HEALTH CARE COMMITTEE

The Health Care Committee was assigned three studies:

- Section 53 of Senate Bill No. 2012 (2023) directed a study of the benefits of basing provider reimbursement rates for the Medicaid program in accordance with a provider's performance under established and accepted value-based care metrics.
- Section 1 of House Bill No. 1476 (2023) directed a study of the impact of entities that receive Medicaid and Medicaid Expansion funding using contract nursing agencies.
- Section 1 of Senate Bill No. 2389 (2023) directed a study of prior authorization (PA) in health benefit plans. The study required consideration of the extent to which PA is used by health insurance companies in this state, including the types of services and procedures for which PA is required; the impact of PA on patient care, including the effects on patient health outcomes, patient satisfaction, health care costs, and patient access to care; the impact of PA on health care providers and insurers, including the administrative burden, time, and cost associated with obtaining PA, and the appropriate utilization of health care services; state and federal laws and regulations that may impact PA; and input from stakeholders, including patients, providers, and commercial insurance plans.

The Legislative Management assigned the committee the responsibility to receive six reports and complete one directive:

- A biennial report from the State Fire Marshal on the State Fire Marshal's findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes, pursuant to North Dakota Century Code Section 18-13-02(6).
- A biennial report from the Department of Health and Human Services (DHHS), Indian Affairs Commission, and the Public Employees Retirement System on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes, pursuant to Section 23-01-40.
- A biennial report from DHHS regarding progress made toward the recommendations provided in Section 23-43-04, regarding stroke centers and stroke care, and any recommendations for future legislation, pursuant to Section 23-43-04.
- An annual report from the Maternal Mortality Review Committee regarding the identification of patterns, trends, and policy issues related to maternal mortality, pursuant to Section 23-51-08.
- Annual reports from the North Dakota Legislative Health Care Task Force on its activities and any recommendations to improve health care in the state, pursuant to Section 50-06-45.
- A report from DHHS regarding the study of basic care funding rates, as directed by Section 10 of Senate Bill No. 2012 (2023).
- A directive to recommend a private entity with which to contract, after receiving recommendations from the Insurance Commissioner, to provide a cost-benefit analysis of every legislative measure mandating health insurance coverage of services or payment for specified providers of services, or an amendment that mandates such coverage or payment, pursuant to Section 54-03-28.

Committee members were Senators Kyle Davison (Chairman), Sean Cleary, Tim Mathern, and Kristin Roers and Representatives Gretchen Dobervich, Clayton Fegley, LaurieBeth Hager, Dawson Holle, Carrie McLeod, Jon O. Nelson, Emily O'Brien, Karen M. Rohr, Mary Schneider, Greg Stemen, Michelle Strinden, and Robin Weisz.

MEDICAID PROVIDER REIMBURSEMENT ARRANGEMENTS STUDY

Section 53 of Senate Bill No. 2012 (2023) directed a study of the benefits of basing provider reimbursement rates for the Medicaid program in accordance with a provider's performance under established and accepted value-based care metrics.

Background

Value-based payment (VBP) is an incentive-based health care reimbursement structure that prioritizes outcomes rather than services delivered. Traditionally, the health care system has operated under a fee-for-service (FFS) model, in which health care providers and hospitals are paid for each service they provide. Value-based care ties the amount health care providers earn for their services to the results they deliver for patients, rather than rewarding providers based on the volume of services provided. The goal of value-based care is to lower costs, improve the quality of care, and incentivize patient-centered practices.

The Centers for Medicare and Medicaid Services (CMS), spurred by the federal Patient Protection and Affordable Care Act, has taken a leading role in implementing VBP models and has implemented more than 50 unique models among the 50 states, largely designed for Medicare. Value-based payment models designed by CMS impact more than 41 million beneficiaries and are aimed at addressing disparities and providing regulatory authority to establish rates and manage hospital budgets. The Centers for Medicare and Medicaid Services has directed all Medicaid health care facilities to move toward value-based reimbursement systems for all health insurers by 2030. Many commercial payers and state Medicaid agencies have followed CMS's blueprints when implementing their own value-based models.

The pay-for-performance (PFP) model has emerged as a common VBP subtype through which providers are rewarded or penalized according to predetermined quality targets. The PFP model aligns payment with value and quality of care by tying reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction. The PFP model commonly is implemented in tandem with an FFS model in which payers make baseline payments for services and then use an incentive and penalty approach to increase or decrease a provider's income.

Value-Based Care in North Dakota

Comprehensive Primary Care Plus

North Dakota is 1 of 18 states that participated in Comprehensive Primary Care Plus (CPC+), a 5-year multipayer model through CMS which began in January 2017. Comprehensive Primary Care Plus was an advanced primary care medical home model that rewarded value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. Participating providers followed one of two track models. Track 1 was the pathway for practices to build their capabilities to deliver comprehensive primary care. Track 2 was for more established primary care facilities to increase their comprehensiveness of care. The key payment elements of the CPC+ model included a care management fee, performance-based incentive payment, and payment under a Medicare physician fee schedule.

Primary Care First

Beginning in 2021, many providers moved to an alternative 5-year model offering an innovative pay structure based on the underlying principles of CPC+. The Primary Care First (PCF) model prioritizes the clinician-patient relationship, enhances care for patients with complex chronic needs, and focuses financial incentives on improved health outcomes for Medicare enrollees. The model tests whether delivery of advanced primary care can reduce the total cost of care, accommodating practices at multiple stages of readiness to assume accountability for patient outcomes. The PCF model focuses on advanced primary care practices ready to assume financial risk and receive performance-based payments. The PCF model aims to be transparent, simple, and hold practitioners accountable by providing model payments to practices through a simple payment structure.

The payment structure includes a flat payment that encourages patient-centered care and compensates practices for in-person treatment; a population-based payment to provide more flexibility in the provision of patient care along with a flat primary care visit fee; and a performance-based adjustment providing an upside of up to 50 percent of model payments as well as a small downside incentive to reduce costs and improve quality, assessed and paid to practices on a quarterly basis.

Medicaid

Testimony provided by DHHS during the 2023 legislative session indicated the department was working toward implementing value-based care in the state's traditional Medicaid programming. The department seeks to move from an FFS model to a pay-for-reporting model by 2026, and thereafter to a PFP model. The proposed prospective payment system would base certain inpatient and outpatient hospital payments on quality measures. Targets would be set for hospitals based upon a hospital's peers, and up to 4 percent of Medicaid revenue for the specified subset of services would be returned to the state if the measures are not met. If certain performance metrics are satisfied, providers would have the opportunity to earn funds back.

Testimony

The committee received testimony from representatives of DHHS, the National Conference of State Legislatures, health care providers, health insurance carriers, and other interested stakeholders.

Testimony provided by DHHS indicated the department traditionally has used an FFS model for Medicaid in which the state pays providers directly for each covered service received by a Medicaid recipient. Testimony indicated nursing facility reimbursement rates are set annually based on cost reports submitted by facilities, and each facility has individualized rates.

Testimony indicated DHHS's value-based care strategies include accountability; improved patient outcomes; stable and predictable revenue for providers; enhanced health care delivery with greater focus on wellness, prevention, and care coordination; and achieving results to shift the cost curve and lower long-term costs. The committee was informed

value-based care is being implemented in prospective payment system hospitals, nursing facilities, and through the Medicaid Expansion managed care contract.

Prospective Payment System Hospitals

Testimony indicated DHHS began implementing the value-based care program for prospective payment system hospitals in July 2023. The health system value-based care puts a portion of hospital payments at risk for performance on a set of quality measures. If a hospital system fails to meet certain targets, up to 4 percent of Medicaid revenue for a subset of services and population returns to the state. The department estimated $4.2 million in payments were at risk for the 2023-25 biennium, which represents 1.1 percent of the inpatient and outpatient hospital budget. A hospital system is given the opportunity to earn back funds based on the hospital system's performance on measures as compared to the performance of the hospital system's peers.

To support systems in being successful, DHHS provides regular access to data analytics that highlight gaps in care and performance on measures. In addition, DHHS limits the number of providers with at-risk payments by limiting hospital risk to prospective payment system hospitals. Providers are at risk only for members assigned to them; providers are not at risk for unassigned members or members who belong to another system.

Testimony from DHHS indicated the initial quality measure set includes primary care access and preventative care, maternal health services, behavioral health services, care of acute and chronic conditions, and oral health services. The expanded measure set includes the same services as the initial measure set and adds colorectal cancer screening, services aimed at controlling high blood pressure, provider options for alcohol and other drug abuse or dependence services, and prenatal, postpartum, and contraceptive care.

Testimony from DHHS indicated pay for reporting on the initial measure set was implemented in July 2023, with pay for reporting on the expanded measure set to begin in 2025. Testimony indicated PFP on the initial measure set will begin in 2025, with PFP on the expanded measure set to begin in 2026. Providers are not at risk for losing payments during the pay-for-reporting period (through 2024); providers become at risk for losing payments only during the PFP period (beginning in 2025). If the system satisfies the pay-for-reporting requirements, the system retains 100 percent of the at-risk funds.

Testimony from DHHS indicated value-based care program successes for this biennium included CMS approval of the state plan amendment providing federal authority for the program and refinements of the initial and expanded measures to align to industry standards. Additionally, primary access process improvements included expanding clinic office hours, combining sports physicals with well child checks, scheduling a next appointment at the end of a visit, planning screenings and immunizations in advance, providing outreach and reminders via letters and messages, and encouraging patients to sign up for electronic health communication systems. Testimony indicated challenges included data validation and collection.

Testimony from a provider indicated 62 percent of rural hospitals in the state belong to an accountable care organization. These rural providers view value-based care as a model to deliver better health outcomes for patients and a feasible financial mechanism to continue providing care. Testimony from a provider indicated value-based care focuses on improving overall patient health, connecting patients with the appropriate care at the right time, and providing access to integrated care through the entire patient journey. Provider testimony indicated value-based care requires investment in practice transformation and quality improvement, and having the appropriate structure to support the service is critical.

Nursing Facilities

Testimony from a representative of DHHS indicated nursing facility value-based care is an incentive program for nursing facilities that have been operating for at least 10 months. The program provides annual payments based on quality measure performance and no payments are at risk. The committee was informed $12 million was appropriated for this program for the 2023-25 biennium, which represents 2 percent of the total nursing facility budget. Testimony indicated the first incentive payment for nursing facilities was issued in June 2024.

The committee was informed annual payments are based on quality measure performance, split into four tiers:

1. 100 percent of the incentive payment;
2. 85 percent of the incentive payment;
3. 60 percent of the incentive payment; and
4. Not eligible for an incentive payment.

There are no restrictions on when or the manner in which incentive dollars may be used. Nursing facilities use an annual cost report to communicate use of incentive funds.

The committee was informed nursing facility quality measures are split into two groups--patient care and facility process measures. The patient care measures include measures for long-stay urinary tract infections, antipsychotic use, and pressure ulcers. The facility process measures include measures for long-stay hospitalizations and the American Health Care Association and National Center for Assisted Living National Quality Award framework

Testimony from a representative of DHHS indicated some initial data sets showed positive outcomes and others provided room for improvement. From 2021-23, the percentage of long-stay residents with a pressure ulcer steadily decreased and remained below the national average. In addition, for each year from 2019-23, the number of hospitalizations per 1,000 long-stay resident days was lower than the national average. However, for each year from 2019-23, the percentage of long-stay residents with urinary tract infections and the percentage of long-stay residents who received antipsychotic medication was higher than the national average.

Testimony indicated nursing facilities have shown marked improvement since the incentive program was implemented, and overall quality indicator scores are improving because of the focus on quality of care.

Managed Care Organization

The committee was informed DHHS uses a Managed Care Organization (MCO) for Medicaid Expansion in which the state pays a monthly fee called a premium or capitation payment to the MCO. The monthly fee is paid to the MCO regardless of member use of services. Testimony indicated Medicaid's managed care contract for Medicaid Expansion members requires the vendor to create a strategic plan, implement alternative methodologies, and increase the number of providers participating and members attributed over time. All Medicaid Expansion members are assigned to a primary care facility, with more than 90 percent of primary care providers participating in BlueAlliance Care+. The goals of BlueAlliance Care+ are to improve quality, reduce unnecessary utilization, and manage costs. The providers are eligible to receive performance-based payments based on certain measures, including primary care visits, post-discharge follow up, and potentially preventable emergency room visits, admissions, and readmissions.

Committee Considerations

The committee recognized the value of an incentive-based Medicaid reimbursement structure that prioritizes better outcomes for patients and better-quality care. The committee determined there is value in continuing these programs, and the related program funding, during the 2025 legislative session.

Conclusion

The committee makes no recommendation regarding its study of Medicaid provider reimbursement arrangements.

CONTRACT NURSING STUDY

Section 1 of House Bill No. 1476 (2023) directed a study of the impact of entities that receive Medicaid and Medicaid Expansion funding using contract nursing agencies.

Background

Contract nursing agencies provide temporary, immediate assistance to hospitals and other health care facilities seeking short-term, nurse staffing solutions. Contract nurses, also known as travel nurses, often are employed by an independent staffing agency and may need to travel across state or international borders to fulfill a contract. Contract nurses typically earn higher wages than traditional full-time nurses, which places a greater financial burden on hospitals and other health care providers that rely heavily on these services.

The health care industry has been impacted by a decades-long shortage of health care professionals, with the shortage in nurses being the most pronounced. Nurses are a critical component of the health care system and are a majority of the industry's workforce. Factors contributing to the nursing shortage include an aging population, a lack of educators, and turnover rates from 8.8 to 37 percent, depending on geographic location and specialty. Rural communities are disproportionately impacted by the shortage of nurses due to older populations, fewer resources, and low staff retention. The COVID-19 pandemic further exacerbated nursing shortages, requiring health care facilities to contract with nursing agencies to keep facilities staffed during periods of increased demand.

Many states have proposed and enacted legislation to regulate contract nurses and nursing staff agencies. Although some states regulated contract nursing before the COVID-19 pandemic, state regulation efforts increased overall in response to the pandemic. Few states have directly tied reform efforts to Medicaid; most state legislation has been broad in nature.

Contract Nursing in North Dakota

Hospitals and long-term care facilities depend on contract nurses to provide essential health care services. According to the North Dakota Long Term Care Association, contract nursing expenditures for long-term care facilities in North

Dakota have increased steadily, costing $19.9 million in 2019, $24.2 million in 2020, $28.8 million in 2021, and $63.8 million in 2022. Of the 77 long-term care facilities in the state, 91 percent, or 70 facilities, utilize contract nursing services. North Dakota does not have any statutory provisions that pertain to contract nursing.

Testimony

The committee received testimony from representatives of the North Dakota Long Term Care Association, North Dakota Hospital Association, health care providers, nursing services agencies, and other interested stakeholders.

Testimony indicated the biggest challenge facing hospitals is the workforce, and the lack of nurses is acute in urban and rural areas. Since 2019, hospital contract nursing costs have increased by 321 percent. In 2019, hospitals paid $59.3 million to contract nursing agencies and, in 2022, that amount increased to $249.8 million. If hospitals did not utilize contract nursing, there would be more than 1,400 open nursing positions across the state.

Testimony from a representative of the North Dakota Long Term Care Association indicated many long-term care facilities rely on contract nursing to maintain the staffing requirements imposed by federal regulation. The committee was informed the Long Term Care Association formed a committee to study contract nursing, which includes members from the North Dakota Hospital Association, North Dakota Nurses Association, Interim HealthCare, nursing services agencies, and other interested stakeholders. The committee discussed the challenges impacting resident safety and the difficulties in evaluating staff. The committee considered the need for minimum standards for contract agencies to ensure quality and safety, including the potential benefits of licensing requirements for contract agencies.

Committee Considerations

The committee considered a bill draft relating to establishing a regulatory framework for nursing services agencies. The bill draft provides nursing services agencies may not operate without a license issued by DHHS, provides for an annual licensure fee, and establishes standards of operation which include recordkeeping and reporting requirements. The bill draft authorizes DHHS to revoke or suspend the license of a nursing services agency for failing to follow the standards of operation and includes a penalty provision.

The committee recognized the value of establishing a regulatory framework relating to nursing services agencies. Committee members expressed differing opinions relating to whether the reporting requirements should be expanded to require nursing services agencies to submit financial reports providing information about costs and potentially setting a limit on costs.

Recommendation

The committee recommends a bill draft [25.0241.02000] relating to establishing a regulatory framework for nursing services agencies.

PRIOR AUTHORIZATION STUDY

Section 1 of Senate Bill No. 2389 (2023) directed a study of PA in health benefit plans. The study required consideration of the extent to which PA is used by health insurance companies in this state, including the types of services and procedures for which PA is required; the impact of PA on patient care, including the effects on patient health outcomes, patient satisfaction, health care costs, and patient access to care; the impact of PA on health care providers and insurers, including the administrative burden, time, and cost associated with obtaining PA, and the appropriate utilization of health care services; state and federal laws and regulations that may impact PA; and input from stakeholders, including patients, providers, and commercial insurance plans. The study allowed for consideration of issues related to response times, retroactive denial, data reporting, clinical criteria and medical necessity, transparency, fraud and abuse, reviewer qualifications, exceptions, and an appeal process.

Background

As introduced, Senate Bill No. 2389 would have created new requirements, restrictions, and timelines to standardize the PA process, including mandating the disclosure of PA requirements and restrictions; required a licensed physician to make adverse determinations; prohibited the use of PA for emergency services and the institution of timelines for urgent and nonurgent circumstances; standardized the timeline of PA appeals; and required typical PAs to be valid for 6 months, PAs for chronic conditions to be valid for 12 months, and prohibited the ability to revoke, limit, or condition an authorization within 45 days following the date of receipt. The bill was amended by the Senate to provide for a study.

The American Medical Association (AMA) describes the PA process as a cost-control mechanism that requires health care providers to seek advanced approval from health insurers before the delivery of a service, device, supply, or medication to ensure cost coverage. As health expenditures increased throughout the 1960s, programs to review insurance claims for appropriateness also increased. By the mid-1970s, most hospitals and the federal government were applying mandated utilization review programs for health expenditures. Utilization review conducted before the delivery of a health care service is known as PA. Purchasers of health care, including private payers and the government, have

become more aggressive in detecting and eliminating the use of nonessential health goods and services through further expansion of PA. Health care providers submit PA requests in response to patient needs and await approval or denial before the service or good is administered to the patient. Providers must be aware of a patient's individual insurance plan and the plan's intricacies to know what is required with each PA request. A request for PA can be approved, approved or denied in part, or denied. If a request for PA is denied, a provider may appeal the denial through another administrative process, which varies by state and payer.

The goal of PA is to ensure the prescribed service, device, supply, or medication is medically necessary, clinically appropriate, and evidence based. Prior authorization also aims to shift utilization toward lower-cost alternatives, namely when there are no additional safety or efficacy benefits associated with the higher-priced alternative. Requiring PA ensures prescribed treatments align with specific Food and Drug Administration-approved indications in which the benefits to the patient outweigh the potential risks.

While PA is intended to contain costs and ensure appropriate utilization, both patients and physicians have identified significant barriers associated with the PA process. Concerns include care delays, treatment abandonment, serious adverse events, including loss of life, increased administrative burden, and high processing costs. The American Medical Association identifies the PA process as the most common barrier to accessing medically necessary patient care, with 93 percent of physicians experiencing delays and 91 percent reporting a negative effect on patients' clinical outcomes.

Many states, including North Dakota, do not have clear timeline requirements that need to be met by the utilization review committee when responding to PA requests. This lack of standardization often leads to delays in care which increase burdens on the health care system because patients then may require additional or more intensive treatment methods. The PA process is burdensome not only to providers but also to patients. Patients may choose to forgo or discontinue pertinent care in response to PA requirements. Data from the AMA shows 82 percent of physicians indicated patients abandon treatment due to authorization struggles with health insurers.

Providers also indicate frustration with unclear reasoning when a PA is denied by health insurers, resulting in greater administrative burden. Providers and health insurers often use different sources of clinical information in their decisionmaking process, which leads to discrepancies. Many states do not require the utilization review entity to disclose the basis for its decisionmaking. North Dakota is among several states that lack a standardized appeal process with timelines and transparency.

Prior Authorization in North Dakota

North Dakota has several statutory provisions relating to PA usage and practice. Section 23-01-38 requires PA requests for drugs to be accessible on the prescribing provider's electronic software system and to be accepted electronically by the applicable utilization review committee, payer, insurance company, or pharmacy benefit manager. Chapter 26.1-26.4 outlines requirements for health care service utilization review, requiring agents to follow minimum standards set by the federal government, and prohibiting utilization review denial of and PA usage for emergency services. Section 26.1-36-03.1 requires insurers to disclose a general description of any utilization review policies and procedures, including a description of any required PA requirements and appeal procedures. Also included within the Century Code are provisions:

- Prohibiting a dental benefit plan from retroactively denying coverage for services that previously have received PA, unless certain conditions are met (Chapter 26.1-36.9);
- Requiring providers to obtain PA from preferred provider organization health plans prior to obtaining air ambulance services (Section 26.1-47-10); and
- Creating a PA drug program for individuals on medical assistance which meets federal requirements (Chapter 50-24.6).

Testimony

The committee received testimony from representatives of the AMA, health care providers, insurers, and other interested stakeholders. Testimony from the AMA indicated 80 percent of physicians report the number of medical services for which PA is required by insurers has increased over the last 5 years, and 89 percent of physicians report PA interferes with the continuity of patient care.

Health Care Providers

Testimony from health care providers indicated when properly used, PA can control costs to ensure patients receive medically necessary care. Testimony indicated harmful impacts of PA include delays in treatment, negative patient experiences, potential for treatment abandonment, barriers to innovative care models, and additional administrative burdens on providers. The committee received suggestions regarding the manner in which the PA process could be improved, including through legislation addressing time limits to standardize the time an insurance company must

determine whether a request for PA is approved, with a mechanism to generate an automatic approval if a provider does not receive an answer within the allotted time frame.

Testimony from physicians indicated insurance providers and physicians rarely communicate directly regarding PA requests. Testimony indicated physicians feel medical directors at certain insurance companies do not spend adequate time reviewing a patient's claim, and vetted physicians within an insurance provider's network should be trusted to make the correct decisions. Testimony indicated PAs should be reviewed by qualified specialists within the field of the proposed treatment.

Testimony indicated CMS recently published a final rule related to PA. The committee was informed the rule includes three key elements--interoperability, PA reform, and reporting requirements. The rule only impacts health insurance plans governed by CMS. The interoperability component of the rule provides for the creation of a standardized application programming interface, which includes information about PA decisions, integrated into the patient's application of choice. The rule requires impacted payers to implement and maintain a provider access application programming interface to share patient data with in-network providers, identify whether an item or service requires PA, and support the creation and exchange of PA requests from providers and responses from payers. The rule also requires prior authorization requirements to include standardized time frames, with a response deadline of within 7 calendar days for routine care requests and within 72 hours for urgent or expedited requests. The rule requires payers to provide specific information about why a PA request was denied, regardless of how the request was submitted. The rule requires payers to report on PA processes on their public website on an annual basis, including the percentage of requests approved, denied, and approved after appeal, and the average amount of time between submission of the request and the decision. Payers also must report annually regarding metrics relating to patient use of the application programming interface.

Insurers

Testimony received from insurers indicated PA serves as an important safety check to confirm with the provider the care recommendation is safe, medically evidenced, and not duplicative. When reviewing PA requests, a representative of one insurer testified it takes into consideration safety, best care, and cost, and encourages communication between a member's doctor and the member's insurance company.

Testimony indicated one insurer has a utilization management team that reviews highly utilized authorizations for pharmacy and medical requests quarterly and makes changes to the PAs with a higher trend of approval and a lower risk for fraud and abuse.

Testimony from insurers indicated areas of opportunity for improving the PA process include providers only submitting requests on services that require PA, the submission of requests electronically, and the inclusion of all necessary supporting documentation with the initial request.

Committee Considerations

The committee discussed encouraging the use of modern technology and electronic records in the PA process. The committee recognized there have been improvements in the process between health care providers and insurers, but discussion regarding PA reform must continue.

Conclusion

The committee makes no recommendation regarding its study of PA in health benefit plans.

STATE FIRE MARSHAL REPORT

Section 18-13-02 directs the State Fire Marshal to review the effectiveness of the section and report any findings and recommendations to the Legislative Management. Section 18-13-02 requires all cigarettes sold or offered for sale in the state to be tested in accordance with the American Society of Testing and Materials E2187-04. The report indicated the effectiveness of the fire safer cigarette program is difficult to decipher. Although the number of reported fires caused by cigarettes has increased in recent years, so has the overall number of fires reported. Since 2018, fire reporting by fire departments has increased from 50 to 80 percent of departments. Ensuring cigarettes are tested and remain a low-probability ignition source remains a positive approach to fire prevention.

DIABETES REPORT

The committee received a report, pursuant to Section 23-01-40, from DHHS, the Indian Affairs Commission, and the Public Employees Retirement System on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. The report indicated obesity is a primary risk factor for type 2 diabetes, increasing the risk for disease by at least six times as compared to individuals who are not obese. Rates of obesity and type 2 diabetes have increased linearly in recent decades, with the rate of diabetes increasing primarily among obese individuals. The report also indicated the most vulnerable and underserved populations suffer from the highest rates of diabetes and have the

poorest health outcomes. Adults over the age of 65 remain the population with the highest rate of diabetes; however, adults between the ages of 45 and 55 have the fastest growing rate of diabetes. The report indicated prevention of diabetes is best achieved through a cross-sector, community-based approach which includes access to nutritious food options, wellness programming for youth, and mental and behavioral health services for persons with or at risk of diabetes.

STROKE REPORT

The committee received a report from DHHS regarding progress made toward the recommendations provided in Section 23-43-04, relating to stroke centers and stroke care. The report indicated DHHS has established and maintained a comprehensive stroke system that ensures nationally recognized guidelines and protocols are followed with the intention to improve outcomes and reduce mortality and morbidity related to strokes.

MATERNAL MORTALITY REPORT

The committee received a report from the Maternal Mortality Review Committee as required by Section 23-51-08. The committee was informed there were six maternal deaths in 2022 and five in 2023; however, the 2023 cases still are being reviewed. The report indicated the leading underlying causes of pregnancy-related death include mental health conditions, excessive bleeding, cardiac conditions, infection, thrombotic embolism, cardiomyopathy, and hypertensive disorders during pregnancy. The report indicated challenges include the increasing number of deaths due to mental health issues.

HEALTH CARE TASK FORCE REPORT

The committee received a report from the North Dakota Legislative Health Care Task Force as required by Section 50-06-45. The report indicated the task force was tasked with meeting to discuss issues affecting health care delivery and spending in the state, researching and analyzing data, conducting stakeholder interviews, and creating subcommittees to deeply explore priority issues. The task force reported, in 2020, North Dakota had the 14th highest per-person spending on health care in the nation. The report also indicated growth in health care spending is outpacing growth in other economic indicators of well-being, including median income and inflation.

Actions recommended pursuant to the report included collecting data biennially to allow for ongoing understanding and monitoring of health care expenditures and utilization, and using a Medicaid Expansion fact sheet to provide consistent baseline data and understanding of the program. Establishing a statewide quality collaborative focused on identifying core measures to be used across payers to allow for ongoing understanding of health care quality and outcomes, and alignment of measures for VBP models, also was recommended in the report. Lastly, the report recommended developing initiatives aimed at improving access to and utilization of well visits and cancer screenings.

BASIC CARE REPORT

The committee received a report from DHHS regarding the study of basic care, as directed by Section 10 of Senate Bill No. 2012 (2023). Recommendations under the report to strengthen and modernize the basic care program included creating a single licensure type to cover both assisted living and basic care facilities; strengthening existing policy and developing additional policy to reflect current requirements within the program, incorporate best practices, and align with state and federal requirements; updating regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs; implementing a fair rental value methodology to reimburse basic care provider property costs; and implementing tiered add-on payments for residents with increased activities of daily living service need and aligning reimbursement methodologies.

HEALTH INSURANCE MANDATE COST-BENEFIT ANALYSIS RECOMMENDATION

Section 54-03-28 requires a cost-benefit analysis on a legislative measure providing for a health insurance mandate and provides a measure may not be referred to committee unless the cost-benefit analysis is appended to the measure. A standing committee may request a cost-benefit analysis if the analysis is missing, or the measure is amended.

The committee was informed the Insurance Commissioner received proposals from Incline Actuarial Group, Lewis & Ellis Actuaries and Consultants, and NovaRest Actuarial Consulting to provide the cost-benefit analysis. The Insurance Commissioner recommended, based on the proposals received, the Legislative Management contract with NovaRest Actuarial Consulting to perform the cost-benefit analyses of legislative measures to be considered by the 69th Legislative Assembly.

Recommendation

The committee recommends the Legislative Council contract with NovaRest Actuarial Consulting for the cost-benefit analyses of legislative measures to be considered by the 69th Legislative Assembly mandating health insurance coverage pursuant to Section 54-03-28.