# HUMAN SERVICES COMMITTEE

The Human Services Committee was assigned the following studies:

- Section 1 of House Bill No. 1026 (2023) directed a study of the implementation of the recommendations of the 2018 North Dakota behavioral health system study conducted by the Human Services Research Institute (HSRI) and the 2022 acute psychiatric and residential care needs study conducted by Renee Schulte Consulting, LLC.
- Section 51 of Senate Bill No. 2012 (2023) directed a study of early child care programs and child care services to identify major needs and systemic approaches to stabilize child care infrastructure.
- Section 54 of Senate Bill No. 2012 (2023) directed a study of payment rates for intermediate care facilities, including options to increase the rates.
- Section 2 of Senate Bill No. 2155 (2023) directed a study of federally qualified health care centers (FQHC).
- House Concurrent Resolution No. 3017 (2023) directed a study of the increasing need for inpatient mental health care for children and whether there are adequate home- and community-based care and outpatient services for the number of children and the location of need.

The Legislative Management assigned the committee the responsibility to:

- Receive an annual report from the Department of Health and Human Services (DHHS) regarding the progress of the pay for success program developed by the department to improve educational, social, or emotional achievements of at-risk children, improve the health of children, and increase participation in the workforce by individuals who qualify for governmental assistance (North Dakota Century Code Section 50-06-47).
- Receive a report from DHHS during the 2023-24 interim regarding the status of early childhood programs managed by the department (Section 4 House Bill No. 1540 (2023) and Section 56 of Senate Bill No. 2012 (2023)).
- Receive a report from DHHS by January 1, 2024, and every 6 months thereafter during the 2023-25 biennium, on the department's findings and recommendations regarding the foster care and adoption child welfare redesign (Section 7 of Senate Bill No. 2080 (2023)).
- Receive periodic reports from DHHS on the impact, usage, and costs associated with the family caregiver service pilot project (Section 50-24.1-47).
- Receive an annual report from the Children's Cabinet regarding the activities and findings of the cabinet (Section 50-06-43.1).
- Receive a report from DHHS and the steering committee for the developmental disabilities system reimbursement project on development activities and status information for the project (Section 50-06-37).
- Receive a report from DHHS before August 1 of each even-numbered year regarding provider reimbursement rates under the medical assistance expansion program (Section 50-24.1-37).
- Receive a biennial report from DHHS before August of each even-numbered year on the tribal health care coordination fund and tribal government use of money distributed from the fund (Section 50-24.1-40(4)).
- Receive an annual report from DHHS describing enrollment statistics and costs associated with the children's health insurance program state plan (Section 50-29-02).

Committee members were Representatives Matthew Ruby (Chairman), Karen A. Anderson, Mike Beltz, Jayme Davis, Kathy Frelich, Dwight Kiefert, Alisa Mitskog, Brandon Prichard, Karen M. Rohr, Mary Schneider, Greg Stemen, and Michelle Strinden and Senators Sean Cleary, Kyle Davison, Dick Dever, Kathy Hogan, Judy Lee, and Kent Weston.

## STUDY OF THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE 2018 NORTH DAKOTA BEHAVIORAL HEALTH SYSTEM STUDY

House Bill No. 1026 (2023) directed a study of the implementation of the recommendations of the 2018 HSRI study of North Dakota's behavioral health system and the 2022 Renee Schulte Consulting's study of acute psychiatric and residential care needs. The study required the committee to:

1. Receive regular updates on each of the major recommendation areas from the reports;
2. Identify the availability, access, and delivery of behavioral health services;

3. Seek input from stakeholders, including law enforcement, social and clinical service providers, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court personnel, educators, tribal governments, and state and local agencies; and
4. Consider options for improving access and the availability for behavioral health care.

## Previous Studies

### 2017-18 Human Services Committee Updates

The 2017-18 interim Human Services Committee received updates from the Department of Human Services (DHS) and HSRI regarding the study of the state's behavioral health system. The committee recommended Senate Bill No. 2030 (2019) which included a general fund appropriation of $408,000 and 1.5 full-time equivalent positions for the purpose of coordinating the implementation of recommendations of the study of the state's behavioral health system. The bill did not pass but Senate Bill No. 2012 (2019), which was approved by the Legislative Assembly, included a $300,000 general fund appropriation for the implementation of study recommendations.

### 2021-22 Acute Psychiatric Hospitalization and Residential Care Study

Section 5 of House Bill No. 1012 (2021) provided for a study of options for a long-term plan for acute psychiatric hospitalization and related step-down residential treatment and support needs in the state and short-term options during the next 2 bienniums to contract with private provider acute psychiatric care facilities to provide treatment services in four or more cities in the state, workforce needs of such specific locations, and options to replace the existing State Hospital facility with one or more treatment facilities focused on forensic psychiatric evaluation and treatment. The 2021 Legislative Assembly appropriated one-time funding of $500,000 from the general fund to the Legislative Council for consulting services of the study.

The Chairman of the Legislative Management approved the Acute Psychiatric Treatment Committee contracting with Renee Schulte Consulting, LLC, for $247,000 to assist the committee in its study and provide recommendations regarding the number of beds needed, the location of beds, and facilities needed for acute psychiatric services.

The committee received short- and long-term recommendations regarding facilities needed and recommended bill and resolution drafts to:

- Provide for a Legislative Management study regarding the implementation of behavioral health and acute psychiatric treatment recommendations.
- Provide a one-time $4 million appropriation from the general fund to DHHS to demolish unused buildings on the State Hospital campus, including the administrative building, employee building, associated tunnels, water tower, pig barn, and water treatment plant buildings.
- Replace outdated terminology in the Constitution of North Dakota related to the State Hospital and other institutions.

## Human Services Research Institute Study and Report

In 2017, DHS contracted with HSRI to conduct a review of the state's behavioral health system. The goals of the study were to conduct an in-depth review of the state's behavioral health system; to analyze current utilization and expenditure patterns by payer source; to provide recommendations for enhancing the integration, cost-effectiveness, and recovery orientation of the system to effectively meet community needs; and to establish strategies for implementing the recommendations. The study gathered data by reviewing existing reports and documents, by conducting stakeholder interviews, and by reviewing Medicaid claims and state service utilization data for behavioral health services.

As a result of the study, the final HSRI report identified 13 recommendations and 65 specific strategies to direct future behavioral health policy and services in the state. The following are the recommendations and strategies included in the report:

| Recommendation | Strategy |
|---|---|
| 1. Develop a comprehensive implementation plan | 1.1 Reconvene system stakeholders, including service users and their families<br>1.2 Form an oversight steering committee to coordinate with key stakeholder groups<br>1.3 Establish workgroups to address common themes identified in this report |
| 2. Invest in prevention and early intervention | 2.1 Prioritize and implement evidence-based social and emotional wellness initiative<br>2.2 Expand existing substance use prevention efforts, restore funding for the Parents Listen, Educate, Ask, Discuss program<br>2.3 Build upon and expand current suicide prevention activities<br>2.4 Continue to address the needs of substance exposed newborns and their parents<br>2.5 Expand evidence-based services for first-episode psychosis |

| Recommendation | Strategy |
| --- | --- |
| 3. Ensure all North Dakotans have timely access to behavioral health services | 3.1 Coordinate and streamline information on resources<br>3.2 Expand screening in social service systems and primary care<br>3.3 Ensure a continuum of timely and accessible crisis response services<br>3.4 Develop a strategy to remove barriers to services for persons with brain injury<br>3.5 Continue to invest in evidence-based harm-reduction approaches |
| 4. Expand outpatient and community-based service array | 4.1 Ensure access to needed coordination services<br>4.2 Continue to shift funding toward evidence-based and promising practices<br>4.3 Expand the continuum of substance use disorder treatment services for youth and adults<br>4.4 Support and coordinate efforts to enhance the availability of outpatient services in primary care<br>4.5 Address housing needs associated with behavioral health needs<br>4.6 Promote education and employment among behavioral health service users<br>4.7 Restore/enhance funding for recovery centers<br>4.8 Promote timely linkage to community-based services following a crisis<br>4.9 Examine community-based alternatives to behavioral health services currently provided in long-term care facilities |
| 5. Enhance and streamline system of care for children and youth | 5.1 Improve coordination between education, early childhood, and service systems<br>5.2 Expand targeted, proactive in-home supports for at-risk families<br>5.3 Develop a coordinated system to enhance treatment-related foster care capacity and cultural responsiveness<br>5.4 Prioritize residential treatment for those with significant/complex needs |
| 6. Continue to implement and refine criminal justice strategy | 6.1 Ensure collaboration and communication between systems<br>6.2 Promote behavioral health training among first responders and others<br>6.3 Review behavioral health treatment capacity in jails<br>6.4 Ensure Medicaid enrollment for individuals returning to the community |
| 7. Engage in targeted efforts to recruit and retain competent behavioral health workforce | 7.1 Establish a single entity for supporting workforce implementation<br>7.2 Develop a single database of statewide vacancies for behavioral health positions<br>7.3 Provide assistance for behavioral health students working in areas of need in the state<br>7.4 Raise awareness of student internships and rotations<br>7.5 Conduct comprehensive review of licensure requirements and reciprocity<br>7.6 Continue establishing training and credentialing programs for peer services<br>7.7 Expand credentialing programs to prevention and rehabilitation practices<br>7.8 Support a robust peer workforce through training, professional development, and competitive wages |
| 8. Expand the use of telebehavioral health | 8.1 Support providers to secure necessary equipment/staff<br>8.2 Expand the availability of services for substance use disorders, children and youth, and American Indian populations<br>8.3 Increase types of services available<br>8.4 Develop clear, standardized regulatory guidelines |
| 9. Ensure the system reflects values of person centeredness, cultural competence, and trauma-informed approaches | 9.1 Promote shared decisionmaking<br>9.2 Promote mental health advance directives<br>9.3 Develop a statewide plan to enhance commitment to cultural competence<br>9.4 Identify cultural/language/service needs<br>9.5 Ensure effective communication with individuals with limited English proficiency<br>9.6 Implement additional training<br>9.7 Develop/promote safe spaces for LGBTQ individuals within the behavioral health system<br>9.8 Ensure a trauma-informed system<br>9.9 Promote organizational self-assessments |
| 10. Encourage and support the efforts of communities to promote high-quality services | 10.1 Establish a state-level leadership position representing persons with lived experience<br>10.2 Strengthen advocacy<br>10.3 Support the development of and partnerships with peer-run organizations<br>10.4 Support community efforts to reduce stigma, discrimination, and marginalization<br>10.5 Provide and require coordinated behavioral health training among related service systems |
| 11. Partner with tribal nations to increase health equity | 11.1 Collaborate within and among tribal nations and with state and local human service agencies |
| 12. Diversify and enhance funding for behavioral health | 12.1 Develop an organized system for identifying/responding to funding opportunities<br>12.2 Pursue 1915(i) Medicaid state plan amendments<br>12.3 Pursue options for financing peer support and community health workers<br>12.4 Sustain/expand voucher funding and other flexible funds for recovery supports<br>12.5 Enroll eligible service users in Medicaid<br>12.6 Join in federal efforts to ensure behavioral and physical health parity |

| Recommendation | Strategy |
| --- | --- |
| 13. Conduct ongoing, systemwide, data-driven monitoring of needs and access | 13.1 Enhance and integrate provider data systems<br>13.2 Develop system metrics to monitor progress on key goals<br>13.3 Identify and target services to those with the highest service costs |

## State Hospital

### Background

The State Hospital was authorized in 1883, opened in May 1885, and is located on the south side of Jamestown. The State Hospital is referenced in Section 12 of Article IX of the Constitution of North Dakota. It provides psychiatric and chemical dependency treatment to residents of the state. Chapter 25-02 contains various provisions related to the hospital, including Section 25-02-01, which provides an institution for the care of the mentally ill must be maintained in Jamestown, the institution must be known as the State Hospital, and is to be administered and controlled by DHHS.

Section 25-02-03 provides the State Hospital is an institution for mental disease serving specialized populations of the mentally ill, including persons suffering from drug addiction or alcoholism. The State Hospital is one component of the North Dakota mental health delivery system and serves as a resource to community-based treatment programs. The State Hospital, pursuant to rules adopted by DHHS, receives and cares for all persons with mental illness, including persons suffering from drug addiction or alcoholism, residing within the state, and is required to furnish to those persons all needed food, shelter, treatment, and support necessary to restore their mental health or to alleviate their illness or suffering.

### Services

The State Hospital provides short-term acute inpatient psychiatric and substance abuse treatment, intermediate psychosocial rehabilitation services, forensic services, and safety net services for adults. Clinical services include psychiatry, psychology, nursing, social work, addiction counseling, chaplaincy, education, occupational therapy, therapeutic reaction, and vocational rehabilitation services. Treatment is provided for individuals with serious mental illness or chemical dependency diagnoses. Inpatient evaluation and treatment services are provided for sexually dangerous individuals. The Adult Psychiatrics Services Unit provides services for patients aged 18 and older who have a primary diagnosis of serious mental illness. Inpatient services include short-term stabilization, trauma program, geropsychiatric services, and psychosocial rehabilitation services.

Behavioral health services available at the State Hospital include residential substance use disorder (SUD) treatment, residential sexual offender treatment, residential transitional living, outpatient SUD treatment, outpatient adult forensic assessments, outpatient youth forensic assessments, and outpatient restoration treatment. Statistics provided include:

- The State Hospital serves 1,000 to 1,200 patients a year.
- The State Hospital has 100 inpatient acute psychiatric beds, but 25 beds were closed due to the Coronavirus (COVID-19) pandemic to establish an isolation area for residents who test positive for COVID-19.
- Of the 73 inpatient beds filled at the State Hospital in October 2021, 24 beds were for rehabilitation patients, 22 beds were for geropsychiatric patients, 16 beds were for acute psychiatric patients, 7 beds were for restore-to-competency patients, and 4 beds were for jail patients.
- Of the 51 residential beds filled at the State Hospital in October 2021, 30 beds were for sex offender patients, 13 beds were for SUD patients, and 8 beds were for transitional living patients.
- On average, patients at the State Hospital are referred for admission from private hospitals (41 percent), local admissions primarily emergency room referrals from Jamestown and Devils Lake (24 percent), residential SUD programs (17 percent), jails for psychological evaluation (12 percent), and forensic referrals for assessment of criminal responsibility and sex offenses (6 percent).
- The State Hospital receives patients needing inpatient acute psychiatric hospitalization services primarily from Cass, Burleigh, Williams, and Grand Forks Counties.

### Facilities

The following is a summary of buildings located on the State Hospital campus:

| Buildings | Use | Year Built | Square Footage | Percentage Used |
| --- | --- | --- | --- | --- |
| Electrical substation | Main electrical substation for campus, houses, and backup generator | 1984 | 1,800 | 100% |
| Powerhouse | Centralized power plant and smokestack | 1914 | 39,285 | 100% |
| Sewage lift station | Sanitary sewer lift station to connect to city water | 2012 | 800 | 100% |
| Grounds shop | Equipment storage | 1956 | 3,200 | 100% |
| Vehicle maintenance shop | Equipment repair | 1949 | 4,550 | 100% |

| Buildings | Use | Year Built | Square Footage | Percentage Used |
|---|---|---|---|---|
| Therapeutic pool | All hospital therapeutic exercise | 1967 | 6,800 | 100% |
| LaHaug | Inpatient services | 1984 | 143,127 | 90% |
| Gronewald-Middleton | Residential sex offender treatment | 1956 | 82,670 | 60% |
| New Horizons | Residential SUD services and inpatient treatment | 1968 | 75,485 | 75% |
| Cottages (7) | Residential services, student housing, and storm accommodations | 1954 | 21,000 | 75% |
| Learning Resource Center | Patient services, staff offices, and cafe | 1916 | 75,485 | 75% |
| Greenhouse | Patient services and treatment space | 1997 | 3,000 | 25% |
| 16 West | Plant services offices and storage | 1930 | 39,990 | 50% |
| Superintendent cottage | Storm sleeping rooms and event space | 1917 | 5,552 | 20% |
| Pedestrian tunnels | Pedestrian traffic and dietary delivery | N/A | 24,832 | 60% |
| Garages | Storage | 1988 | 1,360 | 25% |
| Grounds warehouse | Supply storage | 1917 | 2,755 | 25% |
| Warehouse 1 | Storage | 1929 | 6,020 | 10% |
| Warehouse 2 | Plumbing and electrical storage | 1925 | 23,414 | 10% |
| Grounds implement shed | Large equipment storage | 1926 | 5,370 | 20% |
| Quonset | Plant equipment storage | 1965 | 3,130 | 25% |
| Administration building[1] | N/A | 1916 | 24,675 | 0% |
| Water tower | N/A | N/A | N/A | 0% |
| Water pressure pump house | N/A | 1958 | 4,802 | 0% |
| Chapel[1] | N/A | 1961 | 13,140 | 0% |
| Water treatment | N/A | 1958 | 4,802 | 0% |
| Employee building[1] | N/A | 1952 | 34,345 | 0% |

[1]Section 17 of House Bill No. 1012 (2021) authorized DHHS to demolish the administration building, chapel, employee building, and associated tunnels during the 2021-23 biennium.

**LaHaug Building**

The LaHaug Building, built in 1984, on the State Hospital campus is used for the treatment of adults who receive psychiatric and substance abuse services. The building contains the State Hospital clinic, pharmacy, laboratory, x-ray, staff offices, and recreational and treatment areas.

## Residential Treatment Facilities

Psychiatric residential treatment facilities provide children and adolescents with therapeutic services, integrating group living, educational services, and a clinical program based on a clinical assessment and individual treatment plan that meets the needs of the child and family. The facilities are available to children in need of active psychotherapeutic intervention who cannot be effectively treated in their home, another home, or a less restrictive setting. North Dakota residential treatment providers include:

- Dakota Boys and Girls Ranch - Bismarck, Fargo, and Minot;
- Nexus-PATH Family Healing - Fargo;
- Pride Manchester House - Bismarck; and
- Ruth Meiers Adolescent Center - Grand Forks.

## Behavioral Health Funding

The Legislative Assembly has increased the biennial appropriations to DHHS for behavioral health programs as detailed in the schedule below since the 2017-19 biennium.

| | 2017-19 Biennium Appropriation | 2019-21 Biennium Appropriation | 2021-23 Biennium Appropriation | 2023-25 Biennium Appropriation |
|---|---|---|---|---|
| **Behavioral health** | | | | |
| General fund | $7,975,380 | $21,981,044 | $42,025,043 | $74,909,557 |
| Other funds | 35,853,789 | 50,420,587 | 50,073,179 | 65,502,059 |
| Total | $43,829,169 | $72,401,631 | $92,098,222 | $140,411.616 |

## Testimony Received and Committee Considerations

The committee received information from DHHS that the Behavioral Health Planning Council selected the following 13 areas of recommendations for improvements with associated goals:

1. Develop and implement a comprehensive strategic plan.
2. Invest in prevention and early intervention.

3. Ensure all North Dakotans have timely access to behavioral health services.
4. Expand outpatient and community-based service array.
5. Enhance and streamline the system of care for children with complex needs.
6. Continue to implement and refine the criminal justice strategy.
7. Engage in targeted efforts to recruit and retain a qualified and competent behavioral health workforce.
8. Continue to expand the use of telebehavioral health services.
9. Ensure the system reflects values of percent-centeredness, health equity, and trauma-informed approaches.
10. Encourage and support communities to share responsibility with the state for promoting high-quality services.
11. Partner with tribal nations to increase health equity for American Indian populations.
12. Diversify and enhance funding for behavioral health.
13. Conduct ongoing, systemwide data-driven monitoring of need and access.

The Department of Health and Human Services reported many of the goals will take several years to achieve. The department has established a timeline to address recommendations made in previous studies.

Committee members noted the importance of continuing to implement the recommendations of the studies to address gaps in the behavioral health needs of the state.

### Conclusions

The committee makes no recommendation regarding the study of the implementation of the recommendations of the 2018 North Dakota behavioral health system study.

## STUDY OF EARLY CHILD CARE PROGRAMS AND SERVICES

Section 51 of Senate Bill No. 2012 (2023) directed a study of early child care programs and child care services. This study required the identification of major needs and systemic approaches to stabilize child care infrastructure. Section 4 of House Bill No. 1540 (2023) and Section 56 of Senate Bill No. 2012 (2023) also required a report on the status of early childhood programs managed by DHHS.

### Previous Studies and Reports

#### 2013-14 Economic Impact Committee Child Care Services Study

During the 2013-14 interim, the Economic Impact Committee conducted a study to determine the current and potential needs for child care services and the current and potential needs related to child care, and the current quality of child care services. According to the United States Census Bureau, in approximately 78 percent of the families in North Dakota with children under the age of 18, both the husband and wife are in the labor force. The 2013 Kids Count Factbook produced by the Annie E. Casey Foundation reports in 2010 over 82 percent of mothers with children under the age of 17 in this state are engaged in the labor force. The factbook also reports in 2011 there were an estimated 16,000 families in the state in which the family income was less than twice the federal poverty level, at least one parent worked 50 or more weeks during the previous year, and there was at least one child under the age of 18 in the family.

#### 2015-16 Health Services Committee Child Care Assistance Review

During the 2015-16 interim, the Health Services Committee conducted a study on the employment restrictions in public assistance programs. As part of the study, the committee requested DHS review child care subsidies and provide recommendations regarding gradual reductions in benefits to mitigate the "cliff effect" on participants when work hours are increased. The department made no recommendation regarding polices to mitigate the cliff effect. The committee received testimony that due to the 2015-17 general fund budget reductions, effective April 1, 2016, DHS revised the child care sliding fee schedule from 85 percent of state median income to 60 percent of state median income and increased family's monthly copayments. Families eligible for the temporary assistance for needy families program are not subject to the sliding fee schedule and were not affected by the change. The child care assistance program caseload decreased from 2,049 in April 2016 to 1,549 in June 2016.

### North Dakota Law

Chapter 50-11.1 addresses early childhood services. Section 50-11.1-02 defines early childhood services as "the care, supervision, education, or guidance of a child or children, which is provided in exchange for money, goods, or other services." However, the following are excluded from the definition of early childhood services:

- Substitute parental child care provided pursuant to Chapter 50-11.

- Child care provided in any educational facility, whether public or private, in grade 1 or above.
- Child care provided in a kindergarten or a nonpublic elementary school.
- Child care, preschool, and prekindergarten services provided to children under 6 years of age in any educational facility through a program approved by the Superintendent of Public Instruction.
- Child care provided in facilities operated in connection with a church, business, or organization where children are cared for during periods of time not exceeding 4 continuous hours while the child's parent is attending church services or is engaged in other activities on the premises.
- Schools or classes for religious instruction conducted by religious orders during the summer months for not more than 2 weeks, Sunday schools, weekly catechism, or other classes for religious instruction.
- Summer resident or day camps for children which serve no children under 6 years of age for more than 2 weeks.
- Sporting events, practices for sporting events, or sporting or physical activities conducted under the supervision of an adult.
- Head Start and early Head Start programs that are federally funded and meet federal Head Start performance standards.
- Child care provided in a medical facility by medical personnel to children who are ill.

Section 50-11.1-06 allows an in-home provider to apply for a voluntary annual registration document from DHHS. An in-home provider is defined under Section 50-11.1-01 as "any person who provides early childhood services to children in the children's home." Except for onsite child care services for fewer than 10 children per location and which are located in the actual building in which the child's parent is employed, a person may not operate a family child care, group child care, preschool, school-age child care, or child care center unless licensed by DHHS. A family child care is defined as "a private residence licensed to provide early childhood services for no more than seven children at any one time, except the term includes a residence licensed to provide early childhood services to two additional school-age children." A group child care is defined as "a child care program licensed to provide early childhood services for thirty or fewer children." A preschool is "a program licensed to offer early childhood services, which follows a preschool curriculum and course of study designed primarily to enhance the educational development of the children enrolled and which serves no child for more than three hours per day." A school-age child care program is "a child care program licensed to provide early childhood services on a regular basis for children aged at least five years through eleven years." A child care center is "an early childhood program licensed to provide early childhood services to nineteen or more children."

To obtain a license to operate an early childhood program, an applicant must submit an application and a license fee to DHHS. In addition, Section 50-11.1-04 requires the department or an authorized agent of the department to investigate the applicant's activities and proposed standards of care and the applicant's premises. The applicant for a license and the staff members and, if the application is for a program that will be located in a private residence, every individual living in that residence must be investigated in accordance with the rules adopted by the department to determine whether any of them has a criminal record or has had a finding of services required for child abuse or neglect filed against them. Section 50-11.1-06.2 requires upon a determination by the department that a criminal history record check is appropriate, a provider holding or an applicant for early childhood services licensure, self-declaration, or in-home provider, as well as new staff members of early childhood services programs and new household members of a residence out of which early childhood services are provided, must obtain two sets of the individual's fingerprints from a law enforcement agency or other local agency authorized to take fingerprints. The individual is required to request the agency to submit the fingerprints and a completed fingerprint card for each set to the Division of Children and Family Services of DHHS or to the department's authorized agent. If the division has no record of a determination of services required for child abuse or neglect, the division is required to submit the fingerprints to the Bureau of Criminal Investigation to determine if there is any criminal history record information regarding the applicant, household members, or staff members. The results of the investigations must be forwarded to the division or to the department's authorized agent.

In addition to the licensed early childhood programs, Chapter 50-11.1 provides for a voluntary self-declaration for documentation of an individual providing early childhood services in a private residence for up to three children below the age of 24 months or for no more than five children through the age of 11. An individual may apply to DHHS for a self-declaration, and the department is responsible for determining if the individual meets the standards determined by rule by the department for a self-declaration.

Section 50-11.1-07 authorizes DHHS to investigate and inspect an early childhood program, or a holder of a self-declaration or registration document and the conditions of their premises, the qualifications of a provider of early childhood services, of current and prospective staff members, of any in-home provider or applicant seeking or holding a license, self-declaration, or registration document. In addition, Chapter 50-11.1 provides procedures under which the

department may issue correction orders, fiscal sanctions, or suspension or revocation of a license, self-declaration, or registration document.

Section 50-11.1-08 authorizes DHHS to adopt reasonable minimum standards for early childhood programs and adopt rules for the regulation of early childhood services. Section 50-11.1-14 authorizes DHHS to establish a statewide system to build systematic early childhood workforce voluntary training which may include distance learning formats, a professional registry, certificates, and specializations.

Section 50-11.1-14.1 also addresses early childhood care and education workforce issues. Under that section, the department is required to provide voluntary, progressive training opportunities leading to credentials, provide supports for the early childhood care and education workforce, and implement a registry to track workforce participation. In addition, that section requires the department to implement a voluntary quality improvement process for licensed early childhood facilities. The department is authorized to provide a quality incentive payment and a higher reimbursement rate for child care assistance program payments to a participating early childhood facility, provide technical assistance and support to an early childhood facility that applies for quality improvement, and provide financial incentives to an early childhood facility that sustains and increases program quality. The department may contract with a private, nonprofit agency to provide the technical assistance.

Section 50-11.1-18 authorizes DHHS to establish an early childhood inclusion support services program and hire early childhood services specialists for providing direct payments and technical assistance to providers serving children with disabilities, special needs, or developmental delays.

Chapter 50-33 provides for a child care assistance program. Under that chapter, DHHS is responsible for paying child care costs required as a result of participation in allowable activities by the eligible caretaker in a temporary assistance for needy families program household or diversion assistance household. Subject to the availability of funding, the department may expand child care assistance to include an eligible caretaker who is attending a postsecondary education program in pursuit of a 1-year, 2-year, or 4-year degree or certificate. The chapter provides application requirements and requires the department to adopt rules for administration of the program.

## Early Childhood Programs and Services

### Child Care Assistance Program

The child care assistance program (CCAP) helps pay a portion of the cost of child care for working families, or families in training or education programs. Payment is made directly to the provider unless the provider requests that payment be made directly to the family. Families with low income must meet certain eligibility criteria to qualify for the program. In most cases, families pay a copayment, which is a portion of the child care cost. A copayment is determined on a sliding fee scale based on a family's income, household size, age of the child, type of provider, and level of care. In 2022, North Dakota increased the income level for CCAP to 85 percent of the state's median income to increase the number of families eligible for the program. The program serves an average of 4,911 children from 3,002 families. A total of 1,469 providers are enrolled in the program.

### Best in Class

Beginning in 2021, North Dakota's best in class program is a targeted state investment in programs committed to delivering the highest quality experiences to the children and families they serve, and whose actions can demonstrate the return that is possible with intentional, research-supported investments in early childhood. The program is built on characteristics that drive results, including high-quality, supported interactions between adults and children based on developmentally appropriate experiences.

Teaching staff are coached and supported in implementing developmentally appropriate environments, play-based curriculum, and authentic observation-based assessments to drive individualized experiences to support children in reaching widely held expectations in the year before kindergarten.

The work done in these programs is monitored, evaluated, and supported to ensure the investment is making an impact.

For the 2023-24 academic year, there were 45 programs serving 881 children. This model provides educational services to 4-year-olds and parent training to all families involved.

### Head Start and Early Head Start

Head Start and Early Head Start are child development programs serving children from birth to age 5, expectant mothers, and families. The overall goal of Head Start is to increase the social ability of children in low-income families and children with disabilities and improve the chances of success in school.

Head Start has been the creator in the movement to address the needs of the whole child, including the educational, vocational, and material needs of the entire family. Head Start's philosophy is parents are the primary educators of their children, and successful child development programs must involve and empower parents in order to have a lasting impact on the lives of low-income children. This philosophy is reflected in Head Start's administrative structure which includes a parent Policy Council that has decisionmaking authority.

Head Start began in 1965 and has been recognized through seven presidential administrations for its effectiveness in helping children become more self-confident and successful. Though federally funded, each program is required to provide a 20 percent local funding match. This nationwide program works through several major areas, including education, health and nutrition, parent involvement, and social services. There have been Head Start programs in North Dakota since 1965.

The basic elements of Head Start are regulated through federal Program Performance Standards. Grantees and parents have control over their programs, and each is designed to meet the needs of families in the local community. Broadly, the objectives of Head Start are based on the idea that children deserve the opportunity to enter school ready to learn and that children's readiness depends on their educational experience, their physical and mental health, and the involvement of their parents and families. The following are objectives of Head Start:

- The improvement of the child's health and physical abilities, including appropriate steps to correct present physical and mental problems and to enhance every child's access to an adequate diet.
- The improvement of the family's attitude toward future health care and physical abilities.
- The encouragement of self-confidence, spontaneity, curiosity, and self-discipline which will assist in the development of the child's social and emotional health.
- The enhancement of the child's mental processes and skills with particular attention to conceptual and communications skills.
- The establishment of patterns and expectations of success for the child, which will create a climate of confidence for present and future learning efforts and overall development.
- An increase in the ability of the child and the family to relate to each other and to others.
- The enhancement of the sense of dignity and self-worth within the child and his or her family.

Early Head Start is responding to strong evidence suggesting that early intervention through high-quality programs enhances children's physical, social, emotional, and cognitive development; enables parents to be better caregivers and teachers to their children; and helps parents meet their goals, including economic independence. Early Head Start programs are designed to reinforce and respond to the unique strength and needs of each child and family. These services include:

- Quality early education both in and out of the home;
- Home visits, especially for families with newborns and other infants;
- Parent education, including parent-child activities;
- Comprehensive health and mental health services, including services for women before, during, and after pregnancy;
- Nutrition; and
- Ongoing support for parents through case management and peer support groups.

**North Dakota Afterschool Network**

The North Dakota Afterschool Network works to equip North Dakota after school, before school, and summer learning programs with the tools and support to expand program quality, build leadership capacity, and increase access to high-quality out-of-school time programs for youth across the state. Afterschool includes any program serving youth in prekindergarten through grade 12 with organized, regularly scheduled academic or enrichment activities in a supervised environment. These programs can take place in schools, school-age licensed child care facilities, community-based organizations, libraries, summer camps, and more.

**2023-25 Biennium Child Care Funding**

The 68th Legislative Assembly appropriated $113.9 million, of which $77.8 million is from the general fund, for child care assistance programs for the 2023-25 biennium. This represents an increase of $79.2 million from the 2021-23 biennium. The increased funding was for the following purposes:

| Purpose | Amount |
| --- | --- |
| Expand program eligibility and cost and caseload changes | $35,619,826 |
| Increase payments for infant and toddler care | 15,000,000 |
| Establish quality tiers | 3,000,000 |
| Eliminate certain family copays | 2,300,000 |
| Provide application assistance and outreach | 500,000 |
| Provide state match for employer-led child care cost-sharing program | 5,000,000 |
| Provide child care provider grants for startup, inclusion, and quality | 7,000,000 |
| Provide nontraditional hours child care | 1,800,000 |
| Provide worker training stipends | 2,000,000 |
| Provide grants to improve provider infrastructure | 3,000,000 |
| Automate the background check process | 1,000,000 |
| Provide matching funds for state employee participation in program | 3,000,000 |
| Total | $79,219,826 |

### Testimony Received and Committee Considerations

The committee received information and reports from DHHS regarding child care programs. The department reported there are 45,000 households in the state with a child under age 5. Seventy-five percent of households with children under age 5 have all parents working. There are 37,842 child care placements being provided by 1,165 licensed early childhood service providers. Child care assistance program expenditures for the 1st year of the 2023-25 biennium totaled $26 million, and the average assistance per child per month was $609.

According to testimony, to be affordable, child care should cost no more than seven percent of a household budget. However, many families are paying up to 40 percent of their gross household income on child care. The average cost for infant care ranges from $672 to $838 per month depending on whether the care is provided in a center-based or a home-based setting. Most households earning less than 150 percent of the state median income will have difficulty paying for child care. Effective July 2023, families with income at or below 30 percent of the state median income are no longer charged a copayment for child care expenses.

The Department of Health and Human Services has implemented a series of grants and incentives intended to support child care facilities, including:

- Quality improvement grants awarded to 142 child care providers who have attained or maintained a Step 2, 3, or 4 quality rating.
- Inclusive care support grants awarded to 52 child care providers to help the providers create and maintain inclusive environments that can support children with disabilities or developmental delays to learn, grow, play, and develop with their peers.
- Facility improvement grants awarded to 142 child care providers to revitalize child care facilities and support providers in meeting space-based licensing requirements with a disbursement of $1.1 million for the 2023-25 biennium.
- Grow child care grants awarded to six providers that created 80 spaces, supporting both child care startups and expansions.

Committee members noted there are more job openings in the state than workers available and lack of child care can be a barrier for someone to obtain employment. In some instances, an individual may not advance in employment opportunities because the higher income would result in a loss of benefits, including CCAP.

### Conclusions

The committee makes no recommendation regarding the study of child care programs and services.

## STUDY OF PAYMENT RATES FOR INTERMEDIATE CARE FACILITIES

Section 54 of Senate Bill No. 2012 (2023) directed a study of the payment rates for intermediate care facilities, including options to increase the rates. The study required the consideration of the funded percentage of costs for services, including day and small group care, individual employment, in-home supports, respite care, habilitative care, independent habitation, and residential habitation.

### Previous Reports and Studies

#### 2009-10 Interim Rate Structure of Developmental Disability Providers Study

Section 1 of House Bill No. 1556 (2009) required DHS to report to the Legislative Management regarding the outcomes and recommendations from the study of the methodology and calculations for the ratesetting structure for public and private licensed developmental disabilities and home- and community-based service providers. The

committee recommended a bill to require DHS to implement a prospective reimbursement pilot project for the developmental disabilities program during the 2011-13 biennium. The committee also recommended the department maintain the 95 percent occupancy rule while proceeding with the prospective reimbursement pilot project.

**Interim Status Reports**

During each interim since 2011, a Legislative Management committee has been assigned the duty to receive updates regarding the developmental disabilities system reimbursement project.

## Intermediate Care Facility

An intermediate care facility for individuals with an intellectual disability (ICF/ID) is an optional Medicaid benefit that provides comprehensive and individualized health care and rehabilitation services to individuals. The ICF/ID services are the highest level of care to provide active treatment. A total of 15 developmental disability providers are licensed to provide services in 22 communities. A total of 457 individuals were authorized to receive ICF/ID services between April and June 2023.

## Developmental Disability Funding

The Legislative Assembly approved $742,793,592 of grant funding for the 2023-25 biennium as follows:

| | |
|---|---:|
| Intermediate care facility grants | $224,289,381 |
| Home- and community-based services | 518,504,211 |
| Total | $742,793,592 |
| Less other funds | 390,731,727 |
| General fund | $352,061,865 |

Home- and community-based services include residential habilitation, day programs, infant development, family support, individual employment, family care option, self-directed supports, extended home health, and independent habilitation.

## Intermediate Care Facility Rates

The ICF/ID daily rate is all inclusive and includes room, board, day programming, and habilitative care. The rate does not include direct health-related costs such as dental and pharmacy. At the completion of the state fiscal year, each provider is required to complete a statement of cost to determine an upper payment limitation.

The ICF/ID rate includes the following components:

- Direct care staff wages;
- Employment-related expenditures;
- Relief staff wages;
- Program support expenditures;
- Room and board expenditures;
- General and administrative expenditures; and
- Vacancy factor.

Additional components can be included in the rate calculation for new facility costs, medically intensive individuals, and additional support for individuals between the ages of 16 and 21 to account for additional support during school holidays and summer hours.

The final rate is based on the individual receiving services. An individual is assessed by a third party to determine the level of intensity needed. The assessment level of need is converted to determine the average hours of services needed by the individual. The number of hours of services needed each day is multiplied by the previously computed rate to determine the total payment.

## Testimony Received and Committee Considerations

The committee received the following testimony regarding the study:

- ICF/ID providers are paid 89.7 percent of the amount calculated through the developmental disability provider funding formula.

- Residential habilitation providers are paid 91.6 percent of the amount calculated through the development disability provider funding formula.
- The average cost of providing services through an ICF/ID is significantly higher than providing home- and community-based services.

The committee considered a bill draft that would have provided an appropriation of $23.1 million, of which $11.3 million is from the general fund, to DHHS to study the payment rates for intermediate care facilities and residential habilitation services providers and would have increased the provider rates based on the results of the study.

### Conclusions

The committee makes no recommendation regarding the study of payment rates for intermediate care facilities.

## STUDY OF FEDERALLY QUALIFIED HEALTH CENTERS

Section 2 of Senate Bill No. 2155 (2023) directed a study of the expansion of FQHCs. The study required consideration of increasing the number of FQHCs in the state and improving FQHC collaboration with local public health units.

### Previous Studies and Reports

#### 2011-12 Interim Health Services Committee

The Legislative Management assigned the 2011-12 interim Health Services Committee the duty to review the public health model of the FQHC established by the Coeur d'Alene Tribe in Idaho. The review included services, governance, and funding of the center.

#### 2011-12 Interim Health Care Reform Review Committee

The 2011-12 interim Health Care Reform Review Committee studied the state's health care delivery plan. As part of the study, the committee received an overview of how community health centers (CHCs) operate in North Dakota. A community health center is a nonprofit entity that exists in areas where health care is scarce. The committee received testimony indicating approximately 31 percent of the North Dakota CHC patients are uninsured. Under the federal Affordable Care Act, CHCs received funds to expand the program. The Affordable Care Act provision relating to CHCs had the potential to add 20 million new CHC patients nationwide.

### Overview of Community Health Centers

The mission of CHCs is to provide high-quality, affordable, comprehensive primary and preventive health care, including medical, dental, and behavioral health services. regardless of a patient's insurance status or ability to pay. Community health centers are nonprofit, community-driven clinics with a unique FQHC designation. Federally qualified health centers are entities that receive federal funds to provide services for low-income residents on a sliding fee scale basis.

Community health centers are governed by community- and patient-led boards. In some cases, the centers collaborate with local health and service providers. North Dakota has five CHCs in 19 communities with 21 delivery sites. The centers serve approximately 36,000 medical and behavioral health care patients and nearly 13,000 dental patients. In 2021, about 20 percent of health center patients were uninsured, 12 percent were best served in a language other than English, and nearly half lived in families with an income below the federal poverty level. Community health centers, located in rural and urban communities across North Dakota, also offer dental services while focusing on the unmet needs of Medicaid patients.

Community health centers offer sliding fee discounts based on the income of uninsured and underinsured patients. Each health center's sliding fee discount amount is reported to the federal government. The centers reported in 2020 and 2021 providing total sliding fee discounts of $5.4 million to patients by North Dakota CHCs and total uncompensated care of $11 million, which is the sliding fee discounts plus the patient balances that were written off due to patients being unable to pay.

### Funding History

The Legislative Assembly, pursuant to Section 1 of Senate Bill No. 2155 (2023), provided $2 million from the general fund to DHHS to provide grants to FQHCs during the 2023-25 biennium. The Department of Health and Human Services is required to award grants to FQHCs in North Dakota to continue, expand, and improve FQHC services to low-income populations. The grant amount for each center must be proportional to the amount of discounts granted to patients of the center for the most recent calendar year to the total amount of discounts granted by all centers in North Dakota during the most recent calendar year as reported on the federal uniform data system report in conformance with the Bureau of Primary Health Care program expectations policy information note 98-23, except one FQHC may receive no more than 50 percent of the total amount of grants awarded under this section.

The Department of Health and Human Services provides funding to FQHCs for services provided to Medicaid-eligible patients. The following schedule provides the funding budgeted by the department for FQHCs for the 2005-07 biennium through the 2023-25 biennium:

| Biennium | Budget | Increase (Decrease) |
|---|---|---|
| 2005-07 | $1,745,228 | N/A |
| 2007-09 | $2,237,118 | $491,890 |
| 2009-11 | $2,939,309 | $702,191 |
| 2011-13 | $5,169,468 | $2,230,159 |
| 2013-15 | $7,921,657 | $2,752,219 |
| 2015-17 | $10,103,340 | $2,181,683 |
| 2017-19 | $8,012,737 | ($2,090,603) |
| 2019-21 | $11,563,270 | $3,550,533 |
| 2021-23 | $10,461,194 | ($1,102,076) |
| 2023-25 | $9,117,992 | ($1,343,202) |

### Testimony Received and Committee Considerations

The committee received information indicating the majority of patients at FQHCs have income under 200 percent of the poverty level and the average payor sources at the centers is 41.2 percent Medicaid, 13.3 percent Medicare, 15.3 percent uninsured, and 31.5 percent private payor insurance. Medicaid allows FQHCs to bill for medical, behavioral health, and dental services. Only 44 percent of the need for dental care in the state is being met and some FQHC facilities provide dental care in underserved areas. Some FQHCs provide services to children at their schools.

The committee acknowledged providing care through FQHCs can reduce the number of emergency room visits and FQHC mobile units are able to serve individuals in rural areas.

### Conclusions

The committee makes no recommendation regarding the study of FQHCs.

## STUDY OF INPATIENT MENTAL HEALTH CARE FOR CHILDREN

House Concurrent Resolution No. 3017 (2023) directed a Legislative Management study relating to the need for inpatient mental health care for children. The resolution indicated because of an increasing need for inpatient mental health care for children in the state, the study was to determine recommendations to address the gaps between home- and community-based services available in the state and the need for inpatient mental health care for children.

### Previous Reports and Studies

#### 2019-20 Interim Education Policy Committee

The 2019-20 interim Education Policy Committee studied student behavioral health issues. The committee received information from DHHS and other key stakeholders regarding the needs for student behavioral health services. The committee received updates regarding the implementation of behavioral health services in elementary and secondary schools.

### North Dakota Law

Section 50-06-01 defines "behavioral health" as the planning and implementation of preventive, consultative, diagnostic, treatment, crisis intervention, rehabilitative, and suicide services for individuals with mental, emotional, or substance use disorders, and psychiatric conditions. According to its website, DHHS defines behavioral health further as "a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health conditions affect people from all walks of life and all age groups."

Section 50-06-41 provides for DHHS to publish a quarterly report on behavioral health services provided by or supported by the department. The report must include each type of behavioral health service, the number of clients served for each service, and the amount of state and federal funds budgeted and spent for each service. The data must be identified for behavioral health services by human service region and by mental health services provided to children, mental health services provided to adults, and substance abuse services.

Section 50-06-43.1 establishes the Children's Cabinet to assess, guide, and coordinate the care for children across the state's branches of government and tribal nations.

### Overview of 2020-21 National Survey of Children's Health

According to the 2020-21 National Survey of Children's Health, approximately 34,412 children and youth in the state have a special health care need. Children with special health care needs are defined as those children and youth who have a chronic condition of at least 1 year, a physical disability, or a mental health/behavior health diagnosis. Many

children and youth who may have a physical disability and a chronic health issue also may have a co-occurring mental health diagnosis.

The National Data Center for Child and Adolescent Health provides data on the complexities of children and youth with special health care needs. Data reviewed by the committee provided an overview related to mental, emotional, developmental, or behavioral needs in North Dakota. The data indicated 24.4 percent of children aged 3 to 17 have one or more mental, emotional, developmental, or behavioral problem. Of the total children identified with a problem, 50.8 percent received treatment or counseling and 49.2 percent received no services.

### Psychiatric Residential Treatment Facilities

Psychiatric residential treatment facilities are facilities that provide children and adolescents with a comprehensive 24-hour therapeutic environment integrating group living, educational services, and a clinical program based upon an interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. Psychiatric residential treatment facilities are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be treated effectively in their family home or in another home, or in a less-restrictive setting. North Dakota psychiatric residential treatment providers include the Dakota Boys and Girls Ranch in Bismarck, Fargo, and Minot; Nexus-PATH Family Healing in Fargo; Pride Manchester House in Bismarck; and Ruth Meiers Adolescent Center in Grand Forks. Psychiatric residential treatment facilities are licensed by DHHS and may be accredited by national accreditation bodies.

### Funding History

The following schedule provides a comparison of funding for the psychiatric residential treatment facilities program for the 2015-17 biennium through the 2023-25 biennium, including funding from the general fund and other funds, including federal funds.

| Biennium | Budget | Increase (Decrease) |
|---|---:|---:|
| 2015-17 | $25,615,188 | N/A |
| 2017-19 | $32,407,032 | $6,791,844 |
| 2019-21 | $42,087,531 | $9,680,499 |
| 2021-23 | $34,657,042 | ($7,430,489) |
| 2023-25 | $23,651,704 | ($11,005,338) |

### Testimony Received and Committee Considerations

The Department of Health and Human Services provided information regarding the North Dakota system of care grant which will be used to provide community-based behavioral health services and supports for children and youth with serious emotional disturbances. The services will include outpatient programs, 24-hour crisis services, case management, day treatment, respite care, recovery support services, and services to transition youth into adult programs.

The Department of Health and Human Services reported there are 64 youth acute psychiatric beds, 82 psychiatric residential treatment facility beds, 76 qualified residential treatment program beds, 45 youth shelter beds, and 73 substance abuse youth beds in the state. The testimony contended the behavioral health bed management system will assist in placing individuals needing care into available beds.

Committee members noted the importance of providing community-based mental health care to allow children to be served from home instead of an institution. Crisis and mental health services also may be used to divert children from being placed in an institution.

### Conclusions

The committee makes no recommendation regarding the study of inpatient mental health care services for children.

## PAY FOR SUCCESS PROGRAM

House Bill No. 1480 (2023) requires DHHS to provide a report to the Legislative Management regarding the progress of the pay for success program developed by the department. The department is required to develop the program with outcomes focused on improving educational, social, or emotional achievement of at-risk children, improving the health of children, and increasing participation in the workforce by individuals who qualify for government assistance.

The pay for success program may include a performance-based grant, contract, or other agreement for initiatives to improve outcomes that result in increased public value and social benefits, including improved outcomes, cost-savings, increased public revenue, or minimal administrative requirements. The pay for success program must include the following:

1. A provision that a bonus payment may be provided to the recipient of the grant, contract, or agreement to expand capacity for a proposed initiative;
2. A provision that a bonus payment may be provided to the recipient of the grant, contract, or agreement only after a 20 percent cost reduction has been achieved;
3. A provision that a bonus payment may not exceed half of the cost reduction; and
4. A formal evaluation to determine whether the program has met its proposed outcomes.

The Legislative Assembly approved a transfer, during the 2023-25 biennium, of $2.5 million from the strategic investment and improvements fund to the pay for success fund for the program.

### Report

Representatives of DHHS reported:

- The goals for the pay for success program include reducing foster care numbers, reducing institutional placements, reducing length of stay in out-of-home settings, reducing out-of-state placements, reducing substance abuse as an abuse and neglect factor, reducing severity of school-based behaviors, and increasing evidence-based supports for children.
- Neglect accounted for 60 percent of reports of suspected abuse or neglect, and 85 percent of child neglect reports involved families with income less than 200 percent of the federal poverty level.
- The pay for success program will help families address their most basic financial needs and provide greater stability.
- Payments from the fund will begin when partners are selected for the program and formal definitions of success and methods to measure success are developed.

## FOSTER CARE AND ADOPTION CHILD WELFARE REDESIGN

Section 7 of Senate Bill No. 2080 (2023) requires DHHS to conduct a foster care and adoption child welfare redesign. The redesign must include a review of methods to streamline adoptions by licensed, certified, or approved family foster home for children providers and identify a fit and willing relative interested in adoption earlier in the process. The department is required to report its findings and recommendations to the Legislative Management by January 1, 2024, and every 6 months after the initial report during the 2023-25 biennium.

### Report

A representative of DHHS reported:

- Adoption redesign sought to streamline the process of adopting children from foster care with a goal of adoption finalization to occur within 60 days of termination of parental rights in 80 percent of those cases.
- Four specific constraint areas in the adoption process identified for improvement are termination of parental rights/legal issues; relative search/active efforts; referral paperwork process/custodial team meeting; and adoption home study/foster care licensing.
- Catholic Charities North Dakota manages the adoption program contract for the state.
- DHHS will pay for background checks for adopting families.

## FAMILY CAREGIVER SERVICE PILOT PROJECT

Section 2 of Senate Bill No. 2276 (2023) requires DHHS to provide periodic reports on the impact, usage, and costs associated with the family caregiver service pilot project. The department is required to establish the family caregiver service pilot project to assist in making payments to a legally responsible individual who provides extraordinary care to an eligible individual who is a participant in the Medicaid 1915(c) waivers, excluding the home- and community-based services aged and disabled waiver. The family caregiver service pilot project may include funding for extraordinary care, which means care:

1. Exceeding the range of activities a legally responsible individual would ordinarily perform in the household on behalf of an individual without extraordinary medical or behavioral needs; and
2. Is necessary to assure the health and welfare and avoid institutionalization of the individual in need of care.

The Department of Health and Human Services may adopt rules addressing management of the family caregiver service pilot project and establish the eligibility requirements and exclusions for the family caregiver service pilot project. The department is required to utilize an assessment of an eligible individual to determine the level of care authorized

and to determine the best interests of the individual in need of care. The pilot project may not provide a payment for any care that is otherwise compensated through a Medicaid 1915(c) waiver or the Medicaid state plan.

The Legislative Assembly, in Senate Bill No. 2276, appropriated $2.5 million from the general fund to establish and issue payments as part of a family caregiver service pilot project. Of this amount, $300,000 may be used by the department for the purpose of hiring up to 1 full-time equivalent position to serve as the family caregiver service pilot project coordinator, who would be responsible for implementing the pilot project, and for establishing a payment portal. Participation in this service pilot project is capped at 120 individuals.

### Report

Representatives of DHHS reported administrative rules for the program were developed and approved by the Administrative Rules Committee. The department reviewed examples of the program in other states and tested the program rules with a sample of volunteers. Application criteria, program guidelines, instructions, and the development of a payment portal were completed, and the program began on April 1, 2024.

Through October 2024, there were 42 households approved for the program and $410,550 spent for direct care services. The total estimated funding required for the program for the 2023-25 biennium is $2.1 million.

## CHILDREN'S CABINET

Section 1 of Senate Bill No. 2034 (2023) requires DHHS to provide an annual report to the Legislative Management regarding the activities and findings of the Children's Cabinet. The cabinet was created by the 2019 Legislative Assembly to assess, guide, and coordinate the care for children across the state's branches of government and the tribal nations.

The Legislative Assembly amended Section 50-06-43.1 in 2021 and 2023 to change the membership and duties of the cabinet. The Chairman of Legislative Management is required to appoint one of the legislative members to serve as the presiding officer of the cabinet. The Children's Cabinet selects one of its members to serve as the vice-presiding officer.

The Children's Cabinet consists of the following members:

1. The Governor, or the Governor's designee;
2. The Chief Justice of the Supreme Court, or the Chief Justice's designee;
3. A member of the House of Representatives from an even-numbered legislative district and a member of the House of Representatives from an odd-numbered legislative district appointed by the Majority Leader of the House of Representatives to serve 2-year terms;
4. A member of the Senate from an even-numbered legislative district and a member of the Senate from an odd-numbered legislative district appointed by the Majority Leader of the Senate to serve 2-year terms;
5. The Superintendent of Public Instruction, or the Superintendent's designee;
6. The Director of the Committee on Protection and Advocacy, or the Director's designee;
7. The Commissioner of the department, or the Commissioner's designee;
8. A representative of the tribal nations in the state, who is appointed by the Governor; and
9. Four individuals representing parents, private service providers, or other community interests, who are appointed by the Governor to serve a term of 2 years, at the pleasure of the Governor.

The Children's Cabinet is required to:

1. Coordinate broad-based leadership across programs, agencies, branches of government, and tribal nations to meet the needs of children;
2. Develop strategies to address gaps or needs regarding early care and education, medical and behavioral health, community, child welfare, and juvenile justice;
3. Develop strategies to provide for the full continuum of care in the delivery of services, including promotion, prevention, early identification and intervention, service delivery, and recovery;
4. Seek to engage cooperation across public and private service providers;
5. Provide a comprehensive vision for how and where children are best served, attending to children in a respectful and relevant manner;

6. Seek strategies to provide services to children without consideration of prior engagement with juvenile services;
7. Provide for the active participation of consumers and providers statewide on advisory committees;
8. Receive information and recommendations from DHHS, Department of Corrections and Rehabilitation, and other state agencies; and
9. Provide an annual report to the Legislative Management and Governor regarding the activities and findings of the cabinet.

The Department of Health and Human Services is required to provide the Children's Cabinet with staffing and administrative services. The cabinet is required to meet at least quarterly and additional meetings may be held at the discretion of the presiding officer.

### Report

Representatives of the Children's Cabinet reported the cabinet meets monthly to review children's services. The cabinet has received information regarding children's services provided through state agencies, including DHHS, the Department of Public Instruction, and the Protection and Advocacy Project. The cabinet also received updates regarding other programs and services, including updates from regional education associations, the Juvenile Justice Commission, and the Dakota Boys and Girls Ranch. The cabinet is developing strategic goals with a main goal to connect agencies, nonprofit organizations, and private-sector businesses.

## DEVELOPMENTAL DISABILITIES SYSTEM REIMBURSEMENT PROJECT

Section 50-06-37, as enacted by Senate Bill No. 2043 (2011), required DHHS, in conjunction with developmental disabilities providers, to develop a prospective developmental disabilities payment system based on the support intensity scale. A steering committee was created to guide DHHS on the development of the new payment system. The new payment system was implemented on April 1, 2018. The new system is based on a needs assessment for each individual served and rates standardized across all providers.

Section 50-06-37 was amended by Senate Bill No. 2247 (2019) to provide DHHS maintain the payment system based on a state-approved assessment. A steering committee of no more than 18 individuals is to be used to provide guidance for the system. The steering committee must include no more than two clients, no more than one family member of a client, a representative of DHHS, and a representative of the Protection and Advocacy Project. The steering committee is to analyze appropriate data and recommend to DHHS any rate adjustments, resource allocation modifications, or process assumptions. The department and the steering committee are to report developmental activities and state information to the Legislative Management.

### Report

A representative of DHHS reported the following regarding the developmental disabilities payment system:

- Before April 2018, a retrospective payment system was utilized for developmental disability provider payments.
- The current system provides a standard rate statewide and the level of staffing is based on the needs of individuals utilizing services.
- The developmental disabilities payment steering committee will continue to review the payment system.

## MEDICAID EXPANSION PROVIDER REIMBURSEMENT RATES

Section 32 of House Bill No. 1012 (2021) continued the Medicaid Expansion program by removing the sunset clause on Section 50-24.1-37. The section provides for the contract between DHHS and the insurance carrier to include a provision for the carrier to provide DHHS with provider reimbursement rate information when selecting a carrier. The section also requires DHHS to provide the Legislative Management a report before August 1 of each even-numbered year regarding provider reimbursement rates under the medical assistance expansion program.

### Report

A representative of DHHS provided the following report detailing the actual percentage for each service for Medicaid Expansion rates compared to traditional Medicaid rates in 2018 and 2022:

| Service | 2018 | 2022 |
|---|---|---|
| Inpatient | 166.0% | 151.9% |
| Outpatient | 169.5% | 124.2% |
| Professional | 174.5% | 144.3% |
| Overall | 169.7% | 140.3% |

## TRIBAL HEALTH CARE COORDINATION FUND

Section 50-24.1-40 requires DHHS to facilitate care coordination agreements between health care providers and tribal health care organizations that will result in 100 percent federal funding for eligible medical assistance provided to an American Indian. The section, as originally enacted, created a tribal health care coordination fund and provided that any funding received in excess of the state's regular share of federal medical assistance funding due to a care coordination agreement was to be deposited 60 percent in the tribal health care coordination fund and 40 percent in the general fund. House Bill No. 1407 (2021) amended the section to provide that any funding received in excess of the state's regular share of federal medical assistance funding due to a care coordination agreement is to be deposited 80 percent in the tribal health care coordination fund and 20 percent in the general fund. Money in the tribal health care coordination fund is appropriated on a continuing basis for distribution to tribal government in accordance with agreements between DHHS and the tribal governments. The agreements must require the tribal governments to use funding distributed from the tribal health care coordination fund for the 10 essential services of public health identified be the federal Centers for Disease Control and Prevention and the development or enhancement of community health representative programs or services. Through June 30, 2025, no more than 50 percent, and after June 30, 2025, no more than 35 percent, may be used for capital construction. The agreements between DHHS and tribal governments also must require tribal governments to submit annual reports to DHHS regarding the use of money distributed from the tribal health care coordination fund. Tribal governments must submit to DHHS every 2 years an audit report regarding the use of funding distributed from the tribal health care coordination fund.

The Department of Health and Human Services is required to report to the Legislative Management before August 1 of each even-numbered year regarding the tribal health care coordination fund, including how participating tribal governments used funding distributed from the fund.

### Report

Representatives of DHHS reported the following regarding the tribal health care coordination fund:

- DHHS has signed agreements with the Turtle Mountain Band of Chippewa Indians and the Three Affiliated Tribes of the Fort Berthold Reservation.
- Total savings from the agreements through June 2024 have been $165,033, with $33,007 deposited in the general fund and $132,026 deposited in the tribal health care coordination fund.

## CHILDREN'S HEALTH INSURANCE PROGRAM

Section 50-29-02 provides DHHS is to prepare, submit, and implement a children's health insurance program state plan and report annually to the Legislative Management. The report must include enrollment statistics and costs associated with the plan.

Healthy Steps, North Dakota's children's health insurance plan, provides premium-free health coverage to uninsured children in qualifying families. The plan intended to help meet the health care needs of children from working families whose earnings exceed qualifying for full Medicaid coverage but are insufficient to afford private insurance. To be eligible for the program, the family's net income may not exceed 175 percent of the federal poverty level.

### Report

A representative of DHHS reported the following:

- From July 1, 2023, through August 1, 2024, a total of $16,593,465 was expended for the following program services:

| Service | Amount |
|---|---:|
| Inpatient services | $2,245,033 |
| Outpatient services | 2,884,995 |
| Psychiatric residential treatment facility services | 967,426 |
| Professional services | 3,815,476 |
| Other services | 4,806,113 |
| Dental services | 1,874,422 |
| Total | $16,593,465 |

- From August 2023 through August 2024, program enrollment ranged from 3,227 enrollees to 4,503 enrollees.

## OTHER INFORMATION RECEIVED

In addition to the committee's other responsibilities, the committee received information regarding:

- Geriatric psychiatric care in the state.
- Federal minimum staffing standard changes for long-term care facilities.

- The status of domestic violence programs in the state.
- DHHS child welfare services and child abuse concerns in the state.
- The Medicaid institution for mental disease waiver.
- The cross-disability advisory council.