NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, July 31, 2013
Fort Totten Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson, Jr., Robert Erbele, Joan Heckaman, Tim Mathern; Representatives Dick Anderson, Alan Fehr, Curt Hofstad, Rick Holman, Jon Nelson, Marvin E. Nelson

Member absent: Senator Oley Larsen

Others present: George J. Keiser, State Representative, Bismarck
Senator Ray Holmberg, member of the Legislative Management, was also in attendance.
See Appendix A for additional persons present.

Mr. Allen H. Knudson, Legislative Budget Analyst and Auditor, reviewed the *Supplementary Rules of Operation and Procedure of the North Dakota Legislative Management*.

COMMENTS BY COMMITTEE CHAIRMAN

Chairman Lee welcomed the committee. She said in addition to the studies already assigned to the committee by the Legislative Management, the Chairman of the Legislative Management has assigned the committee to study funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies.

DENTAL SERVICES STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Dental Services Study - Background Memorandum* relating to the committee's study of how to improve access to dental services and ways to address dental service provider shortages. The Legislative Assembly approved 2013 House Bill No. 1454. Section 1 of the bill provides for the Legislative Management study on how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing midlevel providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services.

The Legislative Council staff provided information regarding programs available in the state that offer free or low-cost dental care, including Medicaid, Healthy Steps, Caring for Children, Health Tracks, and mobile dental care services. For those that qualify, Medicaid may provide aid to those without health insurance or for those whose health insurance does not cover all of their needs. Funding is shared by federal, state, and county governments with eligibility determined at the county level. Medicaid provides limited dental care services, and copayments may apply for certain recipients. Healthy Steps--the state children's health insurance program (CHIP)--provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage but not enough to afford private insurance. Healthy Steps-covered services include dental services and there are no monthly premiums in the Healthy Steps program, but most families are required to pay copayments for certain services. Caring for Children is a benefit program for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps and have no other insurance. Benefits include primary and preventative medical and dental care. Health Tracks--formerly early periodic screening diagnosis and treatment--is a preventative health program that is free for children aged 0 to 21 who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics. Mobile dental care services began in 2009 when the Legislative Assembly provided $196,000 of one-time funding from the general fund to the State Department of Health to help establish a mobile dental facility. An area foundation is responsible for ongoing costs estimated at $400,000 per year. The 2013 Legislative Assembly provided an additional one-time appropriation of $100,000 from the general fund to the State Department of Health for a grant to the organization to provide mobile dental care services, including dental treatment, prevention, and education services to low-income and underserved children in areas of the state with limited or unavailable dental services.

The Legislative Council staff provided information regarding dental service provider programs, including the dentists' loan repayment program, the public health dentists' loan repayment program, and the dental practice grant program. The dentists' loan repayment program, which is administered by the Health Council, was established in 2001. Each year the Health Council is to select up to three dentists who agree to provide dental services in the state. The dentists are eligible to receive funds, not to exceed a total of $80,000 per applicant, for the repayment of their educational loans. The funds are payable over a four-year period ($20,000 per year). The dentists' loan repayment program is to provide the highest priority for acceptance into the program to dentists willing to serve the smallest and most underserved communities in North Dakota. The 2007 Legislative Assembly provided a dentist practicing in Bismarck, Fargo, or Grand Forks must have received dental medical payments of at least $20,000 in the form of medical assistance reimbursement or practiced at least two full workdays per week at a public health clinic or nonprofit dental clinic in order to qualify for the dentists' loan repayment program. The 2009 Legislative Assembly created North Dakota Century Code Section 43-28.1-01.1 which allows, if funds are appropriated, the Health Council to select up to three dentists who provide or will provide dental services for three years in a public health clinic or nonprofit dental clinic that uses a sliding fee schedule to bill patients for loan repayment grants. The grant award is $60,000 per recipient and is paid over a two-year period. The 2007 Legislative Assembly provided for a dental practice grant program. A dentist who has graduated from an accredited dental school within the previous five years and is licensed to practice in North Dakota may submit an application to the Health Council for a grant for the purpose of establishing a dental practice in North Dakota cities with populations of 7,500 or less. The Health Council may award a maximum of two grants per year with a maximum grant award of $50,000 per applicant to be used for buildings, equipment, and operating expenses. The community in which the dentist is located must provide a 50 percent match. The grant must be distributed in equal amounts over a five-year period, and the dentist must commit to practice in the community for five years.

The Legislative Council staff provided information regarding an environmental scan and contextual assessment of the oral health of North Dakota's residents done in 2012 by the Center for Health Workforce Studies at the School of Public Health, University at Albany, New York. The executive summary of the report indicated 360 licensed dentists had practice addresses in North Dakota, and another 24 dentists were licensed in North Dakota but had principal practice addresses in a contiguous state. A total of 518 licensed dental hygienists have practice addresses in North Dakota, and another 82 dental hygienists are licensed to practice in North Dakota but have practice addresses in contiguous states. The report also indicated 83 dental hygienists maintain a North Dakota license, but have no current practice address, suggesting there is more capacity within the profession than jobs.

The Legislative Council staff said to fully function as a registered dental assistant in North Dakota, a dental assistant must be a graduate of an accredited program or be certified by the Dental Assisting National Board as a certified dental assistant. Chairside-trained dental assistants--known as qualified dental assistants--exist, but the scope of their work is more restrictive than that performed by a registered dental assistant. Some dental hygienists, with either formal or chairside training, are working as dental assistants in dental practices. The scope of the work performed by these dually trained dental hygienists is more restrictive, but they may provide flexibility in a dental practice since they can function in a number of roles allowing the practice to respond to changing demands.

The Legislative Council staff said as is true in the rest of the country, oral health professionals are located mostly in urban areas of the state. Sixteen counties are without a practicing dentist. The federal government has designated 31 dental health professional shortage areas in the state which lack sufficient providers to meet the dental needs of the population. The environmental scan and assessment indicates, while the state has made progress in increasing access to oral health services, some populations still have limited access to these services, including children, especially the very young and those Medicaid-eligible; rural populations; low-income adults; the elderly; and American Indians. A shortage of dentists willing to accept Medicaid patients has resulted in a small number of dentists in the state treating the majority of children on Medicaid and limiting the availability of oral health services even in areas of the state where there is an adequate supply of dental professionals.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding dental service needs in the state, options to improve access to dental services in the state--especially in rural areas, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, whether the state's medical assistance reimbursement rates impact access to dental services, and ways to address dental service provider shortages in the state, including the role of midlevel providers in providing dental services in the state. Organizations to request information from include the North Dakota Dental Association, North Dakota Dental Hygienists' Association, North Dakota Dental Assistants' Association, Department of Human Services, State Department of Health, and University of North Dakota (UND) Center for Rural Health.

2. Receive information regarding the environmental scan and contextual assessment of the oral health of North Dakota's residents performed in 2012 by the Center for Health Workforce Studies at the School of Public Health, University at Albany, New York, with support from the Otto Bremer Foundation and the Pew Research Center on the States Children's Dental Campaign.
3. Receive information from the Department of Human Services and the State Department of Health regarding programs and services available to provide dental services in rural areas of the state.
4. Receive information from the North Dakota University System regarding shortages of dental service professionals in the state and how University System programs address dental service provider shortages in the state.
5. Gather and review information on federal health care initiatives, including how they will affect access to dental services in the state.
6. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
7. Prepare a final report for submission to the Legislative Management.

Senator Mathern suggested the study plan include information from consumer advocates regarding access to dental services, how to improve access to dental services, and ways to address dental service provider shortages.

Representative M. Nelson suggested the committee receive information regarding the potential for establishing dental residencies in the state and any related costs.

AUTOPSY STUDY

Chairman Lee invited Senator Ray Holmberg, Chairman, Legislative Management, to provide information regarding the study of autopsy funding in the state assigned to the Health Services Committee. Senator Holmberg said the Legislative Management was asked to consider a study of the funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies performed by the State Department of Health and the UND School of Medicine and Health Sciences. He said the study was not originally prioritized by the Legislative Management, but it appears the 2015 Legislative Assembly will need to address issues regarding the funding of autopsies. He asked the committee to gather information regarding funding for autopsies and make a recommendation to the 2015 Legislative Assembly.

Chairman Lee invited Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, Grand Forks, to comment on the autopsy study assigned to the committee. Dr. Sens said it is important that deaths are appropriately assigned and that law enforcement and judicial needs are met. She said a comprehensive review of the system is needed to develop an equitable plan for the whole state.

Chairman Lee invited Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, to comment on the autopsy study assigned to the committee. Ms. Smith said the State Department of Health requested $640,000 from the general fund to contract with the medical school for autopsies in the eastern part of the state but was appropriated $480,000. She said the department has been working with the medical school to determine the effects of the reduced funding.

In response to a question from Representative Holman, Ms. Smith said between 455 autopsies and 460 autopsies were done in fiscal year 2013.

Dr. Sens said nationally, if deaths are investigated as they should be, the number of autopsies should average approximately 1 autopsy per 1,000 in population. She said based on the state's estimated population, it is anticipated that approximately 700 autopsies should be performed each year in the state. She said the transient nature of the workforce and more hazardous working conditions in the oil-producing counties would likely increase the proportion of autopsies to population in that area of the state. She said approximately 56 autopsies to 60 autopsies are performed annually in Grand Forks County, which is about 1 autopsy per 1,000 in population.

Senator Lee suggested the committee receive information regarding the regions in which autopsies are originating, the demographics of those autopsied, and any regional gaps in autopsy services.

Representative J. Nelson suggested the committee receive information regarding the cost of an autopsy and state and county responsibilities for the cost.

DENTAL SERVICES STUDY

Ms. Jodi Hulm, Children's Health Insurance Program and Health Tracks Administrator, Medical Services Division, Department of Human Services, provided information (Appendix B) regarding dental services available through Department of Human Services programs. She said Medicaid and CHIP provide both preventative and restorative dental services. In addition, she said, orthodontic services are available for children. She said North Dakota Medicaid also provides adult dental benefits beyond emergency dental care. She reviewed fee schedule increases from 2007 through 2013. She said the department implemented a Medicaid and CHIP Dental Access project in 2012 to increase the number of dentists practicing in nonprofit dental clinics. She said the program awards funds to a nonprofit clinic to support the recruitment of a dentist. She said the department also maintains a federal website of dental providers who accept new Medicaid and CHIP recipients. She said 2007 House Bill No. 1293 authorized fluoride varnish treatments to be provided by registered nurses, registered dental hygienists, registered dental assistants, physicians, physician assistants, and nurse practitioners. She said the number of fluoride varnishes provided to Medicaid recipients by these providers--not including dentists--has more than doubled from 2,673 in 2009 to 5,619 in 2012. She said the average monthly units for dental services received by children totaled 7,334 in fiscal year 2009, and in fiscal year 2013 average monthly units for dental services received by children through March totaled 10,271. She said the average monthly units for dental services received by adults totaled 4,871 in fiscal year 2009, and in fiscal year 2013 average monthly units for dental services received by adults through March totaled 6,048.

In response to a question from Senator Lee, Ms. Hulm said based on a request for proposal, the department awarded a contract for dental services beginning July 1, 2013, to Delta Dental. She said approximately 79 percent of the dentists in the state currently participate with Delta Dental.

Dr. Alison Fallgatter, President, North Dakota Dental Association, provided information (Appendix C) regarding barriers to accessing oral health care and the donated dental services program. She said barriers to accessing oral health services in the state include poverty, geography, workforce, inadequate Medicaid funding for dental services, lack of oral health education, language, cultural barriers, fear, and the belief that people who are not in pain do not need dental care. She said additional barriers, particularly in reservation communities, include insufficient federal funding and administrative challenges in clinics. She said the association supports efforts to reduce barriers to care, including mobile dental care services, the application of fluoride varnish by medical personnel, and an expanded scope of practice for dental hygienists. She said the dental loan repayment programs have been successful in providing access to dental care in many rural communities. She said public health clinics are an integral part of the state's oral health delivery system. She said a significant increase in dentists practicing in the state in the past decade has meant an adequate workforce in the state. In addition, she said, there are many hygienists in the state that are not working, but there is a significant shortage of dental assistants.

Dr. Fallgatter said the Oral Health Division of the State Department of Health received a DentaQuest grant and surveyed the state to assess the oral health needs of residents. She said the effort established two priorities--develop dental and medical collaboration to facilitate education and prevention among children and provide a pathway to oral health care in long-term care facilities. She expressed concern regarding the possible loss of a federal grant used to fund the Oral Health Division. She said the loss of funding would adversely affect children's oral health programs. She said a case management program in communities with the most need could provide oral health education and coordinate dental care to help eliminate the no-show problem faced by providers. She said creating an expanded function dental assistant and expanding the scope of practice of hygienists would free up dentists to provide other services. She said increasing the Medicaid reimbursement would encourage more dental service providers to serve that population.

Representative M. Nelson suggested the committee receive information regarding the appropriate number of dentists based on population. Senator Lee suggested the committee receive information regarding the distribution of dentists in the state.

In response to a question from Representative Fehr, Mr. Joe Cichy, Executive Director, North Dakota Dental Association, said it is difficult to get and keep dentists in Indian Health Service (IHS) facilities. He said the association is working with tribal governments to bring volunteer dentists to the reservations.

Ms. Rita Sommers, Executive Director, North Dakota State Board of Dental Examiners, provided information (Appendix D) regarding midlevel dental service providers. She expressed concern regarding public safety, scope of practice, testing, accreditation, regulating agreements, licensing a workforce, and laws governing certain populations or locations. She said Minnesota recognizes dental therapists to provide specific dental services. She said two models exist in Minnesota--the dental therapist and the advanced dental therapist. She said while North Dakota requires a candidate to complete both a clinical board and a national board for licensure, Minnesota dental therapists are not required to take a national board. She said a national board designed to assure minimal

competency of midlevel dental service providers does not currently exist. She said the Minnesota Board of Dental Examiners has developed a written examination and certification process for the advanced dental therapist, but the Minnesota board is not a clinical testing agency nor a nationally recognized accrediting body. She said North Dakota statute requires a degree from an accredited dental school or dental hygiene program for licensure, but the Minnesota therapist programs are not yet accredited. She suggested the committee consider the requirements of any collaborative agreements between midlevel dental service providers and licensed dentists and the proximity of the collaborating dentist.

In response to a question from Senator Mathern, Ms. Sommers said accreditation is important and must be maintained.

In response to a question from Senator Anderson, Ms. Sommers said dental professionals listed in order of most training to least would begin with dentists who receive the most training, followed by the advanced dental therapists, who, in the case of the Minnesota program, would enter as dental hygienists and receive a master's level training. She said the next level would be dental hygienists, who could either have a two-year or four-year degree. She said dental assistants receive either 12 months or 18 months of training depending on the program. She said dental assistants can be trained by dentists but must still complete the Dental Assisting National Board examination to be registered to perform expanded functions.

Ms. Dana Schmit, President-Elect, North Dakota Hygienists' Association, provided information (Appendix E) regarding expanded functions for dental hygienists. She said there were 518 active dental hygiene licenses in the state in 2012, and many are unable to find employment. She said dental hygienists may provide oral health education, perform prophylaxis, deliver preventative treatments such as fluorides and sealants, and inform patients of health status. She said dental hygienists may not diagnose or perform restorative procedures; however, in many states, with proper training, hygienists with expanded functions may place temporary fillings and, in some cases, permanent amalgam fillings.

In response to a question from Senator Heckaman, Ms. Schmit said the surplus of dental hygienists in the state is regional.

In response to a question from Senator Heckaman, Ms. Schmit said dental hygienists may perform limited services outside of a dentist's office under a collaborative agreement with a dentist but may not open an office of their own.

In response to a question from Representative J. Nelson, Ms. Schmit said other states are researching dental therapist models, but models under consideration vary significantly from state to state.

Senator Lee suggested the committee receive information regarding dental therapist models in other states.

Dr. Brent Holman, Pediatric Dentist, Fargo, provided information (Appendix F) regarding dental service providers in the state. He said the net number of licensed dentists in the state has been increasing over the last five years, and the overall dentist to population ratio in the state is "adequate" based on a UND Center for Rural Health DentaQuest grant presentation in 2011. He said viability is why dentists do not locate in a small towns. He said there are concerns with dental services available on the American Indian reservations. He said improvements are needed to be made with the federal IHS provision of dental services on the reservation before proposing new midlevel providers to work with these populations. He said it would be difficult for a midlevel provider who is paid less than a dentist to establish a viable practice in a small town with the same overhead cost as a dentist who is able to bill more. He said the possibility that the state may lose a key grant that funds oral health in the state is of immediate concern. He suggested the study include:

- An investigation of expanded function dental assistants to augment the workforce not just as restorative dental service providers but as case managers able to eliminate barriers to care in low-income and rural communities.
- Expanded public and private support of the state's dental public health clinics targeted to areas with greatest need.
- The continued development of market-based reform of dental Medicaid to include adequate reimbursement.
- An action plan supported by a partnership of all stakeholders.
- Improved communication between state government oral health policymakers and organized dental groups to produce more effective programs.

In response to a question from Senator Anderson, Dr. Holman said IHS procedures are onerous for volunteers. He said it can take six months to nine months to be able to perform services at an IHS clinic.

Senator Lee said federally qualified health centers (FQHCs) are able to provide services to tribal and nontribal members. She said further investment in FQHCs and nonprofit clinics may help serve the population on the reservations.

Mr. Larry Shireley, Director of Policy and Community Planning, Community HealthCare Association of the Dakotas, provided information regarding community health centers in the state that provide primary and preventative dental care to patients regardless of ability to pay. He said community health centers are located in Grand Forks, Fargo, and Turtle Lake. He said attracting dental service providers is one of the challenges faced by community health centers in the state.

Ms. Marcia Olson, Executive Director, Bridging the Dental Gap, North Dakota Oral Health Coalition, Bismarck, provided a copy of the State Department of Health publication *Oral Health in North Dakota - Burden of Disease and Plan for the Future 2012-2017*. She said the coalition has worked with the State Department of Health to collect information for the report and with the DentaQuest Foundation to survey individuals and meet with consumer groups.

Ms. Kathleen Mangskau, Bismarck, said the State Department of Health, as part of the federal grant process, prepares an extensive needs assessment document which focuses on access. She said the information collected by the oral health program of the department may be useful to the committee.

Senator Lee suggested the committee receive information from the State Department of Health regarding oral health needs assessment documents prepared by the department as part of the federal grant process.

Senator Heckaman suggested the study plan include information from the Indian Affairs Commission regarding ways to improve access to dental services on reservations.

Senator Mathern suggested the study plan include information from the State Department of Health regarding the status of Centers for Disease Control and Prevention (CDC) grant funding related to oral health at the next meeting.

Ms. Marsha Krumm, President, North Dakota Dental Assistants Association, provided written testimony (Appendix G) regarding the role of expanded function dental assistants. She said the North Dakota Dental Assistants Association opposes the creation of a new licensed category of provider. She said the association supports the expansion of dental assisting training programs to establish an expanded function dental assistant able to perform case management functions in communities where barriers exist.

It was moved by Representative Hofstad, seconded by Representative Anderson, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding dental service needs in the state, options to improve access to dental services in the state--especially in rural areas, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, whether the state's medical assistance reimbursement rates impact access to dental services, and ways to address dental service provider shortages in the state, including the role of midlevel providers in providing dental services in the state. Organizations to request information from include the North Dakota Dental Association, North Dakota Dental Hygienists' Association, North Dakota Dental Assistants' Association, Department of Human Services, State Department of Health, UND Center for Rural Health, Indian Affairs Commission, North Dakota State Board of Dental Examiners, and appropriate consumer advocate organizations.**
2. **Receive information regarding the environmental scan and contextual assessment of the oral health of North Dakota's residents performed in 2012 by the Center for Health Workforce Studies at the School of Public Health, University at Albany, New York, with support from the Otto Bremer Foundation and the Pew Research Center on the States Children's Dental Campaign.**
3. **Receive information from the Department of Human Services and the State Department of Health regarding programs and services available to provide dental services in rural areas of the state.**
4. **Receive information from the State Department of Health regarding the status of CDC grant funding related to oral health.**

5. **Receive information from the University System regarding shortages of dental service professionals in the state and how University System programs address dental service provider shortages in the state.**
6. **Gather and review information on federal health care initiatives, including how the initiatives will affect access to dental services in the state.**
7. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
8. **Prepare a final report for submission to the Legislative Management.**

COMPREHENSIVE STATEWIDE TOBACCO PREVENTION AND CONTROL STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Comprehensive Statewide Tobacco Prevention and Control Study - Background Memorandum* relating to the study of the comprehensive statewide tobacco prevention and control plan as provided for in Section 2 of 2013 Senate Bill No. 2024. As part of the study, the Tobacco Prevention and Control Executive Committee and the State Department of Health must work together to create a single assessment of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state. The Tobacco Prevention and Control Executive Committee and the State Department of Health must present this assessment to the Legislative Management. In addition, the bill provides the study may include:

- A review of the service delivery system for the comprehensive statewide tobacco prevention and control programs provided by the two agencies, whether the delivery system is fiscally efficient, and how the delivery system is consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*;
- A review of the effectiveness of the comprehensive statewide tobacco prevention and control programs provided in the state and ways to improve the health and policy outcomes of the programs; and
- A review of how the comprehensive statewide tobacco prevention and control programs provided by the two agencies address the Native American population on the Indian reservations.

The Legislative Council staff said as a result of a multistate settlement agreement negotiated between various states' Attorneys General and tobacco manufacturers, North Dakota receives annual distributions of tobacco settlement proceeds. The 1999 Legislative Assembly established a plan for the use of this money through the passage of House Bill No. 1475 (Section 54-27-25), which established a tobacco settlement trust fund. Actual tobacco settlement collections through the 2009-11 biennium and revised estimated tobacco settlement collections, including payments to be received under both subsection IX(c)(1) and subsection IX(c)(2) of the Master Settlement Agreement, through 2025 total approximately $745.6 million.

The Legislative Council staff said tobacco settlement payments received by the state under the Master Settlement Agreement are derived from two subsections of the Master Settlement Agreement. Subsection IX(c)(1) of the Master Settlement Agreement provides payments on April 15, 2000, and on April 15 of each year thereafter in perpetuity, while subsection IX(c)(2) of the Master Settlement Agreement provides for additional strategic contribution payments that begin on April 15, 2008, and continue each April 15 thereafter through 2017. Section 54-27-25, created by 1999 House Bill No. 1475, did not distinguish between payments received under the separate subsections of the Master Settlement Agreement and provided for the deposit of all tobacco settlement money received by the state into the tobacco settlement trust fund. Money in the fund, including interest, is transferred within 30 days of deposit in the fund to the community health trust fund (10 percent), common schools trust fund (45 percent), and water development trust fund (45 percent).

The Legislative Council staff said in the November 2008 general election, voters approved initiated measure No. 3 that amended Section 54-27-25 to establish the tobacco prevention and control trust fund. The measure provided for a portion of tobacco settlement dollars received by the state to be deposited in the tobacco prevention and control trust fund rather than the entire amount in the tobacco settlement trust fund. Tobacco settlement money received under subsection IX(c)(1) of the Master Settlement Agreement, which continues in perpetuity, continues to be deposited in the tobacco settlement trust fund and allocated 10 percent to the community health trust fund (with 80 percent used for tobacco prevention and control), 45 percent to the common schools trust fund, and 45 percent to the water development trust fund. Tobacco settlement money received under subsection IX(c)(2) of the Master Settlement Agreement relating to strategic contribution payments, which began in 2008 and continue through 2017, began to be deposited in 2009 into the newly created tobacco prevention and control trust fund. Interest earned on the balance in the tobacco prevention and control trust fund is deposited in the fund. Tobacco settlement proceeds under subsection IX(c)(1) of the Master Settlement Agreement are estimated to total $40 million during the 2013-15 biennium and will be transferred to the common schools trust fund ($18 million), the water development trust fund

($18 million), and the community health trust fund ($4 million). Tobacco settlement proceeds received under subsection IX(c)(2) of the Master Settlement Agreement are estimated to total $22.6 million during the 2013-15 biennium and will be deposited into the tobacco prevention and control trust fund.

The Legislative Council staff said the tobacco prevention and control trust fund is administered by the Tobacco Prevention and Control Executive Committee for the purpose of creating and implementing the comprehensive plan. The 2013-15 executive budget recommended $13,016,197 from the tobacco prevention and control trust fund to the Tobacco Prevention and Control Executive Committee. The Legislative Assembly increased funding from the tobacco prevention and control trust fund to provide $15,815,828 for tobacco prevention and control, $2,893,214 more than the 2011-13 biennium. The 2011-13 biennium estimated ending balance in the tobacco prevention and control trust fund is $39.5 million. Based on 2013-15 biennium estimated deposits and funds appropriated to the Tobacco Prevention and Control Executive Committee for tobacco prevention and control, the estimated 2013-15 biennium ending balance in the tobacco prevention and control trust fund is $46.4 million.

The Legislative Council staff said Section 54-27-25, created by 1999 House Bill No. 1475, also established the community health trust fund and provides money in the fund may be used by the State Department of Health--subject to legislative appropriation--for community-based public health programs and other public health programs, including programs with an emphasis on preventing or reducing tobacco usage. The 2003 Legislative Assembly authorized the establishment of a telephone "Tobacco Quitline" and provided funding from the community health trust fund. In 2007 the Legislative Assembly increased the funding for the quitline to provide nicotine replacement therapy and cessation counseling and authorized one full-time equivalent (FTE) tobacco prevention coordinator position and related funding for salaries and wages and operating expenses for the position. Beginning with the 2011-13 biennium, the Legislative Assembly did not approve direct funding for the quitline or the tobacco prevention coordinator position but rather appropriated $3,510,496 from the community health trust fund to the department for tobacco prevention and control programs. The department anticipates expending $3,210,178 from the fund for the 2011-13 biennium. The 2013-15 executive budget recommended, and the Legislative Assembly approved, an appropriation of $3,220,354 from the community health trust fund to the department for tobacco prevention and control programs for the 2013-15 biennium. Measure No. 3 provides 80 percent of the funds allocated to the community health trust fund from the tobacco settlement trust fund be used for tobacco prevention and control. Based on estimated tobacco settlement trust fund transfers during the 2013-15 biennium, tobacco prevention and control expenditures from the community health trust fund are required to total $3.2 million. Funds appropriated by the Legislative Assembly for tobacco cessation from the community health trust fund from the 1999-2001 biennium through the 2013-15 biennium total $33.9 million.

The Legislative Council staff said the CDC has established "best practices" guidelines to help states plan and carry out effective tobacco use prevention and control programs. The CDC published its *Best Practices for Comprehensive Tobacco Control Programs*, including related funding recommendations, in October 2007. The recommended program budgets outlined in the publication include state and community interventions, health communication interventions, cessation interventions, surveillance and evaluation, and administration and management. Recommended program intervention budgets totaled $14.67 per capita per year in 2007 for North Dakota, and the CDC-recommended annual investment was $9.3 million or $18.6 million per biennium. Based on CDC guidelines, not adjusted for inflation or population growth, recommended biennial funding by intervention is:

- State and community interventions - $9,344,640.
- Health communication interventions - $2,358,480.
- Cessation interventions - $4,462,140.
- Surveillance and evaluation - $1,623,780.
- Administration and management - $810,960.

The Legislative Council staff said initiated measure No. 3, approved in November 2008, added seven new sections to the Century Code to establish the Tobacco Prevention and Control Advisory Committee and an executive committee and to develop and fund a comprehensive statewide tobacco prevention and control plan. The Tobacco Prevention and Control Advisory Committee is responsible for developing a comprehensive statewide tobacco prevention and control program that is consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. Because certain tobacco-related programs provided through the State Department of Health qualify as best practices as outlined by the CDC, funding for programs administered by the Tobacco Prevention and Control Executive Committee is adjusted accordingly. Tobacco prevention and control funding provided for the 2013-15 biennium totaled $21.3 million, of which $3.2 million is from the community health trust fund, $15.8 million is from the tobacco prevention and control trust fund, and $2.3 million is from federal funds. Funding provided for tobacco prevention and control from the 2007-09 biennium through the 2013-15 biennium

totaled $68.5 million, including $16.5 million from the community health trust fund, $41.7 million from the tobacco prevention and control trust fund, and $10.3 million from federal funds.

The Legislative Council staff said the 2013 Legislative Assembly reviewed information regarding CDC-recommended funding levels for tobacco control programs and the effect of inflation and population changes on the recommended funding level for North Dakota. The Tobacco Prevention and Control Executive Committee provided information regarding CDC-recommended funding levels, adjusted for inflation and population growth in the state. The Executive Committee indicated, based on published consumer price index changes and Moody's Analytics most recent forcasted consumer price index changes for 2013 and 2014, the recommended annual per capita funding rates for state and community interventions, health communication interventions, cessation interventions, surveillance and evaluation, and administration and management would total $17.02 and $17.44 for 2013 and 2014, respectively. Total CDC-recommended funding based on these rates and state population totals, adjusted proportionally for recent growth, would total $25 million for the 2013-15 biennium.

The Legislative Council staff said the 2011-12 Health Services Committee received information regarding smoking rates and related trends in tobacco prevention and control spending, cigarette tax rates, and smoke-free environment laws. The committee learned cigarette use is measured based on data from the CDC behavioral risk factor surveillance survey. The committee received information regarding adult cigarette use in each state and the District of Columbia from 2000 to 2010. Overall adult cigarette use in North Dakota declined from 23.2 percent in 2000 to 17.4 percent in 2010. The 5.8 percent reduction in adult cigarette use from 2000 to 2010 in the state ranked North Dakota 18th among the 50 states and the District of Columbia.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding the service delivery systems for the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Prevention and Control Executive Committee and how the delivery systems are consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*.
2. Receive a report on an assessment completed by the State Department of Health and the Tobacco Prevention and Control Executive Committee of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state.
3. Review the effectiveness and fiscal efficiency of the comprehensive statewide tobacco prevention and control programs provided in the state, including the cost of cessation programs, the number of clients served, effectiveness of cessation programs, and ways to improve the health and policy outcomes of the programs.
4. Receive information regarding how the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Prevention and Control Executive Committee address tobacco use by the Native American population on the Indian reservations.
5. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
6. Prepare a final report for submission to the Legislative Management.

Senator Lee suggested the committee receive an updated risk behavior survey prepared by the Legislative Council.

Ms. Krista Fremming, Director, Tobacco Prevention and Control Program, State Department of Health, provided information (Appendix H) regarding a review of the service delivery systems for the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and how the delivery systems are consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. She said the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (October 2007) includes five focus areas:

1. State and community interventions;
2. Health communications;
3. Cessation;
4. Surveillance and evaluation; and
5. Administration and management.

Ms. Fremming said the tobacco prevention and control program within the State Department of Health is the lead for state and community interventions disparities activities; cessation, including promotion and evaluation related to the cessation services; and surveillance and evaluation only for cessation programs. She said the department has approximately 4.5 FTE positions working directly on tobacco prevention and control, including administrative support.

Ms. Fremming said state and community interventions include work with disparate populations. She said these populations are more susceptible to certain diseases or risk factors and/or have a harder time finding help to overcome illnesses or risk factors. She said groups at high risk for tobacco use in North Dakota include American Indians, adults aged 18 to 24, pregnant women, individuals with lower education status and/or lower economic earnings, and other groups such as members of the military, members of the lesbian/gay/bisexual/transgender (LGBT) communities, homeless people, bar and casino workers, new Americans (refugees, immigrants), rural residents, and people with mental or physical disabilities.

Ms. Fremming said programs dedicated to assisting the disparate populations include:

- Tribal tobacco programs which provide grant funds, guidance, and technical assistance to each reservation.
- The Campus Tobacco Prevention Project (CTPP) which is a partnership between the State Department of Health tobacco prevention and control program and the North Dakota University System Consortium for Substance Abuse Prevention. She said the project addresses challenges North Dakota campuses are facing regarding awareness of tobacco cessation services among the campus community, including disparate populations.
- Baby and Me Tobacco Free is a cessation program created to reduce the burden of tobacco use on pregnant women and new mothers.
- Million Hearts Community Action Grant "S" (smoking cessation) program provides funding to the major health care systems in North Dakota to establish "cessation centers."
- NDQuits partners with Medicaid to provide coverage for all seven of the Food and Drug Administration-approved medications for cessation to Medicaid enrollees who want to quit tobacco and enroll in counseling.
- Lesbian/gay/bisexual/transgender/Fargo-Moorhead Pride includes providing information in partnership with Fargo-Moorhead Pride Collective about disparate tobacco use among LGBT populations and about quitting tobacco use through NDQuits.

Ms. Fremming said other partnerships that are not related to a specific program but have an impact on tobacco use in disparate populations include the Department of Public Instruction, North Dakota School Boards Association, Governor's Prevention Advisory Council on Drugs and Alcohol, mental health and substance abuse prevention through the Department of Human Services and its eight regional human service centers, Statewide Epidemiological Outcomes Workgroup, Prevention Expert Partners Workgroup, and the North Dakota Center for Persons with Disabilities. She said the State Department of Health tobacco program monitors emerging tobacco products, including preparation of educational materials regarding new tobacco products like electronic cigarettes, hookahs, and dissolvable sticks, strips, orbs, and snus, among others. She said the department stays current with national partners related to the Food and Drug Administration Family Smoking Prevention and Tobacco Control Act. She said worksite wellness and statewide coalition involvement are also important areas that relate to the state and community intervention area.

Ms. Fremming said cessation services provided by the State Department of Health and others include NDQuits, the Public Employees Retirement System (PERS) cessation program for state employees and eligible family members, the city/county cessation program for county employees and eligible family members, and the public health service guidelines initiative to Ask-Advise-Refer patients.

Ms. Fremming said surveillance, as defined by the CDC's *Best Practices for Comprehensive Tobacco Control Programs*, is the process of monitoring tobacco-related attitudes, behaviors and health outcomes at regular intervals of time. She said the State Department of Health tobacco prevention and control program is involved with surveys that measure the adult and youth smoking and tobacco usage rates in North Dakota. She said state-specific fact sheets to support the data are then developed. She said surveys include the behavioral risk factor surveillance system (BRFSS), adult tobacco survey (ATS), youth tobacco survey (YTS), youth risk behavior survey (YRBS), and North Dakota secondhand smoke study. She said evaluations of the cessation programs offered through the State Department of Health are conducted on an ongoing basis and are used to assess program activities and to guide program improvement.

Senator Lee suggested, as part of the study plan, the committee receive information regarding:

- How much is spent per tobacco user on tobacco prevention and control.
- Changes in the number of tobacco users statewide (adult and youth), the number of tobacco users on the reservations (adult and youth), and how the number of tobacco users on reservations affects the overall percentage of tobacco users in the state.
- Recent tobacco prevention and control newspaper campaigns, including the cost of the campaign, demographics of the readers, and effect of the advertisements on the Tobacco Quitline.
- How the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Control Executive Committee address tobacco use among youth.

Representative J. Nelson suggested the study plan include information regarding a breakdown of funding by focus area outlined in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*.

Ms. Jeanne Prom, Executive Director, North Dakota Center for Tobacco Prevention and Control Policy, provided information (Appendix I) regarding a review of the service delivery systems for the comprehensive statewide tobacco prevention and control programs provided by the Tobacco Prevention and Control Executive Committee (Center) and how the delivery systems are consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. She provided the following information regarding the CDC-recommended funding allocations and actual State Department of Health and Center funding allocations for the 2011-13 biennium:

2011-13 Biennium Tobacco Prevention and Control Funding Allocation

	State Department of Health	Tobacco Prevention and Control Executive Committee	Total	CDC-Recommended Funding Allocation
State and community interventions	5%	40%	45%	50%
Health communications		12%	12%	13%
Cessation	21%	10%	31%	24%
Surveillance and evaluation	2%	5%	7%	8%
Administration and management	2%	3%	5%	5%
Total	30%	70%	100%	100%

Ms. Prom provided information regarding the effect of inflation and population increases on CDC-recommended funding. She said population in the state has grown from 649,422 in 2006 to an estimated 733,224 in 2014. She said inflation has been positive in all but one year since 2007, and Moody's Analytics forecasts include positive growth in inflation in 2013 and 2014. She said increases in population and inflation result in larger recommended funding allocations for each CDC best practices focus area, bringing per capita spending for tobacco prevention and control from $14.67 in 2007 to $17.44 in 2015. She said applying the increased per capita rate to recent population estimates results in recommended spending of approximately $12.2 million in 2014 and $12.8 million in 2015, for a total of approximately $25 million for the 2013-15 biennium.

Ms. Prom provided information regarding a summary of total tobacco prevention and control spending by the State Department of Health and the Center for the 2009-11 and 2011-13 bienniums compared to the CDC-recommended funding levels for each focus area. She said total spending for tobacco prevention and control was less than recommended by the CDC, as adjusted for inflation and population, in each biennium presented. She provided the following information regarding the estimated allocation of the $21.4 million provided to the State Department of Health and the Center for tobacco prevention and control during the 2013-15 biennium and the CDC-recommended funding for the same period:

Estimated Allocations of the 2013-15 Biennium Tobacco Prevention and Control Funding Appropriation and CDC-Recommended Funding

	State Department of Health[1]	Tobacco Prevention and Control Executive Committee	Total	CDC-Recommended Funding Allocation[2]
State and community interventions	$942,522	$9,614,644	$10,557,166	$11,725,765
Health communications		2,639,944	2,639,944	2,952,430
Cessation	3,880,976	1,486,282	5,367,258	5,597,024
Surveillance and evaluation	388,098	1,408,221	1,796,319	2,028,921
Administration and management	332,655	666,737	999,392	1,021,457
Total	$5,544,251	$15,815,828	$21,360,079	$23,325,597[2]

[1]The State Department of Health allocation by focus area is based on 2011-13 allocation percentages.

[2]The CDC-recommended funding allocation provided is based on known inflation and population at the time the budget is drafted. A CDC-recommended funding allocation based on anticipated increases in population and inflation during the 2013-15 biennium would result in total recommended funding of $25 million, approximately $3.6 million more than the funding appropriated by the 2013 Legislative Assembly.

Ms. Prom said the CDC best practices spending levels should be updated annually for inflation and population changes. She said tobacco settlement revenues received by the state are increased each year based on actual inflation or 3 percent, whichever is greater. She said tobacco settlement revenues are also adjusted for changes in tobacco sales volume. She said reductions in revenue received by the state relate to reduced sales of tobacco.

Ms. Prom said based on current spending levels and anticipated tobacco settlement revenues, the tobacco prevention and control trust fund balance is anticipated to grow to an estimated $53.7 million in 2017--the last year funding from the strategic settlement payments will be received. She said the Center would use the balance in the fund at that time to continue CDC's *Best Practices Tobacco Prevention and Control Programs* until 2023, when it is estimated the funds in the tobacco prevention and control trust fund will be exhausted. Beyond 2023, she said, programs would continue to receive funding from 80 percent of the tobacco settlement revenue deposited in the community health trust fund.

Ms. Prom provided information regarding Center programs and their relevance to the CDC best practices focus areas. She said Center programs focus on the population as a whole. She said there is an estimated 120,000 individuals in the state who smoke, and of those, approximately 13,000 are Native American. She said the Center's budget for state and community interventions is $10.4 million and includes three FTE positions who manage 100 grants. She said grants include local policy grants, tobacco settlement state aid grants, and special initiative grants and contracts. She said the Center's budget for health communications includes $1.5 million for one to five contracts and is staffed by one FTE position and one temporary position. She said staff is responsible for the implementation of the statewide plan and provide daily assistance to other staff, grantees, and contractors on public education to assure health communications is combined with state and community interventions. She said the Center's budget for statewide evaluation includes $1.2 million for one to three contracts and is staffed by one FTE position. She said staff is responsible for evaluation of the statewide plan and its impact and provides daily assistance to other staff, grantees, and contractors on evaluation.

Ms. Prom provided information regarding tobacco prevention and control outcomes. She said since 2009, 11 communities have adopted local smoke-free policies and statewide the percentage of the state's population covered by comprehensive smoke-free air laws rose from 19.5 percent to 100 percent with the passage of a statewide measure in 2012. She provided information regarding the percentage of schools covered by tobacco-free school policies, college and university tobacco-related policies, smokers reached in the Ask-Advise-Refer initiative, monthly enrollment in the NDQuits smoking cessation program, tobacco-free parks, per capita cigarette sales in the state, smoking rates among high school and middle school students, and students smoking for the first time under age 13. She said the state tobacco tax remains one of the lowest in the nation. She said the cigarette excise tax is currently $2.83 in Minnesota, $1.70 in Montana, $1.53 in South Dakota, and $.44 in North Dakota.

In response to a question from Senator Mathern, Ms. Prom said there is no requirement for the Center to report spending to the CDC and they do not report spending; however, the Center shares information with the CDC. She said there is no penalty for spending less than the CDC-recommended level.

Ms. Erin Hill Oban, Executive Director, Tobacco Free North Dakota, presented testimony (Appendix J) on behalf of Dr. Eric L. Johnson, President, Tobacco Free North Dakota. She said the management of tobacco prevention and control funds by an entity separate from the State Department of Health is advantageous to the state. She said the Center is able to focus on prevention in ways the department could not. She said the Center engages partners across the state to change public policy regarding tobacco and facilitate large-scale efforts through legislative action or ballot measures. She said Tobacco Free North Dakota is a statewide nonprofit organization based in Bismarck that, with the support of the Center, has engaged partners in the public and private sector who share a common interest in reducing tobacco use. She said 21 percent of adults in North Dakota still smoke, and the smoking rate among high school students is 19 percent.

Ms. Barbara Andrist, Community Programs Manager, North Dakota Center for Tobacco Prevention and Control Policy, presented testimony (Appendix K) on behalf of Ms. Theresa Will, Director, City-County Health District. She said the detailed reporting required by the grant programs administered by the Center require data monitoring documentation of tobacco prevention outcomes. She said while the health district is responsible for numerous grant-based programs, the reporting required by Center grant programs is more detailed than other grant programs implemented by the health district. She said the "Ask-Advise-Refer" intake protocol implemented by the health district, local providers, and health care systems is a highly effective intervention.

Representative Fehr suggested the study plan include information regarding the impact of trends in smokeless tobacco, electronic cigarettes, and other smoking alternatives.

It was moved by Representative Holman, seconded by Representative Hofstad, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding the service delivery systems for the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Prevention and Control Executive Committee, a breakdown of funding by focus area outlined in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*, and how the delivery systems are consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*.**
2. **Receive a report on an assessment completed by the State Department of Health and the Tobacco Prevention and Control Executive Committee of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state.**
3. **Review the effectiveness and fiscal efficiency of the comprehensive statewide tobacco prevention and control programs provided in the state, including how much is spent per tobacco user on tobacco prevention and control in the state, the cost of cessation programs, the number of clients served, effectiveness of cessation programs, and ways to improve the health and policy outcomes of the programs.**
4. **Receive information regarding the impact of trends in smokeless tobacco, electronic cigarettes, and other smoking alternatives.**
5. **Receive information regarding how the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Prevention and Control Executive Committee address tobacco use among youth.**
6. **Receive information from the State Department of Health regarding recent tobacco prevention and control newspaper campaigns, including the cost of the campaign, demographics of the readers, measurable results of the campaign, and effect of the advertisements on the Tobacco Quitline.**
7. **Receive information regarding changes in the number of tobacco users statewide (adult and youth), the number of tobacco users on and off the reservations (adult and youth), and how the number of tobacco users on reservations affects the overall percentage of tobacco users in the state.**
8. **Receive information regarding how the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and the Tobacco Prevention and Control Executive Committee address tobacco use by the Native American population on the Indian reservations.**
9. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
10. **Prepare a final report for submission to the Legislative Management.**

COMMUNITY PARAMEDIC STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Community Paramedic Study - Background Memorandum* relating to the study as provided for in 2013 Senate Concurrent Resolution No. 4002, of the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive third-party reimbursement for the cost of these services and the effect of these services on the operations and sustainability of the current emergency medical services (EMS) system.

The Legislative Council staff provided information regarding EMS licensing, supervision, and training and certification. Chapter 23-27 provides the State Department of Health is the licensing authority for EMS operations and may designate their service areas. The Health Council is responsible for establishing rules for licensure. In addition to licensing five industrial ambulance services, which only respond to property owned by the company they serve, and 78 quick response units, the state also provides licenses for two levels of ground ambulance service--basic life support and advanced life support. Basic life support ambulances must have a minimum staff training level of an emergency medical technician and a driver certified in CPR, while advanced life support ambulances must have a minimum staff training level of a paramedic and an emergency medical technician. The state currently has 20 advanced life support ambulance services and 118 basic life support ambulance services, of which 8 basic life support ambulance services are substation ambulance services, meaning they are licensed as a secondary base location from which an ambulance can be dispatched, but 24-hour coverage is not required. Section 23-27-04.4 allows certified or licensed emergency medical technician-intermediates and paramedics, who are employed by a hospital, to provide patient care within a scope of practice established by the State Department of Health. These EMS professionals are under the supervision of the hospital's nurse executive.

The Legislative Council staff said the Legislative Assembly in 2011 House Bill No. 1044 created Chapter 23-46 related to EMS. Section 23-46-03 requires the State Department of Health to establish and update biennially a plan for integrated EMS in the state. In addition, Section 23-46-02 requires the State Department of Health to establish an Emergency Medical Services Advisory Council and consider the recommendations of the council on the plan for integrated EMS in the state, development of EMS funding areas, development of the EMS funding areas application process and budget criteria, and other issues relating to EMS as determined by the State Health Officer.

The Legislative Council staff said the Legislative Assembly in 2009 Senate Bill No. 2004 increased funding provided from the insurance tax distribution fund for EMS by $1.5 million. Section 6 of the bill authorized $2.25 million for EMS operations grants as provided in Chapter 23-40 during the 2009-11 biennium and $500,000 for a grant to contract with an organization to develop, implement, and provide an access critical ambulance service operations assessment process for the purpose of improving EMS delivery; to develop, implement, and provide leadership development training; to develop, implement, and provide a biennial EMS recruitment drive; and to provide regional assistance to ambulance services to develop a quality review process for EMS personnel and a mechanism to report to medical directors. This funding was in addition to $1,240,000 provided for EMS training grants, of which $940,000 was from the general fund and $300,000 was from the community health trust fund.

The Legislative Council staff said for the 2011-13 biennium, the Legislative Assembly in 2011 House Bill No. 1044 appropriated $3 million from the general fund for state assistance grants to EMS operations and related administrative costs. In addition, 2011 House Bill No. 1004 provided $1,250,000 from the insurance tax distribution fund for EMS staffing grants and $940,000 from the general fund for EMS training grants. House Bill No. 1266 (2011) provided $100,000 from the general fund to support a comprehensive state trauma system and authorized the State Health Officer to appoint an EMS and trauma medical director to provide medical oversight and consultation in the development and administration of the state EMS and trauma systems.

The Legislative Council staff said the 2011-12 Health Services Committee received information regarding the EMS improvement grant to study rural EMS issues awarded to SafeTech Solutions, LLP, from the Emergency Medical Services Advisory Council. The SafeTech Solutions, LLP, report on the challenges facing EMS in rural North Dakota expressed a concern regarding the lack of adequate rural, out-of-hospital EMS in North Dakota. The committee learned in rural areas, where volumes of medical transports are low, EMS relies on donations, local tax revenues, and volunteer labor. In western North Dakota, increasing demand for services is a concern, including a need for specific training and environmental challenges. In other parts of the state, the aging population is an issue. The committee received information from the State Health Officer regarding community paramedics. The committee learned there is the potential for community paramedics to provide additional cost-effective clinical and public health services, particularly in rural areas of the state. The ability to receive reimbursement for these services could enhance the sustainability of the current EMS system. The committee learned EMS systems can function with volunteer personnel by responding to up to approximately 350 emergency calls per year, while fee-for-service systems are generally not sustainable until the service responds to at least 650 emergency calls per year. Increased demand is causing some communities with volunteer responders to increase to more than 350 emergency calls but still less than 650. The committee learned if the role of paramedics could be expanded to that of community paramedics, fee-for-service EMS systems could likely be sustained. The committee learned appropriately trained community paramedics could provide billable services, including:

1. Community midlevel clinical evaluation and treatment;
2. Community-level call-a-nurse service and advice;
3. Chronic disease management support;
4. Case management of complex cases;
5. Worksite wellness facilitation and onsite clinical support; and
6. School wellness and midlevel clinical services.

The Legislative Council staff said the Governor recommended and the Legislative Assembly approved, in 2013 Senate Bill No. 2004, $276,600 from the general fund for one FTE position ($135,000) for the State Department of Health to implement a community paramedic/community health care worker pilot project and educational startup costs ($141,600) during the 2013-15 biennium. The department's request for the FTE position is to coordinate the ongoing community health care providers, establish a training program for the project, and coordinate ST-elevation myocardial infarction (STEMI).

The Legislative Council staff said the State Department of Health request for pilot project funding indicated the program would coordinate workers to utilize the downtime of paramedics between ambulance calls in order to assist community health workers. The department indicated there appears to be significant overlap between

community health care workers and community paramedics, so it seems natural for these two divisions to collaborate on a new health care delivery system in both rural and urban areas. The department indicated there is a need in the state to help transition patients from the clinical system into the community to avoid continued chronic disease readmissions into the clinical systems. Efforts throughout the country to establish an alternative to the existing health care delivery system include a medical home model or a transition model of care; however, most of the new models require an additional workforce and compensation. The department indicated collaboration between the community health worker and community paramedics would effectively use the workforce that currently exists with significant downtime between ambulance calls or transports. The department indicated the project would fill the needs of the community by training the current workforce and reinforcing the decreasing number of volunteers by providing some paid staff for ambulance services. The department indicated a curriculum exists for the training of the providers; however, changes to existing rules and statutes may be necessary to make the program fully functional.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding clinical and public health services that may be performed by community paramedics, particularly in rural areas of the state, including the types of services community paramedics could perform, additional training necessary to perform additional services, and any legislation required to allow community paramedics to perform additional services.
2. Gather and review information regarding the ability to receive third-party reimbursement for the cost of clinical and public health services performed by community paramedics and the effect of performing these services on the operations and sustainability of the current EMS system.
3. Receive information from the State Department of Health regarding community paramedic programs operating in other states, including the benefits and challenges experienced by states implementing community paramedic programs and the status of the community paramedic and community health care worker pilot program.
4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

Mr. Tom Nehring, Director, Emergency Medical Services and Trauma Division, State Department of Health, provided information (Appendix L) regarding the feasibility and desirability of community paramedics providing additional clinical and public health services--particularly in rural areas of the state, including the effect of these services on the operations and sustainability of the current EMS system and on the status of the community paramedic and community health care worker pilot program. He said the concept of community paramedics or community health EMS, is to use portions of the EMS workforce to address community health and medical needs that communities currently do not have the resources to address. He said community paramedics could deliver services, including assessments, chronic disease management, blood draws, diagnostic cardiac monitoring, fall prevention, and medication reconciliation in places such as homes, schools, and places of employment. He said benefits of a community health EMS program include the provision of services in rural communities where there are gaps in the community health care system and where no clinical services or hospitals currently exist, a reduction in unnecessary and expensive visits to emergency departments, and sustainment of the existing EMS system by creating revenue sources not exclusively tied to the transport of patients. He said the community health EMS model creates a team approach to health care and promotes coordinated and integrated care by the EMS system with physicians, nurse practitioners, physician assistants, hospitals, home health agencies, long-term care facilities, and public health departments. He said a community health EMS subcommittee of the Emergency Medical Services Advisory Council has been formed.

In response to a question from Senator Lee, Mr. Nehring said in early 2013, there were 5 community paramedic programs across the nation; there are currently 17. He said some states have not yet addressed the increased scope of practice of the community paramedic. He said Minnesota was the first state to establish Medicaid reimbursement for this type of service, and it took approximately two years.

In response to a question from Senator Heckaman, Mr. Nehring said community paramedic training could be expanded to include information related to autism, developmental disabilities, and Alzheimer's, to better prepare EMS for issues related to these diagnoses.

Ms. Cindy Sheldon, Deputy Director, Medical Services Division, Department of Human Services, provided information (Appendix M) regarding the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive Medicaid reimbursement for the cost of these services. She said based on a January 2012 Minnesota Department of Human

Services report, there is no standard list of services provided by a community paramedic nor is there a globally accepted scope of practice. She said roles of a community paramedic identified by a medical facility training program in Minnesota include health screening assessments, health teaching, immunizations, disease management, screening for mental health issues and referral, wound care, and safety programs. She said in 2011 Minnesota approved legislation to provide for Medicaid reimbursement of community paramedic services. She said Minnesota has received approval for a State Plan Amendment submitted to the Centers for Medicare and Medicaid (CMS). She said in Minnesota, authorized services are based on an individual care plan created by the primary care provider in consultation with the medical director of the ambulance service. She said in order to receive reimbursement for community paramedic services in North Dakota, the Department of Human Services would need to submit and receive approval for a State Plan Amendment from CMS. She said if the amendment is approved, each community paramedic would be required to enroll as a provider with North Dakota Medicaid.

In response to a question from Senator Mathern, Ms. Maggie D. Anderson, Director, Medical Services Division, Department of Human Services, said a community paramedic may be able to assist with mental health calls, but this type of service would require a higher level of mental health training. She said it may be possible for a community paramedic to perform mental health assessments and refer patients to a human service center.

Ms. Cheryl Rising, Legislative Liaison, North Dakota Nurse Practitioner Association, said the organization is supportive of programs that will decrease unnecessary transport to hospital emergency departments and bring services to more individuals. She said it may be possible for family nurse practitioners to partner with EMS. She shared information (Appendix N) regarding a partnership in Arizona.

In response to a question from Senator Lee, Mr. Nehring said it is possible for a community paramedic to provide school nurse or occupational health services.

Senator Lee suggested the study plan include recommendations from the State Department of Health for the implementation of a community paramedic program relating to liability and scope of practice.

It was moved by Senator Mathern, seconded by Senator Erbele, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding clinical, behavioral, and public health services that may be performed by community paramedics, particularly in rural areas of the state, including the types of services community paramedics could perform, additional training necessary to perform additional services, and any legislation required to allow community paramedics to perform additional services.**
2. **Gather and review information regarding the ability to receive third-party reimbursement for the cost of clinical and public health services performed by community paramedics and the effect of performing these services on the operations and sustainability of the current EMS system.**
3. **Receive information from the State Department of Health regarding community paramedic programs operating in other states, including the benefits and challenges experienced by states implementing community paramedic programs and the status of the community paramedic and community health care worker pilot program.**
4. **Receive information from the State Department of Health regarding recommendations related to the implementation of a community paramedic program, including liability, scope of practice, and reimbursement.**
5. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
6. **Prepare a final report for submission to the Legislative Management.**

OTHER COMMITTEE RESPONSIBILITIES

The Legislative Council staff presented a background memorandum entitled *Other Duties of the Health Services Committee - Background Memorandum*. In addition to the study responsibilities assigned to the Health Services Committee for the 2013-14 interim, the committee has also been assigned to:

- Receive a report from the State Fire Marshal regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes;
- Recommend a private entity to contract with for preparing cost-benefit analyses of health insurance mandate legislation;

- Receive a report from the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS before June 1, 2014, 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; and
- Receive a report from the University System before November 15, 2013, regarding the findings of its study of the out-of-state programs in veterinary medicine, optometry, and dentistry; the access of North Dakota students to those programs; and the state's needs for dentists, optometrists, and veterinarians.

Effectiveness of Legislation Related to Reduced Ignition Propensity Standards for Cigarettes

The Legislative Council staff said the Legislative Assembly in 2009 House Bill No. 1368 created Chapter 18-13 relating to reduced ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. The bill provides for enforcement of the standards by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. No funds were deposited into the fire prevention and public safety fund during the 2011-13 biennium, and there was no balance in the fund as of June 30, 2013. In addition, fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial $250 fee for certification, which is deposited in the reduced cigarette ignition propensity and Firefighter Protection Act enforcement fund. Deposits into the fund totaled $120,000 during the 2011-13 biennium and expenditures totaled $25,352. As of June 30, 2013, the balance in the reduced cigarette ignition propensity and Firefighter Protection Act enforcement fund was $313,960. Section 18-13-02(6) requires the State Fire Marshal review the effectiveness of test methods and performance standards and report each interim to the Legislative Management the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The Health Services Committee has been assigned the responsibility to receive this report.

Health Insurance Coverage Mandates

The Legislative Council staff said Section 54-03-28 provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Health Services Committee has been assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2013 legislative session. The Insurance Commissioner is to pay the costs of the contracted services, and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

The section also provides a legislative measure mandating the health insurance coverage must provide:

1. The measure is effective only for the next biennium.
2. The application of the mandate is limited to the public employees health insurance program and the public employees retiree health insurance program.
3. For the next Legislative Assembly, PERS prepare and request introduction of a bill to repeal the expiration date and extend the mandated coverage to apply to all accident and health insurance policies.

The Legislative Council staff said the PERS Board is also required to prepare a report, which is attached to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The board must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue. The 2009-10 interim Health and Human Services Committee learned PERS is not required the use of a consultant when evaluating legislative measures mandating health insurance coverage. However, if a future analysis does require additional resources, Section 54-52.1-06.1 provides a continuing appropriation to PERS for consulting services related to the uniform group insurance program.

A majority of the members of the standing committee to which the legislative measure is referred during a legislative session, acting through the Vhairman, determines whether a legislative measure mandates coverage of services. Any amendment to the legislative measure that mandates health insurance coverage may not be acted on by a committee of the Legislative Assembly unless the amendment has had a cost-benefit analysis prepared and attached.

The Insurance Department has categorized and defined mandated health insurance benefits:

1. Service mandates - Benefit or treatment mandates that require insurers to cover certain treatments, illnesses, services, or procedures. Examples include child immunization, well-child visits, and mammography.
2. Beneficiary mandates - Mandates or defines the categories of individuals to receive benefits. Examples include newborns from birth, adopted children from the time of adoption, and handicapped dependents.
3. Provider mandates - Mandates that require insurers to pay for services provided by specific providers. Examples include nurse practitioners, optometrists, and psychologists.
4. Administrative mandates - Mandates that relate to certain insurance reform efforts that increase the administrative expenses of a specific health care plan. Examples include information disclosures, precluding companies from basing policy rates on gender, and precluding insurers from denying coverage for preauthorized services.

The Legislative Council staff said the 2003-04 and 2005-06 interim Budget Committees on Health Care, the 2007-08 interim Human Services Committee, the 2009-10 interim Health and Human Services Committee, and the 2011-12 Health Services Committee recommended the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, 2009, 2011, and 2013 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of $8,323. In addition, the Insurance Department paid $5,606 to Milliman USA for general project work during the 2005 legislative session for total payments during the 2005 legislative session of $13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The Insurance Department paid a total of $28,070 to Milliman USA for analyses conducted on three bills during the 2009 legislative session and $14,982 to Milliman USA for analysis conducted on one bill during the 2011 legislative session. There were no health insurance mandates referred for cost-benefit analysis during the 2013 legislative session.

Report on Plans to Reduce the Incidence of Diabetes in the State, Improve Diabetes Care, and Control Complications Associated With Diabetes

The Legislative Council staff said the Legislative Assembly approved 2013 House Bill No. 1443 which requires the Department of Human Services, the State Department of Health, the Indian Affairs Commission, and PERS collaborate 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. Section 2 of the bill requires before June 1 of each even-numbered year, the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

a. The financial impact and reach diabetes is having on the agency, the state, and localities. Items included in this assessment must include the number of lives with diabetes impacted or covered by the agency, the number of lives with diabetes and family members impacted by prevention and diabetes control programs implemented by the agency, the financial toll or impact diabetes and diabetes complications places on the agency's programs, and the financial toll or impact diabetes and diabetes complications places on the agency's programs in comparison to other chronic diseases and conditions.

b. An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment must document the amount and source for any funding directed to the agency from the legislative assembly for programs and activities aimed at reaching those with diabetes.

c. A description of the level of coordination existing between the agencies on activities, programmatic activities, and messaging on managing, treating, or preventing diabetes and diabetes complications.

d. The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the legislative assembly. The plans must identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan must identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing relevant forms of diabetes.

e. The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in subdivision d. This blueprint must include a budget range for all options presented in the plan identified in subdivision d for consideration by the legislative assembly.

Report on the University System Study of Professional Student Exchange Programs

The Legislative Council staff said the Legislative Assembly approved 2013 Senate Bill No. 2160 which requires the University System to study the out-of-state programs in veterinary medicine, optometry, and dentistry. The study must include the accessibility of North Dakota students to the programs; the provision of state funding for students attending the programs; the amount of debt incurred by students attending the programs; and the state's short-term and long-term needs for dentists, optometrists, and veterinarians. Section 1 of the bill requires the University System to report its findings to the Legislative Management by November 15, 2013. The Health Services Committee has been assigned the responsibility to receive this report.

Senator Lee suggested the committee review a copy of a bill introduced by Senator Heckaman during the 2013 legislative session relating to the repayment of tuition assistance provided through professional student exchange programs if the participant does not return to the state to practice. She said funds recovered from participants not returning to the state to practice could be deposited into a revolving fund to provide assistance to additional program participants.

Senator Heckaman said a majority of veterinarians returning to the state are caring for small animals. She suggested the committee consider incentives to specialize in large animal care. In addition, she said, there are programs to assist with startup costs related to a dental practice, but no startup programs exist for optometrists and veterinarians. She said the proposed legislation included a three-year grace period before repayment to allow for the startup of a practice.

Senator Anderson suggested the committee receive information regarding the cost of educating health care professionals in the state, including physicians, pharmacists, and physical and respiratory therapists, and the estimated cost of educating dentists, optometrists, and veterinarians in the state.

Senator Mathern suggested the committee receive information regarding the need for optometrists in the state.

Senator Lee said the University System is authorized to lower the tuition assistance provided to each participant in any professional student exchange program and provide more awards.

Senator Erbele suggested the committee receive information regarding the number of students applying to professional student exchange programs, including WICHE and non-WICHE programs, and the number of students accepted.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Lee said the committee will be notified of the next meeting date.

No further business appearing, Chairman Lee adjourned the meeting at 2:53 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:14