0	$500,000
Less estimated income	0	0	0	0	0	0
General fund	$0	$0	$500,000	$500,000	$0	$500,000
FTE	0.00	0.00	0.00	0.00	0.00	0.00
State Department of Health						
Total all funds	$0	$0	$563,430	$563,430	$563,430	$0
Less estimated income	0	0	281,715	281,715	281,715	0
General fund	$0	$0	$281,715	$281,715	$281,715	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00
DHS - Management						
Total all funds	$154,711,362	$231,188,314	$6,412,831	$237,601,145	$239,601,145	($2,000,000)
Less estimated income	90,021,088	139,928,943	1,698	139,930,641	139,930,641	0
General fund	$64,690,274	$91,259,371	$6,411,133	$97,670,504	$99,670,504	($2,000,000)
FTE	107.95	97.85	0.00	97.85	97.85	0.00
DHS - Program/Policy						

Total all funds	$3,414,166,080	$3,762,575,571	$37,040,473	$3,799,616,044	$3,820,111,004	($20,494,960)
Less estimated income	2,232,568,138	2,468,391,493	37,159,380	2,505,550,873	2,506,594,323	(1,043,450)
General fund	$1,181,597,942	$1,294,184,078	($118,907)	$1,294,065,171	$1,313,516,681	($19,451,510)
FTE	383.25	648.67	17.50	666.17	691.17	(25.00)
DHS - County Social Services Financing						
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	$0
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995	188,676,995	0
General fund	$0	$1,311,724	($71,333)	$1,240,391	$1,240,391	$0
FTE	140.00	143.00	0.00	143.00	143.00	0.00
DHS - Field Services						
Total all funds	$342,177,623	$297,544,383	$2,773,716	$300,318,099	$303,422,588	($3,104,489)
Less estimated income	127,314,955	113,944,012	329,283	114,273,295	114,273,295	0
General fund	$214,862,668	$183,600,371	$2,444,433	$186,044,804	$189,149,293	($3,104,489)
FTE	1,599.03	1,342.31	0.00	1,342.31	1,342.31	0.00
Bill total						
Total all funds	$4,084,755,065	$4,481,459,783	$47,081,321	$4,528,541,104	$4,553,615,553	($25,074,449)
Less estimated income	2,623,604,181	2,911,104,239	37,634,280	2,948,738,519	2,949,756,969	(1,018,450)
General fund	$1,461,150,884	$1,570,355,544	$9,447,041	$1,579,802,585	$1,603,858,584	($24,055,999)
FTE	2,230.23	2,231.83	17.50	2,249.33	2,274.33	(25.00)

House Bill No. 1012 - Office of Management and Budget - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
ADA consultant			$25,000	$25,000		$25,000
Total all funds	$0	$0	$25,000	$25,000	$0	$25,000
Less estimated income	0	0	25,000	25,000	0	25,000
General fund	$0	$0	$0	$0	$0	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00

Department 110 - Office of Management and Budget - Detail of Conference Committee Changes

	Adds Funding for ADA Consultant[1]	Total Conference Committee Changes
ADA consultant	$25,000	$25,000
Total all funds	$25,000	$25,000
Less estimated income	25,000	25,000
General fund	$0	$0
FTE	0.00	0.00

[1] One-time funding from the Capitol building fund is added to obtain consulting services to determine the compliance of the Capitol building with 2010 Americans with Disabilities Act standards. The House and Senate versions did not include this funding.

House Bill No. 1012 - Legislative Council - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Legislative management study			$500,000	$500,000		$500,000
Total all funds	$0	$0	$500,000	$500,000	$0	$500,000
Less estimated income	0	0	0	0	0	0
General fund	$0	$0	$500,000	$500,000	$0	$500,000
FTE	0.00	0.00	0.00	0.00	0.00	0.00

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Department 160 - Legislative Council - Detail of Conference Committee Changes

	Adds Funding for Legislative Management Study[1]	Total Conference Committee Changes
Legislative management study	$500,000	$500,000
Total all funds	$500,000	$500,000
Less estimated income	0	0
General fund	$500,000	$500,000
FTE	0.00	0.00

[1] One-time funding is added for consultant costs associated with a study of the statewide acute psychiatric and residential care needs. The House and Senate versions did not include this funding.

House Bill No. 1012 - State Department of Health - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Grants			$563,430	$563,430	$563,430	
Total all funds	$0	$0	$563,430	$563,430	$563,430	$0
Less estimated income	0	0	281,715	281,715	281,715	0
General fund	$0	$0	$281,715	$281,715	$281,715	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00

Department 301 - State Department of Health - Detail of Conference Committee Changes

	Adds Funding for Task Force[1]	Total Conference Committee Changes
Grants	$563,430	$563,430
Total all funds	$563,430	$563,430
Less estimated income	281,715	281,715
General fund	$281,715	$281,715
FTE	0.00	0.00

[1] Funding is added to provide a grant to the Task Force on the Prevention of Sexual Abuse of Children for staff and programming materials focused on primary prevention activities. The Senate also added this funding.

House Bill No. 1012 - DHS - Management - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$20,222,500	$19,332,219	$7,638	$19,339,857	$19,339,857	
Operating expenses	134,438,862	211,781,095	6,405,193	218,186,288	220,186,288	($2,000,000)
Capital assets	50,000	75,000		75,000	75,000	
Total all funds	$154,711,362	$231,188,314	$6,412,831	$237,601,145	$239,601,145	($2,000,000)
Less estimated income	90,021,088	139,928,943	1,698	139,930,641	139,930,641	0
General fund	$64,690,274	$91,259,371	$6,411,133	$97,670,504	$99,670,504	($2,000,000)
FTE	107.95	97.85	0.00	97.85	97.85	0.00

Department 326 - DHS - Management - Detail of Conference Committee Changes

	Adjusts Funding for Management[1]	Total Conference Committee Changes
Salaries and wages	$7,638	$7,638
Operating expenses	6,405,193	6,405,193
Capital assets		
Total all funds	$6,412,831	$6,412,831
Less estimated income	1,698	1,698
General fund	$6,411,133	$6,411,133
FTE	0.00	0.00

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		$5,940	$1,698	$7,638
A portion of funding reduced by the House for operating expenses is restored. The Senate restored the entire $8,405,193 reduced by the House.		6,405,193		6,405,193
Total ongoing funding changes	0.00	$6,411,133	$1,698	$6,412,831

House Bill No. 1012 - DHS - Program/Policy - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$68,994,873	$119,359,007	$3,367,122	$122,726,129	$126,777,313	($4,051,184)
Operating expenses	150,961,583	166,664,510	4,611,975	171,276,485	170,131,921	1,144,564
Capital assets	10,000	10,000		10,000	10,000	
Grants	452,041,904	461,353,354	6,093,486	467,446,840	466,005,392	1,441,448
Grants - Medical assistance	2,742,157,720	3,015,188,700	22,967,890	3,038,156,590	3,057,186,378	(19,029,788)
Total all funds	$3,414,166,080	$3,762,575,571	$37,040,473	$3,799,616,044	$3,820,111,004	($20,494,960)
Less estimated income	2,232,568,138	2,468,391,493	37,159,380	2,505,550,873	2,506,594,323	(1,043,450)
General fund	$1,181,597,942	$1,294,184,078	($118,907)	$1,294,065,171	$1,313,516,681	($19,451,510)
FTE	383.25	648.67	17.50	666.17	691.17	(25.00)

Department 328 - DHS - Program/Policy - Detail of Conference Committee Changes

	Adjusts Funding for Program and Policy[1]	Total Conference Committee Changes
Salaries and wages	$3,367,122	$3,367,122
Operating expenses	4,611,975	4,611,975
Capital assets		
Grants	6,093,486	6,093,486
Grants - Medical assistance	22,967,890	22,967,890
Total all funds	$37,040,473	$37,040,473
Less estimated income	37,159,380	37,159,380
General fund	($118,907)	($118,907)
FTE	17.50	17.50

[1] Funding for Program and Policy is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Provides salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($3,512)	($24,341)	($27,853)
Adjusts provider inflation funding to provide a 2.0 percent increase the 1st year of the biennium and a 0.25 percent increase the 2nd year of the biennium. The House provided 1.0 percent annual inflationary increases. The Senate provided a 1.5 percent increase the 1st year of the biennium and a 2.0 percent increase the 2nd year of the biennium.		5,520,484	5,863,322	11,383,806
Adds funding and FTE positions for refugee resettlement services. The positions and funding were also added by the Senate.	4.00		4,337,408	4,337,408
Economic Assistance				
Adds 1 FTE specialty eligibility position. The Senate also added this position.	1.00	43,639	130,917	174,556
Child Support				
Adds FTE positions and funding for duties being transferred from the judicial branch to Child Support. The Senate also added the funding and FTE positions.	3.50	308,126	209,662	517,788
Medical Services				
Increases funding from the community health trust fund to $31.5 million and reduces funding from the general fund. The House and Senate versions included $24 million		(7,500,000)	7,500,000	0

from the community health trust fund.				
Adds funding to allow interpreter services to be covered by Medicaid, the same as the Senate.		249,600	249,600	499,200
Adds funding for the costs to provide Medicaid coverage for continuous glucose monitoring devices as provided in House Bill No. 1288. The Senate also added this funding.		479,585	1,297,885	1,777,470
Adjusts funding based on changes to the tribal health care coordination fund in House Bill No. 1407, the same as the Senate.			7,181,628	7,181,628
Adds funding for costs to provide Medicaid coverage of metabolic supplements as provided in Senate Bill No. 2224. The Senate also added this funding.		9,300	10,700	20,000
Long-Term Care				
Adjusts funding based on updated estimates regarding funding needed to provide services resulting from a federal Department of Justice lawsuit settlement agreement, the same as the Senate.		(619,550)	(712,824)	(1,332,374)
Transfers $300,000 of funding from the autism waiver program to the autism voucher program, the same as the Senate.				0
Aging Services				
Increases funding for dementia services grants to provide a total of $1.3 million, the same as the Senate.		268,000		268,000
Funding is added from the federal Coronavirus Relief Fund for senior nutrition services. The House and Senate did not add this funding.			2,457,638	2,457,638
Adjusts funding for senior nutrition programs.		(1,000,000)		(1,000,000)
Children and Family Services				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment, the same as the Senate.		26,250		26,250
Adjusts funding for a new early childhood program to provide a portion of funding from federal funds received by the Department of Public Instruction, the same as the Senate.		(3,958,910)	3,958,910	0
Delays the realignment of therapeutic foster care targeted case management rates, the same as the Senate.		549,585	632,319	1,181,904
Adds funding for regulatory duties of child care and early childhood programs. The Senate version included 33 FTE positions for the regulation and delivery of early childhood programs.	8.00	430,000	150,000	580,000

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Behavioral Health Division				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment, the same as the Senate.		5,625		5,625
Increases funding for substance use disorder vouchers to $15 million and reduces substance use disorder grant funding to $2 million. The House increased funding for the vouchers from $8 million to $12 million and the Senate increased funding from $8 million to $17 million. Both the House and Senate provided $3 million for substance use disorder grants.		2,000,000		2,000,000
Adds 1 FTE grants and funding position. The Senate also added this position.	1.00	171,455		171,455
Adds funding from the federal Coronavirus Relief Fund for the community behavioral health program. The House and Senate versions did not include this funding.			1,750,000	1,750,000
Developmental Disabilities				
Restores a portion of funding for small agency accreditation costs removed in the agency savings plan to provide a total of $100,000, the same as the Senate. The House restored $25,000 of funding.		75,000		75,000
Adds funding for the experienced parent program. The Senate also added this funding.		260,000		260,000
Restores funding removed in agency savings plan for Section 11 supported housing and employment, the same as the Senate.		373,261		373,261
Increases corporate guardianship slots by 10 to provide for total slots of 499. The Senate also added the slots.		98,311		98,311
Restores a portion of funding removed in agency savings plan for recreational and leisure services grants, the same as the Senate.		150,000		150,000
Adjusts funding for crisis beds to reflect updated budget estimates, the same as the Senate.		(30,156)	116,556	86,400
Restores a portion of funding reduced in the agency savings plan for adjustments to provider rates. The Senate restored the entire amount of $11,150,000, of which $5,240,000 is from the general fund.		2,000,000	2,200,000	4,200,000
Total ongoing funding changes	17.50	$93,907	$37,309,380	$37,215,473
One-Time Funding Items:				
Removes funding added by the House for a study of the use of an administrative services organization for Medicaid		($150,000)	($150,000)	($300,000)

Expansion behavioral health services. The Senate also removed this funding.				
Adds one-time funding to provide emergency stabilization grants to developmental disability providers. The Senate also added this funding.		125,000		125,000
Total one-time funding items		($25,000)	($150,000)	($175,000)
Total changes to House	17.50	$118,907	$37,159,380	$37,040,473

DA 21024 4/8/24

House Bill No. 1012 - DHS - County Social Services Financing - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
County social services	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	$0
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995	188,676,995	0
General fund	$0	$1,311,724	($71,333)	$1,240,391	$1,240,391	$0
FTE	140.00	143.00	0.00	143.00	143.00	0.00

Department 333 - DHS - County Social Services Financing - Detail of Conference Committee Changes

	Adjusts Funding for Salaries and Wages[1]	Total Conference Committee Changes
County social services	($234,129)	($234,129)
Total all funds	($234,129)	($234,129)
Less estimated income	(162,796)	(162,796)
General fund	($71,333)	($71,333)
FTE	0.00	0.00

[1] Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250. The adjustments are made as follows:

	General Fund	Other Funds	Total
DHS employees	($71,333)	$762	($70,571)
County employees		(163,558)	(163,558)
Total	($71,333)	($162,796)	($234,129)

House Bill No. 1012 - DHS - Field Services - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Human service centers	$204,701,143	$166,926,620	$2,857,406	$169,784,026	$169,888,515	($104,489)
Institutions	137,476,480	130,617,763	(83,690)	130,534,073	133,534,073	(3,000,000)
Total all funds	$342,177,623	$297,544,383	$2,773,716	$300,318,099	$303,422,588	($3,104,489)
Less estimated income	127,314,955	113,944,012	329,283	114,273,295	114,273,295	0
General fund	$214,862,668	$183,600,371	$2,444,433	$186,044,804	$189,149,293	($3,104,489)
FTE	1,599.03	1,342.31	0.00	1,342.31	1,342.31	0.00

Department 349 - DHS - Field Services - Detail of Conference Committee Changes

	Adjusts Funding for Field Services[1]	Total Conference Committee Changes
Human service centers	$2,857,406	$2,857,406
Institutions	(83,690)	(83,690)
Total all funds	$2,773,716	$2,773,716
Less estimated income	329,283	329,283
General fund	$2,444,433	$2,444,433
FTE	0.00	0.00

[1] Funding is adjusted for Field Services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($146,283)	$22,582	($123,701)
Funding for provider inflation is adjusted to provide a 2.0 percent increase the 1st year of the biennium and a 0.25 percent increase the 2nd year of the biennium. The Senate provided a 1.5 percent increase the 1st year of the biennium and a 2.0 percent increase the 2nd year of the biennium. The House provide 1.0 percent annual inflationary increases.		167,854		167,854
Human Service Centers				
A portion of funding for supportive housing grants reduced as part of the 1915i realignment is restored. The Senate restored funding of $1.7 million.		1,747,086		1,747,086
Rent expenses removed in the agency savings plan for the Northeast Human Service Center are restored, the same as the Senate.		168,736		168,736
Institutions				
Funding for psychiatrist transition costs at the Life Skills and Transition Center is increased to $183,040, the same as the Senate. The House provided funding of $100,000 for transition costs.		83,040		83,040
Funding authority is added for adaptive equipment at the Life Skills and Transition Center, the same as the Senate.			306,701	306,701
Total ongoing funding changes	0.00	$2,020,433	$329,283	$2,349,716

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4/29/24

One-Time Funding Items

Funding for a State Hospital study is removed and instead appropriated to the Legislative Council for a Legislative Management study. The House provided $300,000 for a DHS study of the State Hospital complex and the Senate provided $3 million for architectural reviews and the development of detailed plans for the construction of a new State Hospital.		($300,000)		($300,000)
One-time funding is added for heat pump and carpet replacement projects at the Southeast Human Service Center, the same as the Senate.		724,000		724,000
Total one-time funding changes	0.00	$424,000	$0	$424,000
Total changes to House funding	0.00	$2,444,433	$329,283	$2,773,716

House Bill No. 1012 - Other Changes - Conference Committee Action

This amendment also:

- Adjusts the amount of funding being provided from the human service finance fund for the county social and human services program, the same as the Senate.
- Provides that DHS develop a funding methodology to distribute permanent supportive housing grants, the same as the Senate.
- Adds a section to provide for an emergency grant allocation program for developmental disabilities providers and removes a section relating to DHS applying for an Appendix K waiver. Neither the House nor Senate versions included this adjustment.
- Adjusts a section added by the Senate for DHS to work with applicable federal and private partners to resettle new refugees in communities in the state where resettlement efforts are not already occurring.
- Provides legislative intent regarding DHS seeking funding to transition individuals from the Life Skills and Transition Center to private providers. The Senate included funding to transfer individuals to providers.
- Provides legislative intent regarding future appropriations for the federal Department of Justice lawsuit settlement, the same as the Senate.
- Provides for certain substance use disorder providers to be reimbursed at similar levels, provides for a moratorium on new substance use disorder residential providers, and provides for no more than 45 percent of substance use disorder vouchers be allocated for residential substance use disorder services administered by programs with more than 16 beds. The House provided for a limit of 30 percent of substance use disorder voucher may be used for residential services and the Senate increased the limit to 50 percent.
- Adds a section to authorize DHS to collect fees for early childhood services training and development courses, the same as the Senate.
- Removes the sunset clause on the Medicaid Expansion program and adjusts language regarding provider reimbursement rates being open records, the same as the Senate. The House extended the expiration date by 2 years.
- Adds a section to provide for interpreter services to be covered under the Medicaid program, the same as the Senate.
- Provides for DHS to establish a behavioral health bed management system, the same as the Senate.
- Authorizes the conveyance of land at the Life Skills and Transition Center to the Grafton Fire Department. The Senate also authorized this conveyance.
- Authorizes exemptions to continue appropriation authority into the 2021-23 biennium. The exemptions will reduce general fund turnback by $4,085,000. The Senate also authorized the exemptions.
- Provides for DHS to conduct a study of the early and periodic screening, diagnostic, and treatment program, the same as the Senate.
- Removes a section providing for a DHS study of using an administrative services organization for behavioral health services in the Medicaid Expansion program. The Senate also added this section.
- Adjusts a section added by the Senate for DHS to develop a new payment methodology for basic care facilities

in collaboration with the basic care industry.

- Provides for a DHS report to the Legislative Management regarding the early childhood 4-year old grant program. The Senate also added this report.
- Authorizes positions for child care licensing to be used for other purposes, the same as the Senate.
- Adds a section not included in the House or Senate versions to use person-first language in statute.
- Adds two sections not included in the House or Senate versions to prohibit the disenrollment of individuals in certain programs during federal emergencies if it would affect the receipt of federal funds. The sections are declared to be an emergency measure.
- Adds a section not included in the House or Senate versions to provide for DHS to reduce developmental disability provider rates by $6.95 million for the 2021-23 biennium.
- Adds a section not included in the House or Senate versions to require DHS to submit quarterly reports to the Budget Section regarding substance use disorder treatment vouchers.
- Adds a section not included in the House or Senate versions to provide for DHS appropriation authority to transition to the Department of Health and Human Services on September 1, 2022, as provided in House Bill No. 1247.
- Adds a section not included in the House or Senate versions to prohibit DHS from spending any general fund savings resulting from federal enhancements to the federal medical assistance percentage above budgeted rates.
- Adds a section not included in the House or Senate versions to provide guidelines for supported employer funding.
- Adds a section not included in the House or Senate versions to transfer DHS appropriation authority to the Department of Health and Human Services on September 1, 2022.
- Adds a section not included in the House or Senate versions to provide intent that DHS and the State Department of Health utilize consulting services to facilitate the merger of the departments.
- Adds a section not included in the House or Senate versions to provide intent that future special sessions of the 67th Legislative Assembly consider providing an additional inflationary increase the 2nd year of the 2021-23 biennium.

Date: 1/29/20621
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1012 as engrossed

House "Enter committee name" Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen Mathern Seconded by: Rep Kreidt

Representatives	4/29	4/29	4/29	Yes	No		Senators	4/29	4/29	4/29	Yes	No
Chairman Nelson	x	x	x	X			Sen Dever	x	x	x	X	
Rep Kreidt	x	x	x	X			Sen Hogue	x	x	x	X	
Rep Mitskog	x	x	x	X			Sen Mathern	x	x	x	X	
Total Rep. Vote				3	0		Total Senate Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep Nelson Senate Carrier Sen Dever

LC Number 21.0271 . 02036 of amendment

LC Number 21.0271 . 04000 of engrossment

Emergency clause added

Statement of purpose of amendment

Insert LC: 21.0271.02036
House Carrier: J. Nelson
Senate Carrier: Dever

REPORT OF CONFERENCE COMMITTEE

HB 1012, as engrossed: Your conference committee (Sens. Dever, Hogue, Mathern and Reps. J. Nelson, Kreidt, Mitskog) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1650-1658, adopt amendments as follows, and place HB 1012 on the Seventh order:

Page 1, line 2, after "services" insert "; to provide an appropriation to the state department of health; to provide an appropriation to the legislative council; to provide an appropriation to the office of management and budget"

Page 1, line 2, after "a" insert "new section to chapter 1-02, two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 2, after "50-06" insert ", and a new section to chapter 50-24.1"

Page 1, line 3, after the first "to" insert "person-first language,"

Page 1, line 3, after "grants" insert ", a behavioral health bed management system, and medical assistance coverage of interpreter services; to create and enact a new paragraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, relating to the North Dakota early childhood council membership"

Page 1, line 4, after "50-06-42" insert ", 50-11.1-14, 50-24.1-02.7, 50-24.1-31,"

Page 1, line 5, after "program" insert ", early childhood workforce development fees, Medicaid coverage for workers with disability coverage and families of children with disabilities,"

Page 1, line 9, after "application" insert "; to provide for retroactive application"

Page 1, remove lines 22 through 24

Page 2, remove lines 1 through 30

Page 3, replace lines 1 through 10 with:

"Salaries and wages	$20,222,500	($882,643)	$19,339,857
Operating expenses	134,438,862	83,747,426	218,186,288
Capital assets	50,000	25,000	75,000
Total all funds	$154,711,362	$82,889,783	$237,601,145
Less estimated income	90,021,088	49,909,553	139,930,641
Total general fund	$64,690,274	$32,980,230	$97,670,504

Subdivision 2.

PROGRAM AND POLICY

	Base Level	Adjustments or Enhancements	Appropriation
Salaries and wages	$68,994,873	$53,731,256	$122,726,129
Operating expenses	150,961,583	20,314,902	171,276,485
Capital assets	10,000	0	10,000
Grants	452,041,904	15,404,936	467,446,840
Grants - medical assistance	2,742,157,720	295,998,870	3,038,156,590
Total all funds	$3,414,166,080	$385,449,964	$3,799,616,044

Less estimated income	2,232,568,138	274,982,735	2,505,550,873
Total general fund	$1,181,597,942	$112,467,229	$1,294,065,171

Subdivision 3.

FIELD SERVICES

	Base Level	Adjustments or Enhancements	Appropriation
Human service centers	$204,701,143	($34,917,117)	$169,784,026
Institutions	137,476,480	(6,942,407)	130,534,073
Total all funds	$342,177,623	($41,859,524)	$300,318,099
Less estimated income	127,314,955	(13,041,660)	114,273,295
Total general fund	$214,862,668	($28,817,864)	$186,044,804

Subdivision 4.

COUNTY SOCIAL SERVICE FINANCING

	Base Level	Adjustments or Enhancements	Appropriation
County social services	$173,700,000	$16,217,386	$189,917,386
Total all funds	$173,700,000	$16,217,386	$189,917,386
Less estimated income	173,700,000	14,976,995	188,676,995
Total general fund	$0	$1,240,391	$1,240,391

Subdivision 5.

TOTAL - SECTION 1

	Base Level	Adjustments or Enhancements	Appropriation
Grand total general fund	$1,461,150,884	$117,869,986	$1,579,020,870
Grant total special funds	2,623,604,181	324,827,623	2,948,431,804
Grant total all funds	$4,084,755,065	$442,697,609	$4,527,542,674
Full-time equivalent positions	2,230.23	19.10	2,249.33"

Page 3, after line 18, insert:

"Capital projects - southeast human service center	0	724,000
Developmental disabilities provider stabilization grants	0	125,000"

Page 3, replace lines 21 and 22 with:

"State hospital study	200,000	0"

Page 3, replace lines 24 through 26 with:

"Total all funds	$22,068,926	$75,690,747
Less estimated income	20,556,323	51,457,531
Total general fund	$1,512,603	$24,233,216"

Page 4, line 5, remove "political subdivision "

Page 4, line 6, replace "for the state share of costs relating to the purchase of a fire truck" with "city located in a county of fewer than 25,000 individuals and provides prevention and extinguishment of fires at the North Dakota state hospital"

Page 4, line 10, remove "shall discontinue any agreement with a political subdivision for fire protection"

Page 4, line 11, remove "services and"

Page 4, after line 12, insert:

"**SECTION 4. APPROPRIATION - STATE DEPARTMENT OF HEALTH.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $281,715, or so much of the sum as may be necessary, and the sum of $281,715 from special funds derived from grants, donations, and other income, to the state department of health for the purpose of providing a grant to the task force on the prevention of sexual abuse of children for staff and programming materials focused on primary prevention activities, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 5. APPROPRIATION - LEGISLATIVE MANAGEMENT STUDY - STATEWIDE ACUTE PSYCHIATRIC AND RESIDENTIAL CARE NEEDS.

1. During the 2021-22 interim, the legislative management shall study the acute psychiatric hospitalization and related step down residential treatment and support needs of individuals with mental illness. The legislative management shall create an acute psychiatric treatment committee consisting of eight members to conduct the study. The legislative management chairman shall designate the committee chairman and vice chairman and the legislative council shall provide staff services for the committee. The committee must complete the study by October 1, 2022.

2. As part of the study, the committee shall gather input from stakeholders and other groups, including private hospitals, the department of human services, and mental health advocates.

3. The study must review options for a long-term plan for acute psychiatric hospitalization and related step down residential treatment and support needs in the state and short-term options during the next two bienniums to contract with private provider acute psychiatric care facilities to provide treatment services in four or more cities in the state, workforce needs of such specific locations, and options to replace the existing state hospital facility with one or more treatment facilities focused on forensic psychiatric evaluation and treatment.

4. The committee, with the approval of the legislative management, may obtain consulting services to determine the total number of acute care beds needed in the state and to develop recommendations for private provider contracts, treatment requirements and outcome measures, locations in the state, including private and public facilities, the future use of facilities at the state hospital campus including the LaHaug building, and other items identified in subsection 3. The consulting services may also develop conceptual drawings for recommendations for a new state hospital.

5. The department of human services shall provide to the consultants and the committee a complete description of other outpatient and inpatient private and public behavioral health services, including substance use disorder facilities, existing in the state to prevent acute behavioral health hospitalization and to support patients following discharge from psychiatric hospitalization and related residential care.

6. The department of human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services provided in institutions for mental diseases to Medicaid beneficiaries between the ages of twenty-one and sixty-four.

7. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

8. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $500,000, or so much of the sum as may be necessary, to the legislative council for consulting services for the study identified in this section, for the period beginning with the effective date of this section, and ending June 30, 2023. The funding appropriated in the section is considered a one-time funding item.

SECTION 6. APPROPRIATION - OFFICE OF MANAGEMENT AND BUDGET - CAPITOL BUILDING FUND. There is appropriated out of any moneys in the capitol building fund in the state treasury, not otherwise appropriated, the sum of $25,000, or so much of the sum as may be necessary, to the office of management and budget for the purpose of utilizing a consultant to determine the compliance of the capitol building with 2010 Americans with Disabilities Act standards, for the biennium beginning July 1, 2021, and ending June 30, 2023. The funding appropriated in this section is considered a one-time funding item.

SECTION 7. SPENDING RESTRICTION - 2021-23 BIENNIUM - FEDERAL MEDICAL ASSISTANCE PERCENTAGE. The department of human services may not spend any general fund savings resulting from federal enhancements or adjustments that cause the federal medical assistance percentage to exceed the rates used by the sixty-seventh legislative assembly for budgeting purposes for the biennium beginning July 1, 2021, and ending June 30, 2023."

Page 5, line 1, after "**SERVICES**" insert "**- LEGISLATIVE INTENT**"

Page 5, line 5, after the period insert "It is the intent of the sixty-seventh legislative assembly that future legislative assemblies retain and exercise unfettered discretion to appropriate funds as they deem appropriate without regard to the federal department of justice lawsuit settlement.

SECTION 11. TRANSFER OF APPROPRIATION AUTHORITY. Section 1 of this Act includes appropriation authority for the department of human services for the biennium beginning July 1, 2021, and ending June 30, 2023. On September 1, 2022, in accordance with provisions of House Bill No. 1247, as approved by the sixty-seventh legislative assembly, the office of management and budget shall transfer remaining appropriation authority contained in section 1 of this Act, and any remaining appropriation authority for the department of human services in other bills approved by the sixty-seventh legislative assembly, to the department of health and human services. The appropriation authority in section 1 of this Act and appropriation authority for the department of human services from any other bill that is transferred to the department of health and human services must be maintained and reported separately from other appropriation authority transferred to the department of health and human services.

SECTION 12. ESTIMATED INCOME - FEDERAL CORONAVIRUS RELIEF FUND. The estimated income line item in subdivision 2 of section 1 of this Act includes the sum of $2,457,638 from the federal coronavirus relief fund for senior nutrition services and the sum of $1,750,000 from the federal coronavirus relief fund for the community behavioral health program."

Page 5, line 7, replace "$187,385,888" with "$187,223,092"

Page 5, line 11, replace "$24,000,000" with "$31,500,000"

Page 5, line 20, remove "**STATE HOSPITAL -**"

Page 5, line 22, after "chapel" insert ", administrative building,"

Page 5, line 23, replace "4" with "8"

Page 5, after line 29, insert:

"**SECTION 18. PERMANENT SUPPORTIVE HOUSING GRANTS.** Subdivision 2 of section 1 of this Act includes the sum of $4,672,536 from the general fund for permanent supportive housing grants. The department of human services shall develop a funding methodology to distribute the funding to qualified entities that utilize best practices for permanent supportive housing, provide recovery-oriented and person-centered services, submit process and outcome measures to the department, and authorize the department to conduct onsite visits to review program operations.

SECTION 19. EMERGENCY STABILIZATION GRANTS - DEVELOPMENTAL DISABILITIES WAIVER.

1. Subdivision 2 of subsection 1 of this Act includes the sum of $125,000 from the general fund for the purpose of providing emergency stabilization grants to developmental disability in-home support providers to support the sustainability of newly licensed providers within the developmental disability provider network. To be eligible to receive an emergency stabilization grant, a licensed developmental disability in-home support provider must be in operation as of October 1, 2020, with an initial license date of October 15, 2015, or later, and comply with grant requirements established by the department of human services. The requirements of chapter 54-44.4 do not apply to the selection of a grantee, the grant award, or payments made under this section.

2. The department of human services shall include in-home support providers in future appendix K applications, to allow eligibility for retainer payments in a manner equivalent to day support services.

SECTION 20. REFUGEE RESETTLEMENT SERVICES - LEGISLATIVE MANAGEMENT REPORT. Subdivision 2 of section 1 of this Act includes the sum of $6,069,408 of federal funds for the refugee resettlement program. The department of human services shall collaborate with applicable federal and private placement agencies to develop a plan to resettle refugees in at least five geographically diverse communities in the state outside of the existing resettlement communities with a goal of resettling twenty-five percent of new refugees outside of existing resettlement communities. During the 2021-22 interim, the department of human services shall provide a report to the legislative management regarding refugee resettlement services."

Page 7, replace lines 15 through 19 with:

"**SECTION 22. EXPENDITURES MAY NOT EXCEED APPROPRIATION - MEDICAL ASSISTANCE EXPANSION PROGRAM - APPLICATION.**

1. Subdivision 2 of section 1 of this Act includes the sum of $703,317,464, of which $80,934,488 is from the general fund, for the medical assistance expansion program for the biennium beginning July 1, 2021, and ending

June 30, 2023. The expenditures for individuals eligible for the medical assistance expansion program may not exceed this amount. For purposes of this section:

a. Expenditures do not include those made for individuals identified as medically frail and who receive services through the traditional Medicaid program administered by the department of human services for which there is a separate appropriation of $10,184,568 included in subdivision 2 of section 1 of this Act.

b. Expenditures do not include prescription drugs for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $29,460,720 included in subdivision 2 of section 1 of this Act.

c. Expenditures do not include coverage for individuals ages nineteen and twenty for the medical assistance expansion program population which is administered by the department of human services through its fee-for-service Medicaid program for which there is a separate appropriation of $12,705,466 included in subdivision 2 of section 1 of this Act.

2. The department of human services may exceed appropriations for increases in medical assistance expansion program caseload and for the addition of coverage consistent with the traditional Medicaid 1915(i) state plan.

3. The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department. The managed care organization shall reimburse all North Dakota substance use providers of American society of addiction medicine level 2.5 at consistent levels and with consistent methodology. The managed care organization may consider urban and rural providers as different provider types. Critical access hospitals may not be paid less than one hundred percent of Medicare allowable costs.

4. The managed care organization and the department of human services shall ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

5. The department of human services shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

SECTION 23. A new section to chapter 1-02 of the North Dakota Century Code is created and enacted as follows:

Person-first language

The provisions of this code, unless the context otherwise requires, must be construed in person-first language and any new enactments of this code must be written in person-first language."

Page 8, line 9, replace "three" with "two"

Page 8, remove lines 19 through 31

Page 9, replace lines 1 through 13 with:

"**SECTION 25. AMENDMENT.** Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, ~~and~~ hospital- or medical clinic-based programs for medical management of withdrawal~~.~~, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

SECTION 26. AMENDMENT. Section 50-06-42 of the North Dakota Century Code is amended and reenacted as follows:

50-06-42. Substance use disorder treatment voucher system.

1. The department shall establish and administer, within the limits of legislative appropriations, a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by licensed substance abuse treatment programs, excluding regional human service centers, hospital- or medical clinic-based programs for medical management of withdrawal, and any institution for mental diseases in accordance with subsection 2.

2. The department shall deny a licensed substance abuse treatment program's substance use disorder treatment voucher system application and deny reimbursement by the substance use disorder treatment voucher system if the licensed substance abuse treatment program is an institution for mental diseases and reimbursement is requested for residential beds added on or after July 1, 2020.

3. Services eligible for the voucher program include only those levels of care recognized by the American society of addiction medicine, with particular emphasis given to underserved areas and programs. The department shall ensure that a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers collects and reports process and outcome measures. The department shall develop requirements and provide training and technical assistance to a licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers. A licensed substance abuse treatment program, hospital, and medical clinic program accepting vouchers shall provide evidence-based services.

4. The department shall allocate funding appropriated for the substance use disorder treatment voucher as follows:

   a. No more than forty-five percent of the appropriated amount may be allocated for residential substance use disorder services administered by licensed substance abuse treatment programs with more than sixteen beds.

   b. The remaining appropriation must be allocated for residential programs with sixteen or fewer beds, nonresidential outpatient, and ancillary substance use disorder services administered by licensed substance abuse treatment programs.

SECTION 27. A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Behavioral health bed management system.

The department shall establish and maintain a behavioral health bed management system to improve utilization of behavioral health bed capacity. Public and private providers of residential or inpatient behavioral health services shall participate in and report daily to the department the information and documentation necessary to maintain the behavioral health bed management system in the form and manner prescribed by the department.

SECTION 28. AMENDMENT. Section 50-11.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-11.1-14. Workforce development.

1. The department may establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

2. The department may charge reasonable fees for all training and development courses to offset costs. All fees collected under this section must be paid to the department or the department's authorized agent and must be used to defray the cost of providing training and development courses to providers and staff members of early childhood services.

SECTION 29. A new paragraph to subdivision l of subsection 1 of section 50-11.1-22 of the North Dakota Century Code, as created by section 8 of House Bill No. 1416, as approved by the sixty-seventh legislative assembly, is created and enacted as follows:

A special education director;

SECTION 30. AMENDMENT. Section 50-24.1-02.7 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-02.7. Workers with disabilities coverage.

The department shall establish and implement a buyin program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program ~~must~~:

1. ~~Be~~Must be made available to an individual with a disability who is a member of a household with a net income less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget applicable to the household size;

2. ~~Allow~~Must allow up to an additional ten thousand dollars in assets;

3. ~~Require~~Must require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;

4. ~~Include~~Must include a one-time program enrollment fee of one hundred dollars; ~~and~~

5. ~~Provide~~Must provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program; and

6. May not require the payment of a premium or enrollment fee or disenroll an individual for failure to pay a premium or enrollment fee for workers with disabilities coverage during a federally declared emergency if collection of the premium or enrollment fee may impact the receipt of federal funds.

SECTION 31. AMENDMENT. Section 50-24.1-31 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-31. Optional medical assistance for families of children with disabilities.

1. The department shall establish and implement a buyin program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. 1396] to provide medical assistance and other health coverage options to families of children with disabilities and whose net income does not exceed two hundred fifty percent of the federal poverty line published by the federal office of management and budget applicable to the household size.

2. The department may not require the payment of a premium or disenroll an individual for failure to pay a premium for families of children with disabilities coverage during a federally declared emergency if collection of the premium may impact the receipt of federal funds."

Page 9, line 16, overstrike "**Effective through**"

Page 9, line 17, overstrike "**July 31,**"

Page 9, line 17, remove "**2023**"

Page 9, line 17, overstrike "**-**"

Page 11, remove the overstrike over line 1

Page 11, line 2, remove the overstrike over "~~section is~~"

Page 11, line 4, after "~~section~~" insert "an open record"

Page 11, line 4, remove the overstrike over the overstruck period

Page 11, after line 4, insert:

"**SECTION 34.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Interpreter services.

Medical assistance coverage, including Medicaid expansion, must include payment for sign and oral language interpreter services for assistance in providing covered health care services to a recipient of medical assistance who has limited English proficiency or who has hearing loss and uses interpreting services. The department shall adopt rules to implement this section."

Page 11, after line 13, insert:

"**SECTION 37. CONVEYANCE OF LAND AUTHORIZED - LIFE SKILLS AND TRANSITION CENTER.** The state of North Dakota, by and through the department of human services, may convey real property associated with the life skills and transition center in Grafton to the Grafton fire department. The department of human services may convey a parcel of land, 7.45 acres, more or less, located in part of lot 1, block 1, state school first addition to the city of Grafton, which is located within the southwest ¼ of the southwest ¼ of section 13, township 157 north, range 53 west, on the terms and conditions determined appropriate by the department and attorney general. Sections 54-01-05.2 and 54-01-05.5 do not apply to this conveyance."

Page 11, remove lines 23 through 28

Page 12, line 3, replace "4" with "8"

Page 13, remove lines 13 through 31

Page 14, replace lines 1 through 6 with:

SECTION 48. EXEMPTION. The sum of $750,000 from the general fund appropriated to the department of human services for the purpose of providing suicide prevention grants in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation

are available for the suicide prevention grants during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 49. EXEMPTION. The sum of $3,000,000 from the general fund appropriated to the department of human services for the purpose of providing a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the community behavioral health program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 50. EXEMPTION. The sum of $335,000 from the general fund appropriated to the department of human services for the purpose of providing a grant to an entity to develop a hyperbaric oxygen therapy pilot program in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the grant to an entity to develop a hyperbaric oxygen therapy pilot program during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 51. EXEMPTION. The sum of $572,000 from the strategic investment and improvements fund appropriated to the department of human services for the purpose of a roof replacement project at the state hospital in chapter 37 of the 2019 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation are available for the completion of the roof replacement project at the state hospital during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 52. EXEMPTION. The amount appropriated for the development of the electronic visit verification project in chapter 11 of the 2017 Session Laws is not subject to the provisions of section 54-44.1-11. Any unexpended funds from this appropriation approved under section 54-44.1-11 for continuation into the 2019-21 biennium are available for the completion of the electronic visit verification project during the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 53. LEGISLATIVE INTENT - UTILIZATION RATE ADJUSTMENT. It is the intent of the sixty-seventh legislative assembly that the department of human services seek a deficiency appropriation from the sixty-eighth legislative assembly for any expenditures that exceed appropriated amounts as a result of utilization rates, nursing home costs associated with the establishment of the new rate structure as provided in House Bill No. 1090, or developmental disability provider reimbursement rate adjustments, during the biennium beginning July 1, 2021, and ending June 30, 2023, if funding is not sufficient to pay actual expenses.

SECTION 54. DEVELOPMENTAL DISABILITY PROVIDER RATES. By July 1, 2021, the department of human services, in consultation with the developmental disabilities payment steering committee, shall identify $6,950,000 in reductions to be made to payment rates for intermediate care facilities and residential services for individuals with developmental disabilities, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 55. LEGISLATIVE INTENT - STATE FISCAL RECOVERY FUND OR OTHER FUNDS - TRANSITION OF INDIVIDUALS FROM LIFE SKILLS AND TRANSITION CENTER. It is the intent of the sixty-seventh legislative assembly that the department of human services seek an appropriation during any special session of the sixty-seventh legislative assembly from the state fiscal recovery fund received through H.R. 1319 of the 117th Congress, also known as the federal American Rescue Plan Act, or from any eligible federal or other funds made available to the

department, for the purpose of transitioning individuals from the life skills and transition center to community-based providers.

SECTION 56. LEGISLATIVE INTENT - SUPPORTED EMPLOYMENT FUNDING. It is the intent of the sixty-seventh legislative assembly that funding appropriated from the general fund for supported employment in section 1 of this Act be used to continue contracts with existing evidence-based supported employment providers during the biennium beginning July 1, 2021, and ending June 30, 2023, and that any funding available through the federal Medicaid 1915(i) state plan amendment be utilized before funding appropriated from the general fund.

SECTION 57. LEGISLATIVE INTENT - CONSULTANTS. It is the intent of the sixty-seventh legislative assembly that the department of human services and state department of health utilize federal funds available to the departments to obtain consulting services to facilitate the merger of the department of human services and state department of health as provided for in House Bill No. 1247 as approved by the sixty-seventh legislative assembly for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 58. LEGISLATIVE INTENT - PROVIDER RATE INCREASE. Section 1 of this Act includes funding for human service provider inflation increases of two percent the first year and one-quarter of one percent the second year of the biennium beginning July 1, 2021, and ending June 30, 2023. It is the intent of the sixty-seventh legislative assembly that future special sessions of the sixty-seventh legislative assembly consider an additional second year inflationary increase during the 2021-23 biennium based on any extensions of the enhanced federal Medicaid assistance percentage and a review of budget needs of all areas of the department of human services.

SECTION 59. REPORT TO LEGISLATIVE MANAGEMENT - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT PROGRAM. During the 2021-22 interim, the department of human services shall conduct a study of the early and periodic screening, diagnostic, and treatment program and prepare a report. The department of human services may contract with a consultant to assist in the study and the preparation of the report. The report shall include data on the number, ages, and geographic locations of children receiving screening, diagnostic, and treatment services; the capacity of the program to ensure all children who require screening, diagnostic, and treatment services are identified and receive services; data on the disposition of referrals of children who are screened and eligible for diagnostic and treatment services, including how many receive services and how many do not receive those services by county; an assessment of the program's efforts to provide comprehensive screening and treatment for children as required by federal law; an assessment of the deficits of the program's efforts to provide comprehensive screening and treatment as required by federal law; recommendations to ensure or expand services so that all eligible children are adequately served by the program; and additional data needed to assess the program accountability and efficiency. Before October 1, 2022, the department of human services shall provide the report to the legislative management.

SECTION 60. REPORT TO LEGISLATIVE MANAGEMENT - REVISED PAYMENT METHODOLOGY FOR BASIC CARE FACILITIES. The department of human services, in collaboration with basic care providers and other representatives of the basic care industry, shall develop a report for payment methodology revisions for basic care facilities that must include recommendations for:

1. Methods of reimbursement for basic care facility cost categories, including direct care, indirect care, room and board, and property; and

2. The feasibility of standardizing payments for basic care facilities in the same peer group.

Before October 1, 2022, the department shall present the report to the legislative management regarding the revised payment methodology. The estimated costs related to the implementation of the payment methodology revisions must be included in the department's 2023-25 biennium budget request submitted to the sixty-eighth legislative assembly.

SECTION 61. LEGISLATIVE MANAGEMENT REPORT - FOUR-YEAR OLD PROGRAM - EARLY CHILDHOOD GRANTS. During the 2021 22 interim, the department of human services shall provide reports to the legislative management regarding the status of four-year old program approvals, the North Dakota early childhood council, and the early childhood grant for best in class four-year old experiences.

SECTION 62. SUBSTANCE USE DISORDER TREATMENT VOUCHERS - REPORT TO BUDGET SECTION. During the 2021-22 interim, the department of human services behavioral health division shall submit quarterly reports to the budget section on the status of the substance use disorder treatment voucher system program, including data on the utilization of the program, data on program expenditures, and an estimate of the number of months of funding remaining in the program.

SECTION 63. TRANSFER OF EMPLOYEES. The department of human services may use the identified twenty-seven full-time equivalent child care licensing positions of the human service zone transferred to the department pursuant to chapter 391 of the 2019 Session Laws for child care licensing, quality control, and early childhood administration.

SECTION 64. RETROACTIVE APPLICATION. Section 25 of this Act applies retroactively to July 1, 2020.

Page 14, line 7, replace "Section 17" with "Sections 22 and 33"

Page 14, line 7, replace "becomes" with "become"

Page 14, line 9, replace "14" with "24"

Page 14, line 11, replace "Section" with "The sum of $2,457,638 from the federal coronavirus relief fund included in subdivision 2 of section 1 for senior nutrition services, sections"

Page 14, line 11, after "3" insert ", 5, 30, 31, and 54"

Page 14, line 11, replace "is" with ", and section 22 of Senate Bill No. 2086, as approved by the sixty seventh legislative assembly, are"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:
STATEMENT OF PURPOSE OF AMENDMENT:

House Bill No. 1012 - Summary of Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Office of Management and Budget						
Total all funds	$0	$0	$25,000	$25,000	$0	$25,000

Less estimated income	0	0	25,000	25,000	0	25,000
General fund	$0	$0	$0	$0	$0	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00
Legislative Council						
Total all funds	$0	$0	$500,000	$500,000	$0	$500,000
Less estimated income	0	0	0	0	0	0
General fund	$0	$0	$500,000	$500,000	$0	$500,000
FTE	0.00	0.00	0.00	0.00	0.00	0.00
State Department of Health						
Total all funds	$0	$0	$563,430	$563,430	$563,430	$0
Less estimated income	0	0	281,715	281,715	281,715	0
General fund	$0	$0	$281,715	$281,715	$281,715	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00
DHS - Management						
Total all funds	$154,711,362	$231,188,314	$6,412,831	$237,601,145	$239,601,145	($2,000,000)
Less estimated income	90,021,088	139,928,943	1,698	139,930,641	139,930,641	0
General fund	$64,690,274	$91,259,371	$6,411,133	$97,670,504	$99,670,504	($2,000,000)
FTE	107.95	97.85	0.00	97.85	97.85	0.00
DHS - Program/Policy						
Total all funds	$3,414,166,080	$3,762,575,571	$37,040,473	$3,799,616,044	$3,820,111,004	($20,494,960)
Less estimated income	2,232,568,138	2,468,391,493	37,159,380	2,505,550,873	2,506,594,323	(1,043,450)
General fund	$1,181,597,942	$1,294,184,078	($118,907)	$1,294,065,171	$1,313,516,681	($19,451,510)
FTE	383.25	648.67	17.50	666.17	691.17	(25.00)
DHS - County Social Services Financing						
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	$0
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995	188,676,995	0
General fund	$0	$1,311,724	($71,333)	$1,240,391	$1,240,391	$0
FTE	140.00	143.00	0.00	143.00	143.00	0.00
DHS - Field Services						
Total all funds	$342,177,623	$297,544,383	$2,773,716	$300,318,099	$303,422,588	($3,104,489)
Less estimated income	127,314,955	113,944,012	329,283	114,273,295	114,273,295	0
General fund	$214,862,668	$183,600,371	$2,444,433	$186,044,804	$189,149,293	($3,104,489)
FTE	1,599.03	1,342.31	0.00	1,342.31	1,342.31	0.00
Bill total						
Total all funds	$4,084,755,065	$4,481,459,783	$47,081,321	$4,528,541,104	$4,553,615,553	($25,074,449)
Less estimated income	2,623,604,181	2,911,104,239	37,634,280	2,948,738,519	2,949,756,969	(1,018,450)
General fund	$1,461,150,884	$1,570,355,544	$9,447,041	$1,579,802,585	$1,603,858,584	($24,055,999)
FTE	2,230.23	2,231.83	17.50	2,249.33	2,274.33	(25.00)

House Bill No. 1012 - Office of Management and Budget - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
ADA consultant			$25,000	$25,000		$25,000
Total all funds	$0	$0	$25,000	$25,000	$0	$25,000
Less estimated income	0	0	25,000	25,000	0	25,000
General fund	$0	$0	$0	$0	$0	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00

Department 110 - Office of Management and Budget - Detail of Conference Committee Changes

	Adds Funding for ADA Consultant[1]	Total Conference Committee Changes
ADA consultant	$25,000	$25,000
Total all funds	$25,000	$25,000
Less estimated income	25,000	25,000
General fund	$0	$0
FTE	0.00	0.00

[1] One-time funding from the Capitol building fund is added to obtain consulting services to determine the compliance of the Capitol building with 2010 Americans with Disabilities Act standards. The House and Senate versions did not include this funding.

House Bill No. 1012 - Legislative Council - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Legislative management study			$500,000	$500,000		$500,000
Total all funds	$0	$0	$500,000	$500,000	$0	$500,000
Less estimated income	0	0	0	0	0	0
General fund	$0	$0	$500,000	$500,000	$0	$500,000
FTE	0.00	0.00	0.00	0.00	0.00	0.00

Department 160 - Legislative Council - Detail of Conference Committee Changes

	Adds Funding for Legislative Management Study[1]	Total Conference Committee Changes
Legislative management study	$500,000	$500,000
Total all funds	$500,000	$500,000
Less estimated income	0	0
General fund	$500,000	$500,000
FTE	0.00	0.00

[1] One-time funding is added for consultant costs associated with a study of the statewide acute psychiatric and residential care needs. The House and Senate versions did not include this funding.

House Bill No. 1012 - State Department of Health - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Grants			$563,430	$563,430	$563,430	
Total all funds	$0	$0	$563,430	$563,430	$563,430	$0
Less estimated income	0	0	281,715	281,715	281,715	0
General fund	$0	$0	$281,715	$281,715	$281,715	$0
FTE	0.00	0.00	0.00	0.00	0.00	0.00

Department 301 - State Department of Health - Detail of Conference Committee Changes

	Adds Funding for Task Force[1]	Total Conference Committee Changes
Grants	$563,430	$563,430
Total all funds	$563,430	$563,430
Less estimated income	281,715	281,715
General fund	$281,715	$281,715
FTE	0.00	0.00

[1] Funding is added to provide a grant to the Task Force on the Prevention of Sexual Abuse of Children for staff and programming materials focused on primary prevention activities. The Senate also added this funding.

House Bill No. 1012 - DHS - Management - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$20,222,500	$19,332,219	$7,638	$19,339,857	$19,339,857	
Operating expenses	134,438,862	211,781,095	6,405,193	218,186,288	220,186,288	($2,000,000)
Capital assets	50,000	75,000		75,000	75,000	
Total all funds	$154,711,362	$231,188,314	$6,412,831	$237,601,145	$239,601,145	($2,000,000)
Less estimated income	90,021,088	139,928,943	1,698	139,930,641	139,930,641	0
General fund	$64,690,274	$91,259,371	$6,411,133	$97,670,504	$99,670,504	($2,000,000)
FTE	107.95	97.85	0.00	97.85	97.85	0.00

Department 326 - DHS - Management - Detail of Conference Committee Changes

	Adjusts Funding for Management[1]	Total Conference Committee Changes
Salaries and wages	$7,638	$7,638
Operating expenses	6,405,193	6,405,193
Capital assets		
Total all funds	$6,412,831	$6,412,831
Less estimated income	1,698	1,698
General fund	$6,411,133	$6,411,133
FTE	0.00	0.00

[1] Funding for management is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		$5,940	$1,698	$7,638
A portion of funding reduced by the House for operating expenses is restored. The Senate restored the entire $8,405,193 reduced by the House.		6,405,193		6,405,193
Total ongoing funding changes	0.00	$6,411,133	$1,698	$6,412,831

House Bill No. 1012 - DHS - Program/Policy - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Salaries and wages	$68,994,873	$119,359,007	$3,367,122	$122,726,129	$126,777,313	($4,051,184)
Operating expenses	150,961,583	166,664,510	4,611,975	171,276,485	170,131,921	1,144,564
Capital assets	10,000	10,000		10,000	10,000	
Grants	452,041,904	461,353,354	6,093,486	467,446,840	466,005,392	1,441,448
Grants - Medical assistance	2,742,157,720	3,015,188,700	22,967,890	3,038,156,590	3,057,186,378	(19,029,788)
Total all funds	$3,414,166,080	$3,762,575,571	$37,040,473	$3,799,616,044	$3,820,111,004	($20,494,960)
Less estimated income	2,232,568,138	2,468,391,493	37,159,380	2,505,550,873	2,506,594,323	(1,043,450)
General fund	$1,181,597,942	$1,294,184,078	($118,907)	$1,294,065,171	$1,313,516,681	($19,451,510)
FTE	383.25	648.67	17.50	666.17	691.17	(25.00)

Department 328 - DHS - Program/Policy - Detail of Conference Committee Changes

	Adjusts Funding for Program and Policy[1]	Total Conference Committee Changes
Salaries and wages	$3,367,122	$3,367,122
Operating expenses	4,611,975	4,611,975
Capital assets		
Grants	6,093,486	6,093,486
Grants - Medical assistance	22,967,890	22,967,890
Total all funds	$37,040,473	$37,040,473
Less estimated income	37,159,380	37,159,380
General fund	($118,907)	($118,907)
FTE	17.50	17.50

[1] Funding for Program and Policy is adjusted as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Provides salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($3,512)	($24,341)	($27,853)
Adjusts provider inflation funding to provide a 2.0 percent increase the 1st year of the biennium and a 0.25 percent increase the 2nd year of the biennium. The House provided 1.0 percent annual inflationary increases. The Senate provided a 1.5 percent increase the 1st year of the biennium and a 2.0 percent increase the 2nd year of the biennium.		5,520,484	5,863,322	11,383,806
Adds funding and FTE positions for refugee resettlement services. The positions and funding were also added by the Senate.	4.00		4,337,408	4,337,408
Economic Assistance				
Adds 1 FTE specialty eligibility position. The Senate also added this position.	1.00	43,639	130,917	174,556
Child Support				
Adds FTE positions and funding for duties being transferred from the judicial branch to Child Support. The Senate also added the funding and FTE positions.	3.50	308,126	209,662	517,788

Medical Services				
Increases funding from the community health trust fund to $31.5 million and reduces funding from the general fund. The House and Senate versions included $24 million from the community health trust fund.		(7,500,000)	7,500,000	0
Adds funding to allow interpreter services to be covered by Medicaid, the same as the Senate.		249,600	249,600	499,200
Adds funding for the costs to provide Medicaid coverage for continuous glucose monitoring devices as provided in House Bill No. 1288. The Senate also added this funding.		479,585	1,297,885	1,777,470
Adjusts funding based on changes to the tribal health care coordination fund in House Bill No. 1407, the same as the Senate.			7,181,628	7,181,628
Adds funding for costs to provide Medicaid coverage of metabolic supplements as provided in Senate Bill No. 2224. The Senate also added this funding.		9,300	10,700	20,000
Long-Term Care				
Adjusts funding based on updated estimates regarding funding needed to provide services resulting from a federal Department of Justice lawsuit settlement agreement, the same as the Senate.		(619,550)	(712,824)	(1,332,374)
Transfers $300,000 of funding from the autism waiver program to the autism voucher program, the same as the Senate.				0
Aging Services				
Increases funding for dementia services grants to provide a total of $1.3 million, the same as the Senate.		268,000		268,000
Funding is added from the federal Coronavirus Relief Fund for senior nutrition services. The House and Senate did not add this funding.			2,457,638	2,457,638
Adjusts funding for senior nutrition programs.		(1,000,000)		(1,000,000)
Children and Family Services				
Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment, the same as the Senate.		26,250		26,250
Adjusts funding for a new early childhood program to provide a portion of funding from federal funds received by the Department of Public Instruction, the same as the Senate.		(3,958,910)	3,958,910	0
Delays the realignment of therapeutic foster care targeted case management rates, the same as the Senate.		549,585	632,319	1,181,904
Adds funding for regulatory duties of child care and early childhood programs. The Senate version included 33 FTE positions for the regulation and delivery of early childhood programs.	8.00	430,000	150,000	580,000
Behavioral Health Division				

Restores funding for parent-to-parent support groups reduced as part of the 1915i realignment, the same as the Senate.		5,625		5,625
Increases funding for substance use disorder vouchers to $15 million and reduces substance use disorder grant funding to $2 million. The House increased funding for the vouchers from $8 million to $12 million and the Senate increased funding from $8 million to $17 million. Both the House and Senate provided $3 million for substance use disorder grants.		2,000,000		2,000,000
Adds 1 FTE grants and funding position. The Senate also added this position.	1.00	171,455		171,455
Adds funding from the federal Coronavirus Relief Fund for the community behavioral health program. The House and Senate versions did not include this funding.			1,750,000	1,750,000
Developmental Disabilities				
Restores a portion of funding for small agency accreditation costs removed in the agency savings plan to provide a total of $100,000, the same as the Senate. The House restored $25,000 of funding.		75,000		75,000
Adds funding for the experienced parent program. The Senate also added this funding.		260,000		260,000
Restores funding removed in agency savings plan for Section 11 supported housing and employment, the same as the Senate.		373,261		373,261
Increases corporate guardianship slots by 10 to provide for total slots of 499. The Senate also added the slots.		98,311		98,311
Restores a portion of funding removed in agency savings plan for recreational and leisure services grants, the same as the Senate.		150,000		150,000
Adjusts funding for crisis beds to reflect updated budget estimates, the same as the Senate.		(30,156)	116,556	86,400
Restores a portion of funding reduced in the agency savings plan for adjustments to provider rates. The Senate restored the entire amount of $11,150,000, of which $5,240,000 is from the general fund.		2,000,000	2,200,000	4,200,000
Total ongoing funding changes	17.50	$93,907	$37,309,380	$37,215,473
One-Time Funding Items:				
Removes funding added by the House for a study of the use of an administrative services organization for Medicaid Expansion behavioral health services. The Senate also removed this funding.		($150,000)	($150,000)	($300,000)
Adds one-time funding to provide emergency stabilization grants to developmental disability providers. The Senate also added this funding.		125,000		125,000
Total one-time funding items		($25,000)	($150,000)	($175,000)
Total changes to House	17.50	$118,907	$37,159,380	$37,040,473

House Bill No. 1012 - DHS - County Social Services Financing - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
County social services	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	
Total all funds	$173,700,000	$190,151,515	($234,129)	$189,917,386	$189,917,386	$0
Less estimated income	173,700,000	188,839,791	(162,796)	188,676,995	188,676,995	0
General fund	$0	$1,311,724	($71,333)	$1,240,391	$1,240,391	$0
FTE	140.00	143.00	0.00	143.00	143.00	0.00

Department 333 - DHS - County Social Services Financing - Detail of Conference Committee Changes

	Adjusts Funding for Salaries and Wages[1]	Total Conference Committee Changes
County social services	($234,129)	($234,129)
Total all funds	($234,129)	($234,129)
Less estimated income	(162,796)	(162,796)
General fund	($71,333)	($71,333)
FTE	0.00	0.00

[1] Funding is adjusted to provide salary increases of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary increases of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250. The adjustments are made as follows:

	General Fund	Other Funds	Total
DHS employees	($71,333)	$762	($70,571)
County employees		(163,558)	(163,558)
Total	($71,333)	($162,796)	($234,129)

House Bill No. 1012 - DHS - Field Services - Conference Committee Action

	Base Budget	House Version	Conference Committee Changes	Conference Committee Version	Senate Version	Comparison to Senate
Human service centers	$204,701,143	$166,926,620	$2,857,406	$169,784,026	$169,888,515	($104,489)
Institutions	137,476,480	130,617,763	(83,690)	130,534,073	133,534,073	(3,000,000)
Total all funds	$342,177,623	$297,544,383	$2,773,716	$300,318,099	$303,422,588	($3,104,489)
Less estimated income	127,314,955	113,944,012	329,283	114,273,295	114,273,295	0
General fund	$214,862,668	$183,600,371	$2,444,433	$186,044,804	$189,149,293	($3,104,489)
FTE	1,599.03	1,342.31	0.00	1,342.31	1,342.31	0.00

Department 349 - DHS - Field Services - Detail of Conference Committee Changes

	Adjusts Funding for Field Services[1]	Total Conference Committee Changes
Human service centers	$2,857,406	$2,857,406
Institutions	(83,690)	(83,690)
Total all funds	$2,773,716	$2,773,716
Less estimated income	329,283	329,283
General fund	$2,444,433	$2,444,433
FTE	0.00	0.00

[1] Funding is adjusted for Field Services as follows:

2021-23 Ongoing Funding Changes	FTE Positions	General Fund	Other Funds	Total
Funding is adjusted to provide salary adjustments of 1.5 percent on July 1, 2021, with a minimum monthly increase of $100, and 2 percent on July 1, 2022, the same as the Senate. The House provided salary adjustments of 1.5 percent on July 1, 2021, and July 1, 2022, with a minimum monthly increase of $100 and a maximum monthly increase of $250.		($146,283)	$22,582	($123,701)
Funding for provider inflation is adjusted to provide a 2.0 percent increase the 1st year of the biennium and a 0.25 percent increase the 2nd year of the biennium. The Senate provided a 1.5 percent increase the 1st year of the biennium and a 2.0 percent increase the 2nd year of the biennium. The House provide 1.0 percent annual inflationary increases.		167,854		167,854
Human Service Centers				
A portion of funding for supportive housing grants reduced as part of the 1915i realignment is restored. The Senate restored funding of $1.7 million.		1,747,086		1,747,086
Rent expenses removed in the agency savings plan for the Northeast Human Service Center are restored, the same as the Senate.		168,736		168,736
Institutions				
Funding for psychiatrist transition costs at the Life Skills and Transition Center is increased to $183,040, the same as the Senate. The House provided funding of $100,000 for transition costs.		83,040		83,040
Funding authority is added for adaptive equipment at the Life Skills and Transition Center, the same as the Senate.			306,701	306,701
Total ongoing funding changes	0.00	$2,020,433	$329,283	$2,349,716
One-Time Funding Items				
Funding for a State Hospital study is removed and instead appropriated to the Legislative Council for a Legislative Management study. The House provided $300,000 for a DHS study of the State Hospital complex and the Senate provided $3 million for architectural reviews and the development of detailed plans for the construction of a new State Hospital.		($300,000)		($300,000)
One-time funding is added for heat pump and carpet replacement projects at the Southeast Human Service Center, the same as the Senate.		724,000		724,000
Total one-time funding changes	0.00	$424,000	$0	$424,000
Total changes to House funding	0.00	$2,444,433	$329,283	$2,773,716

House Bill No. 1012 - Other Changes - Conference Committee Action

This amendment also:

- Adjusts the amount of funding being provided from the human service finance fund for the county social and human services program, the same as the Senate.

- Provides that DHS develop a funding methodology to distribute permanent supportive housing grants, the same as the Senate.
- Adds a section to provide for an emergency grant allocation program for developmental disabilities providers and removes a section relating to DHS applying for an Appendix K waiver. Neither the House nor Senate versions included this adjustment.
- Adjusts a section added by the Senate for DHS to work with applicable federal and private partners to resettle new refugees in communities in the state where resettlement efforts are not already occurring.
- Provides legislative intent regarding DHS seeking funding to transition individuals from the Life Skills and Transition Center to private providers. The Senate included funding to transfer individuals to providers.
- Provides legislative intent regarding future appropriations for the federal Department of Justice lawsuit settlement, the same as the Senate.
- Provides for certain substance use disorder providers to be reimbursed at similar levels, provides for a moratorium on new substance use disorder residential providers, and provides for no more than 45 percent of substance use disorder vouchers be allocated for residential substance use disorder services administered by programs with more than 16 beds. The House provided for a limit of 30 percent of substance use disorder voucher may be used for residential services and the Senate increased the limit to 50 percent.
- Adds a section to authorize DHS to collect fees for early childhood services training and development courses, the same as the Senate.
- Removes the sunset clause on the Medicaid Expansion program and adjusts language regarding provider reimbursement rates being open records, the same as the Senate. The House extended the expiration date by 2 years.
- Adds a section to provide for interpreter services to be covered under the Medicaid program, the same as the Senate.
- Provides for DHS to establish a behavioral health bed management system, the same as the Senate.
- Authorizes the conveyance of land at the Life Skills and Transition Center to the Grafton Fire Department. The Senate also authorized this conveyance.
- Authorizes exemptions to continue appropriation authority into the 2021-23 biennium. The exemptions will reduce general fund turnback by $4,085,000. The Senate also authorized the exemptions.
- Provides for DHS to conduct a study of the early and periodic screening, diagnostic, and treatment program, the same as the Senate.
- Removes a section providing for a DHS study of using an administrative services organization for behavioral health services in the Medicaid Expansion program. The Senate also added this section.
- Adjusts a section added by the Senate for DHS to develop a new payment methodology for basic care facilities in collaboration with the basic care industry.
- Provides for a DHS report to the Legislative Management regarding the early childhood 4-year old grant program. The Senate also added this report.
- Authorizes positions for child care licensing to be used for other purposes, the same as the Senate.
- Adds a section not included in the House or Senate versions to use person-first language in statute.
- Adds two sections not included in the House or Senate versions to prohibit the disenrollment of individuals in certain programs during federal emergencies if it would affect the receipt of federal funds. The sections are declared to be an emergency measure.
- Adds a section not included in the House or Senate versions to provide for DHS to reduce developmental disability provider rates by $6.95 million for the 2021-23

biennium.

- Adds a section not included in the House or Senate versions to require DHS to submit quarterly reports to the Budget Section regarding substance use disorder treatment vouchers.
- Adds a section not included in the House or Senate versions to provide for DHS appropriation authority to transition to the Department of Health and Human Services on September 1, 2022, as provided in House Bill No. 1247.
- Adds a section not included in the House or Senate versions to prohibit DHS from spending any general fund savings resulting from federal enhancements to the federal medical assistance percentage above budgeted rates.
- Adds a section not included in the House or Senate versions to provide guidelines for supported employer funding.
- Adds a section not included in the House or Senate versions to transfer DHS appropriation authority to the Department of Health and Human Services on September 1, 2022.
- Adds a section not included in the House or Senate versions to provide intent that DHS and the State Department of Health utilize consulting services to facilitate the merger of the departments.
- Adds a section not included in the House or Senate versions to provide intent that future special sessions of the 67th Legislative Assembly consider providing an additional inflationary increase the 2nd year of the 2021-23 biennium.

Engrossed HB 1012 was placed on the Seventh order of business on the calendar.