2026 JOINT APPROPRIATIONS

HB 1623

2026 JOINT STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1623
1/21/2026

A BILL for an Act to provide an appropriation to the department of health and human services for federal rural health transformation program grant funds; to provide an exemption; to provide for application; to provide a report; and to provide an effective date.

10:46 a.m. Co-Chairman Vigesaa called the meeting to order.

Members present: Co-Chairman Vigesaa, Representatives: Anderson, Berg, Bosch, Brandenburg, Fisher, Ista, Kempenich, Louser, Martinson, Meier, Mitskog, Monson, Murphy, Nathe, Nelson, Pyle, Richter, Sanford, Stemen, Swiontek, Wagner, Warrey, Co-Chairman Bekkedahl, Senators: Burckhard, Cleary, Conley, Davison, Dever, Dwyer, Erbele, Magrum, Mathern, Meyer, Schaible, Sickler, Sorvaag, Thomas, Wanzek

Discussion Topics:

- Big Beautiful Bill
- ND Rural Health Transformation Program
- Care Closer to Home
- Connecting Technical Equipment and Data
- Recruitment and Retention Workforce
- Electronic Healthcare System
- Reimbursable Grants
- Critical Access Hospitals
- Tribal Liaison
- Make ND Healthy Again
- Dental Care
- Eye Care
- Training Pipelines
- Remote Patient Monitoring
- Gyms
- Suicidal Thoughts
- Mental Health Issues
- ND Moves Together
- Hospice

10:49 a.m. Senator Bekkedahl introduced the bill.

11:07 a.m. Brady Larson, Legislative Council, provided an overview of the bill.

11:11 a.m. Patrick Traynor, Interim Commissioner, North Dakota Health and Human Services, testified neutral and submitted testimony #45433.

11:45 a.m. Sherry Adams, North Dakota's State Health Officer, testified in favor.

11:59 a.m. Carlotta McCleary, Mental Health Advocacy Network, testified in favor and submitted testimony #45405.

12:11 p.m. Tracee Capron, Executive Director, Hearts in Action (HIA) Health, testified in favor and submitted testimony #45399.

12:26 p.m. John Nagel, BEK Communications, Cyber Security Division, testified in favor.

Additional written testimony:

Janelle Moos, Associate State Director Advocacy, AARP, submitted testimony in favor #45392.

Marisa Sauceda, Disaster Legal Services Program Manager and Staff Attorney, Legal Services of North Dakota, submitted neutral testimony #45395, #45396.

Stephanie Nelson, Chief Executive Officer, Anne Carlson submitted testimony in favor #45400.

Ann Prifrel, Chief Executive Officer, Great Plains Food Bank, submitted testimony in favor #45416.

Mark Rostad, Medical Director, Hearts in Action (HIA) Health, submitted testimony in favor #45432.

Lance Gaebe, Policy Strategist, North Dakota Farmers Union, submitted testimony in favor #45436.

12:29 p.m. Co-Chairman Vigesaa closed the meeting.

Krystal Eberle, Committee Clerk

House Bill 1623 – Support
January 20, 2026
Joint Appropriations Committee
Janelle Moos, AARP ND- jmoos@aarp.org

Chairman and Members of the Joint Appropriations Committee,

My name is Janelle Moos, Advocacy Director with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. 83,000 of those members live in North Dakota.

Almost one in five Americans reside in rural areas. Residents in rural communities face significant health disparities, and worse health outcomes, across numerous measures and conditions, when compared to urban areas. Lack of access to services is a driver of these disparities. Residents of rural areas also face longer drives to hospitals, as well as hospital closures that leave communities without essential services. All these challenges hit older North Dakotans especially hard as many do not have the mobility, technology, or financial means to obtain care elsewhere. Addressing health care disparities in rural and underserved areas will require a multifaceted approach, and we appreciate you seeking feedback in a variety of areas, related to rural health care.

Our comments focus on health care provider access, which we believe has the most direct and immediate impact on older North Dakotans as outlined in ND's Rural Health Transformation grant program application/budget and in HB 1623.

Health Care Workforce

Family Caregivers

Policies that focus on revitalizing the health care workforce can improve patient access to care. AARP believes that when someone needs care, there needs to be someone to take care of them. Often, a family caregiver is the first and closest point of contact in providing care. Family caregivers are the backbone of the care system in this country, helping older adults, people with disabilities, and veterans live independently in their homes and communities. The physical, emotional, and financial challenges they face in their caregiving roles cannot be overstated, exemplified by a poll released by AARP earlier this year on family caregivers. Millions of family caregivers provide $600 billion annually in unpaid labor to their loved ones. This includes assisting with daily activities such as eating, bathing, dressing, meal preparation, finding and coordinating care, managing medications, transportation to medical and other appointments, performing complex medical/nursing tasks, supporting their loved one through care transitions such as from hospital to home, managing finances, and so much more. The assistance they provide saves taxpayers billions of dollars, by helping to delay or prevent more costly nursing home care

and unnecessary hospital stays. Without them, America's health and long-term care systems would collapse.

However, too often, family caregivers do not get the support, including education and training, that they need to take care of the person they are assisting.

Six in ten family caregivers are also balancing outside employment with caregiving responsibilities. Typical caregivers of someone who lives in a rural area have lower education and household income than caregivers of those living in a suburban or urban area. Caregivers of someone living in a rural area typically do not live in a rural area themselves. Caregivers of rural-living recipients more often report high levels of financial strain and have experienced a greater number of financial impacts due to caregiving. Family caregivers on average spend over $7,200 annually in out-of-pocket caregiving expenses. Caregivers of rural-living recipients more often have difficulty taking care of their own health and less often report having health insurance.

We urge the committee to support family caregivers by offering meaningful assistance through the Rural Health Transformation program. This includes financial relief, access to respite care for temporary breaks, and education and training to help caregivers navigate their responsibilities. Additionally, caregivers need help locating essential resources. It is critical to make both caregiving and the search for paid care more manageable. These efforts will help reduce the economic and emotional burdens associated with caregiving and promote the overall health and well-being of family caregivers.

Direct Care Workers

AARP also notes that most individuals want to live in their own homes and not in a nursing home. In a 2021 AARP survey, three-fourths of adults age 50-plus told us they wish to remain in their current homes and communities for as long as possible. Older adults need more options for getting care at home, which is also generally more cost-effective. Investing in home care will help individuals get the services and support they need, where, when, and how they need them. As noted previously, family caregivers assist their older parents, spouses, siblings, grandparents, and other loved ones so they can live independently in their homes. When family caregivers are not available or cannot provide all the assistance individuals need, the paid direct care workforce are important partners and provide critical support.

Health Care Access

Telehealth

Telehealth can play an integral part in health care delivery. Not only does telehealth provide protection from exposure to infection and allows patients to receive care without putting themselves or their providers at increased health risk, it also has great potential to enhance access to quality care in rural and underserved areas. Telehealth can benefit older adults by reducing or eliminating travel and wait times, distance and transportation barriers, and certain travel or transportation costs. Access to telehealth can also improve independence and autonomy. Telehealth benefits can be particularly significant for older adults in rural areas or underserved communities. These individuals face added

barriers to care and may have to travel further, or incur additional costs, when visiting providers and specialists. In some cases, a

specialist or provider may be so far away that the distance is prohibitive, in which case the person may forgo care altogether.

AARP ND thanks the Committee and the staff from the ND Department of Health and Human Services for examining health care delivery in rural and underserved areas and the transparency in how the money will be spent and allocated, as well as accepting consumer input throughout the process.

Connecting and investing in the health of residents living in rural communities is critical. The Rural Health Transformation grant supports many of the same priorities AARP has, including improving the health, safety and independence of rural North Dakotans. We think HB 1623 is an important step forward in helping older North Dakotans remain in their communities as they age, therefore, we urge you to support the bill.

Thank you.

LSND
Legal Services of North Dakota

LSC America's Partner for Equal Justice
LEGAL SERVICES CORPORATION

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Medical-Legal Partnerships & Disaster Legal Services

Legal Services of North Dakota

Informational Testimony

HB 1623

January 21, 2026

Chairmen Bekkedahl and Committee Members,

Thank you for the opportunity to provide information about the intersection of legal services and health and human services, and thank you for your dedication to rural health.

Legal Services of North Dakota is a 501(c)(3) non-profit with a mission to compassionately and respectfully address the legal needs of vulnerable populations to provide timely access to justice, while empowering our community with education and knowledge. We are eager to share our knowledge with you today as you make appropriations for rural health grant funding. This testimony will provide an overview of two legal services programs that improve health outcomes, especially in rural areas: Medical-Legal Partnerships and Disaster Legal Services.

Medical-Legal Partnerships are Human Services programs that provide an avenue to legal referrals for healthcare patients with legal needs that are exacerbating health issues. At LSND, we regularly see how civil legal issues intersect with health outcomes for rural residents, particularly around housing stability, domestic violence, benefits access, consumer debt, and family law. These issues often surface alongside health challenges and, when left unaddressed, create ongoing barriers to treatment, recovery, and stability.

While LSND does not currently have a formally funded Medical-Legal Partnership program, we are already engaging in informal MLP-type collaboration with health care providers across the state. One example is our work with Community Medical Services, where legal issues arise alongside opioid use disorder treatment, an area that is understandably receiving significant attention and investment in North Dakota. In these settings, legal problem-solving supports patient stability and helps reduce disruptions that can undermine recovery and care plans.

As the state explores rural health transformation in a holistic way, we wanted to flag Medical-Legal Partnerships as one model other states have used to address social and legal determinants of health, particularly in rural and frontier communities. These models focus on early identification, education, and coordination rather than litigation, and they often build on relationships that already exist between health systems and community-based providers.

LSND already operates statewide, including in many rural counties, and works closely with clinics, shelters, and social service organizations. These partnerships are also beneficial when administering our Disaster Legal Services program. Disaster Legal Services is a public health program that addresses the legal needs of disaster survivors related to housing, public benefits, consumer protection, and family law.

LSND's Disaster Legal Services Program has been working to improve the disaster safety net in the state by providing information to disaster relief organizations, offering a forum for organizations to connect, and reviving the statewide disaster relief coordination non-profit VOAD – Voluntary Organizations Active in Disaster. Disaster response is an essential component of public health because prolonged disaster recovery and unaddressed disaster issues - such as an insurance claim denial that delays repair of disaster caused housing damage like standing water, which causes mold – can force disaster survivors into unhealthy circumstances.

Legal Services has achieved many successes related to disaster relief and public health. LSND worked with First District Public Health in Minot to provide feedback on family resource centers for airplane crash victims and educate First District about the legal responsibilities of airlines following a crash; Disaster Legal Services team members at LSND have collaborated with the North Dakota Department of Health and Human Services to prepare the newly revived VOAD for disaster relief coordination; and LSND offers monthly Town Halls that include important updates related to public health policy, resources, and needs.

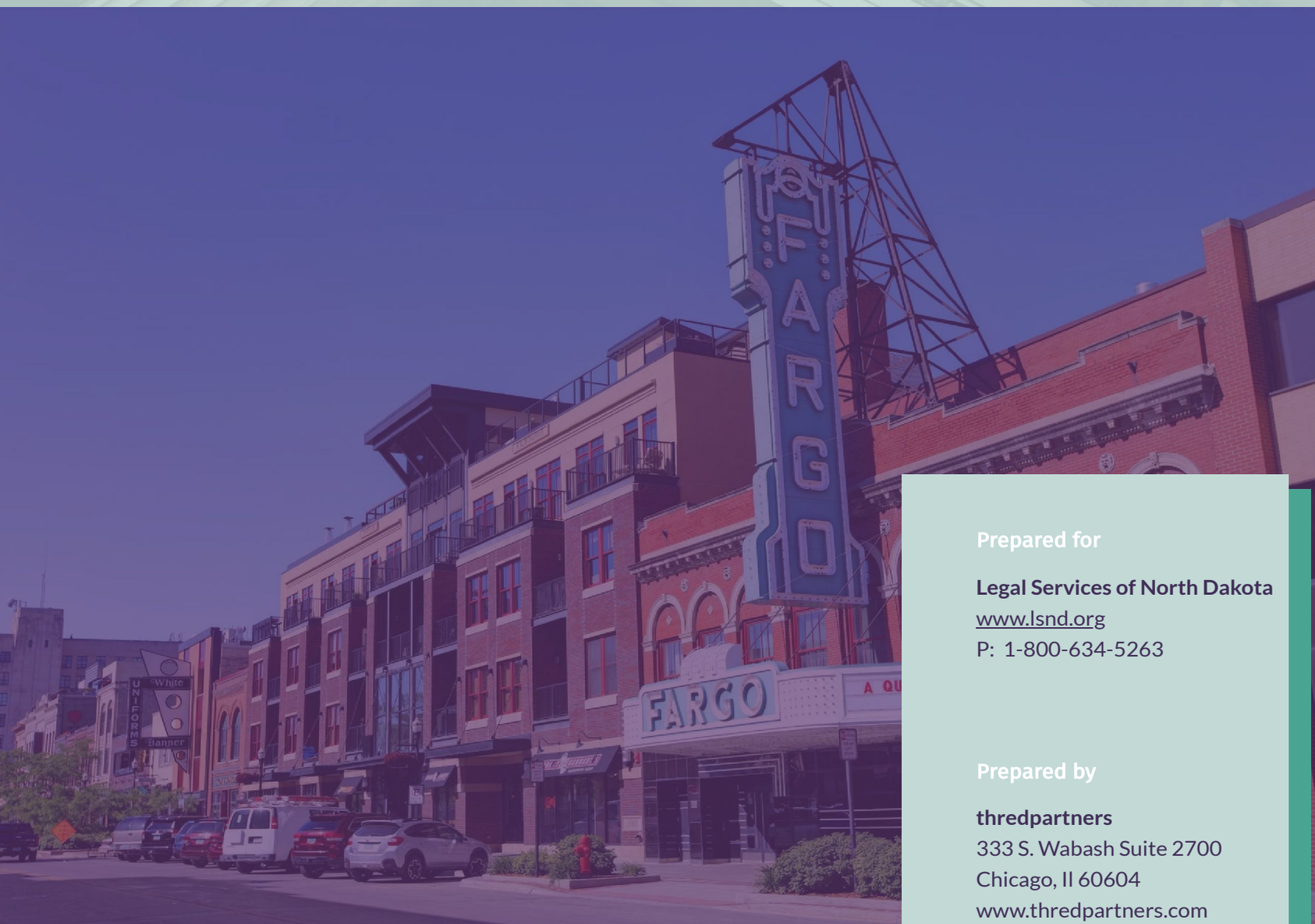
Additional information about Legal Services of North Dakota and the legal needs of North Dakotans are included materials with this testimony.

Thank you again for the opportunity to share how our work positively impacts rural health in North Dakota. We look forward to answering your questions and providing more information as needed.

Jen Lee
Executive Director
Jlee@lsnd.org

Legal Services of North Dakota

2024 Legal Needs Assessment Report



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Executive Summary & Key Take Aways

Legal Services of North Dakota (LSND) conducted a comprehensive Community Legal Needs Assessment from August to December 2024, employing an inclusive approach to engage diverse stakeholders.

We engaged stakeholders from various regions of North Dakota served by LSND focusing on those in need of legal services, those who provide legal services, and those who partner with LSND and the clients they serve. The assessment utilized data from an electronic (online) survey, one-on-one interviews, and insights from focus groups. Targeted surveys were deployed to clients, community members, community partners, and legal service providers. The surveys and interviews aimed to identify and understand the legal needs of low-income individuals and families, along with the legal aid barriers, facilitators, and motivators encountered by those in need, those who provide, and those who partner.

These stakeholders included community members, partner organizations, and legal professionals. Their contributions will play a pivotal role in shaping LSND's strategic direction and addressing critical barriers to justice by:

- Identifying key legal service gaps and underserved populations.
- Highlighting systemic barriers to accessing justice, including cost, awareness, and geographic challenges.
- Elevating the voices of vulnerable communities to inform LSND's priorities.
- Generating actionable insights to guide programmatic, outreach, and capacity-building efforts.

The assessment provides a robust foundation for decision-making. This report encompasses detailed findings, including demographic profiles, participant feedback, and analysis of legal needs and barriers.

'[I] Was evicted and have a no trespass order, but I own the trailer and am being stopped from taking care of it and retrieving my belongings'

~ Survey Participant

Rural Barriers to Justice: North Dakota's rural nature poses significant challenges to accessing legal aid, particularly for elderly residents, low-income families, and those without reliable transportation. Financial eligibility criteria exclude many who cannot afford private attorneys, creating a justice gap for individuals ineligible for traditional legal aid services.

Concentration of Legal Issues in Housing and Family Law: Family-related issues (custody, domestic abuse, divorce) and housing instability dominate legal needs, mirroring LSND's recent case data. Women and low-income households appear to disproportionately experience multiple legal challenges, underscoring the need for targeted legal representation and advocacy.

Veteran-Specific Barriers to Justice: North Dakota's veterans, 6.6% of the adult population, face unique legal challenges, including housing instability, employment discrimination, and difficulty accessing mental health care. High rates of PTSD, depression, and substance abuse further amplify these needs. Expanding LSND's partnerships with veteran-focused organizations and providing specialized legal clinics can bridge the justice gap and address critical unmet needs.

Barriers to Justice for Immigrants: North Dakota's growing immigrant population faces significant legal challenges, including wage theft, housing discrimination, and family reunification. While federally funded legal aid cannot assist with most immigration status cases, it can address other critical civil legal issues affecting documented immigrants, such as employment rights, landlord-tenant disputes, and access to public benefits. Enhancing LSND's multilingual resources, community outreach, and partnerships with immigrant advocacy organizations can bridge gaps and improve legal support for this population.

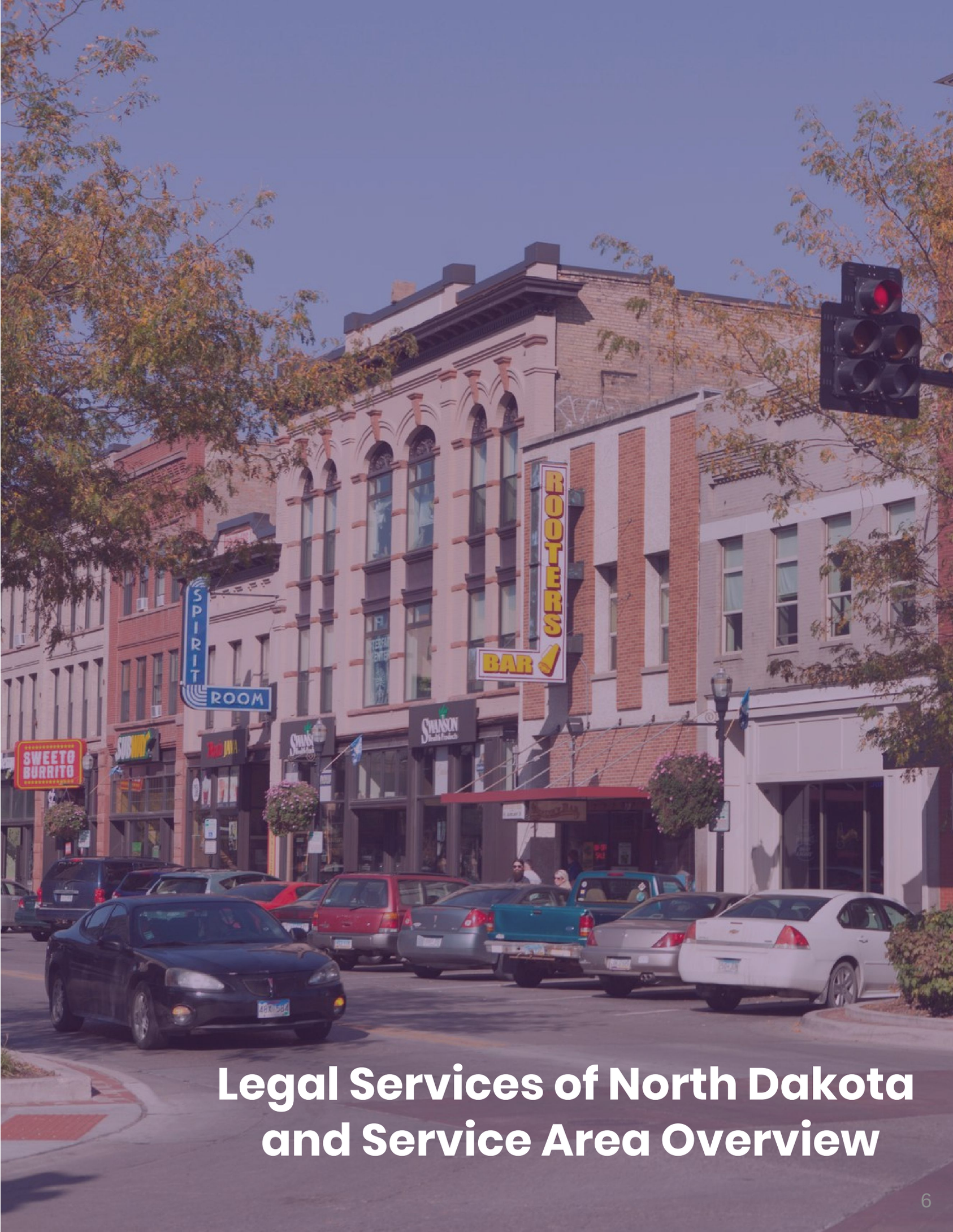
The Impact of Poverty and Defining "How Many Poor is Too Many": Poverty in North Dakota is particularly severe in rural areas, where limited resources and geographic isolation exacerbate legal and economic challenges. Approximately 24% of households are classified as Asset Limited, Income Constrained, Employed (ALICE), meaning they struggle to meet basic needs despite being employed. These households often fall into the justice gap, unable to qualify for legal aid yet lacking the resources to afford private legal representation.

This gap leads to cascading issues such as eviction, debt collection, and other legal problems that further entrench poverty. Addressing these challenges requires expanding legal aid services, increasing rural outreach, and fostering partnerships to tackle the compounded burdens North Dakota's underserved communities face.

Digital Equity and Access to Justice: While North Dakota leads in broadband access, digital literacy and access to affordable devices remain barriers for vulnerable populations. Expanding virtual legal services, remote consultations, and public access to technology can bridge gaps and improve

I**nterconnected Legal and Social Challenges:** Legal issues often overlap with broader social challenges, including mental health, economic instability, and lack of housing. Strengthening partnerships and referral systems with non-legal service providers can enhance holistic support for individuals in crisis.

Natural Disaster Preparedness: North Dakota's climate disasters have doubled in frequency, with 24 major events since 1980 causing over $1 billion in losses. Low-income, rural, elderly, and Native American communities face the greatest risks due to limited resources, infrastructure, and emergency response access. Severe winter storms, flooding, and wildfires further threaten these populations, underscoring the urgent need for targeted preparedness, resource allocation, and legal aid access.



Legal Services of North Dakota and Service Area Overview

Population

North Dakota is a predominantly rural state with a population of approximately 780,000 people , spread across an expansive area of about 70,000 square miles, resulting in a low population density of roughly 11.4 people per square mile . While urban centers such as Fargo, Bismarck, Grand Forks, and Minot serve as hubs of economic and social activity, a significant portion of the population resides in small towns and rural communities. This vast geography and dispersed population present unique challenges in ensuring equitable access to services, particularly in remote regions.

Demographic Composition

The state's demographic makeup is predominantly White, accounting for approximately 83.89% of the population . Other racial and ethnic groups include:

- Native American: 4.48%
- Black or African American: 3.23%
- Asian: 1.35%
- Hispanic or Latino (of any race): 5.0%

The median age in North Dakota is 35.7 years, reflecting a relatively young population.

Economic Landscape

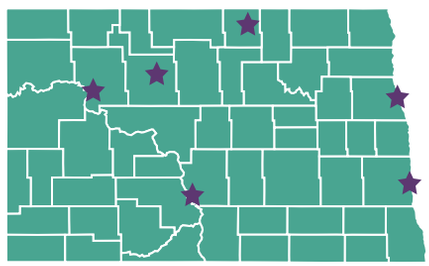
North Dakota's economy is diverse, with several key industries driving growth:

- Energy Sector: The state is a significant producer of oil and natural gas, particularly from the Bakken Formation, making it the third-largest oil-producing state in the U.S. The mining, quarrying, and oil and gas extraction industry contributed approximately $10.63 billion to the state's GDP in 2023.
- Agriculture: Agriculture remains a cornerstone of North Dakota's economy. The state leads the nation in the production of spring wheat and sunflowers and has been the top honey-producing state for 19 consecutive years.
- Manufacturing and Technology: Emerging sectors such as unmanned aerial systems (UAS), advanced manufacturing, and technology are gaining prominence, supported by initiatives like Innovate ND, which provides resources to turn innovative ideas into profitable businesses.

Despite the robust economic indicators, including a low unemployment rate of 2.5%, the state's rural nature means that many residents in isolated areas face systemic barriers to accessing essential services, including legal assistance.

Legal Services of North Dakota

Legal Services of North Dakota (LSND) provides free civil legal assistance to the state's most vulnerable populations, ensuring access to justice regardless of income or geography. LSND serves communities statewide, focusing on areas highly vulnerable to systemic barriers, including rural regions where geographic isolation and limited resources compound access challenges. This Legal Needs Assessment aims to identify unmet civil legal needs across the state, with special attention to the populations and areas most affected by economic hardship, isolation, and systemic inequities.



Social Vulnerability Index (SVI)

'[I] Was evicted and have a no trespass order, but I own the trailer and am being stopped from taking care of it and retrieving my belongings'

~ Survey Participant

The Social Vulnerability Index (SVI) was developed by the Centers for Disease Control and Prevention (CDC) in 2011 to assess the resilience of communities when confronted with external stresses on human health, such as natural disasters or disease outbreaks.

The SVI evaluates communities based on 15 social factors, grouped into four themes:

Socioeconomic Status: Includes variables like income, employment, and education.

Household Composition & Disability: Considers factors such as age, disability status, and single-parent households.

Minority Status & Language: Assesses minority populations and English proficiency.

Housing Type & Transportation: Evaluates housing structures, crowding, and access to transportation.

Each county receives rankings for these themes, as well as an overall SVI score, which ranges from 0 (least vulnerable) to 1 (most vulnerable). These scores are used to guide the allocation of resources, emergency response planning, and service support strategies.

The 2022 Social Vulnerability Index (SVI) highlights significant disparities in social vulnerability across North Dakota. Counties with the greatest vulnerability remained consistent when controlling for population size, while the top ten list of counties with lower vulnerability shifted. This finding could indicate that high social vulnerability in North Dakota is concentrated in specific areas irrespective of population size, particularly in counties like Sioux, Rolette, and Benson. These counties are characterized by a combination of high levels of poverty, minority status (including significant Indigenous populations), and language barriers, as well as other socioeconomic challenges.

The limited shift in counties with lower vulnerability when controlling for population size suggests that sparsely populated counties (e.g., Slope and Billings) may have low vulnerability scores largely due to their small and less diverse populations. However, counties with slightly larger populations (greater than 2,500) are more likely to reflect a broader range of social and economic conditions, leading to slightly higher vulnerability scores.

Social Vulnerability Index (SVI)

In the 2022 SVI, North Dakota's counties exhibit varying levels of social vulnerability. The table below summarizes the SVI for the ten lowest counties in North Dakota.

COUNTY	ESTIMATED TOTAL POP	COUNTY SIZE (SQ MI)	OVERALL VULNERABILITY SCORE	SOCIO-ECONOMIC STATUS	HOUSEHOLD COMP-OSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORT-ATION
Benson County	5960	1389	0.74	0.41	0.86	0.92	0.81
Dunn County	4049	2008	0.41	0.20	0.58	0.55	0.59
Eddy County	2345	630	0.41	0.21	0.56	0.27	0.73
McKenzie County	14081	2760	0.47	0.34	0.11	0.60	0.87
Mountrail County	9648	1825	0.72	0.43	0.79	0.81	0.81
Ramsey County	11613	1185	0.47	0.22	0.58	0.50	0.77
Rolette County	12292	903	0.89	0.84	0.68	0.99	0.89
Sioux County	3896	1094	0.92	0.96	0.62	0.99	0.81
Stutsman County	21609	2222	0.48	0.48	0.22	0.25	0.67
Williams County	39076	2078	0.51	0.23	0.48	0.58	0.88

Critical Challenges Across North Dakota

Veterans' Legal and Social Challenges

Veterans, who comprise 6.6% of North Dakota's adult population, face significant legal and social challenges as they transition to civilian life. Insights from focus groups and interviews revealed that housing instability, including high rates of homelessness and eviction, is a pressing issue for many veterans. Barriers such as limited access to affordable housing and insufficient shelter resources exacerbate their vulnerability. Additionally, veterans experience high rates of mental health conditions like PTSD, depression, and substance abuse, which often intersect with legal challenges, including navigating VA benefits, disability claims, and employment discrimination.

These compounded issues highlight the urgent need for targeted support. By expanding collaborations with veteran-focused organizations and offering specialized legal clinics, LSND can address these critical gaps, providing much-needed advocacy and bridging the justice gap for this vulnerable population.

Concentration of Legal Issues in Housing and Family Law

Family law and housing instability represent the most pressing legal needs in North Dakota, as reflected in LSND's recent case data and community feedback. Issues such as child custody disputes, domestic abuse, divorce, and tenant-landlord conflicts dominate the legal landscape for many vulnerable populations. These challenges are particularly acute for women and low-income households, who disproportionately face multiple legal crises simultaneously. For example, domestic abuse survivors often encounter cascading issues, including the need for protective orders, child custody modifications, and access to safe housing, which can overwhelm their ability to navigate the legal system effectively.

Housing instability compounds these challenges, with rising rental costs, limited affordable housing options, and landlord-tenant disputes placing many households at risk of eviction or homelessness. Women, particularly single mothers, are overrepresented among those experiencing both family law and housing-related legal issues. The overlap between these areas highlights the critical need for targeted legal representation and advocacy to address intersecting vulnerabilities. Providing comprehensive legal support in these areas stabilizes families and individuals and mitigates unresolved legal issues' broader social and economic impacts. Strengthening LSND's capacity to address family and housing law needs through expanded outreach, dedicated legal clinics, and partnerships with local organizations can help ensure these critical issues are met with timely and practical support. By focusing on these high-need areas, LSND can deliver impactful, life-changing services to those most at risk, creating pathways to stability and justice for North Dakota's most vulnerable residents.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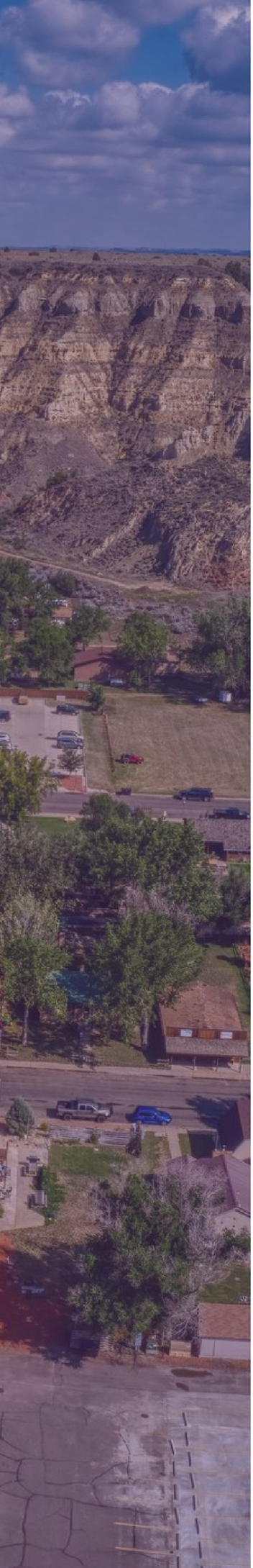

Rural Barriers to Justice

North Dakota's rural communities offer a beautiful place to live, with scenic landscapes, close-knit neighborhoods, and health outcomes that rank among the top 15 states nationwide. However, the state's rural nature also presents significant obstacles to accessing legal aid, particularly for elderly residents, low-income families, and individuals without reliable transportation.

Vast geographic distances and a scarcity of legal professionals in rural areas often leave vulnerable populations without the resources to address critical legal issues. Limited or nonexistent public transportation exacerbates isolation, making it difficult for residents to attend court hearings, meet with attorneys, or access legal clinics.

Strict financial eligibility criteria for legal aid exclude many who fall into the "justice gap"—those who earn too much to qualify for assistance but cannot afford private attorneys. Technological barriers, such as inconsistent digital literacy or device access, persist despite the state's leadership in broadband availability. These challenges underscore the need for innovative solutions, including expanded outreach, mobile legal services, and community partnerships, to ensure equitable access to justice for all North Dakotans.

Immigrant Population in North Dakota

Growing Immigrant Community: North Dakota's immigrant population has grown steadily due to economic opportunities, particularly in the agriculture and energy sectors. However, this growth has highlighted significant legal and social support services gaps.

Language and Cultural Barriers: Limited English proficiency and unfamiliarity with the U.S. legal system hinder immigrants' access to justice. These challenges are compounded for refugees and asylum seekers, who face additional complexities in immigration law.

Legal Issues Faced by Immigrants: Common legal concerns include wage theft, housing discrimination, family reunification, visa applications, and navigating citizenship pathways.
Addressing Barriers: Increasing multilingual legal resources, partnering with immigrant advocacy organizations, and offering targeted outreach programs can help address the specific needs of immigrant communities.

The Impact of Poverty and Defining "How Many Poor is Too Many"

Despite North Dakota's relatively low poverty rate of 10.5%, financial insecurity remains a pervasive issue, with 24% of households classified as ALICE (Asset Limited, Income Constrained, Employed). These households earn above federal poverty thresholds but struggle to meet basic needs such as housing, food, and healthcare. This precarious financial situation often triggers cascading legal challenges, including eviction, debt collection, family law disputes, and limited access to public benefits. Individuals caught in this "justice gap" cannot qualify for free legal aid yet cannot afford private attorneys, leaving critical legal issues unresolved and perpetuating cycles of instability and hardship.

	NORTH DAKOTA	UNITED STATES
Cost of Living Index	84.61	100
% Households Below Poverty Level	10.50%	11.10%
ALICE (Asset Limited, Income Constrained, Employed)	24%	42%
Violent Crime per 100,000 People	280	381
Total Homeless per 100,000 People	78.3	200
Median Household Income	$76,525	$80,610
Median Monthly Rent	$912	$2,015
Median House Value	$263,410	$356,026

These challenges are especially pronounced in rural communities, where geographic isolation, limited resources, and a lack of transportation amplify economic and legal burdens. Residents in these areas face more incredible difficulty accessing essential services, exacerbating their vulnerability to financial strain and legal crises. The intersection of poverty and legal needs frequently forces individuals to sacrifice essentials like food and healthcare, creating compounding hardships that ripple through families and communities. Addressing these intertwined challenges requires a holistic approach, including expanding legal aid eligibility to encompass the justice gap population, tailoring outreach to the unique needs of rural residents, and fostering partnerships with non-legal social service providers. By addressing the compounded burdens of poverty and isolation, North Dakota can take meaningful steps to ensure equitable access to justice and break the cycle of financial and legal insecurity for its most vulnerable populations.


PERUCCI BUILDING
PROPER
SHANNALEE
Starion
BANK
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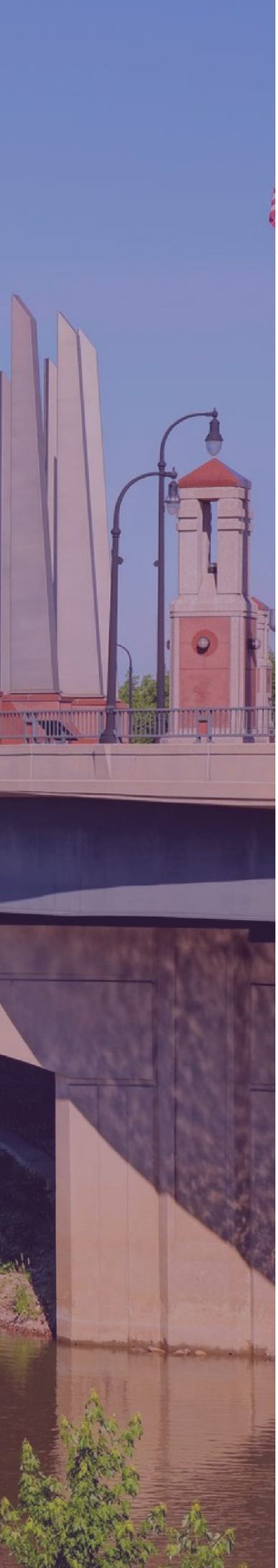
BANK
Sammy's
PIZZA



Digital Equity and Access to Justice

North Dakota is a national leader in broadband access, with over 95% of households capable of achieving speeds of at least 100 Mbps and more than 70% able to access 1 Gbps service. Rural residents benefit from this infrastructure, with 76.6% of rural households having access to high-quality fiber broadband, significantly surpassing the national rural average of 19.1%. Among LSND's community survey respondents, 92% reported having internet access, highlighting the potential for technology to bridge geographical barriers and expand access to justice, healthcare, and education for low-income and vulnerable populations.

However, digital infrastructure alone is not enough. Consistent access to affordable devices and digital literacy challenges prevent many from fully utilizing available broadband services. These barriers are particularly pronounced among homeless individuals and other marginalized groups, who often rely on public access points with significant limitations, such as restricted hours and lack of privacy. To ensure equitable access, North Dakota must address these gaps through targeted initiatives, such as expanding virtual legal services, enhancing remote consultations, and increasing the availability of affordable devices and digital literacy training. Achieving digital equity will require sustained collaboration among state agencies, nonprofits, and community organizations, ensuring the state's robust broadband infrastructure translates into meaningful access to justice and essential services for all residents, particularly those most in need.

Interconnected Legal and Social Challenges:

Legal issues in North Dakota often intertwine with broader social challenges such as mental health crises, economic instability, housing insecurity, and limited access to healthcare. These overlapping challenges amplify the vulnerabilities of individuals and families, creating a cycle of instability that cannot be addressed through isolated interventions. Insights from community needs assessments conducted by the Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences (2023) and the Community Action Partnership of North Dakota in conjunction with North Dakota State University (NDSU) and the North Dakota Department of Commerce, Division of Community Services (2023) underscore the critical need for holistic approaches that integrate legal aid with social support systems. LSND community members and stakeholders consistently highlighted these intersections, emphasizing that individuals facing legal issues frequently require access to multiple services, such as housing assistance, mental health care, and financial counseling.

Despite the recognized importance of collaboration, focus groups revealed a gap in direct referral systems between non-legal service providers and legal aid organizations. This disconnect, often driven by capacity and funding limitations, weakens the safety net for vulnerable populations. LSND community members, partners, and other stakeholders amplified the information from these two reports. Key themes from the community assessments reinforce the urgency of a multi-faceted strategy:

- **Employment:** Addressing job availability, workforce development, and livable wages to improve economic stability for individuals and families.
- **Income and Asset-Building:** Providing opportunities for financial literacy, savings programs, and asset-building initiatives to support economic self-sufficiency.
- **Education:** Enhancing access to quality education, childcare services, and workforce training to empower individuals and families.
- **Food Insecurity:** Tackling hunger and ensuring access to affordable and nutritious food for vulnerable populations.
- **Housing Insecurity (i.e., Rental Assistance):** Expanding affordable housing options and rental assistance programs to address persistent housing challenges.
- **Health and Social/Behavior Development:**
- **Mental Health Services:** Ensuring access to mental health providers and treatment for depression, anxiety, and substance use disorders.
- **Primary Care Providers and Nurses:** Improving healthcare staffing, particularly in rural areas.
- **Affordable Healthcare:** Reducing costs for insurance, services, and medications.
- **Dental Insurance/Affordable Dental Care:** Addressing gaps in oral health care access.
- **Attracting and Retaining Young Families:** Supporting population sustainability through family-friendly policies, jobs, housing, and community resources.
- **Resources for the Elderly:** Providing home-based care and support to enable seniors to live independently.
- Access to Transportation: Reducing transportation barriers that limit access to healthcare, education, employment, and other essential services.
- **Alcohol and Substance Use/Abuse:** Strengthening prevention, education, and treatment efforts for both youth and adults.
- **Civic Engagement:** Encouraging participation in community decision-making and support networks to foster connectedness and resilience.
- **Other Supports:** Addressing miscellaneous needs, such as public safety and access to specialized care, to ensure a comprehensive safety net for vulnerable populations.

Poverty in North Dakota is particularly severe in rural areas, where limited resources and geographic isolation exacerbate legal and economic challenges. Approximately 24% of households are classified as Asset Limited, Income Constrained, Employed (ALICE), meaning they struggle to meet basic needs despite being employed. These households often fall into the justice gap, unable to qualify for legal aid yet lacking the resources to afford private legal representation.

These findings reveal a stark perception of inequality in the civil legal system and emphasize the vital role LSND plays in bridging systemic gaps. Legal aid strengthens confidence in the system and fosters a more equitable and inclusive society by providing trusted representation and addressing barriers to justice.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BROADWAY SQUARE
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Conclusion

The Legal Services of North Dakota (LSND) Community Legal Needs Assessment highlights the critical legal challenges faced by North Dakota's most vulnerable populations. From rural barriers and housing instability to the unique legal needs of veterans and immigrants, the findings underscore the urgency of addressing systemic inequalities in access to justice. The impact of poverty, geographic isolation, and digital disparities further complicate the ability of underserved communities to secure legal support, reinforcing the need for expanded outreach, strategic partnerships, and innovative service delivery models.

This report serves as a call to action for LSND and its stakeholders. It provides a data-driven foundation for strengthening legal aid efforts, advocating for policy reforms, and fostering collaborative solutions that bridge service gaps. By leveraging these insights, LSND is committed to ensuring that all North Dakotans—regardless of income, location, or background—can access the legal resources they need to protect their rights and build stable futures.

Through partnerships, advocacy, and community-driven solutions, LSND will continue to champion justice, equity, and dignity for all

Thank You & Call to Action

LSND extends its gratitude to the staff, partners, and community members who contributed to this report. Over the past ## months, the LSND Strategic Planning Committee, staff, Board of Directors, and community partners have demonstrated unwavering dedication to serving North Dakota. Community members generously shared their time through survey responses and focus groups, providing critical insights for this needs assessment.

The findings of this assessment underscore that the challenges our communities face—systemic barriers, natural disasters, inflation, poverty, housing instability, and struggling infrastructure—are too complex for any one organization to solve alone. We are inspired not only by the commitment of those who serve LSND community members each day but also by the resilience of the community members themselves, who fight daily to create better lives for their families. LSND is committed to using these findings to stand alongside our community and partners in addressing these challenges and building a better North Dakota for all.

EDUCATE:

Tell someone about the issues who didn't know about them before! Start a discussion within your community and talk to local leaders about the need for civil legal aid.

VOLUNTEER:

If you are an attorney, there is someone in North Dakota who needs your help. No matter what area of practice you are in, someone needs what you can do for them.

DONATE:

LSND depends on grants and donations to provide their services to the vulnerable populations of North Dakota. Prioritize those in your community who cannot afford a lawyer, support LSND today!


LSND
Legal Services of North Dakota

TESTIMONY
HOUSE BILL 1623 – HIA HEALTH
JOINT APPROPRIATIONS COMMITTEE
SENATOR BRAD BEKKEDAHL, CO-CHAIRMAN
REPRESENTATIVE DON VIGESAA, CO-CHAIRMAN
JANUARY 21, 2026

Chairpersons Bekkedahl and Vigesaa, and members of the Joint Appropriations Committee, thank you for the opportunity to speak with you today.

For the record, my name is Tracee Capron, and I serve as Executive Director of HIA Health. I am here today not only on behalf of HIA Health, but on behalf of the citizens of North Dakota, to provide testimony in support of House Bill 1623 and respectfully request a **DO PASS** recommendation.

I want to begin by expressing sincere gratitude to the North Dakota Legislature, Governor Kelly Armstrong, Interim Commissioner Pat Traynor, the Department of Health and Human Services, and the people of North Dakota. Your willingness to act on Rural Health Transformation funding reflects a shared commitment to protecting access to care for every community—no matter how rural, remote, or frontier.

We are here today because rural healthcare systems are strained—but they are not beyond repair.

For more than 40 years, HIA Health—formerly Hospice of the Red River Valley—has delivered care in the community. What we offer today is not theoretical. It is a proven, scalable continuum of care that includes hospice, palliative care, home-based primary care, chronic and principal care management, Qualified Service Provider services, non-medical transportation, community health workers, and grief and bereavement services (provided at no cost to the community).

Care is not defined by a building. It is defined by where life is lived—whether that is a farmhouse, an apartment, a senior living setting, or a tribal community. This model keeps care closer to home, reduces fragmentation, prevents avoidable crises, and strengthens families and communities.

My confidence in this initiative comes from the moment Rural Health Transformation funding became a possibility. We were in Washington, D.C., attending a national conference when we learned about it and immediately contacted the North Dakota Department of Health and Human Services because we believed the state needed to be aware.

What I learned was striking: North Dakota already knew.

Not only did the North Dakota Department of Health and Human Services understand the opportunity, they had already begun laying groundwork identifying gaps, setting expectations, and preparing for disciplined execution.

Workforce shortages remain the single greatest threat to rural healthcare. When a nurse leaves a small town, care often leaves with them. When a provider burns out, an entire region feels it.

Our plan directly addresses this reality. HIA Health has built a local, community-based workforce model with an incredible retention rate, no reliance on locums or traveling staff, and volunteer engagement exceeding federal requirements. Along with the North Dakota Department of Health and Human Services and this body, we also understand that retention of clinicians is imperative to the sustainability of providing quality care in our state – this will require systems that are supported by loan repayment pathways, partnerships with educational institutions, flexible scheduling, clinical ladders, leadership development, and community-rooted training pipelines. This is how you build a durable rural workforce—not just for today, but for the next generation.

This model also strengthens North Dakota's rural and critical access hospitals, rather than replacing them. By expanding home-based care, reducing unnecessary transports, and supporting and building telehealth capacity – we help preserve critical emergency and inpatient services while giving families more options to receive care at home.

House Bill 1623 allows us to deepen our work in tribal and frontier communities, including expanded home-based primary, palliative, and hospice education; community health worker development; and culturally aligned care integration. Not everyone starts life with the same health or access—but our responsibility is to help people remain as healthy as possible, for as long as possible, where they want to live.

Finally, I want to emphasize one critical operational point: funding structure matters. Rural providers operate on thin margins while traveling long distances, providing grief and bereavement care, and filling gaps others cannot. Upfront investment is essential. When organizations are required to carry too much early financial burden, the real cost is borne by leadership and frontline staff—and workforce erosion follows. HIA Health has worked hard to retain its workforce, and early, equitable distribution of funds is essential to sustaining that success.

As an addendum to this testimony, we have included in our submission a map outlining the current healthcare services and communities our organization serves; additionally, we have included what those healthcare services could be with our scalable model and Rural Health Transformation funding. As a safety-net healthcare provider we understand not just the importance but the necessity of access to quality rural healthcare. We have developed an organizational plan that is comprehensive, replicable, and scalable. Our organization is prepared to transform rural health – we are excited to work with the North Dakota Department of Health and Human Services, community partners, and the state to serve as a beacon for the rest of country. For these reasons, I respectfully ask for a **DO PASS** recommendation on House Bill 1623.

On behalf of HIA Health, our partners, and the thousands of families we serve, thank you for your leadership and your commitment to transforming rural health in North Dakota.

Contact:

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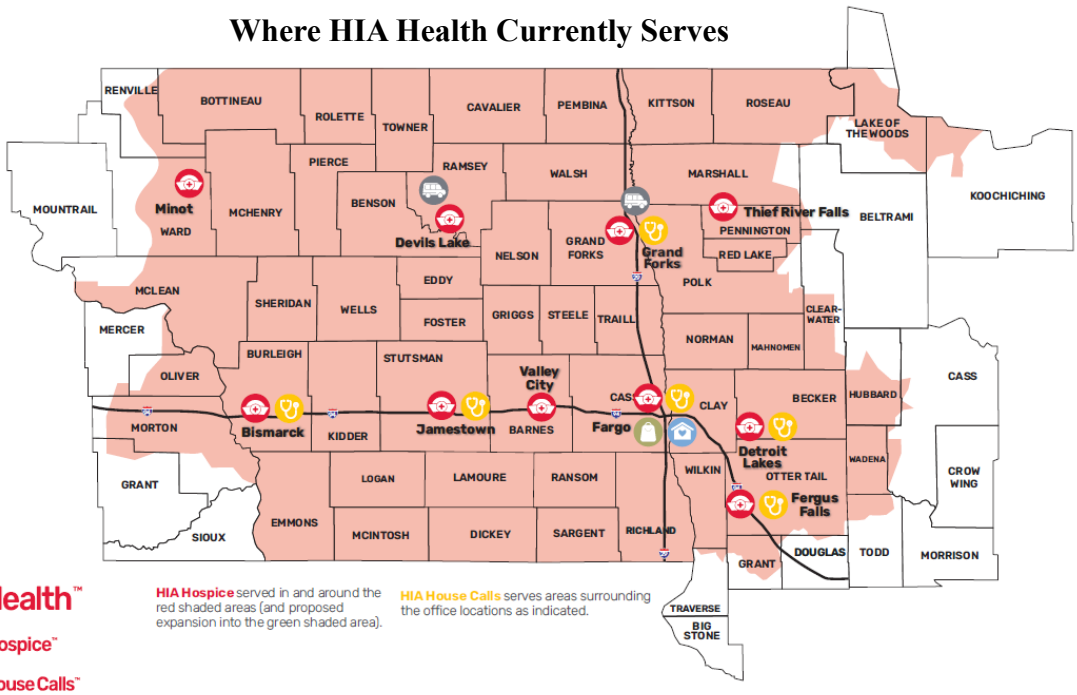
tracee.capron@HIAHealth.org
(701) 356-1515

Where HIA Health Currently Serves



HIA Health™

HIA Hospice™

HIA House Calls™

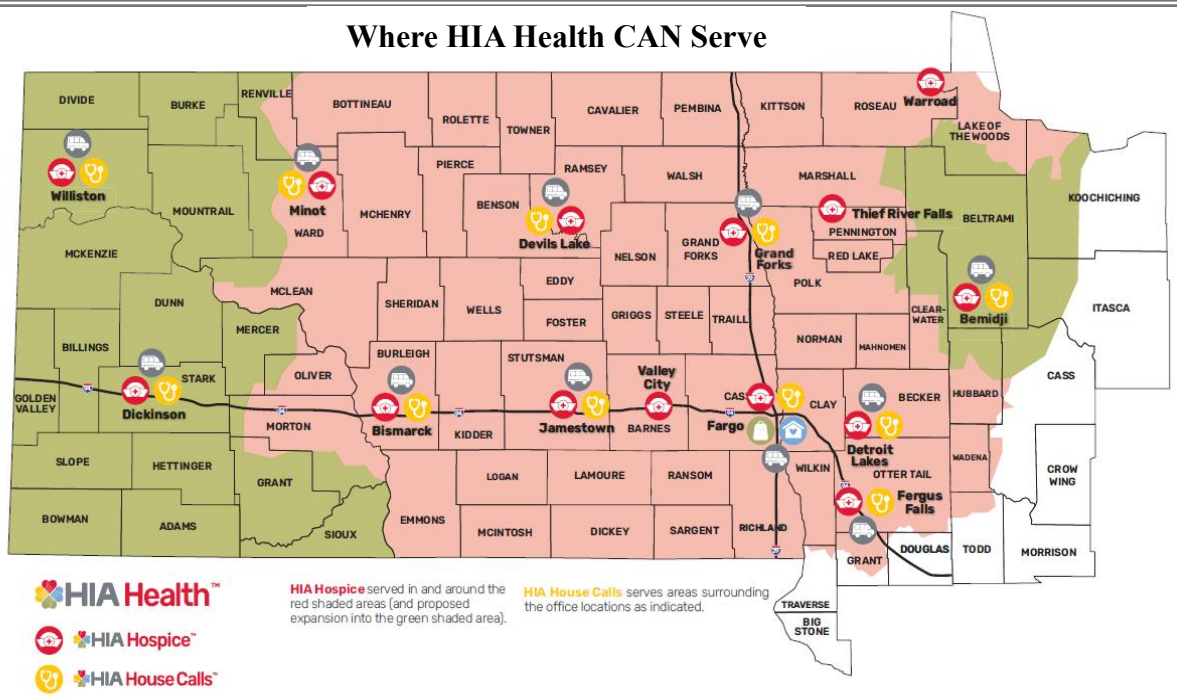
HIA Heirlooms

HIA Heather's House

HIA Hospice served in and around the red shaded areas (and proposed expansion into the green shaded area).

HIA House Calls serves areas surrounding the office locations as indicated.

Where HIA Health CAN Serve



HIA Health™

HIA Hospice™

HIA House Calls™

HIA Heirlooms

HIA Heather's House

HIA Transport

HIA Hospice served in and around the red shaded areas (and proposed expansion into the green shaded area).

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Testimony in Support of House Bill 1623
Joint Appropriations Committee
January 21, 2026

Mr. Chairman and Members of the Committee,

My name is Stephanie Nelson, and I serve as the Chief Executive Officer of Anne Carlsen. I am honored to be here today in this new role, and I want to thank you for the opportunity to provide testimony in support of House Bill 1623.

About Anne Carlsen
Anne Carlsen has been serving individuals with intellectual and developmental disabilities and their families for nearly 85 years. Annually we provide programs, services, and supports to nearly 3,000 individuals based out of eight service locations and reaching people from 173 different North Dakota zip codes. Our work spans early intervention, residential services, education, therapy, behavioral health/autism services and complex medical care—often for children and young adults with some of the most significant medical and behavioral needs in the state.

House Bill 1623 is critically important to providers like Anne Carlsen. The Rural Health Transformation Program represents a meaningful investment in North Dakota's future—particularly in rural and frontier communities—by recognizing that sustainable access to care requires thoughtful alignment of licensure, workforce, infrastructure, and technology. This bill directly supports that vision.

Sustaining Care for Medically Complex Children at the Jamestown ICF
A major and ongoing need for Anne Carlsen continues to be our Intermediate Care Facility (ICF) in Jamestown, which serves children and adolescents with the most medically complex needs. As you may recall, during the 2025 legislative session, Anne Carlsen leadership provided testimony outlining the escalating operational and financial challenges of serving this population within the existing Developmental Disabilities system. The existing system simply did not support the type and level of care these children require.

That testimony emphasized the urgent need for sustainable funding methodologies that more accurately reflect the comprehensive, medically complex care being delivered. We are sincerely thankful for the Legislature's response through grant funding, which has provided critical stability, ensuring that services for medically complex children have remained uninterrupted while longer-term solutions are developed. The work we are doing today builds directly on that conversation and is designed to position Anne Carlsen for long-term sustainability.

Advancing Licensure and Scope Changes to Better Match Patient Needs
Central to this effort is our ongoing partnership with the North Dakota Department of Health and Human Services. Together, we have been actively exploring licensure and funding options that better align with the needs of those served at the Jamestown ICF. As part of this collaboration, the Department has recommended the addition of a Specialty Hospital licensure category for a portion of ICF beds. This change would allow reimbursement to more appropriately reflect the level of care required.

To share an update on our work since the session adjourned, Anne Carlsen has:

- Engaged a national firm to work alongside our team and the Department;
- Identified appropriate licensure and certification categories to better align with patient needs;
- Begun active work on rate methodology development; and
- Started planning for the next steps, including proposing rates, code requirements, and any necessary operational adjustments, such as waivers or targeted remodeling to support implementation

The progress made to date would not have been possible without the Legislature's investment and partnership.

Supporting Medically Complex Children Through Rural Health Transformation
House Bill 1623, through the Rural Health Transformation Program, can play a pivotal role in helping us move from planning to implementation. In particular, Initiative 3—*Bringing High-Quality Health Care Closer to Home*—is highly aligned with our needs. This initiative supports technical assistance for providers pursuing licensure or scope changes, remodeling and technology upgrades for facilities rightsizing services to meet current community needs, and modernization investments that reduce reliance on in-person workforce or support new billing pathways. Resources such as this would be transformative for our organization to successfully transition into a new licensure category.

Beyond our licensure change, several additional Rural Health Transformation initiatives would be of significant benefit to Anne Carlsen. Workforce challenges remain one of the greatest barriers to sustaining access in rural and tribal communities, and initiatives focused on improving retention are critical. Technology as an extender for rural providers is equally important. Investments in remote monitoring, smart technology, robotics, and artificial intelligence can reduce dependence on scarce physical workforce resources and allow professionals to focus on care that truly requires human intervention. Transportation is another persistent barrier. Subawards supporting accessible vans and non-emergency medical transportation would directly improve access for families traveling from rural areas to care delivery sites.

House Bill 1623 represents an important step toward a more responsive, integrated, and sustainable system of care in North Dakota. It recognizes that meeting the needs of our most vulnerable children requires alignment across licensure, workforce strategies, and infrastructure investment. Anne Carlsen remains deeply committed to working in partnership with state leaders to ensure children and families can access timely, high-quality services close to home.

Thank you again for your leadership, your investment, and your thoughtful consideration. I would be happy to answer any questions.

Respectfully submitted,

Stephanie Nelson
Chief Executive Officer - Anne Carlsen
stephanie.nelson@annecenter.org

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

Joint Appropriations Committee
HB 1623 Testimony
January 20, 2026
Senator Bekkedahl, Chair
Representative Vigesaa, Chair

Good morning, Chairmen Bekkedahl and Vigesaa and Members of the Joint Appropriations Committee. I am Carlotta McCleary, Executive Director of Mental Health America of 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. Our vision is for every North Dakotan to have access to the right service—whether it be preventative, treatment, or recovery; at the right time—when the service is needed; and at the right place—as near his or her home as possible.

MHAN is testifying in support of HB 1623. Our priorities and recommendations rely on implementing best practice models of service delivery, including continued pursuit of Certified Community Behavioral Health Clinics (CCBHC) in all eight regions of North Dakota and expanding services in rural communities. Best practices understand that we first need to ensure our citizens receive assistance before they have emergencies. We must have a robust community mental health system of care so that we can reduce the reliance on our costly, intensive institutional care settings. We must have substantial and multifaceted mental health workforce, which includes utilizing those with lived experience to help people navigate services and embark on their recovery.

SAMHSA's best practices models also include crisis response systems, which do need to be responsive to the needs of individuals in rural communities. When a crisis emerges, we must rely on three pillars of crisis response. Those pillars are: 1) a place to call (988), 2) someone to respond (mobile crisis teams), 3) a place to go (crisis stabilization beds/safe beds).

MHAN Priorities

MHAN has realized that while we are not done making improvements to the adult mental health system, the efforts over the last decade have created a solid foundation for further progress. It is now time to expend the same energy in creating a solid foundation for the North Dakota children's mental health system.

Children's Mental Health Services: MHAN urges the state of North Dakota to make a substantial investment in community-based mental health services for children and youth with Serious Emotional Disturbance (SED). One in ten children in North Dakota has a SED, which is over 18,000 children. According to the most recent and corrected data from DHHS, during the 2023-2024 fiscal year, 1,086 children with SED received case management services through the Behavioral Health Clinics.

There is a need for high-fidelity wraparound services for children that are individualized to meet a child and family's needs. These are not simply children who have any mental illness or moderate mental illness, they are those with the most significant mental health challenges. When out-of-home placements are to occur, they should be as near their home

as possible. A proper crisis response system can divert many from needing more costly out-of-home placements such as hospitalization.

Cross-Disability Waiver: MHAN is supporting the establishment of a cross-disability waiver and that it be inclusive of children with mental health needs. As stated earlier, North Dakota is lacking a full continuum of care for children's mental health services in both the public and private sector. Families who have a child with a mental health challenge are expected to make tremendous sacrifices to get their child access to care. North Dakota does not have a mental health waiver for children, and deductibles make it difficult for families to afford services for their child. Having a reimbursable funding stream will allow private providers to invest in needed services for children and their families. Specifically including children with mental health needs into the cross-disability waiver will go a long way to address existing service gaps.

Family Support Organizations: Family organizations that serve children with mental health needs, like the ND Federation of Families for Children's Mental Health (NDFFCMH) and Family Voices of ND do great work with small budgets for families throughout the state of North Dakota. NDFFCMH goes into rural communities to support families with: system navigation in their community, providing education and training to families, and peer support. Many of the families that NDFFCMH support in rural communities do not have access to case management services. Family-run organizations and programs should continue to be supported and funded so that children with mental health needs and their families can receive assistance. Ensuring family-run organizations are sustained through braided funding goes a long way to providing services and support directly to families. Families in rural communities would be lost without them.

Peer Support: MHAN supports efforts to make peer support more accessible, especially in rural communities, where the mental health workforce shortage is acutely felt. MHAN believes that employers should be paid a reimbursement rate that allows all peer support specialist positions to have a living wage with benefits. MHAN also supports the expansion of certification for family peer support specialists, who will be providing support for families raising children with mental health needs. This could include making coverage for peer support and family peer support eligible through standard Medicaid. Currently, peer support for adults has multiple means for reimbursement, but family peer support for children does not. ND Federation of Families has been providing this evidence-based practice to families since 1994 and wants to be part of the solution to needed children's mental health services, especially in rural North Dakota.

Mobile Crisis Teams: MHAN strongly supports the continued expansion of mobile crisis teams statewide, especially in rural communities. ND DHHS is continuing to make strides in expanding crisis service coverage in rural communities (including with Avel), but significant coverage gaps remain for the communities outside the 45-mile radius for Behavioral Health Clinics. In region 2, mobile crisis teams can respond to any crisis in the region, including rural communities outside the 45-mile radius from the Behavioral Health Clinic. MHAN also supports efforts to make mobile crisis teams more functional and accessible for families with a child experiencing a mental health crisis. Compared to adults experiencing crisis, children and families need more in-person communication and deescalation, but those options are not consistently available across the state. For instance, the region 7 mobile crisis teams go directly to the child instead of relying on providing families phone support. We applaud West Central and North Central

Behavioral Health Clinics for adjusting to those community needs, and we wish to see that expanded throughout the state.

Crisis Stabilization Beds: We want to build an appropriate regionalized children's crisis bed stabilization system that is responsive to the needs of children experiencing a mental health crisis. These crisis stabilization beds are the third pillar of SAMHSA's crisis response system. This prevents the escalation of crisis within the family unit, ER visits and hospitalizations. This allows for youth having a mental health crisis to have treatment at the most appropriate level on the continuum of care to meet their needs. Ensuring that each region has readily available crisis stabilization beds would also mean that families, often in rural communities, would not have to travel across the state to receive that service.

Supported Housing: MHAN supports the continuum of services required to support individuals with mental health needs to obtain and maintain housing in the most integrated setting. This would be a financial savings to the state, considering the cost of institutional care vs. community-based placements. This would also assist institutions (jails, prisons, the State Hospital) to be able to offer successful transitions to the community. This would assist in addressing current gaps related to housing and the service delivery system.

This concludes my testimony, and I will be happy to answer any questions you may have.

Carlotta McCleary
Mental Health Advocacy Network, Spokesperson
E-Mail: cmccleary@ndffcmh.com
Phone: (701) 222-3310

January 21, 2026
HB 1623: Rural Health Transformation Funding
Ann Prifrel, CEO of the Great Plains Food Bank

Mr. Chairmen and members of the Joint Appropriations Committee,

My name is Ann Prifrel, and I am the newly appointed Chief Executive Officer of the Great Plains Food Bank. I am grateful for the opportunity to provide testimony in support of HB 1623, the Rural Health Transformation Funding appropriation bill.

Since joining the Great Plains Food Bank, I have been deeply impressed by North Dakota's commitment to addressing hunger, improving health outcomes, and investing in community-based solutions. I want to begin by sincerely thanking the Legislature for its continued partnership and support. Last session, you demonstrated a long-term commitment to ending hunger through a $5 million appropriation toward the construction of a new food bank facility, which will significantly expand our capacity to serve communities across the state for decades to come. You also recognized the immediate needs of our neighbors through a $1.5 million investment to purchase and distribute protein, helping families put food on the table when they needed it most. We are grateful to work alongside you to ensure our neighbors have the food they need today, while also building systems that reduce hunger in the future.

More recently, I would like to thank the Governor's office and the Department of Health and Human Services for their swift execution and collaboration during the federal government shutdown, which created uncertainty around SNAP and impacted approximately 57,000 North Dakotans. Through this partnership and the generosity of our communities, we were able to secure and distribute more than 1.6 million pounds of food in November, reaching families at a critical moment and demonstrating the power of effective public-private collaboration.

For context, the Great Plains Food Bank is North Dakota's only statewide food bank, serving all 53 counties through a network of more than 200 partner agencies, including food pantries, shelters, and community organizations. Over the past year, more than 160,000 children, seniors, and families utilized our services. These include working families, individuals in rural communities where access to healthy food is often limited, and seniors striving to stretch limited budgets. Our work goes beyond food sourcing and distribution and includes building partnerships with organizations that recognize food as a critical component of health and well-being.

We strongly support the Rural Health Transformation Funding and the Legislature's continued investment in initiatives that advance preventive care and promote healthy eating under the goal to "Make North Dakota Healthy Again." We know that food insecurity is not solved by food alone—it also requires addressing the health, education, and awareness factors that influence a person's long-term well-being.

We are encouraged by the Eat Well North Dakota framework to strengthen nutrition education and improve access to healthy foods statewide. The focus on integrating training for families and providers, while partnering with communities and local grocery stores represents a thoughtful and comprehensive approach to improving health outcomes. Efforts to enhance rural food distribution, support SNAP technology, and embed nutrition into healthcare, education, and community initiatives are especially important in a largely rural state.

If the opportunity were to arise, the Great Plains Food Bank would be grateful to partner with the Department of Health and Human Services in advancing the goals of Eat Well North Dakota. As North Dakota's only statewide food bank, we bring established infrastructure, trusted relationships, and experience connecting food access with nutrition education and health-focused initiatives.

Through a potential partnership, the Great Plains Food Bank could help support program goals by:

- Improving access to healthy foods through community and retail partnerships
- Strengthening rural food distribution systems
- Supporting SNAP-related technology and education
- Helping integrate nutrition into healthcare, childcare, and community-based settings through programs such as our Wellness Clinic Pantries, BackPack Program, Kitchen Coalition Program, and School Pantry Programs

Thank you for your leadership, your continued investment in North Dakota communities, and your consideration of the Rural Health Transformation Funding and the DHHS appropriation bill. I look forward to working together to build a healthier North Dakota.

Respectfully,
Ann Prifrel
Chief Executive Officer
Great Plains Food Bank

TESTIMONY
HOUSE BILL 1623 – HIA HEALTH
JOINT APPROPRIATIONS COMMITTEE
SENATOR BRAD BEKKEDAHL, CO-CHAIRMAN
REPRESENTATIVE DON VIGESAA, CO-CHAIRMAN
JANUARY 21, 2026

Chairpersons Bekkedahl and Vigesaa, and members of the Joint Appropriations Committee, my name is Dr. Mark Rostad, and I am a North Dakota physician. I want to thank you for the opportunity to provide written testimony in support of House Bill 1623 and ask that you give it a **DO PASS** recommendation.

I was born in Fargo and grew up in Kindred, North Dakota. I am a fourth-generation healthcare provider in the Red River Valley, with a Dr. David Rostad practicing in the Fargo area since 1918. I married Brynn Peterson, a Bismarck native and the daughter of former North Dakota State Auditor Bob Peterson. My family has been in the Red River Valley for more than a century, and my wife's family has similarly deep roots in west-central North Dakota. In short, my family's North Dakota roots run deep.

I attended medical school at the University of North Dakota and, during my third year, enrolled in the Rural Opportunities in Medical Education (ROME) program. I spent six months living in Dickinson, learning from a small group of exceptional physicians who shaped not only how I practice medicine, but how I understand community, responsibility, and presence. Much of how I care for patients today comes directly from that experience serving people in western North Dakota.

I completed my residency in internal medicine at Gundersen Health System in La Crosse, Wisconsin, followed by a fellowship in hospice and palliative medicine at the University of Iowa. When my wife, daughter, and I returned home to North Dakota, I was only the fourth fellowship-trained hospice and palliative medicine physician in the state.

I began my career at Essentia Health in Fargo, where over four years I helped grow the palliative care department to more than three times its original size. In 2025, I joined HIA Health as Medical Director. Since that time, we have recruited additional Red River Valley–native physicians and clinicians to expand access to the right care, in the right place, at the right time for North Dakotans.

At HIA Health, we are building a true continuum of care. We are establishing a primary care clinic where North Dakotans of any age can partner with a provider across life's journey. We deliver home-based primary care for patients who are unable to travel to clinics. We provide home-based palliative care for individuals living with serious, incurable illness while still receiving life-prolonging treatment. And we deliver hospice care for patients with disease that is both incurable and no longer responsive to treatment.

HIA Health began more than 40 years ago as Hospice of the Red River Valley. While the name has changed, the mission has not. The organization remains deeply rooted in North Dakota communities.

From a physician's perspective, the home-based care continuum is not only clinically effective—it is why many of us choose to practice medicine.

When care is delivered in the home, physicians have the time and context necessary for meaningful care planning. We see how patients actually live. We understand their supports, their limitations, and what matters most to them. That depth of understanding simply cannot be replicated in episodic, high-volume clinical settings.

Technology and telehealth play an important role in this model. Remote monitoring and virtual check-ins help us track symptoms and intervene earlier. But telehealth does not replace presence. It is an adjunct. Healing, trust, and complex decision-making still require human connection, time, and being there.

Most physicians did not enter medicine to maximize volume. We entered medicine to improve outcomes. In home-based care, quality is measured by stability, avoided crises, alignment with patient goals, and the well-being of families—not by how many visits can be compressed into a day.

This is where the Rural Health Transformation Fund is especially important from a workforce perspective. HIA Health is uniquely positioned to train, grow, and retain local clinicians. We work with medical students, residents, fellows, nurse practitioners, nurses, and interdisciplinary team members in real-world rural settings. These experiences are formative. Clinicians who train in communities—who build relationships there—are far more likely to stay.

In many rural and frontier areas of North Dakota, hospice and home-based care teams are the only consistent healthcare presence. Without this infrastructure, some communities would have little to no access to longitudinal medical care at all. The ability to expand this model means we are not only delivering care—we are creating a sustainable workforce pipeline rooted in the communities it serves.

We are well prepared to expand primary care and serious illness care into the rural home setting for three key reasons:

1. We are already doing this work every day.
2. Hospice has given us unmatched expertise in caring for patients in their homes—no specialty spends more time there.
3. We are clinically led by local Red River Valley physicians who understand rural North Dakota's needs and are committed to meeting them.

From a physician's perspective, House Bill 1623 represents an opportunity to support the kind of medicine many of us were trained to practice and hoped to deliver—medicine grounded in relationship, quality, and community.

Thank you for the opportunity to share my perspective and for your commitment to the health of North Dakotans.

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Rural Health Transformation Program

Joint Policy and Appropriations Committees

January 21, 2026

NORTH Dakota | Health & Human Services

Be Legendary.

ND HHS North Star

- HEALTHIEST CITIZENS ON THE PLANET
- MODEL OF EFFICIENCY AND EFFECTIVENESS
- HEALTHIEST, HIGHEST PERFORMING TEAM

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Be Legendary.

North Dakota Rural Health Transformation Program (RHTP) Award

Year 1: Federal Fiscal Year 2026

Award Amount: $198.9MM

- Year 1 Award received on December 29, 2025.
- Future Awards determined by the Centers for Medicare and Medicaid Services (CMS) based on a state's progress in successful implementation.

LINKS:

ND Rural Health Transformation Website

Sign up for RHTP Announcements Here!

CMS Award Notice

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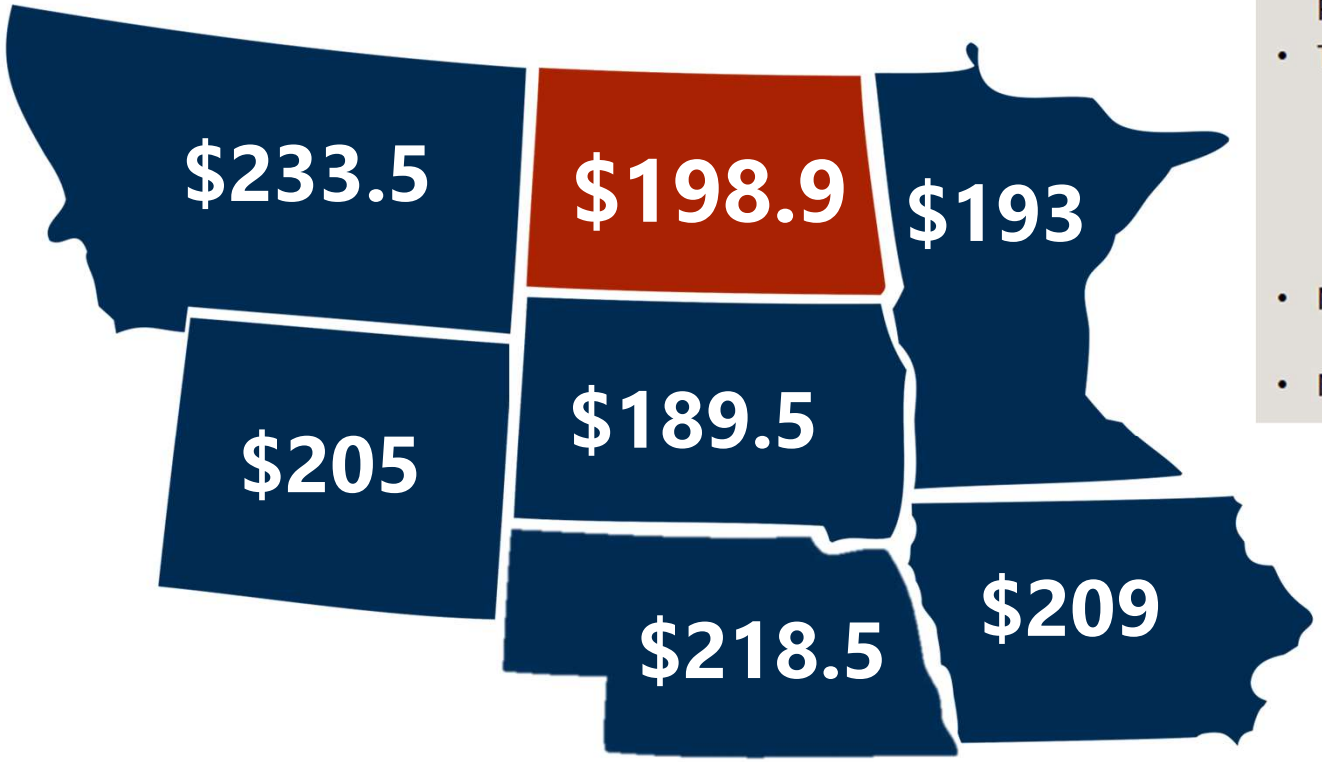
How does North Dakota's award compare?

in millions



National Context

- All 50 states awarded RHTP funds.
- Top Awards:
  - Texas | $281.3 Million
  - Alaska | $272.2 Million
  - California | $233.6 Million
  - Montana | $233.5 Million
  - Oklahoma | $223.5 Million
- Minimum Award Amount:
  - New Jersey | $147.3 Million
- North Dakota's Year 1 Award ranks 29 out of 50.

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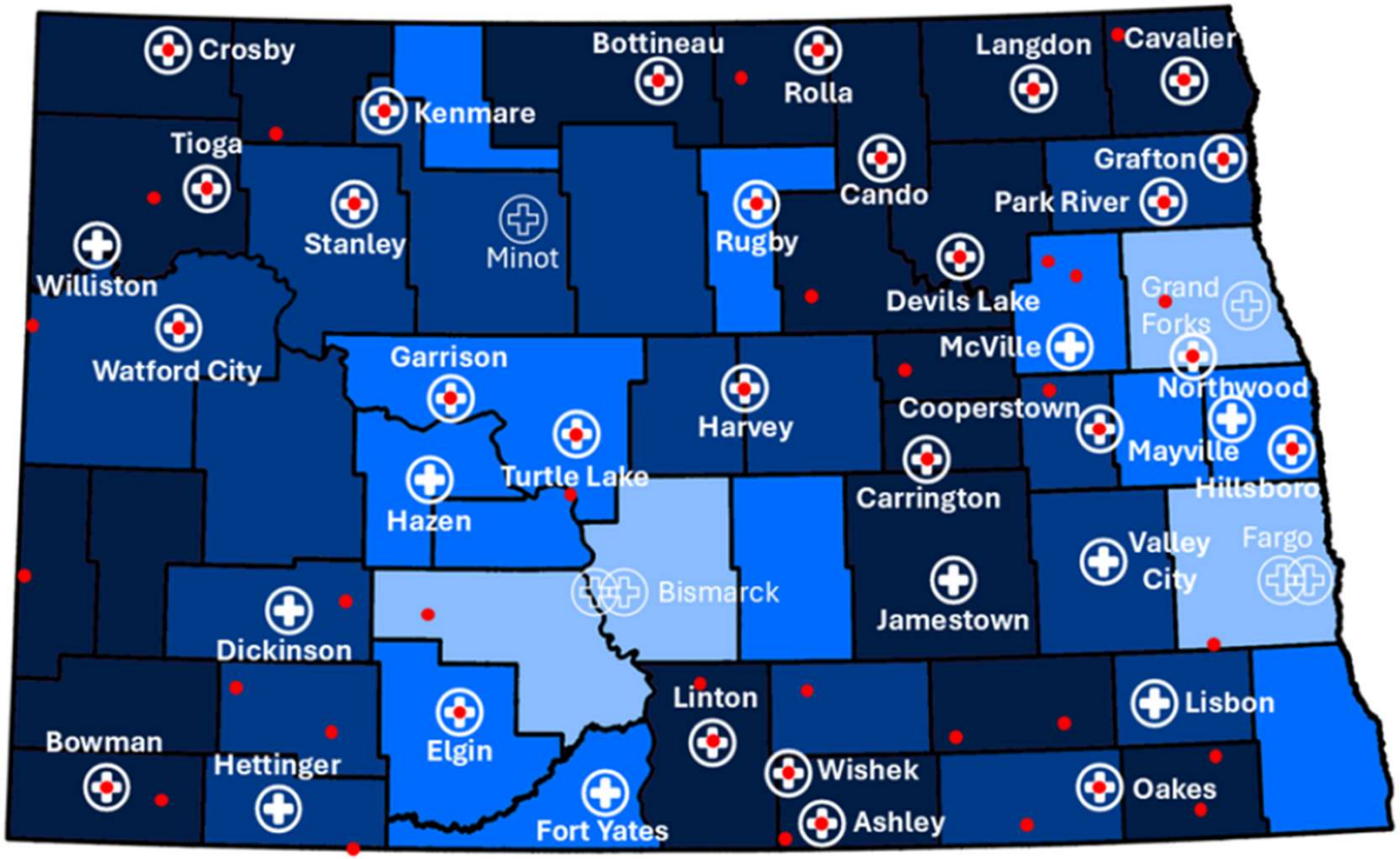
Critical Access Hospitals & Rural Health Clinics



- Partially Rural
- Entirely Rural
- Partially Frontier
- Entirely Frontier
- Critical Access Hospital
- Urban Referral Center
- Rural Health Clinic

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

NORTH Dakota
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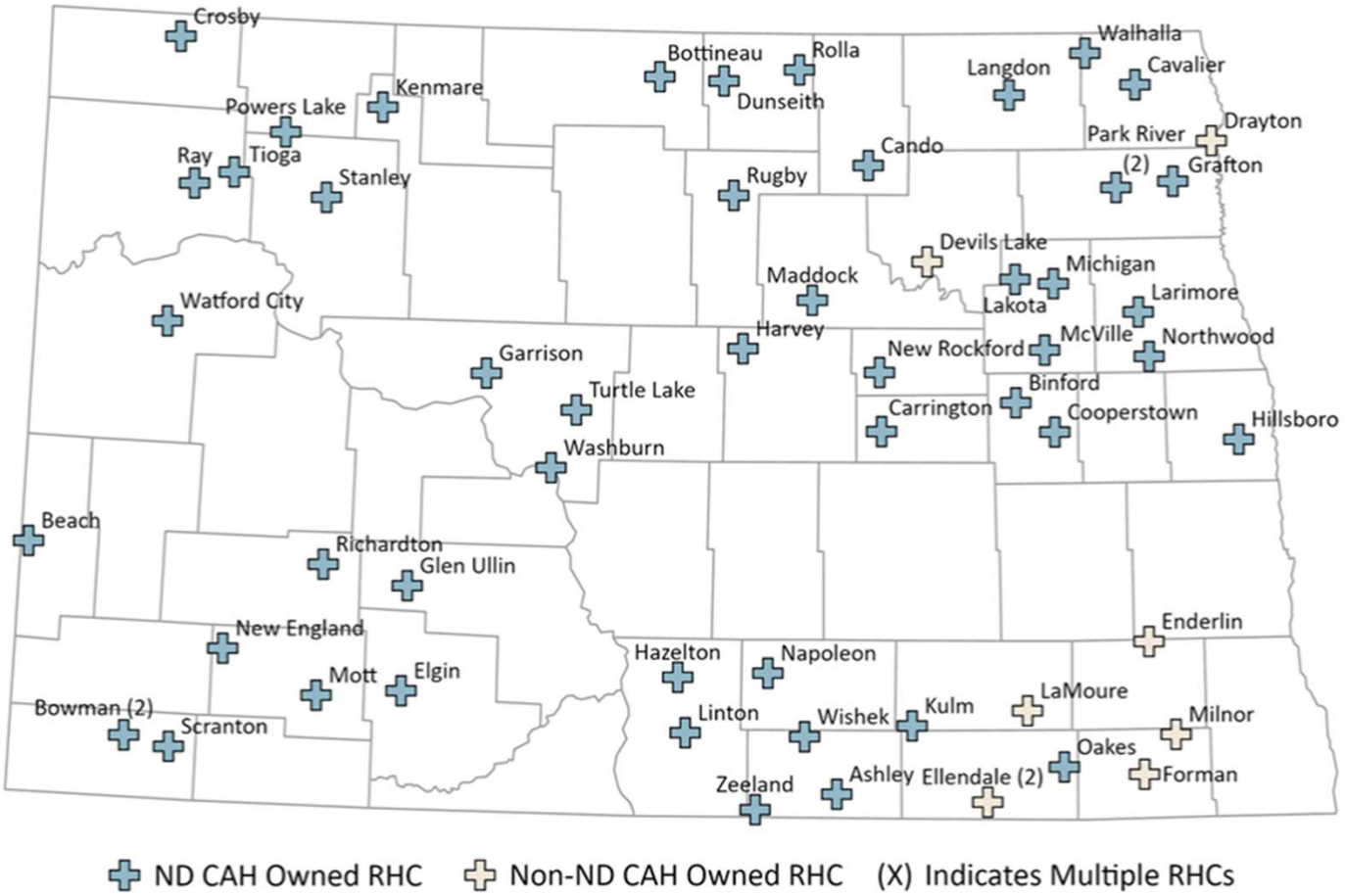
Health & Human Services

North Dakota Rural Health Clinics, 2025



NORTH DAKOTA Rural Health Clinic NETWORK

Center for Rural Health
University of North Dakota School of Medicine & Health Sciences

Sources: HHS.ND.gov, data.HRSA.gov, June 2025.
Created by the North Dakota Healthcare Workforce Group
June 2025

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Locations with North Dakota Critical Access Hospital-Owned Rural Health Clinics:

- Ashley
- Beach
- Binford
- Bottineau
- Bowman (2)
- Cando
- Carrington
- Cavalier
- Cooperstown
- Crosby
- Dunseith
- Elgin
- Garrison
- Glen Ullin
- Harvey
- Hazelton
- Hillsboro
- Kenmare
- Kulm
- Lakota
- Langdon
- Larimore
- Linton
- Maddock
- McVille
- Michigan
- Mott
- Napoleon
- New England
- New Rockford
- Northwood
- Oakes
- Park River (2)
- Powers Lake
- Ray
- Richardton
- Rolla
- Rugby
- Scranton
- Stanley
- Tioga
- Turtle Lake
- Walhalla
- Washburn
- Watford City
- Wishek
- Zeeland

Locations with Non-North Dakota Critical Access Hospital-Owned Rural Health Clinics:

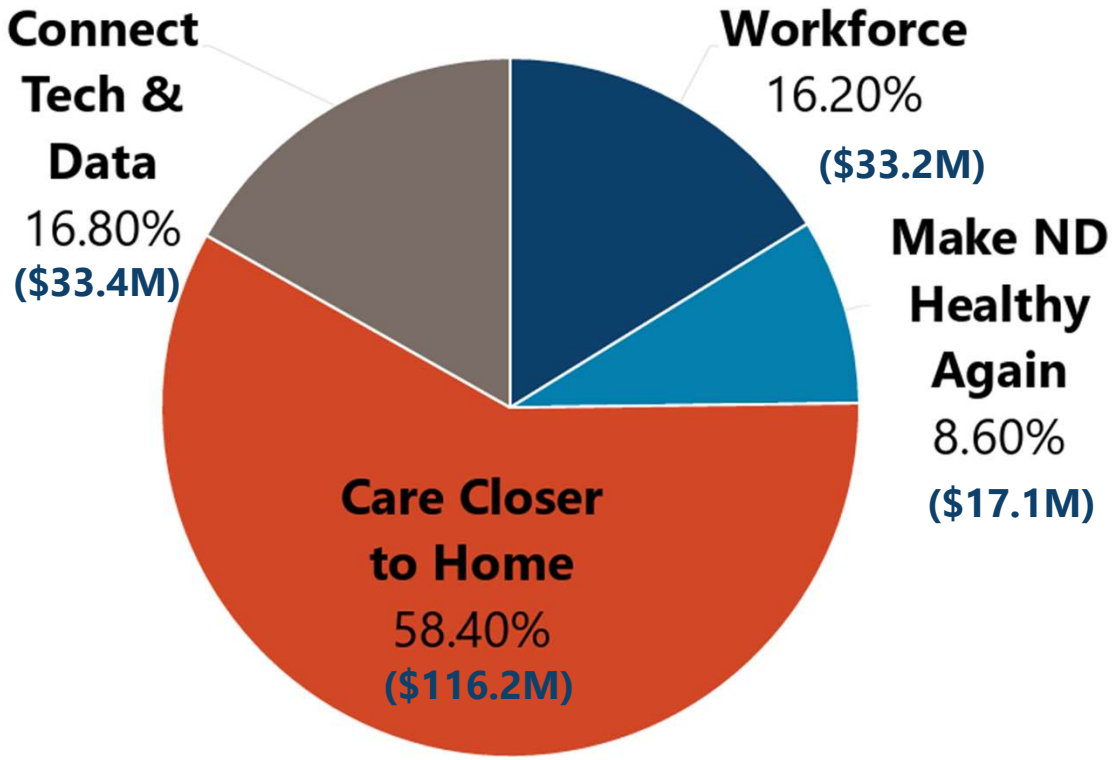
- Devils Lake
- Drayton
- Ellendale (2)
- Enderlin
- Forman
- LaMoure
- Milnor

Guaranteeing Success

- RHTP Leadership
- Coordinators for each initiative
- RHTP Tribal Liaison
- Accounting / Procurement
- Compliance / Legal
- Behavioral Scientists
- Data Analysts
- Consultants / Technical Assistance
- Communication / Education Specialists
- Evaluators
- Diet, Exercise and Workforce Experts

Note: Dedicated full-time employees, temporary staff, or contracted resources as needed to ensure timely delivery, accountability, and completeness. HHS will not increase the number of FTE in the block grant.

Preliminary Funding Allocations By Initiative



Note: Initiative allocations above reflect **estimates** which will vary based upon provider readiness, project implementation guidelines, and CMS approval.

Strategic Priorities and Key Themes

Strengthen and Stabilize Rural Health Workforce

- Expand Rural Healthcare Training Pipelines
- Improve Retention in Rural and Tribal Communities
- Use Tech as Extender for Rural Providers
- Provider TA and Training for Existing Workforce

Bring High-Quality Health Care Closer to Home

- Rightsizing Rural Health Care Delivery Systems for the Future
- Coordinating and Connecting Care
- Clinics without Walls
- Sustaining Revenue
- Ensuring Safety Net Service Delivery
- Ensuring Transportation

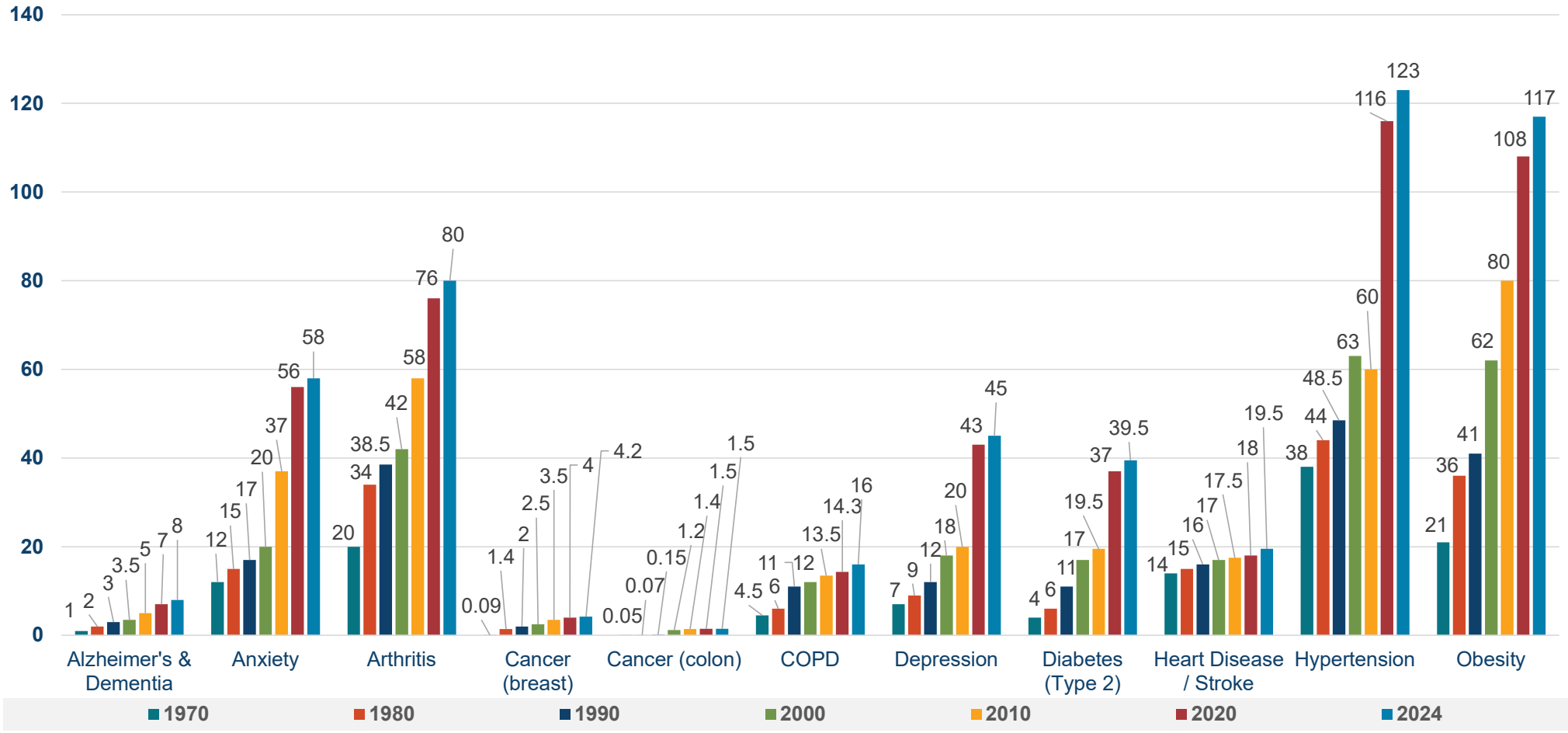
Make ND Healthy Again

- Building Connection and Resiliency
- Eat Well North Dakota
- Investing in Value
- ND Moves Together

Connect Tech, Data and Providers for a Stronger ND

- Cooperative Purchasing for Tech and Other Infrastructure
- Breaking Data Barriers
- Harnessing AI and New Tech

U.S. Adults (18+) Living with Major Chronic Conditions, 1970-2024 (in Millions)*

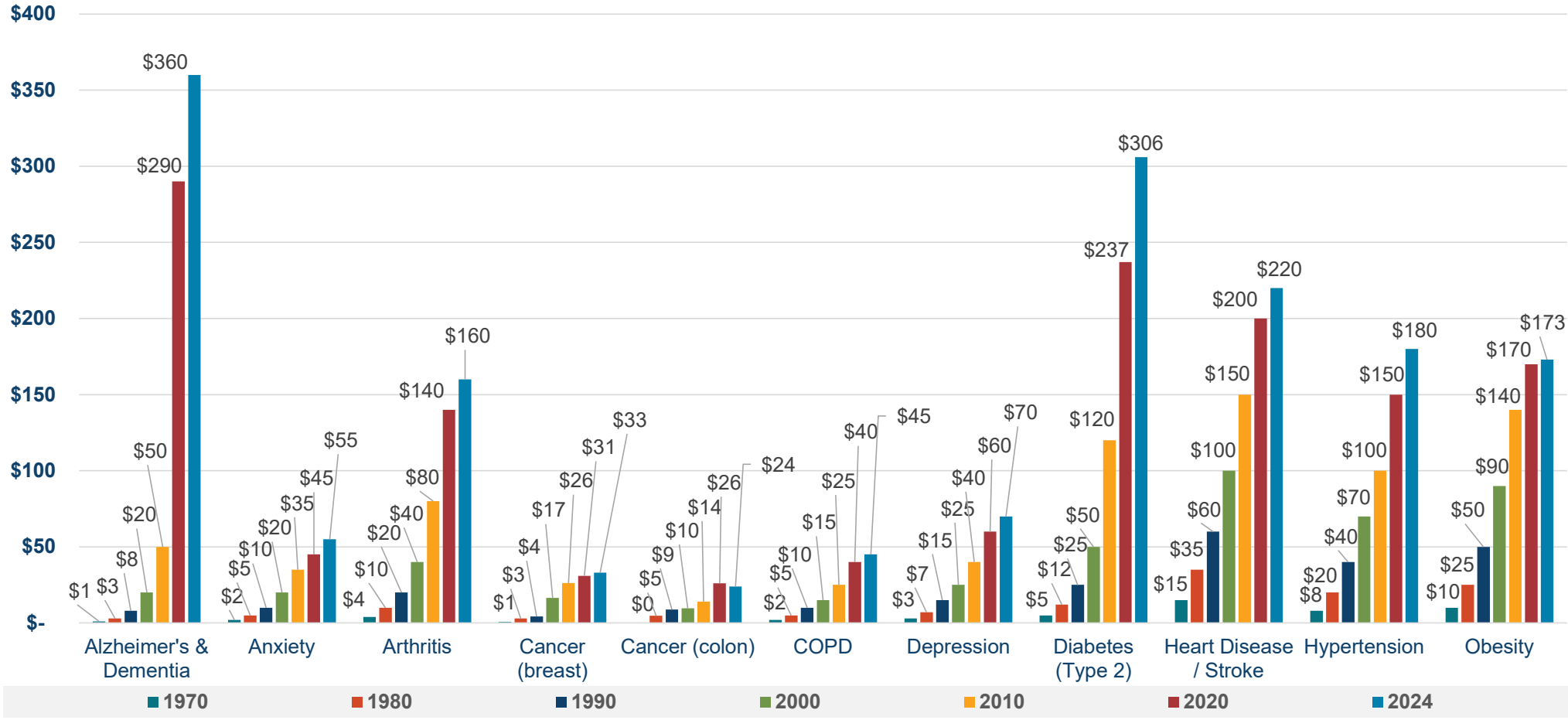


Source Citation

The figures are primarily derived from data collected through national health surveys, specifically the **National Health Interview Survey (NHIS)** and the **Behavioral Risk Factor Surveillance System (BRFSS)**, which are analyzed and published by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH).

***DRAFT** – Under review of ND DHHS, December 2025.*

Annual Direct Healthcare Costs by Chronic Condition for U.S. Adults (18+), 1970-2024 (in Billions)*



Source Citation

These figures are primarily based on analyses from the National Cancer Institute (NCI) and data from the Centers for Disease Control and Prevention (CDC).

***DRAFT** – Under review of ND DHHS, December 2025.*

North Dakota Stats

Deaths and Chronic Disease in ND:

- Heart disease and cancer are the leading causes of death in North Dakota.
- About 71% of North Dakota adults are classified as overweight (BMI ≥ 25-29.9; 35% of those classified are considered obese (BMI ≥ 30).
- 240,000 North Dakotans have high blood pressure.
- Approximately 1 in 5 in North Dakota are affected by heart disease and stroke risk factors
- 58,000 North Dakotans have Type 2 Diabetes; 183,000 have pre-diabetes.
- There are almost 4,000 new cases of cancer diagnosed in ND each year.

***DRAFT** – Under review of ND DHHS, January 2026.*

ND MOVES TOGETHER

The single most impactful thing Americans could do to prevent chronic diseases:

Become and stay physically active – specifically, meet the full Physical Activity Guidelines (150+ minutes moderate aerobic plus 2+ days strength training per week).

OUTCOME	RISK REDUCTION FROM REGULAR PHYSICAL ACTIVITY	SOURCE
Diabetes (Type 2)	30-58% reduction	CDC, Diabetes Prevention Program
Heart Disease / Stroke	30-40% reduction	AHA, NHS England meta-analysis
Hypertension	30-50% lower incidence	ACSM position stand
Obesity	30-50% lower risk of obesity	NIH / WHO
Colon Cancer	24-40% reduction	NCI / IARC
Breast Cancer	12-30% reduction	ACS
Depression	20-35% reduction	JAMA Psychiatry
Anxiety	25-35% reduction	Lancet Psychiatry
Dementia / Alzheimer's	28-45% reduction	HHS Physical Activity Guidelines
All-cause Mortality	19-35% reduction	Multiple studies

If every Americans did only one thing, getting 30-40 minutes of brisk walking (or equivalent) most days plus two short strength sessions per week would prevent more heart disease, diabetes, cancer, depression, and dementia than any drug, diet, or policy ever invented.

The Tragedy: Only ~24% of U.S. adults currently do it – and it's essentially free.

ND EATS WELL

Below is a clear, evidence-based breakdown of how diet (*independent of physical activity*) impacts the top chronic health conditions in America. A healthy diet impacts risk reduction, prevention, or disease progression.

OUTCOME	RISK REDUCTION CONSUMING A HEALTHY DIET	SOURCE
Diabetes (Type 2)	30-50% reduction	The Lancet, NHS | HP Follow-up Study
Heart Disease / Stroke	20-40% reduction	NEJM
Hypertension	25-50% lower incidence	NEJM
Obesity	30-60% lower risk of obesity	Cell Metabolism
Colon Cancer	30-40% reduction	WCRF/AICR
Breast Cancer	9-14% reduction	WCRF/AICR
Depression / Anxiety	20-30% reduction	BMC Medicine
Dementia / Alzheimer's	20-35% reduction	Alzheimer's & Dementia
Chronic Kidney Disease	20-40%	CJASN
All-cause Mortality	23-30% reduction	NHANES

Important framing: Diet affects chronic disease through inflammation, insulin sensitivity, blood pressure, cholesterol, gut microbiome, and body weight. For several conditions, diet is one of the strongest modifiable risk factors.

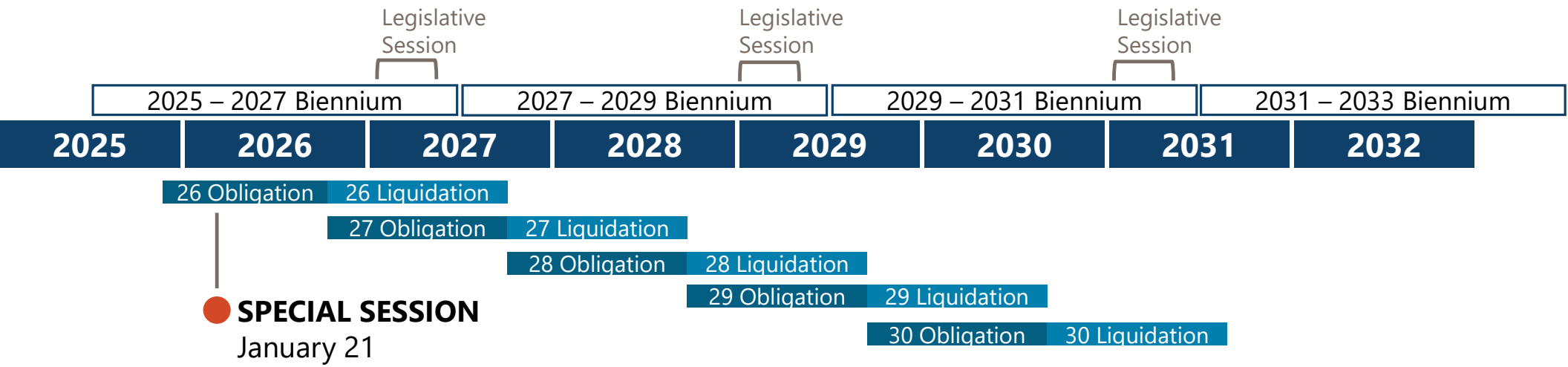
Above ranges commonly cited by the CDC, NIH, American Heart Association, American Cancer Society, and large cohort studies.

Funding Timeline

Grant Year	Baseline Funding Amount	Workload Funding Amount	Award Year Start Date	Obligation Deadline	Liquidation Deadline
FFY 2026	$100,000,000	$98,936,970	12/29/2025	10/30/2026	9/30/2027
FFY 2027	$100,000,000	TBD	10/31/2026	10/30/2027	9/30/2028
FFY 2028	$100,000,000	TBD	10/31/2027	10/30/2028	9/30/2029
FFY 2029	$100,000,000	TBD	10/31/2028	10/30/2029	9/30/2030
FFY 2030	$100,000,000	TBD	10/31/2029	10/30/2030	9/30/2031

Authorization of Funding

- Funding will span 4 biennia.
- HHS will request authority through regular legislative appropriations process in future biennia.



Continued / Future Funding Guidelines

- Conditional on recipient satisfactory performance
  - Process in implementing initiatives approved by CMS
    - Adherence to the implementation plan and timeline
    - Process on self-imposed performance metrics
  - Progress in implementing State policy actions
  - Accurate, complete, comprehensive, and timely submission of quarterly and annual progress report
  - Quality and timely communication with CMS
  - CMS will recalculate recipient's technical score and corresponding workload funding amount for subsequent budget periods
- CMS can decrease, recover funding or terminate an award if requirements not met.
- CMS will redistribute unexpended or unobligated funds in the nearest following fiscal year using the same structure to recalculate technical score
- HHS is allowed to seek prior approval to revise budget and program plans throughout the award year

Unallowable Costs and Limits

10% - $19.89MM Cap on Admin Costs Across All Funding

- Pre-award costs.
- Meeting matching requirements for any other federal funds or for local entities.
- Services, equipment or supports that are the legal responsibility of another party under federal, State or tribal law.
- Supplanting existing State, local, tribal, or private funding of infrastructure or services.
- New construction, building expansion, or purchasing of buildings.
  - Renovations or alterations are allowed if they are clearly linked to program goals. Cannot include cosmetic upgrades or significant retrofitting of buildings.
  - Renovation or alterations cannot exceed **20% - $39.8MM** of total funding in budget period.
- Replacing payment(s) for clinical services that could be reimbursed by insurance.
  - Direct health care services may be funded if not currently reimbursable, will fill a gap in care coverage, and/or may transform current care delivery model.
  - Provider payments can't exceed **15% - $29.8MM** of total funding budget period.

Unallowable Costs and Limits
(continued…)

10% - $19.89MM Cap on Admin Costs Across All Funding

- No more than **5% - $9.9MM** of total funding in a budget period can support funding the replacement of an electronic health record (EHR) system if a previous HITECH certified EMR is in place as of September 1, 2025.
- Funding toward initiatives similar to the "Rural Tech Catalyst Fund Initiative" cannot exceed the lesser of **10% - $19.89MM** of total funding or $20 million of total funding awarded in a budget period.
- Financial assistance to households for installation and monthly broadband internet costs.
- Clinician salaries/wages for facilities that subject clinicians to non-compete clauses.
- Meals and food.

Anticipated Implementation Challenges

- Provider/Vendor readiness and ability to successfully deploy investments in RHT priorities
- Short timeframe for funding obligation and liquidation
- Detailed Federal review and approval of all awards
- Length of procurement, grant and contracting process
- Federal reporting
- IT Resources
- Communication of opportunities

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Processes

HHS anticipates using several mechanisms to award funds:

Direct Contracts	Grants	Requests for Bid (RFB)	Requests for Proposal (RFP)

- Ensure funding is prioritized to benefit citizens in rural communities.
  - Internal/external subject matter expert collaboration.
- HHS intends to limit administrative burden as much as possible within the award process.

Note: Funding awards must be made in compliance with all federal award guidance and requirements. All sub-awards will be approved by CMS.

Investment & Award Process Example

***Note:** Application & implementation technical assistance will be offered when necessary

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Anticipated Funding Opportunities in Q1 2026

Subaward opportunities released on a rolling basis.

- Create workforce recruitment/retention grant opportunities for rural providers.
- Technical assistance, training, equipment and remodeling grants for providers filling a gap in the current service delivery system or expanding outreach and telehealth supports to underserved communities.
- Rightsizing service delivery for rural hospitals utilizing technical assistance and analytical consultants.
- Explore structure for a unified electronic health record (EHR) option for providers.

Policy Provisions Related to RHTP Funding

***for the 5-year award period**

Currently working with CMS to verify award allocations per state policy action

- **Presidential fitness test**
  - Estimated 0.93% of total award **($9M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1383.01000.pdf
- **Nutrition continuing medical education**
  - Estimated 1.75% of total award **($17.5M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1384.01000.pdf
- **Physician assistant compact**
  - Estimated 0.35% of total award **($3.5M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1385.01000.pdf
- **Scope of practice for pharmacists**
  - Estimated 0.4% of total award **($3.9M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1386.01000.pdf

How will HHS communicate about subaward opportunities?

- RHTP Webpage
- Email groups
  - RHTP Email Distribution
  - Tribal Consultation Email
- HHS Committees/Councils
  - Tribal Consultation
- Listening Sessions
- Legislative Committees

Links:

- ND Rural Health Transformation Website
- Sign up for RHTP Announcements Here!

Contact information

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NORTH DAKOTA Farmers Union

Contact:

Lance Gaebe, Policy Strategist
701-952 0103 lgaebe@ndfu.org

Testimony of
Lance Gaebe
North Dakota Farmers Union

to: Special Legislative Session Joint Appropriations Committee
January 21, 2026

Chairmen Vigesaa and Bekkedahl and members of the joint appropriations committee,

Thank you for the opportunity to provide testimony in support of House Bill No 1623. My name is Lance Gaebe, I represent North Dakota Farmers Union and I submit this testimony on behalf of our members. We support HB 1623 and its appropriation of $397.9 million of federal funds for Rural Health Transformation Program functions and grants.

During NDFU's recent annual convention, our members adopted special orders of business outlining our policy priorities. Among these priorities is targeted and effective funding through the Rural Health Transformation Program. North Dakota Farmers Union supports efforts to strengthen rural health systems and ensures that federal investments improve access, workforce capacity, and long-term sustainability in rural communities.

With this funding, we ask the Legislature and North Dakota Department of Health and Human Services to:

- Address agricultural community needs, including emergency services, mental health, prenatal care, and telehealth.
- Prioritize rural and underserved communities in fund distribution, particularly areas lacking basic emergency services or experiencing severe provider shortages.
- Establish clear definitions of "rural" to ensure funds intended for truly remote areas, not be redirected to regional centers with adequate health infrastructure.
- Support community-based solutions that empower local health systems rather than consolidate services in regional centers.

NDFU respectfully requests approval of the transformative funding in HB 1623. We look forward to working with policy makers and the Department of Health and Human Services to provide measurable improvements in rural health, emergency services and sustainable communities.

2026 JOINT STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1623
1/21/2026

A BILL for an Act to provide an appropriation to the department of health and human services for federal rural health transformation program grant funds; to provide an exemption; to provide for application; to provide a report; and to provide an effective date.

5:39 p.m. Co-Chairman Vigesaa opened the meeting.

Members present: Co-Chairman Vigesaa, Representatives: Anderson, Berg, Bosch, Brandenburg, Fisher, Ista, Kempenich, Louser, Martinson, Meier, Mitskog, Monson, Murphy, Nathe, Nelson, Pyle, Richter, Sanford, Stemen, Swiontek, Wagner, Warrey, Co-Chairman Bekkedahl, Senators: Burckhard, Cleary, Conley, Davison, Dever, Dwyer, Erbele, Magrum, Mathern, Meyer, Schaible, Sickler, Sorvaag, Thomas, Wanzek.

Discussion Topics:

- Centers for Medicare and Medicaid Services
- Chemotherapy
- Mental Illness
- Roughrider Network
- Frontier Areas
- Bank of North Dakota
- Rural Health Financing Program
- Revolving Loan Fund

5:41 p.m. Patrick Traynor, Interim Commissioner, North Dakota Health and Human Services, answered questions.

5:43 p.m. Rep Kempenich proposed amendment LC #25.1392.01002.

5:44 p.m. Rep Tveit explained amendment LC #25.1392.01002 and submitted testimony #45467.

6:01 p.m. Co-Chairman Vigesaa proposed an amendment and submitted testimony #45468.

6:02 p.m. Don Morgan, President, Bank of North Dakota testified in favor.

6:14 p.m. Senator Cleary moved the amendment to add the Bank of North Dakota Rural Health Financing Program.

6:14 p.m. Representative Kempenich seconded the motion.

6:16 p.m. Roll Call Vote

Representatives	Vote
Representative Don Vigesaa	Y
Representative Bert Anderson	Y
Representative Mike Berg	Y
Representative Glenn Bosch	Y
Representative Mike Brandenburg	Y
Representative Jay Fisher	Y
Representative Zachary Ista	Y
Representative Keith Kempenich	Y
Representative Scott Louser	Y
Representative Bob Martinson	Y
Representative Lisa Meier	AB
Representative Alisa Mitskog	Y
Representative David Monson	Y
Representative Eric Murphy	Y
Representative Mike Nathe	Y
Representative Jon Nelson	Y
Representative Brandy Pyle	Y
Representative David Richter	Y
Representative Mark Sanford	Y
Representative Greg Stemen	Y
Representative Steve Swiontek	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

6:16 p.m. Motion passed 22-0-1.

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Randy Burckhard	AB
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	Y
Senator Dick Dever	Y
Senator Michael Dwyer	Y
Senator Robert Erbele	Y
Senator Jeff Magrum	Y
Senator Tim Mathern	Y
Senator Scott Meyer	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	Y
Senator Ronald Sorvaag	Y
Senator Paul Thomas	Y
Senator Terry Wanzek	Y

6:16 p.m. Motion passed 15-0-1.

6:20 p.m. Jonathan Alm, Chief Legal Officer, North Dakota Health and Human Services, provided neutral testimony.

6:21 p.m. Senator Cleary moved Do Pass as Amended.

6:21 p.m. Senator Dever seconded the motion.

6:29 p.m. Roll Call Vote

Representatives	Vote
Representative Don Vigesaa	Y
Representative Bert Anderson	Y
Representative Mike Berg	Y
Representative Glenn Bosch	Y
Representative Mike Brandenburg	Y
Representative Jay Fisher	Y
Representative Zachary Ista	Y
Representative Keith Kempenich	Y
Representative Scott Louser	Y
Representative Bob Martinson	Y
Representative Lisa Meier	AB
Representative Alisa Mitskog	Y
Representative David Monson	Y
Representative Eric Murphy	Y
Representative Mike Nathe	Y
Representative Jon Nelson	Y
Representative Brandy Pyle	Y
Representative David Richter	Y
Representative Mark Sanford	Y
Representative Greg Stemen	Y
Representative Steve Swiontek	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

6:29 p.m. Motion passed 22-0-1.

6:29 p.m. Roll Call Vote

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Randy Burckhard	AB
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	Y
Senator Dick Dever	Y
Senator Michael Dwyer	AB
Senator Robert Erbele	Y
Senator Jeff Magrum	Y
Senator Tim Mathern	Y
Senator Scott Meyer	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	Y
Senator Ronald Sorvaag	Y
Senator Paul Thomas	Y
Senator Terry Wanzek	Y

6:29 p.m. Motion passed 14-0-2.

6:30 p.m. Representative Nelson and Senator Dever will carry the bill.

6:31 p.m. Co-Chairman Vigesaa closed the meeting.

Krystal Eberle, Committee Clerk

25.1392.01005
Title.02000

Sixty-ninth
Legislative Assembly
of North Dakota

Prepared by the Legislative Council
staff for Joint Appropriations
January 21, 2026

PROPOSED AMENDMENTS TO

CO
1/21/2026
1 of 6

HOUSE BILL NO. 1623

Introduced by

Legislative Management

(Joint Appropriations Committee)

A BILL for an Act to provide an appropriation to the department of health and human services for federal rural health transformation program grant funds; to provide an appropriation to the Bank of North Dakota to administer a loan program; to provide a transfer; to amend and reenact section 6-09-47 of the North Dakota Century Code, relating to a rural health loan program under the medical facility infrastructure loan fund; to provide an exemption; to provide for application; to provide a report; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION - DEPARTMENT OF HEALTH AND HUMAN SERVICES - FEDERAL RURAL HEALTH TRANSFORMATION PROGRAM. There is appropriated from other funds derived from federal funds, not otherwise appropriated, the sum of $397,873,940, or so much of the sum as may be necessary, to the department of health and human services for the federal rural health transformation program, for the period beginning with the effective date of this Act and ending June 30, 2027.

SECTION 2. EXEMPTION - LINE ITEM TRANSFERS. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer funds between section 1 of this Act and subdivisions 1, 2, 3, 4, 5, and 6 of section 1 of House Bill No. 1012, as approved by the sixty-ninth legislative assembly, as requested by the department of health and human services. Any transfers from section 1 of this Act to the salaries and wages block grant line item in subdivision 1 of section 1 of House Bill No. 1012, as approved by the sixty-ninth legislative assembly, are not subject to the transfer limitation provisions in section 4 of House Bill

assembly, are not subject to the transfer limitation provisions in section 4 of House Bill No. 1012. The department of health and human services shall notify the legislative council of any transfer made pursuant to this section.

SECTION 3. APPROPRIATION - BANK OF NORTH DAKOTA - FULL-TIME EQUIVALENT POSITIONS. There is appropriated out of any moneys in the Bank of North Dakota operating fund in the state treasury, not otherwise appropriated, the sum of $600,000, or so much of the sum as may be necessary, to the Bank of North Dakota for the purpose of administering a rural health loan program for the period beginning with the effective date of this Act and ending June 30, 2027. The Bank is authorized four full-time equivalent positions to administer the rural health loan program.

SECTION 4. TRANSFER - BANK OF NORTH DAKOTA PROFITS TO MEDICAL FACILITY INFRASTRUCTURE LOAN FUND. The Bank of North Dakota shall transfer up to $40,000,000 from the Bank's current earnings and undivided profits to the medical facility infrastructure loan fund during the period beginning with the effective date of this Act and ending June 30, 2027. Funding transferred under this section may be used only for the rural health loan program.

SECTION 5. EXEMPTION - CONTINGENT AUTHORIZATION TO INCREASE APPROPRIATION AUTHORITY. If the department of health and human services awards federal rural health transformation program funds appropriated in section 1 of this Act to another state agency or institution, notwithstanding any other provision of law, the office of management and budget may adjust the state agency or institution's federal funds appropriation authority by the amount of the award during the period beginning with the effective date of this Act and ending June 30, 2027. The office of management and budget shall notify the legislative council of any appropriation adjustments made pursuant to this section.

SECTION 6. AMENDMENT. Section 6-09-47 of the North Dakota Century Code is amended and reenacted as follows:

6-09-47. Medical facility infrastructure loan fund - Medical facility infrastructure loan program - Rural health loan program - Continuing appropriation - Audit and costs of administration.

1. The Bank of North Dakota shall administer a medical facility infrastructure loan program to provide loans to medical facilities to conduct construction that improves the

health care infrastructure in the state or improves access to existing nonprofit health care providers in the state. The construction project may include land purchases and may include purchase, lease, erection, or improvement of any structure or facility to the extent the governing board of the health care facility has the authority to authorize such activity.

2. In order to be eligible under ~~this~~the medical facility infrastructure loan program, the applicant must be the governing board of the health care facility which shall submit an application to the Bank. The application must:
   a. Detail the proposed construction project, which must be a project of at least one million dollars and which is expected to be utilized for at least thirty years;
   b. Demonstrate the need and long-term viability of the construction project; and
   c. Include financial information as the Bank may determine appropriate to determine eligibility, such as whether there are alternative financing methods.
3. A medical facility infrastructure loan provided under this section:
   a. May not exceed the lesser of fifteen million dollars or seventy-five percent of the actual cost of the project;
   b. Must have an interest rate equal to two percent; and
   c. Must provide a repayment schedule of no longer than twenty-five years.
4. A recipient of a medical facility infrastructure loan under this section shall complete the financed construction project within twenty-four months of approval of the loan. Failure to comply with this subsection may result in forfeiture of the entire loan received under this section.
5. The Bank shall administer a rural health loan program to provide short-term gap financing to grant recipients under the federal rural health transformation program with approved projects and a demonstrated financial need.
   a. To be eligible for a rural health loan under this subsection, the applicant:
      (1) Must be approved for a grant by the department of health and human services and the centers for Medicare and Medicaid services, as applicable, under the federal rural health transformation program based on policies developed by the department of health and human services.

(2) Provide information as requested by the Bank, including information substantiating a demonstrated financial need and evidence of project approval from the department of health and human services under the federal rural health transformation program.

b. A loan under this subsection must have:

(1) An annual interest rate that does not exceed two percent;

(2) A term that complies with the criteria established by the department of health and human services, in accordance with the federal rural health transformation program, and does not exceed three years.

c. From the repayment of loans under this subsection, the principal portion must be used to replenish the Bank's profits which were transferred to the fund for the loans under this program, and interest portion must be deposited in the fund.

6. The medical facility infrastructure loan fund is a special fund in the state treasury. This fund is a revolving fund. All moneys transferred into the ~~medical facility infrastructure~~ fund, interest on moneys in the fund, and collections of principal and interest on loans from the fund are appropriated to the Bank on a continuing basis for the purpose of providing loans under this section.

~~6. Funds in the medical facility infrastructure~~

7. Moneys in the fund may be used for loans as provided under this section and to pay the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the ~~medical facility infrastructure~~ fund ~~maintained under this section~~.

~~7.~~8. The ~~medical facility infrastructure~~ fund must be audited in accordance with section 6-09-29. The cost of the audit and any other actual costs incurred by the Bank on behalf of the fund must be paid from the fund.

~~8.~~9. The Bank shall deposit medical facility infrastructure loan ~~repayment funds~~repayments in the ~~medical facility infrastructure~~ fund.

SECTION 7. APPLICATION - EXEMPTION - FEDERAL RURAL HEALTH TRANSFORMATION PROGRAM.

1. Section 54-27-12 does not apply to the erection or improvement of any public building or structure or the purchase of real property utilizing funding appropriated in section 1 of this Act.

2. Notwithstanding chapter 54-44.7, an agency or governing body may use the process outlined in section 37-10-03.6 for consultants in the areas of architecture, engineering, construction management, land surveying, and related matters when using the funding appropriated in section 1 of this Act for public improvements to meet the requirements of section 48-01.2-02.
3. Equipment or supplies purchased by the state with the funding appropriated in section 1 of this Act may be transferred to other entities or individuals in accordance with the requirements of the federal rural health transformation program.
4. Notwithstanding subsection 7 of section 54-44.4-13, cooperative purchasing may be made available to entities eligible to receive funding appropriated in section 1 of this Act in accordance with the requirements of the federal rural health transformation program.
5. Section 32-12.2-15 does not apply to any routine or standardized products that contain adhesive contract terms in shrink wrap documents, third-party end user licenses, or click-through agreements that are not consistent with section 32-12.2-15 for purchases using funding appropriated in section 1 of this Act if the purchase involves training, training and testing materials, reference materials, access to online information, online services, memberships, licensure, conferences, or travel, and the purchase or use does not require the disclosure of confidential information or personally identifiable information as defined in chapter 51-30 and does not impact data or system security. For purposes of this section, "routine or standardized products" means products commercially available to the public.

SECTION 8. GRANT RECIPIENT ACKNOWLEDGMENT AND REPORTING. The funds appropriated in section 1 of this Act are limited duration federal funds allocated to the state through the federal rural health transformation program. The department of health and human services shall require grant recipients to acknowledge in any grant agreement that the funding awarded is from funding that will not continue beyond the duration of the federal rural health transformation program. The department may require grant recipients to submit process and outcome measures to the department for programs and services receiving funds appropriated in section 1 of this Act.

SECTION 9. LEGISLATIVE MANAGEMENT REPORT. During the remainder of the 2025-26 interim, the department of health and human services shall provide periodic reports to the legislative management regarding the status of funding allocations, programs, outcomes, and other requested information associated with the federal rural health transformation program grant.

SECTION 10. EFFECTIVE DATE. This Act becomes effective immediately upon its filing with the secretary of state.

REPORT OF STANDING COMMITTEE
HB 1623

Joint Appropriations Committee (Rep. Vigesaa, Co-Chairman) recommends **AMENDMENTS (25.1392.01005)** and when so amended, recommends **DO PASS** (22 YEAS, 0 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1623 was placed on the Sixth order on the calendar.

REPORT OF STANDING COMMITTEE
HB 1623

Joint Appropriations Committee (Sen. Bekkedahl, Co-Chairman) recommends **AMENDMENTS (25.1392.01005)** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 2 ABSENT OR EXCUSED AND NOT VOTING). HB 1623 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

25.1392.01002
Title.

Prepared by the Legislative Council staff for Representative Tveit
January 21, 2026

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1623

Introduced by

Legislative Management

(Joint Appropriations Committee)

A BILL for an Act to provide an appropriation to the department of health and human services for federal rural health transformation program grant funds; to provide an exemption; to provide for application; to provide a report; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION - DEPARTMENT OF HEALTH AND HUMAN SERVICES - FEDERAL RURAL HEALTH TRANSFORMATION PROGRAM - QUALIFICATIONS. There is appropriated from other funds derived from federal funds, not otherwise appropriated, the sum of $397,873,940, or so much of the sum as may be necessary, to the department of health and human services for the federal rural health transformation program, for the period beginning with the effective date of this Act and ending June 30, 2027. For purposes of the appropriation under this section, the department of health and human services shall develop qualification criteria for the initiative to bring high-quality care closer to home to the extent the criteria do not conflict with requirements of the centers for medicare and medicaid services, including:

1. To qualify as an eligible North Dakota rural health care facility:
   a. Care must be provided and administered at a health care facility located more than five miles from Bismarck, Dickinson, Fargo, Grand Forks, Jamestown, Minot, Watford City, and Williston; or
   b. Care may be a collaborative effort with a health care facility located in Bismarck, Dickinson, Fargo, Grand Forks, Jamestown, Minot, Watford City, or Williston, but

must be administered at a facility located more than five miles from the cities identified under this subsection.

2. To qualify as an eligible expenditure, an expenditure must enhance treatment available at a health care facility located more than five miles from Bismarck, Dickinson, Fargo, Grand Forks, Jamestown, Minot, Watford City, and Williston.

SECTION 2. EXEMPTION - LINE ITEM TRANSFERS. Notwithstanding section 54-16-04, the director of the office of management and budget shall transfer funds between section 1 of this Act and subdivisions 1, 2, 3, 4, 5, and 6 of section 1 of House Bill No. 1012, as approved by the sixty-ninth legislative assembly, as requested by the department of health and human services. Any transfers from section 1 of this Act to the salaries and wages block grant line item in subdivision 1 of section 1 of House Bill No. 1012, as approved by the sixty-ninth legislative assembly, are not subject to the transfer limitation provisions in section 4 of House Bill No. 1012. The department of health and human services shall notify the legislative council of any transfer made pursuant to this section.

SECTION 3. EXEMPTION - CONTINGENT AUTHORIZATION TO INCREASE APPROPRIATION AUTHORITY. If the department of health and human services awards federal rural health transformation program funds appropriated in section 1 of this Act to another state agency or institution, notwithstanding any other provision of law, the office of management and budget may adjust the state agency or institution's federal funds appropriation authority by the amount of the award during the period beginning with the effective date of this Act and ending June 30, 2027. The office of management and budget shall notify the legislative council of any appropriation adjustments made pursuant to this section.

SECTION 4. APPLICATION - EXEMPTION - FEDERAL RURAL HEALTH TRANSFORMATION PROGRAM.

1. Section 54-27-12 does not apply to the erection or improvement of any public building or structure or the purchase of real property utilizing funding appropriated in section 1 of this Act.
2. Notwithstanding chapter 54-44.7, an agency or governing body may use the process outlined in section 37-10-03.6 for consultants in the areas of architecture, engineering, construction management, land surveying, and related matters when using the funding

appropriated in section 1 of this Act for public improvements to meet the requirements of section 48-01.2-02.

3. Equipment or supplies purchased by the state with the funding appropriated in section 1 of this Act may be transferred to other entities or individuals in accordance with the requirements of the federal rural health transformation program.

4. Notwithstanding subsection 7 of section 54-44.4-13, cooperative purchasing may be made available to entities eligible to receive funding appropriated in section 1 of this Act in accordance with the requirements of the federal rural health transformation program.

5. Section 32-12.2-15 does not apply to any routine or standardized products that contain adhesive contract terms in shrink wrap documents, third-party end user licenses, or click-through agreements that are not consistent with section 32-12.2-15 for purchases using funding appropriated in section 1 of this Act if the purchase involves training, training and testing materials, reference materials, access to online information, online services, memberships, licensure, conferences, or travel, and the purchase or use does not require the disclosure of confidential information or personally identifiable information as defined in chapter 51-30 and does not impact data or system security. For purposes of this section, "routine or standardized products" means products commercially available to the public.

SECTION 5. GRANT RECIPIENT ACKNOWLEDGMENT AND REPORTING. The funds appropriated in section 1 of this Act are limited duration federal funds allocated to the state through the federal rural health transformation program. The department of health and human services shall require grant recipients to acknowledge in any grant agreement that the funding awarded is from funding that will not continue beyond the duration of the federal rural health transformation program. The department may require grant recipients to submit process and outcome measures to the department for programs and services receiving funds appropriated in section 1 of this Act.

SECTION 6. LEGISLATIVE MANAGEMENT REPORT. During the remainder of the 2025-26 interim, the department of health and human services shall provide periodic reports to the legislative management regarding the status of funding allocations, programs, outcomes,

and other requested information associated with the federal rural health transformation program grant.

SECTION 7. EFFECTIVE DATE. This Act becomes effective immediately upon its filing with the secretary of state.

SECTION 1. AMENDMENT. Section 6-09-47 of the North Dakota Century Code is amended and reenacted as follows:

6-09-47. Medical facility infrastructure loan fund – Medical facility infrastructure loan program – Rural health financing program – Continuing appropriation – Audit and costs of administration.

1. The Bank of North Dakota shall administer a medical facility infrastructure loan program to provide loans to medical facilities to conduct construction that improves the health care infrastructure in the state or improves access to existing nonprofit health care providers in the state. The construction project may include land purchases and may include purchase, lease, erection, or improvement of any structure or facility to the extent the governing board of the health care facility has the authority to authorize such activity.
2. In order to be eligible under ~~this~~ the medical facility infrastructure loan program, the applicant must be the governing board of the health care facility which shall submit an application to the Bank. The application must:
    a. Detail the proposed construction project, which must be a project of at least one million dollars and which are expected to be utilized for at least thirty years;
    b. Demonstrate the need and long-term viability of the construction project; and
    c. Include financial information as the Bank may determine appropriate to determine eligibility, such as whether there are alternative financing methods.
3. A medical facility infrastructure loan provided under this section:
    a. May not exceed the lesser of fifteen million dollars or seventy-five percent of the actual cost of the project;
    b. Must have an interest rate equal to two percent; and
    c. Must provide a repayment schedule of no longer than twenty-five years.
4. A recipient of a medical facility infrastructure loan under this section shall complete the financed construction project within twenty-four months of approval of the loan. Failure to comply with this subsection may result in forfeiture of the entire loan received under this section.
5. The Bank shall administer a rural health financing program to provide interim financing to recipients with approved projects and demonstrated financial need, through the federal rural health transformation program grant funds.
    a. To be eligible for a loan from the rural health financing program under this subsection, the applicant shall:

i. Submit an application to the department of health and human services. An application for a loan under this section shall be reviewed and approved by the department of health and human services. The department of health and human services shall develop policies for reviewing and approving projects under this section.
ii. Provide additional information as the Bank may determine appropriate; and
iii. Provide evidence of project approval from the department of health and human services for federal rural health transformation program grant funds.

b. An loan under this subsection:
i. Must have an annual interest rate that does not exceed two percent; and
ii. Must have a term that complies with the criteria established by the department of health and human services, in accordance with the rural health transformation program, and does not exceed three years.

6. The medical infrastructure loan fund is a special fund in the state treasury. This fund is a revolving fund. All moneys transferred into the ~~medical facility infrastructure~~ fund, interest on moneys in the fund, and collections of principal and interest on loans from the fund are appropriated to the Bank on a continuing basis for the purpose of providing loans under this section.
7. ~~Funds in the medical facility infrastructure~~ Moneys in the fund may be used for loans as provided under this section and to pay the costs of administration of the fund. Annually, the Bank may deduct a service fee for administering the ~~medical facility infrastructure~~ fund ~~maintained under this section.~~
8. The ~~medical facility infrastructure~~ fund must be audited in accordance with section 6-09-29. The cost of the audit and any other actual costs incurred by the Bank on behalf of the fund must be paid from the fund.
9. The Bank shall deposit loan ~~repayment funds~~ repayments in the ~~medical facility infrastructure~~ fund.

SECTION 2. APPROPRIATION – BANK OF NORTH DAKOTA – FULL-TIME EQUIVALENT POSITION. There is appropriated out of Bank of North Dakota profits, the sum of $600,000, or so much as may be necessary, to the Bank of North Dakota, for the purpose of administering the rural health financing program. The Bank of North Dakota is authorized four full-time equivalent positions to administer the program.

SECTION 3. APPROPRIATION – TRANSFER – BANK OF NORTH DAKOTA PROFITS TO MEDICAL FACILITY INFRASTRUCTURE LOAN FUND – RURAL HEALTH FINANCING

PROGRAM. The Bank of North Dakota shall transfer up to $40,000,000, from the Bank's current and undivided profits to the medical facility infrastructure loan fund – rural health financing program, beginning from the effective date of this act and ending June 30, 2029. Funding transferred under this section must be used to provide loans under the rural health financing program. Repayments to the rural health financing program shall be transferred to replenish the $40,000,000 of the Bank of North Dakota's undivided profits which was transferred under this section.