HUMAN SERVICES COMMITTEE

The Human Services Committee was assigned the following responsibilities:

- A study of the need for a comprehensive system of care for individuals with brain injury pursuant to Section 16 of 2013 House Bill No. 1012. The study was to include an evaluation of services available to veterans who are returning from wars, the impact of the inclusion of all acquired brain injury on traumatic brain injury programs, the need for a statewide registry for brain injury, the need for increased awareness of the impact of brain injury, the need for screening for brain injury in the education system, the availability of community support systems, the availability of specialized substance abuse services, the examination of the long-term care needs, the availability of home and community-based services, services available from independent living centers, the need for transitional supportive housing, and the suitability of the current level of care determination for brain injury.
- A study of behavioral health needs pursuant to Section 1 of 2013 Senate Bill No. 2243. The study was to include consideration of behavioral health needs of youth and adults and consideration of access, availability, and delivery of services.
- A study of home and community-based services in the state pursuant to Section 1 of 2013 Senate Bill No. 2375. The study was to include an evaluation of the need to expand the home and community-based services Medicaid waiver to cover 24-hour emergency assistance, adult companion service, behavioral programming, chore services, customized living services, environmental modifications, and transition modification support.
- Receive the annual status report from the Autism Spectrum Disorder Task Force regarding the autism spectrum disorder plan pursuant to North Dakota Century Code Section 50-06-32.
- Receive a report from the Department of Human Services regarding the autism spectrum disorder voucher program pilot project pursuant to Section 50-06-32.1.
- Receive the annual report from the Department of Human Services describing enrollment statistics and costs associated with the children's health insurance program state plan pursuant to Section 50-29-02.
- Receive a report from the recipient of the grant during the 2014-15 school year to implement a certificate program that prepares individuals with autism spectrum disorder for employment in the technology sector regarding program graduates who found employment in the technology sector, their starting salaries, and their total compensation pursuant to Section 61 of 2013 House Bill No. 1013.
- Receive a report from the Department of Human Services regarding the impact of changing the eligibility requirement for the child care assistance program from 50 percent of the state median income to 85 percent and beginning July 1, 2014, reducing copay requirements for the child care assistance program pursuant to Section 8 of 2013 House Bill No. 1422.

Committee members were Representatives Chuck Damschen (Chairman), Dick Anderson, Curt Hofstad, Kathy Hogan, Dwight Kiefert, Diane Larson, Alex Looysen, Gail Mooney, Naomi Muscha, and Alon Wieland and Senators Tyler Axness, Dick Dever, Robert Erbele, Judy Lee, Tim Mathern, Nicole Poolman, and John M. Warner.

STUDY OF A COMPREHENSIVE SYSTEM OF CARE FOR INDIVIDUALS WITH BRAIN INJURY

The committee was assigned a study of the need for a comprehensive system of care for individuals with brain injury pursuant to Section 16 of 2013 House Bill No. 1012. The study was to include an evaluation of services available to veterans who are returning from wars, the impact of the inclusion of all acquired brain injury on traumatic brain injury programs, the need for a statewide registry for brain injury, the need for increased awareness of the impact of brain injury, the need for screening for brain injury in the education system, the availability of community support systems, the availability of specialized substance abuse services, the examination of the long-term care needs, the availability of home and community-based services, services available from independent living centers, the need for transitional supportive housing, and the suitability of the current level of care determination for brain injury.

Background

Section 50-06.4-01 defines traumatic brain injury as an acquired injury to the brain caused by an external physical force resulting in total or partial disability or impairment, including open and closed head injuries that may result in mild, moderate, or severe impairments in one or more areas including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-solving, sensory perceptual and motor abilities, psychosocial behavior, physical functioning, information processing, and speech. The term does not include brain injuries that are congenital or degenerative or brain injuries induced by birth trauma but may include brain injuries caused by anoxia and other related causes.

The Department of Human Services (DHS) Division of Mental Health and Substance Abuse manages traumatic brain injury (TBI) services. The division implemented a TBI screening tool, the Ohio State University TBI Identification Method - Short form, at all regional human service centers in March 2011. The purpose of the screening is to identify individuals who have sustained a TBI and to assist staff and clients in determining appropriate treatment strategies.

Traumatic Brain Injury Registry

The committee learned the 1987 Legislative Assembly created and enacted Sections 23-01-20 and 23-01-21 relating to a TBI central registry. Section 23-01-20 defined traumatic head injury and Section 23-01-21 directed the State Department of Health to establish and maintain a central registry of persons who sustain traumatic head injury in order to facilitate the provision of appropriate treatment and rehabilitative services to those persons by DHS or other providers. The committee learned Senate Bill No. 2109 approved by the 1999 Legislative Assembly repealed Sections 23-01-20 and 23-01-21 relating to the TBI central registry.

Traumatic Brain Injury Advisory Committee

The committee learned the Traumatic Brain Injury Advisory Committee was established in 2007 to advise DHS on issues relating to TBI. The committee consists of volunteers including individuals with TBI, family members, care givers, community providers, and state agency representatives. The committee meets on a quarterly basis to discuss issues facing individuals with TBI and their family members, provide suggestions and recommendations to DHS, and share information.

Funding

The 2013 Legislative Assembly provided $779,624 from the general fund to DHS for services relating to TBI. Of the appropriation, $320,000 was for the development of resource facilitation for individuals with TBI. Funding for services may also be provided through the DHS home and community-based services Medicaid waiver.

Findings

Department of Human Services

The committee learned the TBI screening tool implemented by the Division of Mental Health and Substance Abuse is important because there is not a registry or surveillance program in North Dakota. Of the 13,793 individuals screened at the regional human service centers during the first year, 3,512 were identified as having a TBI or a history of TBI.

The committee learned DHS has six contracts with private providers for social and recreational services for individuals with TBI, including two contracts in Bismarck, three in Fargo, and one in Grand Forks. The Department of Human Services has a single state-wide contract with an agency to provide prevocational and mentoring services for individuals with TBI. The department also has a contract with the University of North Dakota Center for Rural Health for informal supports, peer mentoring, and resource facilitation for individuals with TBI and their family members.

The committee learned about options to allow access to Medicaid services for individuals with brain injury who are working. If an individual with TBI is interested and has the financial resources to buy in to the Medicaid program, the individual can do so through the workers with disabilities program. The workers with disabilities maximum income eligibility level for one person is $2,155 per month, and the amount of the premium to buy in would be 5 percent of the individual's gross income and unearned income. The committee learned Medicaid Expansion allows an individual to qualify for the Medicaid Expansion group with annual income for one person of up to $15,856.

The committee learned North Dakota currently has 23 prevocational services beds and six extended services beds. The estimated biennial cost to increase the prevocational services contract to provide eight hours of prevocational services per month to 50 individuals would be $568,614 and the cost for an additional 28 extended services beds would be $254,688. The committee learned the estimated biennial cost for a TBI registry would be $271,083.

Other Interested Persons

The committee received information from other interested persons, including individuals with TBI, family members of individuals with TBI, service providers, county social services employees, and other advocates. The committee learned the agency contracted by DHS to provide prevocational and mentoring services does not accept private pay for the services. The committee learned Chapter 34-13 relating to employment agents and agencies requires agencies accepting private pay to register with the Labor Commissioner. Registering with the Labor Commissioner in accordance with Section 34-13-13.1 presents a financial risk to the prevocational services agency because the agency would be subject to partial repayment of fees if an employee is fired or laid off within 90 days. The committee learned the Labor Commissioner and representatives of DHS did not object to an exemption from Chapter 34-13 for providers of employment services who are licensed or certified by DHS.

Key issues regarding TBI services identified by other interested persons include the need for:

- Better financial assistance;
- Reminders for meetings and appointments;
- Assistance with employment responsibilities;
- A more flexible sliding scale plan with regard to government services;
- Social services caseworkers trained in how to work with people with memory issues and those who have suffered brain injuries;
- Improved coordinated advocacy effort;
- More community-based supports;
- Case management services for the lifetime of the brain injury survivor;
- Additional long-term support and day-to-day services;
- A legislative definition change to include all acquired brain injuries in addition to TBI;
- A brain injury registry to connect individuals with brain injury with available services;
- The reestablishment of the traumatic brain injury waiver;
- Adjustment to the level of care screening tool to improve access to current programs offered through home and community-based services;
- A service similar to that of the developmental disability community, where people live in their own apartments with onsite supervision provided to all the clients in the building;
- A flex fund for individuals with TBI who are capable of working to encourage them to continue working and enable them to live independently; and
- Simplification and better coordination of the application process for brain injury services.

Recommendations

The committee recommends a bill [15.0180.02000] to establish a TBI registry administered by the State Department of Health and to appropriate funding for brain injury services. The registry is to facilitate the provision of treatment and rehabilitative services to persons who sustain a TBI by DHS or other providers. The bill provides general fund appropriations of $251,083 to the State Department of Health to establish and administer the registry, $20,000 to DHS for marketing and training relating to the registry, $1,305,000 to DHS to coordinate services for persons with TBI in each human service region, and $650,000 to DHS to expand services, including return to work programming, for individuals with brain injury. The bill also authorizes one full-time equivalent (FTE) position for the State Department of Health.

The committee recommends a bill [15.0181.01000] to provide a general fund appropriation of $250,000 to DHS to establish and administer a flex fund program for persons with TBI.

The committee recommends a bill [15.0311.01000] to amend Section 34-13-13.1 to exempt providers of prevocational services licensed or certified by DHS from registering as an employment agency with the Labor Commissioner.

The committee recommends a resolution [15.3016.01000] to direct the Legislative Management to continue the study of a comprehensive system of care for individuals with brain injury during the 2015-16 interim.

STUDY OF BEHAVIORAL HEALTH NEEDS OF YOUTH AND ADULTS

The committee was assigned a study of behavioral health needs pursuant to Section 1 of 2013 Senate Bill No. 2243. The study was to include consideration of behavioral health needs of youth and adults and consideration of access, availability, and delivery of services. The study was to include input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions.

Background

The Department of Human Services provides behavioral health services through its Division of Mental Health and Substance Abuse Services, the State Hospital, the Life Skills and Transition Center (formerly the Developmental Center at Westwood Park), and the eight human service centers located throughout the state.

The Department of Corrections and Rehabilitation provides behavioral health services through its Division of Adult Services and Division of Juvenile Services.

Department of Human Services

Division of Mental Health and Substance Abuse Services

The committee learned the Division of Mental Health and Substance Abuse Services is responsible for overseeing a statewide network of substance abuse and mental health treatment, recovery support services, mental health promotion, and substance abuse prevention services. During the 2011-13 biennium, the division licensed 84 substance abuse treatment programs, 44 driving under the influence (DUI) education programs, eight regional human service centers, and six psychiatric residential treatment facilities for children and adolescents.

State Hospital

The committee learned the State Hospital, located in Jamestown, provides traditional and secure services to adult patients. Traditional services include short-term acute inpatient psychiatric and substance abuse treatment, intermediate psycho-social rehabilitation services, forensic services, and safety net services for the adult patients. Secure services include inpatient evaluation and treatment services for sexually dangerous individuals.

The committee learned the State Hospital utilizes 289 beds as follows:

- 90 beds for addiction services to 60 male and 30 female offenders at the Tompkins Rehabilitation and Corrections Center;
- 123 beds for acute inpatient and intermediate psycho-social rehabilitation services; and
- 76 beds in the secure services unit (sex offender program).

Human Service Centers

The committee learned DHS operates eight regional human service centers in Williston, Minot, Devils Lake, Grand Forks, Fargo, Jamestown, Bismarck, and Dickinson. The human service centers provide core services, including:

- Aging services;
- Developmental disabilities;
- Vocational rehabilitation;
- Child welfare services;
- Children's mental health;
- Serious mental illness (Extended Care Coordination);
- Acute clinical services;
- Substance abuse services;
- Outpatient sex offender treatment; and
- Crisis/emergency response services.

The committee learned the human service center services are provided in public outpatient clinic settings, rural outreach centers, client homes, or other community settings. The human service centers served 26,494 clients in fiscal year 2012, a reduction of 541 clients from fiscal year 2011.

Life Skills and Transition Center

The committee learned the Life Skills and Transition Center provides services for individuals with developmental and intellectual disabilities. The center provides residential services, including secure services, health services, behavioral services, and youth transition services. The center had a 2013-15 budget of $55,169,929, including $26,070,850 from the general fund. The center had a total adult developmentally disabled and intellectually disabled population of 82 as of June 2014. The committee conducted a tour of the Life Skills and Transition Center.

Department of Corrections and Rehabilitation

Division of Adult Services

The committee learned the Division of Adult Services treatment department provides for the development of personal growth and rehabilitation programs for inmates. Mental health programs are provided to assist inmates with mental health concerns through counseling, psychological services, and psychiatric services. In addition, the State Penitentiary is a licensed addiction treatment center which staffs licensed addiction counselors, licensed social workers, and paraprofessionals to assist inmates in overcoming addictions and personal problems.

The committee learned approximately 3 percent of inmates have been identified as particularly vulnerable adults due to cognitive impairment. The State Penitentiary has allocated eight beds to serve inmates with special mental health and vulnerability concerns who cannot reside in general housing. The James River Correctional Center has a 28 bed mental health unit that allocates additional staff resources to managing the behavior and treatment of offenders with serious mental illness, chronic suicidal tendencies, or vulnerability concerns who cannot reside in general housing.

Division of Juvenile Services

The Division of Juvenile Services includes the Youth Correctional Center and eight regional community-based services offices located throughout the state. The division provides comprehensive case management, treatment, and supervision programs for troubled adolescents. Treatment programs for juveniles include:

- Group counseling;
- Individual counseling;
- Substance abuse education;
- Cognitive-behavioral classes;
- Recovery and relapse prevention counseling;
- Grief/loss counseling;
- Victim impact programming;
- Security intervention (gang) classes;
- Physical fitness;
- Spirituality;
- Health; and
- Work.

The committee learned 63 percent of youth in the juvenile correctional system have mental health concerns, and 74 percent have a substance abuse diagnosis.

Funding

The 2013 Legislative Assembly provided funding as follows for programs and services relating to behavioral health needs:

	General Fund	Other Funds	Total
Department of Human Services			
Division of Mental Health and Substance Abuse Services	$8,520,188	$15,390,004	$23,910,192
State Hospital - Traditional services	45,265,694	19,602,513	64,868,207
Human service centers	105,076,400	77,357,138	182,433,538
Total Department of Human Services	$158,862,282	$112,349,655	$271,211,937
Department of Corrections and Rehabilitation			
Division of Adult Services	$4,400,000		$4,400,000
Division of Juvenile Services	2,300,000		2,300,000
Total Department of Corrections and Rehabilitation	$6,700,000		$6,700,000

Voucher Payment Program

The committee learned the 2011 Legislative Assembly approved Senate Bill No. 2326 requiring DHS to establish and administer a pilot voucher payment program to provide substance abuse services for the 2011-13 biennium. The program was to consist of voucher use and private choice as a method of providing substance abuse services to

beneficiaries, and allow a voucher to be submitted to the beneficiary's provider of choice for payment of substance abuse services.

The Department of Human Services was to apply for funding available through a federal Access to Recovery grant program available from the federal Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. If the federal Access to Recovery grant funding was not available to DHS, the department was not required to implement the pilot voucher payment program. The committee learned DHS did not receive a federal Access to Recovery grant during the 2011-13 interim and, as a result, did not implement the program. The Department of Human Services did not anticipate receiving funding from the Access to Recovery grant for the 2013-15 biennium.

Consultant Services and Methodology

The Legislative Council issued a request for proposal for consultant services for assistance in a study of behavioral health needs of youth and adults in North Dakota. The specific tasks to be addressed included:

1. Identify stakeholders of the behavioral health system.
2. Identify the need for behavioral health services by geographic area of North Dakota.
3. Assess the availability and adequacy of supports, services, and facilities to meet the need for behavioral health services in the state by:
    a. Identifying the services, supports, and facilities available in the state by geographic area;
    b. Identifying gaps in coverage;
    c. Identifying differences in adequacy of access, availability, and delivery of services for youth with behavioral health needs and adults with behavioral health needs;
    d. Assessing the availability of prevention and early intervention services for behavioral health in North Dakota;
    e. Identifying areas of treatment needing improvement, taking into account new evidence-based practices leading to effective recovery; and
    f. Assessing the impact of population changes in North Dakota on behavioral health service systems.
4. Assess the availability of insurance coverage for behavioral health care in North Dakota.
5. Assess the adequacy of communications between the public and private systems of behavioral health services.
6. Assess the adequacy of integration of the physical health care and behavioral health care systems in North Dakota.
7. Develop a plan based on specific goals and objectives to improve behavioral health services in North Dakota.
8. Provide recommendations to implement the plan to improve behavioral health services in North Dakota. Recommendations were to identify the entity responsible for implementing the recommendation, required legislative changes, and any estimated costs by funding source.

The committee received proposals from four entities interested in providing consultant services--the North Dakota Rural Behavioral Health Network; the Public Consulting Group; the Technical Assistance Collaborative, Inc.; and Ms. Renee Schulte, Schulte Consulting, LLC, Iowa. The Public Consulting Group later withdrew its proposal. The committee selected and contracted with Ms. Schulte to conduct the study. The contract cost was $44,000. As part of the study the consultant:

- Traveled to North Dakota six times over the course of six months.
- Held 35 face-to-face meetings with various groups and individuals.
- Conducted five public hearings statewide.
- Coordinated biweekly public conference calls with participation from over 400 individuals.
- Received over 230 documents, not including emails.

Consultant Report on the Study of Behavioral Health Needs

The consultant's report included the following goals and recommendations by opportunity area:

1. Service shortages.
    a. Improve access to services.

(1) Increase use of telemedicine;

(2) Use critical access hospitals for behavioral health services;

(3) Create a bed management system;

(4) Utilize home and community-based services waivers for mental health and substance abuse services; and

(5) Increase substance abuse services including detoxification services.

b. Create conflict-free case management.

(1) Increase access to integrated dual disorder treatment statewide;

(2) Privatize case management to add choice; and

(3) Partner case management and care coordination with peer support.

c. Improve access to crisis assessment services.

(1) Increase after hour services and create after hour intake options;

(2) Increase mobile crisis services in urban areas after hours;

(3) Use telemedicine for crisis assessments; and

(4) Create e-psychiatry in the state.

2. Expand workforce.

a. Improve oversight for licensing issues and concerns.

(1) Create an oversight system for licensing boards utilizing the State Department of Health as the overseer;

(2) Expand the definition of behavioral health professional in Section 25-03.2-01;

(3) Create reciprocity language to identify boards shall accept all professional licenses meeting international and national accreditation standards and the qualified state equivalent for each behavioral health license; and

(4) Ensure all educational requirements are available within the state, with a preference for online availability.

b. Increase use of lay persons in expanding treatment options.

(1) Increase use of peer support and recovery coaches;

(2) Increase training for law enforcement, emergency personnel, corrections staff, and teachers using mental health first aid and other training;

(3) Increase law enforcement in schools; and

(4) Increase educational opportunities for behavioral health providers.

3. Change insurance coverage.

a. Increase funding options for services for youth and adults.

(1) Re-evaluate the essential health benefits package selected to identify unintended consequences;

(2) Determine if insurance coverage meets federal parity standards;

(3) Decide whether to maximize federal funding options or increase use of state and private funds to fill gaps;

(4) Determine what third party payers should be covering; and

(5) Apply for a Medicaid waiver for the serious disabling mental illness population.

b. Increase behavioral health professional coverage in Medicaid and private insurance.

(1) Change administrative code to reimburse qualified behavioral health professionals; and

(2) Increase funding to assist behavioral health professionals in training.

4. Change the structure and responsibilities of DHS.

a. Build transparency and choice in services.

(1) Create an independent appeal process for consumers;

(2) Standardize and distribute rules for uniform access to human service centers;

(3) Encourage hiring throughout the state rather than just in the human service centers;

(4) Increase oversight and accountability for contracts with an independent appeal process; and

(5) Create a list of all services provided only by DHS.

b. Consider structural changes to DHS.

(1) Change human service center responsibilities to oversight, regulatory functions, and program management at the State Hospital similar to the North Dakota developmental disability system;

(2) Improve coordination of care with a county service system for youth;

(3) If county and state behavioral health services are combined, create a regional governance system; and

(4) Improve legislative oversight of the human service center system.

5. Improve communication.

a. Create an integrated system of care.

(1) Create integrated health services, including care coordination in Medicaid;

(2) Seek additional federal funding for visiting nurses programs for behavioral health for children to age 5; and

(3) Strengthen advocacy voices in North Dakota.

b. Improve record sharing.

(1) Review and streamline record sharing options for North Dakota;

(2) Change regulations to accept electronic releases and all other treatment documentation; and

(3) Streamline the application process for residential facilities.

c. Improve communication among mental health and substance abuse service providers.

(1) Establish an intra-agency council for coordination of services;

(2) Improve regional communication from the human service centers to all providers; and

(3) Standardize policies and procedures that foster better communication, including communication regarding job vacancies.

6. Expand data collection and research.

a. Determine what providers are available within the state and map gaps.

(1) Create a provider registry; and

(2) Give the task of oversight of licensing boards to the State Department of Health.

b. Determine what services are available outside the human service center system for youth and adults.

(1) Create a repository for services using 2-1-1 and First Link; and

(2) Map current resource distribution outside the human service center system.

c. Use data to determine the best use of limited funding on treatment.

(1) Use universities or other current systems to build an outcomes-based system; and

(2) Create a list of "legacy" services and their cost to the state and consider reinvesting in evidence-based services.

The consultant also recommended North Dakota further investigate and review transportation, judicial matters, definitions of services, tribal partnerships, and advocate training. Of the recommendations, the report identified the following to be addressed by the 2015 Legislative Assembly:

1. Increase funding for adult and youth substance abuse services, including detoxification services;

2. Authorize use of telemedicine for crisis assessment and remove barriers for full utilization;
3. Increase funding for equipment for critical access hospitals to create e-psychiatry;
4. Create an oversight system for licensing boards utilizing the State Department of Health;
5. Change the definition of behavioral health professional in Century Code to include all qualified professionals;
6. Create reciprocity language for behavioral health professionals;
7. Train law enforcement personnel as first responders using mental health first aid;
8. Amend Century Code to reimburse all qualified behavioral health professionals;
9. Create an independent appeals process for consumers of behavioral health services;
10. Seek to maximize federal funding for visiting nurses and prevention programs for children to age 5;
11. Change regulations to accept electronic documentation, including electronic releases of information;
12. Assist First Link/2-1-1 in obtaining access to provider information;
13. Partner with universities to build an outcomes-based data system;
14. Create an interim committee to review the structure of DHS and provide oversight for the current human service centers system, including defining core services to be provided throughout the system; and
15. Create an interim committee to study judicial issues, including 24-hour hold, termination of parental rights, and court committals.

Behavioral Health Stakeholders Group

The committee learned individuals and agencies throughout the state had formed the Behavioral Health Stakeholders Group to meet and identify behavioral health needs in North Dakota. The group presented a report to the committee identifying recommendations to improve behavioral health services in the state. Recommendations requiring legislation or funding in 2015 include:

1. Adopt the American Society of Addiction Medicine core services grids. Define human service center roles and move to a private and/or voucher system wherever possible.
2. Expand Medicaid to licensed addiction agencies and others that are eligible for third-party reimbursements.
3. Expand the behavioral health training model for first responders used in Cass County to the whole state and integrate the model into post training standards.
4. Establish four adult mental health assessment centers in the four largest communities in North Dakota. Train critical access hospitals to triage behavioral health issues, including access to telemedicine to mental health assessment centers.
5. Assure the 2-1-1 program has access to all funded provider information, including for profit providers. Assure that consumers are aware of services through 2-1-1 and the Substance Abuse and Mental Health Services Administration Director.
6. Involve key behavioral health partners, including law enforcement, health care providers, and private partners, in one region to develop discharge planning protocols in that region, including the establishment of outcome measures. Fund the pilot project for one year.
7. Support DHS task force that addresses hearing timelines. Support changes in expert examiners, including the expansion of nurse practitioners as health care expert witnesses. Establish a mechanism so law enforcement can access information on individuals who may have been committed.
8. Establish a children/adolescent assessment network or centers in each region of the state to incorporate attendant/shelter care. These services should include access through critical access hospitals using telemedicine.
9. Evaluate outcome data on behavioral health screening tools done with Health Tracks and Healthy Steps and monitor referral patterns and unmet needs. Prepare recommendations to establish routine standardized screening using evidence-based practices throughout the state to routinely screen all 2, 3, and 4 year olds at primary care sites.
10. Establish professional licensing board standards to allow:
    a. One year of practice if licensed in another state;
    b. A process for meeting North Dakota licensing standards during the one-year period;

c. Reciprocity of licenses between Montana, South Dakota, and Minnesota; and

d. A method for issuing licenses within 30 days.

11. Expand the number of licensed addiction counselors by establishing a stipend program for licensed addiction counseling interns that would be forgiven if the licensed addiction counselor practices in the state for four years.

12. Expand the number of licensed addiction counselor training slots by providing stipends for organizations that offer the training.

13. Establish a student loan buy-down program for licensed behavioral health clinical staff.

14. Encourage private third-party payers to include coverage for couples and marriage and family therapy as part of behavioral health services and include all licensed mental health professional with established competencies in couples, relationship, and family therapy as eligible providers.

Testimony from Interested Persons

The committee received information from interested persons, including individuals with behavioral health needs, family members of individuals with behavioral health needs, law enforcement representatives, healthcare providers, education officials, insurance officials, service providers, and other advocates.

Key issues regarding behavioral health needs of youth and adults in North Dakota identified by interested persons include:

- Suicide and other behavioral health issues in schools;
- Insurance changes resulting from the implementation of the federal Affordable Care Act;
- Behavioral health training for teachers and law enforcement;
- Identification of behavioral health needs of youth;
- Increased demand for services in western North Dakota;
- Increasing frequency of law enforcement involvement with individuals with mental health and substance abuse issues;
- Unpaid internship hours necessary to become a licensed addiction counselor;
- A state voucher system to pay private providers for services;
- Necessary state funding for peer support services; and
- Substance abuse among pregnant women.

Committee Recommendations

The committee recommends a bill [15.0178.02000] to provide an appropriation of $2 million from the general fund to DHS for a voucher system for addiction treatment services.

The committee recommends a bill [15.0230.03000] to create and enact a new section of Chapter 50-24.1 relating to medical assistance. The bill directs DHS to adopt rules entitling licensed marriage and family therapists and licensed professional clinical counselors to payment for behavioral health services provided to recipients of medical assistance. The bill also directs DHS to develop an outcome-based data system for behavioral health services, directs the Legislative Management to consider studying the structure and services of DHS during the 2015-16 interim, and provides general fund appropriations of $3 million to DHS to expand adult and youth substance abuse services, including detoxification services, and $25,000 to the Highway Patrol to provide mental health first aid training for state and local law enforcement personnel.

The committee recommends a bill [15.0231.02000] to establish an oversight system and reciprocity language for behavioral health licensing boards. The bill also provides for licenses to be issued within 30 days of a qualified application.

The committee recommends a bill [15.0232.03000] to amend Chapter 25-03.2 relating to residential treatment centers for children to expand the definition of qualified mental health professional to include psychologists, advanced registered nurse practitioners with a national certification in psychiatric mental health care, physician assistants with a mental health certification, psychiatrists, and individuals with certain master's degrees and at least two years of post-degree clinical experience.

The committee recommends a bill [15.0277.01000] which appropriates $6 million to DHS Services to establish an adult and youth mental health assessment network, $175,000 to DHS to establish a pilot project to develop planning protocols for discharge or release of individuals with behavioral health issues, and $50,000 to the Department of Public Instruction to provide mental health first aid training for teachers and child care providers. The bill also directs the Legislative Management to consider continuing the study of behavioral health needs of youth and adults and to consider studying mental health screening and assessment programs for children during the 2015-16 interim.

The committee recommends a bill [15.0278.02000] to establish a licensed addiction counselor forgivable loan program and a mental health professional loan repayment assistance program. The bill also appropriates from the general fund $180,000 to the State Board of Higher Education to administer a grant program to assist with the repayment of student loans incurred by behavioral health professionals, $1 million to the Bank of North Dakota for an addiction counselor internship loan program revolving fund, and $200,000 to DHS to provide annual grants to private entities that provide clinical training experiences for individuals pursuing licensure as addiction counselors.

The committee recommends a bill [15.0285.01000] to amend Chapter 25-03.1 relating to commitment procedures to expand the definition of mental health professional to include licensed marriage and family therapists. The bill also amends Chapter 32-03 relating to the judicial remedies of damages and compensatory relief to expand the definition of mental health personnel to include licensed marriage and family therapists.

The committee recommends a resolution [15.3026.01000] to direct the Legislative Management to consider studying judicial issues relating to behavioral health, including 24-hour hold, termination of parental rights, and court committals during the 2015-16 interim.

STUDY OF HOME AND COMMUNITY-BASED SERVICES

The committee was assigned a study of home and community-based services in the state pursuant to Section 1 of 2013 Senate Bill No. 2375. The study was to include an evaluation of the need to expand the home and community-based services Medicaid waiver to cover 24-hour emergency assistance, adult companion services, behavioral programming, chore services, customized living services, environmental modifications, and transition modification support.

Background

The Department of Human Services Aging Services Division provides home and community-based services to assist individuals to remain in their homes and communities. The division administers the following programs and services:

- Home and community-based Medicaid waiver.
- Service payments for elderly and disabled (SPED).
- Expanded SPED.
- Personal care.
- Technology dependent Medicaid waiver.

Home and Community-Based Medicaid Waiver

The home and community-based Medicaid waiver allows individuals currently on Medicaid to receive a variety of services and support in-home and community-based settings rather than in a nursing home. To qualify for services under the Medicaid waiver program, an individual must be:

- A Medicaid recipient;
- Screened at nursing facility level of care;
- At least age 65 or disabled by Social Security disability criteria;
- Capable of directing his or her own care;
- Living in his or her own home or apartment; and
- Able to have his or her services or care needs met within the scope of the waiver.

Service Payments for Elderly and Disabled

The SPED program provides services for elderly and disabled individuals who have difficulty completing tasks that allow them to live independently at home. Eligibility requirements for SPED include:

- Liquid assets of less than $50,000;

- Inability to pay for services;
- Impaired in four activities of daily living (ADLs) involving basic needs, including bathing, dressing, toileting, eating; or five ADLs that require a higher level of cognitive or physical ability to perform, including driving, managing money, and shopping; and
- Impairments must have lasted or be expected to last three months or longer; or
- If an individual is younger than age 18, is screened for nursing facility level of care, and is not eligible for aged and disabled or traumatic brain injury waivers and is not living in an institution, dormitory, or congregate housing; and
- The need for service is not due to mental illness or mental retardation, and the individual is capable of directing his or her own care or has a legally responsible party, and has needs within the scope of covered services.

Expanded SPED

The expanded SPED program provides in-home and community-based services for individuals who would otherwise receive care in a licensed basic care facility. Eligibility requirements for expanded SPED include:

- Receives or is eligible to receive Medicaid;
- Receives or is eligible to receive Social Security income;
- Is not severely impaired in the ADLs of toileting, transferring, or eating; and
- Is impaired in three of four instrumental activities of daily living (IADLs), including meal preparation, housework, laundry, or taking medications; or
- Has health, welfare, or safety needs, including supervision or structured environment, otherwise requiring care in a basic care facility;
- Is not living in an institution or dormitory; and
- Has needs within the scope of covered services.

Personal Care Services - Medicaid State Plan

Personal care services under the Medicaid state plan include assistance with ADLs, including bathing, dressing, toileting, transferring, eating, mobility, and incontinence care and IADLs in conjunction with the ADLs. All recipients of personal care services under the Medicaid state plan must be Medicaid-eligible.

Technology Dependent Medicaid Waiver

An individual may receive attendant care and case management services under the technology dependent Medicaid waiver if the individual is Medicaid-eligible and meets the following functional criteria:

- Meets level of care screening criteria.
- Vent-dependent at least 20 hours per day.
- Medically stable.
- Has an informal caregiver system for contingency planning.
- Is competent to participate in planning.
- If under age 65, the disability must meet Social Security criteria or determined to be physically disabled by the state review team.

Other Services

The Department of Human Services also provides home and community-based services through the children's medically fragile waiver, children's hospice waiver, targeted case management, and the program for all-inclusive care for the elderly (PACE).

Funding for Home and Community-Based Services

The 2013 Legislative Assembly provided funding for home and community-based services as follows:

	General Fund	Other Funds	Total
Home and community-based services Medicaid waiver	$6,093,666	$6,138,635	$12,232,301
SPED	14,545,977	765,584	15,311,561
Expanded SPED	1,356,679		1,356,679
Personal care	14,065,133	14,167,029	28,232,162
Technology dependent waiver	193,586	194,530	388,116
Children's medically fragile waiver	69,342	69,822	139,164
Children's hospice waiver	59,732	60,119	119,851
Targeted case management	852,279	858,533	1,710,812
PACE	5,139,546	5,172,835	10,312,381
Total	$42,375,940	$27,427,087	$69,803,027

Qualified Service Provider System

A qualified service provider (QSP) is an individual or agency providing care for people to enable them to continue to live in their own homes and communities. A QSP does not need a special certificate or license but needs skills necessary to provide care.

Types

There are two types of QSPs:

1. Individual QSPs are self-employed, independent contractors who are responsible to withhold or pay any Social Security, federal or state income tax, unemployment insurance, or workers' compensation insurance premiums from the payment received as a QSP.
2. An agency QSP hires staff and is responsible for ensuring its staff has the skills necessary to provide a specific service. The agency QSP is also responsible for withholding or paying any Social Security, federal or state income tax, unemployment insurance, or workers' compensation insurance premiums relating to its employees.

Enrollment and Services

To become enrolled as a QSP, an individual or agency must submit appropriate forms to DHS. The department will provide the individual or agency with a provider number, instructions on how to bill for services provided, and rules about providing services as a QSP. Enrolled QSPs can choose to have their name added to a public list of QSPs, which is given to clients by county home and community-based services case managers. Home and community-based services recipients use this list to choose an individual or agency QSP. Once chosen, the QSP is authorized to provide services by the county case manager. The authorization provides the amount and type of care the QSP is approved to provide to the client.

Qualified service providers provide care to recipients receiving services from one or more of the following programs:

1. SPED;
2. Expanded SPED;
3. Home and community-based services waiver;
4. Technology dependent Medicaid waiver;
5. Developmental disabilities Medicaid waiver; and
6. Medicaid state plan personal care.

Previous Legislative Studies

The 2011-12 interim Human Services Committee was assigned to study the state's QSP system. The committee recommended the Legislative Assembly and DHS establish a QSP payment rate structure that provides additional funding for mileage. The 2013 Legislative Assembly provided $2,266,733, of which $1,714,301 is from the general fund, to DHS for providing a mileage payment to QSPs traveling more than 20 miles round trip for serving a client.

Findings

Department of Human Services

The committee learned there were 1,584 individual QSPs and 144 QSP agencies enrolled with DHS as of April 2014. The committee learned 615 family members, or 39 percent of the total number of enrolled individual QSPs, are enrolled to provide care. The average number of monthly recipients of home and community-based services in fiscal year 2013 was 2,324.

The committee learned an expansion of SPED to include reimbursement for medical-related transportation services would have an estimated 2015-17 biennium cost of $1.5 million from the general fund. Expansion of SPED to include services to address loneliness and isolation would cost approximately $1.1 million for the 2015-17 biennium, of which $550,000 would be from the general fund. The committee learned the addition of another level of service under SPED by reducing the number of impairments needed to qualify for services would have an estimated cost of $2.5 million, of which $2.3 million would be from the general fund for the 2015-17 biennium. The committee learned removing the requirement that individuals apply for Medicaid in order to be eligible for services under SPED is estimated to have a biennial cost of $1 million from the general fund.

Interested Persons

The committee received information from interested persons, including service providers, county representatives, and other advocates. The committee learned about nonprofit community-based organizations providing volunteer-based services for elderly and disabled persons, including Community of Care and Helping Enderlin Area Residents Thrive (HEART). These organizations provide many services free of charge and receive the majority of funding from donations, fundraisers, and private grants. Community of Care also receives $120,000 per biennium from DHS.

Key issues regarding home and community-based services identified by interested persons include:

- Certain areas of the state are lacking services and certain services are difficult to provide due to the lack of qualified service providers as well as the necessary travel;
- Service gaps exist for individuals who do not meet the total impairments needed to qualify for home and community-based services but still have service needs to remain at home safely;
- The need for medical transportation and escort to be included in allowable tasks under current funding sources;
- Concern relating to the requirement that clients apply for Medicaid if they need personal care services under the SPED program;
- The medical expense deductions for SPED have not been adjusted in more than seven years; and
- Concern regarding the issue of loneliness and the need for funding for services that address loneliness and isolation.

Recommendations

The committee recommends a bill [15.0186.01000] to create and enact a new section to Chapter 50-06.2 relating to eligibility for SPED. The bill would prohibit DHS from requiring an individual to apply for services under Medicaid as a condition of being eligible to apply for services under SPED. The Department of Human Services estimated the fiscal impact of this bill at $1 million from the general fund.

The committee recommends a bill [15.0182.03000] to provide a general fund appropriation of $350,000 to DHS to administer and provide grants to community-based organizations to assist in the establishment of programs to provide volunteer-based services for elderly and disabled persons. The bill also authorizes 1 FTE position for DHS.

AUTISM SPECTRUM DISORDER

Section 50-06-32 identifies the appointment and duties of the Autism Spectrum Disorder Task Force. The section directs the task force to develop a state autism spectrum disorder plan and provide an annual status report regarding the plan to the Governor and the Legislative Management. The committee was assigned the responsibility to receive this report for the 2013-14 interim.

Section 50-06-32.1 established the autism spectrum disorder voucher program pilot project. The program is to assist in funding equipment and general educational needs related to autism spectrum disorder for individuals below 200 percent of the federal poverty level from age 3 to under age 18. The section directs DHS to adopt rules addressing management of the voucher program pilot project and establishing the eligibility requirements and exclusions for the program. The section directs DHS to report to the Legislative Management regarding the program pilot project. The committee was assigned the responsibility to receive this report for the 2013-14 interim.

Section 61 of 2013 House Bill No. 1013 provided, as an emergency measure, if any money remains in the Department of Public Instruction's grants - state school aid line item after the Superintendent of Public Instruction complies with all statutory payment obligations imposed for the 2011-13 biennium, the Superintendent may transfer $250,000 to the Department of Career and Technical Education to provide a grant to an institution implementing a certificate program that prepares individuals with autism spectrum disorder for employment in the technology sector. The section directs the recipient of the grant to report to the Legislative Management regarding program graduates

who found employment in the technology sector, their starting salaries, and their total compensation. The committee was assigned the responsibility to receive this report for the 2013-14 interim.

Autism Spectrum Disorder Task Force

The Autism Spectrum Disorder Task Force consists of the State Health Officer, the Executive Director of DHS, the Director of Special Education, the Executive Director of the Protection and Advocacy Project, and 10 members appointed by the Governor. The task force is to examine early intervention services, family support services that would enable an individual with autism spectrum disorder to remain in the least restrictive home-based or community setting, programs transitioning an individual with autism spectrum disorder from a school-based setting to adult day programs and workforce development programs, the cost of providing services, and the nature and extent of federal resources that can be directed to the provision of services for individuals with autism spectrum disorder. The task force is to develop a state autism spectrum disorder plan and continue to review and periodically update or amend the plan to serve the needs of individuals with autism spectrum disorder.

2013-15 Biennium Funding

The Legislative Assembly in 2013 House Bill No. 1038 provided the following appropriations relating to autism spectrum disorder:

- $235,732 from the general fund and 1 FTE position to the State Department of Health to establish and administer an autism spectrum disorder database.
- $132,568 from the general fund and $132,568 from federal funds and other sources and 1 FTE position to DHS for a state autism coordinator responsible for implementing a resource and service center to provide information and services for individuals with autism spectrum disorder, developing a statewide outreach plan, conducting regional meetings and a conference, and developing a protocol for use after screenings.
- $80,000 from the general fund and $80,000 from federal funds and other funding sources to DHS to implement a statewide autism spectrum disorder training program.
- $539,186 from the general fund to DHS to issue vouchers as part of the autism spectrum disorder voucher program pilot project for the second year of the 2013-15 biennium.
- $449,973 from the general fund and $446,973 from federal funds and other funding sources to DHS to expand the department's autism spectrum disorder Medicaid waiver program to cover 17 additional individuals from birth through age 7.

Status Update Regarding the Autism Spectrum Disorder Plan

The committee learned the Autism Spectrum Disorder Task Force meets quarterly and has an executive committee to assist with issues arising between meetings. The task force provided recommendations on autism waiver slot prioritization as it transitioned to the new waiver, received reports on the voucher program implementation, received information on the various training provided through the Department of Public Instruction, and received updates on the registry development and autism website. The committee learned goals of the task force include:

- Assure that individuals with suspected autism spectrum disorder receive an appropriate diagnosis as soon as possible;
- Create a centralized location for information on autism spectrum disorder;
- Provide a consistent message and information on autism spectrum disorder;
- Establish a model for training and provision of support services that meet the needs of diverse stakeholders;
- Receive feedback from people with autism spectrum disorder and their families and providers which indicates satisfaction with interventions and supports available;
- Instruct families and providers to implement evidence-based strategies as a matter of practice in teaching and caring for people with autism spectrum disorder as well as other individually designed strategies; and
- Assure that data is available and used to guide the services system.

Report Regarding the Autism Spectrum Disorder Voucher Program Pilot Project

The committee learned each qualifying child is eligible for up to $12,500 per year. The committee learned applications for the autism voucher are available online, and as of August 2014, 14 voucher applications had been submitted. Applicants expressed interest in items and services including autism-specific camps, a service dog to detect seizures and prevent wandering, an iPad, a note-taking device, respite care, tutoring, and job coaching.

Report Regarding the Grant to Implement a Certificate Program to Prepare Individuals with Autism Spectrum Disorder for Employment in the Technology Sector

The committee learned the Department of Public Instruction transferred $250,000 to the Department of Career and Technical Education to provide a grant to an institution implementing a certificate program that prepares individuals with autism spectrum disorder for employment in the technology sector.

The committee learned in 2013 the Anne Carlsen Center committed $500,000 to Specialisterne Midwest for training and employing individuals with autism spectrum disorder in the technology field. The committee learned the Department of Career and Technical Education will validate the grant requirements have been fulfilled and then release $9,092 to Specialisterne Midwest per successful individual completion of the 10-week training program. The committee learned placement and employment of the first group of six trainees was to begin September 2014 and the $250,000 grant from the Department of Career and Technical Education would allow for 27 training program participants. The committee learned the individuals serviced by Specialisterne Midwest are high-functioning individuals with autism spectrum disorder and range in age from 21 to 36.

CHILDREN'S HEALTH INSURANCE PROGRAM STATE PLAN

Section 50-29-02 provides DHS is to prepare, submit, and implement a children's health insurance program state plan and report annually to the Legislative Management and describe enrollment statistics and costs associated with the plan. The committee was assigned the responsibility to receive the plan for the 2013-14 interim.

Healthy Steps

North Dakota's children's health insurance plan, Healthy Steps, 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. To be eligible for the program, the family's net income may not exceed 160 percent of the federal poverty level.

Funding

The schedule below summarizes legislative appropriations for the Healthy Steps program since the 2003-05 biennium.

	General Fund	Federal Funds	Total
2003-05	$2,127,162	$7,359,222	$9,486,384
2005-07	$2,895,233	$9,180,309	$12,075,542
2007-09	$4,669,885	$15,534,861	$20,204,746
2009-11	$5,598,799	$16,033,737	$21,632,536
2011-13	$8,517,391	$19,007,011	$27,524,402
2013-15	$11,400,407	$21,293,663	$32,694,070

The schedule below summarizes the federal medical assistance percentage (FMAP) and North Dakota's allocation of federal funds for the Healthy Steps program.

Federal Fiscal Year Ending	FMAP	North Dakota Allocation
September 30, 2005	77.24%	$6,384,719
September 30, 2006	76.10%	$6,346,156
September 30, 2007	75.30%	$7,737,529
September 30, 2008	74.63%	$11,017,680[1]
September 30, 2009	74.21%	$15,821,554
September 30, 2010	74.11%	$16,595,628
September 30, 2011	72.25%	$15,257,665
September 30, 2012	68.78%	$16,063,553
September 30, 2013 (estimate)	66.59%	$17,311,376
September 30, 2014 (estimate)	65.00%	$18,350,056
September 30, 2015 (estimate)	65.00%	$18,900,560

[1]This amount includes one-time additional federal funding of $3,128,684.

Children Enrolled and Premium Rates

The schedule below summarizes the average annual recipients and premium rates in effect for the majority of the year for the majority of children covered.

State Fiscal Year Ending	Average Annual Recipients	Monthly Average Premium Rates
June 30, 2007	3,821	$183.45
June 30, 2008	4,006	$202.32
June 30, 2009	3,470	$204.03
June 30, 2010	3,368	$229.15

State Fiscal Year Ending	Average Annual Recipients	Monthly Average Premium Rates
June 30, 2011	3,718	$232.82
June 30, 2012	3,872	$272.69
June 30, 2013	4,046 (estimate)	$272.67 (estimate)
June 30, 2014	4,303 (estimate)	$311.79 (estimate)
June 30, 2015	4,436 (estimate)	$311.79 (estimate)

Report on the Children's Health Insurance Program State Plan

The committee received an annual report from DHS describing enrollment statistics and costs associated with the children's health insurance program state plan. The committee learned 4,097 children were enrolled in the program as of February 2014. The committee learned the provisions of the federal Affordable Care Act have impacted eligibility for children. Under the Affordable Care Act, children between the ages of 6 and 19 whose household income is below 133 percent of the federal poverty level must be transferred from coverage through Healthy Steps to coverage through the Medicaid program. The approximate number of children within this group is 721 children. The following is a summary regarding the status of the program's legislative appropriation for the 2013-15 biennium:

2013-15 Legislative Appropriation	2013-15 Expenditures through February 2014	Percentage of 2013 Legislative Appropriation Used
$32,694,070	$7,862,143	24.04%[1]

[1]Seven months, or 29.17 percent, of the 2013-15 biennium has expired.

REPORT ON THE CHILD CARE ASSISTANCE PROGRAM

Section 7 of 2013 House Bill No. 1422 provided DHS change the eligibility requirement for the child care assistance program from 50 percent of the state median income to 85 percent of the state median income. The bill provided a contingent appropriation of $2.5 million from the general fund which may be used if the changes in the eligibility requirement requires more funding than the amounts appropriated to DHS in its budget appropriation bill, House Bill No. 1012, as approved by the 63rd Legislative Assembly. If the funding appropriated to DHS is sufficient, DHS may reduce copay requirements for the child care assistance program. In addition to the contingent appropriation identified above, the 2013 Legislative Assembly provided $20.9 million, of which $252,656 is from the general fund and the remaining amount is from the federal child care block grant, for payments for child care services for eligible recipients. The Legislative Assembly also provided $897,336 from the temporary assistance for needy families (TANF) block grant for child care transitional assistance for working TANF families for the 2013-15 biennium.

The committee learned the change in eligibility allows a family of three to have a gross income of up to $4,915 per month to qualify, compared to the previous income limit of $3,074. Copay requirements were reduced from 3 percent to 7 percent of gross family monthly income to 1 percent to 6 percent of gross family monthly income. The number of children receiving child care assistance increased from 1,645 in July 2013 to 2,795 in June 2014. The committee learned the average monthly child care assistance program payment per child per month from July 1, 2013, through June 30, 2014, was $331.32. The committee learned child care provider rates are currently the same throughout the state, but DHS is considering implementing variable rates dependent on location and availability of services.