

FISCAL NOTE
Requested by Legislative Council
02/24/2015

Amendment to: SB 2321

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$446,905		
Expenditures			\$307,408	\$446,905		
Appropriations			\$307,408	\$446,905		

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB 2321 directs the department of human services to seek federal medical assistance coverage for tribal community health representative(CHR) services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the department to seek federal medical assistance coverage for tribal community health representative services for the period beginning with the effective date of this Act and ending June 30, 2017.

Section 4 makes this Act become effective on July 1, 2016, or on approval from the Centers for Medicare and Medicaid Services(CMS) for one hundred percent federal funding of the Medicaid costs for the services of the CHR, whichever occurs later.

These changes increase expenditures for the 15-17 biennium by \$754,313 of which \$307,408 is General Fund and \$446,905 are Federal Funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The revenue increase represents the additional amount of federal Medicaid funding the Department will be able to access due to the reimbursement of CHR's and additional Medicaid services provided to recipients. The revenue increase is estimated at \$446,905 for the 15-17 biennium.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The department has estimated that 20 individuals would become certified the second year of the biennium adding 1 to 2 CHRs each month starting July 1, 2016 through the end of the 2015-2017 biennium. DHS also assumed that each CHR would have 9 clients and each client would have four visits (encounters) from the CHR annually. DHS assumed the CHRs would work with Tribal members and would qualify for 100% federal funding through Medicaid and this estimate is based on receipt of CMS approval for that funding. The estimated cost of the CHR services for the 2015-17 biennium is \$139,515 of which, 100% is from federal funds. In addition, DHS estimates that one half of the clients would become newly enrolled for Medicaid-funded home and community-based services. The estimated cost of the home and community-based services for the 2015-17 biennium is \$614,798 of which \$307,408 is from the General Fund and \$307,390 are Federal Funds.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase for the 15-17 biennium of \$754,313 of which \$307,408 is General Fund and \$446,905 are Federal Funds.

Name: Debra McDemott

Agency: Department of Human Services

Telephone: 701 328-3695

Date Prepared: 02/26/2015

FISCAL NOTE
Requested by Legislative Council
02/10/2015

Amendment to: SB 2321

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$1,665,953		\$12,876,744
Expenditures			\$1,541,787	\$1,665,953	\$11,333,501	\$12,876,744
Appropriations			\$1,541,787	\$1,665,953	\$11,333,501	\$12,876,744

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
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- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The Engrossed Bill creates a new chapter of NDCC relating to the certification by the DoH of a community health worker-community health representative, creates a new section of NDCC relating to medical assistance reimbursement by the DHS, to provide a report & provides for an effective date.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 requires the DoH to establish a certification process which would require one new FTE to coordinate the certification, recertification and database management of community health worker-community health representative along with operating costs.

Section 2 requires Medical Assistance coverage by the DHS for the certified community health worker-community health representative (CHR) and related services.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The federal revenue represents funding received by the DHS from the Centers for Medicare and Medicaid Services (CMS) for the CHR.

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

2015- 17 biennium:

DoH - The estimated expenditures of \$108,337 include salaries of \$99,533, the purchase of computer / office furniture and operating costs of \$8,804.

DHS has estimated that 50 individuals would become certified the second year of the biennium adding 4 to 5 CHR's each month starting July 1, 2016 (to allow the Health Council time to adopt rules and allow CMS approval of the service) through the end of the 2015-2017 biennium. DHS also assumed that each CHR would have 15 clients and each client would have four visits (encounters) from the CHR annually. DHS assumed 40% of the CHR's would work with Tribal members and would qualify for 100% federal funding through Medicaid and this estimate is based on receipt of CMS approval for that funding. The estimated cost of the CHR services for the 2015-17 biennium will be \$285,775 of which \$26,625 is from the general fund and \$259,150 are federal funds. In addition, DHS estimated that one half of the clients would become newly enrolled for Medicaid-funded home and community-based services. The estimated cost of the home and community-based services for the 2015-17 biennium is \$2,813,628 of which \$1,406,825 is from the general fund and \$1,406,803 are federal funds.

2017-2019 biennium:

DoH – The estimated expenditures of \$109,235 includes salaries of \$103,514 (inflated 4%) and operating costs of \$5,721 (inflated 3%)

DHS – Estimated costs for the visits from the CHR's - \$1,989,638 and estimated costs for home and community-based services - \$22,111,372.

There is also a potential impact on the Counties in the 17-19 biennium due to the number of individuals who would require Medicaid eligibility determinations. However, the dollar amount of the impact is not able to be determined at this time.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

These expenditures are not included in the Executive Budget for the DoH (HB 1004), or DHS (SB2012) and therefore would require an appropriation.

Name: Brenda M. Weisz

Agency: Department of Health

Telephone: 328-4542

Date Prepared: 02/11/2015

FISCAL NOTE
Requested by Legislative Council
01/20/2015

Revised
 Bill/Resolution No.: SB 2321

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

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- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This Bill creates a new chapter of NDCC relating to the certification by the Department of Health (DoH) of a community health worker-community health representative and creates a new section of NDCC relating to medical assistance reimbursement by the Department of Human Services (DHS).

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Name: Brenda M. Weisz

Agency: Department of Health

Telephone: 328-4542

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Revenues				\$3,228,298		\$33,339,014
Expenditures			\$785,650	\$3,228,298	\$7,966,006	\$33,339,014
Appropriations			\$785,650	\$3,228,298	\$7,966,006	\$33,339,014

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2017-2019 biennium:

DoH – The estimated expenditures of \$109,235 includes salaries of \$103,514 (inflated 4%) and operating costs of \$5,721 (inflated 3%)

DHS – Estimated costs for the visits from the CHR's - \$25,482,240 and estimated costs for home and community-based services - \$15,713,545.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

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Date Prepared: 01/26/2015

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These expenditures are not included in the Executive Budget for the DoH (HB 1004), or DHS (SB2012) and therefore would require an appropriation.

Name: Brenda M. Weisz

Agency: Department of Human Services

Telephone: 328-4542

Date Prepared: 01/26/2015

2015 SENATE HUMAN SERVICES

SB 2321

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321
1/27/2015
22588

- Subcommittee
 Conference Committee

Donald Mueller



Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement

Minutes:

Attach #1: Testimony by Sen. Tim Mathern
Attach #2: Testimony by Donald Warne
Attach #3: Testimony by Christine Burd
Attach #4: Proposed Amendment

Senator Tim Mathern, District 11 was on hand to introduce the bill to the committee. (Attachment #1) (3:50)

Donald Warne testified in favor of SB 2321 (attachment #2) (4:30-15:55)

Senator Howard Anderson, Jr.: Do you feel that presently there is enough research in this area or with this program, are we setting aside research dollars so NDSU can determine what we are doing now, and then look at outcomes by establishing other programs?

Donald Warne: There is a lot of research in other states that show things like return on investment and better clinical outcomes. In terms of the data in North Dakota, I haven't see reports that adequately summarize committee health worker activities because it is in a piecemeal faction, most of it is grant funded and very targeted and specific issues that are addressed by community health workers so we do not have a comprehensive assessment. Part of the evaluation plan would be to collect data on both costs and clinical outcomes to show improvement over time.

Senator Howard Anderson, Jr.: When we start new program in state, I am interested in the research component that can show us what is going on in the future.

Donald Warne: I think that it is important to document as we are evaluating any program. There needs to be good data collection and evaluation of effectiveness clearly we wouldn't want to develop a program that isn't working.

No further questions of Mr. Warne.

Jessie Taken-Alive: Tribal Member at Standing Rock. Spoke in favor of the bill. (19:00-30:35) You heard mention a lot of important reasons why, from the medical community, that this is a good bill. I have been working for the people of Standing Rock since 1991 by serving the tribal government. This is a bill that is very important to our citizens, if you do not have health you do not have anything. What we have here is an opportunity to see our program on Standing Rock grow which is currently underfunded and understaffed. If we have necessary resources we would be able to implement these resources. I picked up a young woman who was walking along the road today. She was on her way to the hospital in Ft. Yates. She had earned her CNA license because she thought the state job program would expand; her 9 year old daughter is afflicted with Lupus. The reason I bring this up is that when we take a look at health issues I learn something very valuable a few years ago as a lay person. When we set up the ambulance program in Standing Rock and I am proud to say that been able to be an Advanced Life Support unit. Every time one of our ambulances is dispatched to the 2.8 million acre piece of property they always have a paramedic onboard. That provides countless success stories of what we are allowed to see our programs sustain themselves. Likewise, this is an opportunity that will prove to be a partnership between the tribal and state government. I learned about a concept called the 'golden hour' that says if you get to someone within an hour you can prevent a lot of future illnesses from the accident. For us this bill is essentially the same thing, if we are able to go out there with enough staff we would be able to help, as Dr. Warne pointed out, people stay alive. Sadly, our rates of mortality in Indian Country far exceed any race of people in the United States. These individuals are dedicated, they do not make a lot of money but they have been there a long time which tells us that they are committed to what they are doing. That concept can be applied to this opportunity. Should you agree with us a partner to help us sustain and grow programs. The elders have language history to educate the young people about who we are, what we are, where we came from, why we are in this situation and where we want to go. The elderly people have these qualities and we want our young people to hear the language because for centuries we have had an oral history that has kept us going. For them to be able to hear encouraging words, for them to be able to hear the history is medicine in itself and it causes them to continue to go forward with what they are doing.

Mr. Taken-Alive then spoke in his native language (26:10-26:35)

To hear something like that for our young people it would be inspiring because we know our language is spiritual and to see more elders be able to walk on this earth longer goes beyond what we are talking about here in terms of healthcare, money, ect. We need the elders to be with us, we need the young people to hear it, and it is a way of life. What I said was, "Grandchild, take courage. There are some days that we are going to slip and fall and slip and fall but always remember the creator. The Creator is going to pull us up; the Creator is going to help us go forward. Grandchild, you have dreams. Grandchild, take courage and continue to follow your dreams because the Creator has given us a beautiful way of life to live here on this earth." This is what our young people get a chance to hear, see and, more importantly, to feel as a native person in America. Finally, I come before you as a partner; I live on Standing Rock on the South Dakota portion. I am elected at large which means I am inducted by the entire populous of Standing Rock. I really do thank you for listening.

Senator Dever: If this is your last time testifying I want to thank you for your many years of service.

Dr. Christine Burd: Tribal Community Health Consultant. Spoke in favor of SB 2321. (attachment #3). (31:30-39:27)

Julie Schwab: Medical Services, Department of Human Services, proposed amendment (attachment #4). Ms. Schwab read through the amendment.

No further testimony in Favor of SB 2321

OPPOSITION TO SB 2321

No opposed testimony

NEUTRAL TO SB 2321

No neutral testimony

Discussion

V. Chairman Oley Larsen: Can we get a little explanation on the fiscal note please.

Julie Schwab: Department of Human Services did assist department of health with the fiscal note.

Chairman Judy Lee: It would be helpful if you walk us through it. Can you explain the other funding that isn't federal or state?

Julie Schwab: I would like to have our fiscal team get up and explain this.

Karen Tescher: Medical Services with the Department of Human Services. This fiscal note would start July 1, 2016, it would give us time to make sure we get all approvals from CMS to reimburse the program. Looking on the top of the note you will see grants at 50% that comes after we get this program in place. What we are looking for in first year is we would enroll 50 CHR/CHW, broken down to 4 or 5 each month. In the first year of development it would a total 50 individuals who be enrolled. They would see a person that they serve 4 times a month; they would each have 5 individuals they would be working with. At federal match which is encounter rate, they would have a cost of \$370 each time they have an encounter with that person. Counting months starting in July 1, 2016, as you add more CHR/CHW to the program each month, under the 15-17 time periods that would be the \$2,551,000 that would be all federal money. Once they are served by the CHR's and have gotten into various community based service programs that they might need, that's where you get the grant money of 50%, a total \$1,354,611. So it would be general funds of \$677,000 and federal funds for the rest. For the first period, it comes to \$3,905, 611 then federal part is \$3,228,298 so of that amount of money, the general fund is \$677,000. When jumping down to the next biennium, CHR's will be added on incremental basis. Numbers would increase, so the 50% they would be getting would come to \$15,713,545 and then broken down in half for general. The part where they are doing their CHW work is all encounter rate, all federal funds and so that is where you get the \$25,482,240 for a total of \$33,339,014 for the 2017-2019 period of time. It is the gradual of implementing the CHR/CHW's, and costs related to that.

Senator Dever: Spending \$33,000,000 state money is a really big deal. Can we spend \$33,000,000 for federal money without asking for approval?

Karen Tescher: That is where the amendment comes in that we have to be assured that we would have the approval for that and for the concept and program. When getting the CHR's on board for case management and long term care, in 2011 they allowed us to include CHRs in the targeted case management if they had oversight, they alluded that what was in the state plan at that time with the approval of CHRs we would be eligible to use the encounter rate if it is through IHS or tribal entity. At that time it was recommended that the encounter rate would be the way to go.

Chairman Judy Lee: I attended national meeting talked about community paramedics and community health workers which was a new exposure for me. There was a speaker from North Carolina and they have a vigorous program. It relates to everyone working at the top of their scope of practice. It's important way to provide those services, also important to include what Home and Community Based Services will be requested as a result of community health workers' work. Theoretically, they are not as a result of being a community health care worker that those services are there but because a community health worker is going to make sure that the people have access to it.

Karen Tescher: Through our work training for CHR program it was obvious that in tribal areas they have already established that comfort level with the people they visit in their homes.

There was no further testimony or questions, Chairman Lee closed the public hearing on SB 2321.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321

2/4/2015

23247

Subcommittee

Conference Committee

Committee Clerk Signature

Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement

Minutes:

No attachments

Chairman Judy Lee recapped the information from the hearing and prior committee work. (3:00).

Maggie Anderson (DHS) had questions regarding fiscal note, and have exchanged additional information with Dr. Warne. When they tried to put the fiscal note together, they were trying to determine how many of the CHW/CHR's there would be, and then they know what the encounter rate is that CMS says we can provide the Indian Health Services and Tribal 638 programs. They then contacted the Health Department, and you will have to be the ones to certify these people, so how many do you plan to have. The fiscal note was built off of that knowledge. Now, further information they received from Dr. Warne today states that our numbers make sense if all of the community health workers who became certified are CHR's and eligible for the encounter rate. This is where the confusion comes in. If you read the title of the bill and every reference to community health worker, it says community health record / CHR., so it sounds like it is one designation and not two separate designations. We assumed that 100% of the CHW's would be CHR's. Dr. Warne anticipates that most of the community health workers will be working outside of the tribal populations, part of hospital discharge case management teams non-Indian Home and Community Based Care. We haven't had the opportunity to revisit the fiscal note, but we'd be interested in hearing from the committee if you see this as a tribal only or if the CHW and CHR are two different certifications. We also haven't had time to talk to the Health Department yet with the latest information.

Senator Howard Anderson, Jr. stated that he didn't see this as tribal only program, be a broad based program. Didn't perceive at all that they thought it would be tribal only. **Chairman Judy Lee** agrees.

Maggie Anderson (DHS) stated so even with the designation as community health representative, which typically in other states is a tribal designation.

Chairman Judy Lee asked do we differentiate the definitions perhaps. Chairman Judy Lee discussed what she stated during the hearing, where community health worker versus community paramedics are separate people.

Senator Howard Anderson, Jr. asked if the wording should state community health worker or community health representative, if that would solve the problem, so we don't pretend that they are one thing.

(6:49)

Chairman Judy Lee read from the bill, and then discussed the different cultures in Fargo.

(7:34)

Maggie Anderson (DHS) regarding separating, she indicated they need to talk to the Health Department to see how they plan to administer this; if there is going to be another special designation for CHR's or something different, and then relook at the fiscal note. We also assumed some of them would not be getting home and community based services, that they would be doing hospital discharge and some of the case management, as well as non-medical things. We need to figure out that population that's not tribal on non-tribal land and how many of those are on Medicaid, and is anyone else providing reimbursement for them and if not, what's the incentive to become a CHW if you are non-Medicaid. Are we going to assume that 100% of people who get the CHW designation would be doing it solely to access the reimbursement designated in the last section of the bill.

Chairman Judy Lee stated the immigrants and refugees we are talking about are legal, because illegal's don't qualify. They are supposed to be covered by expanded Medicaid if they qualify, which most of them do because they aren't working yet. It means they can't get adult dental. Refugee use to pay for this. The cultural competency part of it for us and for other locations in the state are much more based in refugees and immigrants and less in the tribal component, although it is certainly there as well. Most other parts of the state would have a larger tribal component. They are both important.

Senator Howard Anderson, Jr. said even if these people end up do being mostly on the reservations or serving the tribal population, that is certainly an area that needs a lot of services.

Chairman Judy Lee suggested Mr. Tom Nehring at the Health Department. **Maggie Anderson** (DHS) agreed. They will follow up with them.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321

2/9/2015

23467

Subcommittee

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement

Minutes:

Attach #1: Department of Human Services Fiscal Note Summary

Chairman Judy Lee recapped the bill and prior information.

V. Chairman Oley Larsen from prior testimony, the community health worker and the community health representatives are the same.

Chairman Judy Lee indicated she didn't think they did the same stuff.

Maggie Anderson (DHS) first distributed a Fiscal Note Summary that provides the updates discussed in prior meetings (attach #1). The fiscal summary does not include the Department of Health side. The Community Health Representatives interest in them becoming Medicaid enrolled providers. The Community Health Representative name is specific to tribal areas, where the Community Health Worker is perhaps more off of the tribes. They would do similar things. Historically, on the tribes, they saw themselves as liaison for Long Term Care services, help them bridge the conversation with the clinicians and doctors to ensure the services are there. This impacts the fiscal note, the home and community based services to make sure people understand.

Julie Schwab, Department of Human Services, stated that the department has spoken with Dr. Donald Warne. They proposed a tiered certification as well. Although the community health representatives on the tribes may not be as highly trained as the community paramedics, they would be trained with certification to gap fill care on the reservations. We also talked about likely seeing people who are not part of the tribes as well. It would not be exclusive to the tribe, but the areas.

Chairman Judy Lee stated we've had a problem before with sorting out the fact that Indian Health Services only deal with tribal members. They are not set up to serve non-tribal members who are living on tribal lands. Hope we can serve more.

Ms. Schwab indicated there is very different funding for tribe members. She is not aware of anything that would prevent them from seeing others in the area and not on the tribe.

Chairman Judy Lee assuming the amendment came from Department of Human Services? **Ms. Schwab** confirmed yes.

Senator Howard Anderson, Jr. can we have Maggie Anderson (DHS) address the fiscal note.

Maggie Anderson (DHS) after the first appearance for hearing, there was some conversation with Dr. Warne and Tom Nehring in Health Department. We recalculated the growth on how they will become certified. The Health Department will have to certify them and it will take at least a year to go through the Health Council and get the rules adopted, and certification in place. We then used their numbers by the end of 2017-2019, how many people they thought would be certified, so we used their growth to start with. We estimated those who received certification, they will have more than 3 or 4 clients, but likely Health Department thought it is more likely around 20, so we estimated 15. If they have four visits /encounters per year, that is our estimate. If they are 638'd, not using Indian Health services but using 638 funding stream, if working for tribal program and we have received CMS approval for this or working for Indian Health Services and this has been a covered service, we can receive 100% federal funding for that. But that is also why we have asked for a delayed implementation date to ensure the approval is in-place. That group estimated to be a portion, 1/20th of those enrolled would be 638. The others in the community would be 50/50 match. Some of these people would likely engage in home and community based care services. We assumed about half would receive home and community based services. If not receiving now, they would be on the lower end. On the summary, the biggest chunk of cost is for home and community based services. For 2015-2017, the estimate is \$3,100,000, \$1,400,000 is general, \$1,700,000 is federal. As you grow that from 5 people in the first month to 250, the fiscal estimate grows with that. In 2017-2019, the community health representative expenses are at \$2,000,000, but the home and community based care services could be as much as \$22,000,000.

Senator Howard Anderson, Jr. asked if it is fair to ask Maggie Anderson (DHS) opinion, if she thinks this will help?

Maggie Anderson (DHS) this community health model has been used in other states. Can't speak for Dr. Warne. There are individuals, on the Native American side, that she does not doubt that there are people who forego services because of culture, etc.

Chairman Judy Lee referred to Dr. Warne chart from the initial hearing. There have been reductions in other costs and can see some improvements in outcomes in other states. But it does require an investment.

Senator Warner fiscal note, what kind of outreach do you anticipate, cost, how are we going to use this to access people in their homes? Does the Department of Human Services reach out? How does the delivery of service differ from what we are already doing?

Maggie Anderson (DHS) cannot speak for outside of the Native Americans - that is the part that she is familiar with. The historical perspective where their people, elders in their homes, who have needs and may not be accessing services, sometimes they are unable due to transportation, don't want to interact, sometimes the original treaty rights. If this would pass, the Department of Human Services would collaborate with Health because they do the actual certifications. With leadership that Dr. Warne has stated from NDSU, tribes, their office, you would find a way to do outreach. There are no dollars in this fiscal note for this, as there are mechanism today.

Senator Warner how does this relate to the no wrong door concept? Shouldn't we already have this?

Maggie Anderson (DHS) yes we do. If those individuals came to point of access, they would get service. The problem is they don't access.

Senator Howard Anderson, Jr. referred to a question he asked during the original hearing of this bill to testifiers. Will there be an accountability and research piece that tells us we save money - mostly he got the answer that the research was done.

Maggie Anderson (DHS) stated there are no dollars for research in the fiscal note. These dollars go out the door for practitioners for services, targeted case management. We could do analysis of claims data however, by county, where maybe we had 3 today and 15 in the future, what services they are receiving, if they are able to remain in their homes. Not full blown research, but it will tell us if where the dollars are being spent, keeping people in their homes, and safety in their homes.

Senator Howard Anderson, Jr. stated let's say 3 people in Sioux county today. If this is through Department of Human Services, we can do statistics on this. If we add 12 people, we can see how much money is spent on services, etc.

Maggie Anderson (DHS) correct.

Senator Howard Anderson, Jr. not sure if Dr .Warne would be amenable to having research or study.

Maggie Anderson (DHS) thinks that Dr. Warne would be in favor and would work with the Department of Human Services.

Chairman Judy Lee asked if the committee needs to add money for the research.

Maggie Anderson (DHS) if it is data, pre and post, and looking at medical claims, there is a decision support contractor in Medicaid today, we can come up with the information through that contract.

Senator Howard Anderson, Jr. asked if it would be helpful if we put something in the bill.

Maggie Anderson (DHS) certainly would help. Something they will do anyways, to predict for the 2017 session.

Senator Howard Anderson, Jr. for those who are in favor of this approach, it might help with accountability.

V. Chairman Oley Larsen how do these folks get their funding currently? Does Medicaid expansion allow any of those claims go to this?

Maggie Anderson (DHS) there have been community health representatives who have worked for the tribes for years. We've talked to them about enrolling for transportation providers, some have moved in that direction. It is an expenditure for Indian Health services, but there are no specific Medicaid dollars going in for these specific services. Regarding Medicaid expansion, if need is for elderly, they will not fit under the Medicaid expansion. If it is the hospital discharge, it falls under the follow-up care.

Chairman Judy Lee if someone in Department of Human Services could work with Femi regarding the accountability and evaluation for amendment.

Senator Warner outside agency or outside researcher, that would take money. There won't be enough data in this biennium anyways.

Chairman Judy Lee restated Maggie Anderson (DHS) that there wouldn't be enough data with delayed date of implementation.

The committee took a break.

Maggie Anderson (DHS) read a new proposed amendment regarding the proposed report for accountability.

Chairman Judy Lee so we have the amendment about effective date, and we would now add language for reporting. We have had issues before with signing up children for Children's Health Insurance (CHIP) and money designated specifically for the outreach and it was hard to do, and part of it is a cultural challenge where the treaties became a barrier. The treaties indicated that the federal government has to provide health coverage and we don't want to sign up for a state program. The Indian Health Services is not well funded, so if they signed their children up for CHIP, those dollars in Indian Health Services were then freed up for other purposes for other individuals. It could be some of the reason why their community health representatives are better received when there is a tribal component.

V. Chairman Oley Larsen goes to Fort Berthold for enrollments, state they are there to help them enroll, and they claim they already have their insurance.

Chairman Judy Lee too bad because there are people who can benefit from this.

Senator Howard Anderson, Jr. followed-up on the underfunding of Indian Health Services. The federal government provide 50% and other funds from other areas. Most of the time they don't go to the other areas. 100% reimbursed if they go through Medicaid,

and the State gets 100% back from the federal government. It is underutilized and undermanaged, but not underfunded.

Senator Dever most of the conversation had to deal with the reservations. Under what other places do they provide services?

Chairman Judy Lee said community health representative is specific to tribes, where community health worker is not tribes. They do the same type of work.

Senator Howard Anderson, Jr. appreciate Department of Human Services has tried to capture all the costs, we have to estimate how many are going to use the services, and we may not know for three years.

Senator Warner moved to ADOPT AMENDMENT for SB 2321, as from Department of Human Services which will delay the implementation date and also provide a report. The motion was seconded by **V. Chairman Oley Larsen**.

Roll Call Vote to Amend SB 2321

6 Yes, 0 No, 0 Absent. Motion passes.

Senator Howard Anderson, Jr. moved a DO PASS AS AMENDED for SB 2321 and refer to Appropriations Committee. The motion was seconded by **Senator Dever**. No Discussion.

Roll Call Vote to DO PASS AS AMENDED

5 Yes, 1 No, 0 Absent. Motion passes.

Senator Axness will carry SB 2321 to the floor.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321
2/16/2015
23919

- Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Myeller

Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement.

Minutes:

No attachments

These are minutes from the Senate Human Services Committee on February 16, 2015. It should be noted that SB 2321 has already been processed through this committee and is currently with the Appropriations Committee.

Chairman Judy Lee welcomed **Dr. Donald Warne** to the podium. Dr. Warne expressed interest in clarification regarding the definition of a community health representative - they are separate from a community health worker in that the representative serves the tribe. The concern of the tribes is of who has jurisdiction when the "worker" and "representative" are in the same statement. **Chairman Judy Lee** asked how Dr. Warne would suggest wording for clarification. **Dr. Warne** indicated just as part of the definitions, that this is a community health worker bill, and that the community health representatives are a separate tribal entity and they could become community health workers if they choose to. This would be up to the tribes.

Chairman Judy Lee this could be clarified in appropriations.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321
2/18/2015
24067

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement

Minutes:

Attach #1: Engrossed SB 2321 Draft
Attach #2: Proposed Amendment

Chairman Judy Lee stated we voted this out of the Senate Human Services Committee on February 9, 2015. This bill is currently in the Appropriations committee. There was a concern by Dr. Donald Warne in regards to the term Community Health Representatives. Jennifer Clark has reviewed the changes and has new recommendations.

Jennifer Clark, Legislative Council, provided a marked up engrossed bill (attach #1). She also provided the corresponding proposed amendments (attach #2). In looking at this bill, there could be some clarifications. Ms. Clark reviewed the highlights with discussion with the committee.

- Recommendation of not putting definitions. Changed the definition of a certified community health worker. This was previously a hyphenated word (worker-representative). In discussion with the Department of Health, they plan to certify a community health worker.
- A new definition of community health representative. This is the individual with the Indian Health Services who provides services to tribal members.
- A new definition of community health services.

Ms. Clark next reviewed the intent of the bill.

- The administration pretty much stays the same, but who they are certifying changes to the community health care worker.
- Page 2, line 31, the rules that the Department of Health adopts, stated that instead of continuing educational standards, change to standards for renewal.
- Ms. Clark suggested that the committee may want to consider more concrete parameters for the administrative rules. Perhaps this could be done on the House side.
- Page 3, clarified that there are individuals providing community health services, and as long as they are not infringing on other turf, i.e. nurses, social workers, therapists, then

they can do it. Even with this bill, they can continue to do this, but they cannot claim "certified".

- If you are certified as a community health worker, and you happen to be one of those persons who is a community health representative, you can call yourself a certified community health worker or certified community health representative or both.
- Bottom of page 3, there are fees. Added continuing appropriation language. They have told Department of Health to put it in the operating fund, and be a self-supporting funding to support the program. The title change reflects continuing appropriation because of this language. We have given them the authority to establish fees, and they will establish those fees.
- Page 4 relates to the initial certification. We removed the waiver of criteria. Instead, if you don't meet one of the criteria, the Department of Health can still certify you when looking at training, education or work experience and you meet the standards.
- In the certification renewal by the request of the Department of Health, they removed subsection 3 on continuing education. This doesn't mean they can't have continuing education, but they removed the statutory requirement and can still have it in rule.
- On bottom of Page 4 with scope of practice, she did technical cleanup of the language.

Chairman Judy Lee has discussed changes with **Maggie Anderson (DHS)** but there still needs to be a final review by Department of Human Services and the Department of Health. Chairman Judy Lee also wants to discuss with **Senator Mathern**.

Senator Howard Anderson, Jr. stated our intent was to include reimbursement for certified health care workers and certified health care representatives. Have we made all representative workers? **Chairman Judy Lee** confirmed we have.

Senator Dever asked if any of this impacts the fiscal note.

Chairman Judy Lee stated her understanding is that it does not. Department of Human Services has indicated it will not affect them, but has not confirmed this with the Department of Health.

Jennifer Clark stated there is a continuing appropriation clause which will get their attention. This is for the fees. This may actually decrease any fiscal note attached.

Chairman Judy Lee indicated there was matching federal funding for a fair amount of this.

Senator Warner questioned how the community health workers coordinate with county eligibility workers. Are they referred to county eligibility workers?

Chairman Judy Lee answered they are referred to county eligibility workers and then the services will have the increase in cost. They always qualified for the services but never accessed the services.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2321
2/18/2015
24096

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to the certification of a community health worker-community health representative and to medical assistance reimbursement

Minutes:

Attach #1:	Proposed Amendments by Legislative Council
Attach #2:	Engrossed Bill draft with proposed amendments

Jennifer Clark, Legislative Council, reviewed amendment 15.0422.03002 (attach #1). The marked up engrossed bill with proposed amendment was distributed (attach #2). This is a second version of the latest proposed amendments to SB 2321 that is currently with the Appropriations committee. Ms. Clark highlighted the differences from the morning committee meeting.

- The continuing appropriation language has been removed. Instead, there is an actual appropriation clause for the Department of Health and community services.
- Bottom of page 1 in the markup, the word "who" has been added for the community health representative.
- Page 3 of the markup, the community health representatives who work for the Indian Health Services are called certified community health representatives. Since they are already called "certified", we will not address the certification other than a certified community health worker. We removed the language and replaced with a certified community health representative may pursue certification as a community health worker.

Maggie Anderson (DHS) recognized several changes that need attention. In the markup, page 3, Section 23.48.03, the new item 2, the term for certification should state community health worker, not community health representative.

Maggie Anderson (DHS) back to community health representative, section 6 of effective date, now that we have taken community health representative out of there, if they are not on reservation and an adjunct to hospitals, there isn't 100% funding. Need to remove 100% - a good portion of this won't be eligible for 100% funding. Section 6. Effective July

1, 2016, or upon approval by CMS, for Department of Human Services to secure funding of Medicaid costs. Just remove 100%.

Chairman Judy Lee reviewed the changes again on the marked up bill. Maggie Anderson (DHS) has an issue with fiscal words. Costs of Home and Community Based Care Services will go up because the services will be provided. They need the money for both, so add page 5, line 28, after the first services, "and services" provided by community health workers.

V. Chairman Oley Larsen moved to recommend the amendments to be sent to the Appropriations Committee for consideration. The motion was seconded by **Senator Axness**.

Roll Call Vote

4 Yes, 0 No, 2 Absent. Motion passes.

The recommended proposed amendments will be sent to the Appropriations Committee for consideration.

February 9, 2015

TD
2/9/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2321

Page 1, line 3, after "reimbursement" insert "; to provide a report; and to provide an effective date"

Page 4, after line 16, insert:

"SECTION 3. REPORT.

The department of human services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment by community health workers-community health representatives and on medicaid service utilization of clients receiving services from community health workers-community health representatives. The department of human services shall compare medicaid service utilization before and after the medicaid enrollment of community health workers-community health representatives.

SECTION 4. EFFECTIVE DATE. This Act becomes effective on July 1, 2016, or upon approval from the center for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health worker-community health representative, whichever occurs later."

Renumber accordingly

February 18, 2015

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

Page 1, line 3, replace "worker-community health representative" with "worker"

Page 1, line 3, after "provide" insert "for"

Page 1, line 4, after the semicolon insert "to provide appropriations;"

Page 1, line 10, replace "worker-community health representative" with "worker"

Page 1, line 10, remove "a"

Page 1, line 11, replace "community health worker-community health representative" with "an individual"

Page 1, line 12, remove ", applies an understanding of the experience, language, and culture of the"

Page 1, remove lines 13 through 21

Page 1, line 22, replace "g. Other services as permitted by rule" with "to provide community health services"

Page 1, line 23, remove "worker-community-health"

Page 1, line 24, remove the underscored colon

Page 2, replace lines 1 through 10 with "Indian health service recognizes as a community health representative in order to provide quality outreach health care services and health promotion and disease prevention services to American Indians and Alaskan natives within the community health representative's community."

Page 2, line 11, after "3." insert: "Community health services" may include direct services aimed at optimizing individual and family health and dental outcomes which may include:

- a. Informal and motivational counseling and education;
- b. Intervention to maximize social supports;
- c. Participation in care coordination;
- d. Participation in case management;
- e. Facilitation of access to health care, dental care, and social services;
and
- f. Health and dental screenings.

4."

Page 2, line 14, replace "workers-community health representatives" with "workers"

Page 2, line 17, remove "and"

Page 2, line 17, after "training" insert ", and examination"

Page 2, line 19, replace "Continuing education standards" with "Standards"

Page 2, line 24, replace "**worker-community**" with "**worker - Certified community**"

Page 2, after line line 25 insert:

"1."

Page 2, line 26, replace "Before an" with "An"

Page 2, line 26, replace "practices as, claims to be, or uses" with "may not practice as, claim to be, or use"

Page 2, line 26, remove "that"

Page 2, line 27, replace "worker-community health representative," with "worker, unless"

Page 2, line 28, replace "must be" with "is"

Page 2, after line 28, insert:

"2. A community health representative may pursue community health representative certification under this chapter.

"3. Except as provided under subsection 1, this chapter does not prohibit an individual who is not certified under this chapter from providing community health services or from practicing as and claiming to be a community health worker or a community health representative."

Page 3, line 7, remove "**- Waiver of criteria**"

Page 3, line 10, replace "The department may waive" with "If an applicant fails to meet"

Page 3, line 10, remove "in the case of an"

Page 3, line 11, replace "individual who provides" with ", the department may certify the applicant upon receipt of"

Page 3, remove lines 13 through 17

Page 3, line 18, remove "**Certification -**"

Page 3, line 19, remove "1."

Page 3, remove lines 22 through 25

Page 3, line 26, remove "**Certified community health worker-community health representative -**"

Page 3, line 28, replace "A" with "The scope of practice of a"

Page 3, line 28, remove "worker-community health representative may engage"

Page 3, line 29, replace "only in" with "worker is limited to"

Page 3, line 30, remove "worker-community health"

Page 4, line 1, replace "representative" with "worker"

Page 4, line 9, replace "worker-community health representative" with "worker"

Page 4, line 12, remove "**worker-community health**"

Page 4, line 13, replace "representative" with "worker"

Page 4, line 15, replace "worker-community health representative" with "worker"

Page 4, line 19, after "**REPORT**" insert "**TO THE LEGISLATIVE ASSEMBLY**"

Page 4, line 21, remove "workers-community health"

Page 4, line 22, replace "representatives" with "workers"

Page 4, line 23, replace "workers-community health representatives" with "workers"

Page 4, line 25, replace "workers-community health representatives" with "workers"

Page 4, after line 25 insert:

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$108,337, or so much of the sum as may be necessary, to the state department of health for the purpose of establishing a certification process for community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017. The state department of health is authorized one full-time equivalent position for purposes of implementing this Act.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$1,433,450, or so much of the sum as may be necessary and from special funds derived from federal funds the sum of \$1,665,953 to the department of human services to defray the costs of home and community-based services provided by certified community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Page 4, line 29, replace "worker-community health representative" with "worker"

Re-number accordingly

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. SB2321**

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: Delayed date, Report 15.0422.02001 Title 03000

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar

Other Actions: Reconsider _____

Motion Made By Warner Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 02/09 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2321

Senate Human Services Committee

Subcommittee

Amendment LC# or Description: 15. 0423. 02001 Title. 23000

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
Other Actions: Reconsider _____

Motion Made By Anderson Seconded By Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)		✓	Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 5 No 1

Absent 0

Floor Assignment Axness

If the vote is on an amendment, briefly indicate intent:

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. SB2321**

Senate Human Services Committee

Subcommittee

Amendment LC# or Description:

*15. 0422.03002 No title
 Prepared by Legislative Council for Senator J. Lee*

Recommendation:

- Adopt Amendment
- Do Pass Do Not Pass Without Committee Recommendation
- As Amended Rerefer to Appropriations
- Place on Consent Calendar

Other Actions:

- Reconsider
- Recommended Amendment to be sent to Appropriations for consideration*

Motion Made By

Larsen

Seconded By

Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	<i>Absent</i>	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	<i>Absent</i>				

Total (Yes) 4 No 0

Absent 2

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2321: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2321 was placed on the Sixth order on the calendar.

Page 1, line 3, after "reimbursement" insert "; to provide a report; and to provide an effective date"

Page 4, after line 16, insert:

"SECTION 3. REPORT.

The department of human services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment by community health workers-community health representatives and on medicaid service utilization of clients receiving services from community health workers-community health representatives. The department of human services shall compare medicaid service utilization before and after the medicaid enrollment of community health workers-community health representatives.

SECTION 4. EFFECTIVE DATE. This Act becomes effective on July 1, 2016, or upon approval from the center for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health worker-community health representative, whichever occurs later."

Renumber accordingly

2015 SENATE APPROPRIATIONS

SB 2321

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2321
2/17/2015
Job # 23969

- Subcommittee
 Conference Committee

Committee Clerk Signature

Katia Oliver for Rose Lening

Explanation or reason for introduction of bill/resolution:

Relating to the certification of a community health worker-community health representative and to medical assistance reimbursement; to provide a report; and to provide an effective date.

Minutes:

Attachment 1

Legislative Council - Michael Johnson
OMB - Becky Deichert

Chairman Holmberg called the committee to order on SB 2321.

Judy Lee: State Senator District 13: Will get back to the committee on corrective language. Visiting with Maggie, we have some language.

Anita Brock, Policy Director of American Indian Public Health Resource Center, North Dakota State University. Testified in favor of SB 2321. See attachment #1.

Senator Mathern: This started as \$12,000,000 program and the Human Services committee worked with sponsors and brought it to this level. How is this being used?

Anita Brock: The fiscal note was halved, in the second year, the number of Community Health Worker (CHW) and it's a best estimate. All services for CHW are billable.

Senator Kilzer: How would services here differ from SPED services, - services provided for elderly and disabled.

Anita Brock: This is home based services; if a cancer patient is discharged and assigned a CHW that person goes into home and helps with daily health services. The CHW are members of a primary care team so if that patient is seen by a doctor then they would then assign a community health worker to the patient to go into their home and navigate through a difficult system.

Senate Appropriations Committee

SB 2321

February 17, 2015

Page 2

Senator Kilzer: With the SPED program we have QSPs and they provide home health services.

Anita Brock: And this is very similar to that, yes.

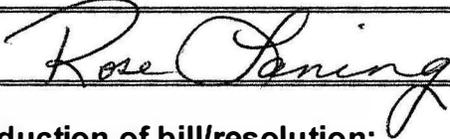
Chairman Holmberg closed the hearing on SB 2321 and awaits information from Senator Lee on adjustments that they recommend.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2321
2/17/2015
Job # 24034

- Subcommittee
 Conference Committee

Committee Clerk Signature 

Explanation or reason for introduction of bill/resolution:

Relating to the certification of a community health worker-community health representative and to medical assistance reimbursement; to provide a report; and to provide an effective date.

Minutes:

Senator Kilzer called the sub-committee to order on SB 2321. Senator Erbele and Senator Mathern were also present. They were looking at a variety of bills that would fall under the realm of the Human Services Department.

Senator Kilzer reminded the committee that this was the tack in the toe bill and would be a whole new class of people that are community health workers. Told of earlier testimony where they showed a picture of a diabetic who had a thumb tack in the flesh of his toe and didn't even know it. There was no feeling. He was unsure what was in Senator Judy Lee's amendment, so we'll hold off on the bill until tomorrow.

Senator Kilzer closed the hearing on SB 2321.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2321
2/19/2015
Job # 24137

- Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Mueller

Explanation or reason for introduction of bill/resolution:

Relating to the certification of a community health worker-community health representative and to medical assistance reimbursement; to provide a report; and to provide an effective date.

Minutes:

Attachment 1

Legislative Council - Chris Kadrmas
OMB - Lori Laschkewitsch

Senator Kilzer called the sub-committee to order on SB 2321.

We now have the minutes and Senator Judy Lee will explain them.

Judy Lee, State Senator, District 13: Amendment 15.0422.03003 - Attachment 1

After we had heard the bill, there was concerns regarding the tribal worker which we had been calling a "community health representative" was described because there was some tribal concerns that the State would take control of the workers. That was not the Tribes goal nor the state's. Dr. Donald Warne, Maggie Anderson (DHS), and Arvy Smith from the Department of Health worked with the Senate Human Services Committee to address the definitions; to change the name to community health worker, and that we need an appropriation. The point is that these workers are not going to cost a lot of money, but as they work with some of the clients, there will be people who will be eligible for services, and that is the increase in cost. The Senate Human Services Committee reviewed the changes yesterday, and Senator Judy Lee visited with Leadership to see if it should be recalled from appropriations and sent back to committee, and Senator Holmberg and Senator Wardner suggested that the amendments be brought to the Appropriations committee for presentation even though it is a policy change.

Senator Kilzer commented that SB 2321 was put together by the Human Services Interim Committee. Did they have input into the bill when it was put together, because this is very late for this type of amendment to be brought forward.

Senator Lee recalled that this was not part of the Human Services Interim Committee recommended. The Department of Human Services and the Department of Health would have been part of the discussions in the interim committees as was true when we heard the bill in the policy committee. It was done because the Tribes wanted this, recognized for the purpose of federal reimbursement for some of their workers.

Senator Kilzer stated that if no one was out-of-the-loop, did the people who wanted this change their mind and have come forward now.

Senator Lee answered they didn't have someone with the expertise of Dr. Warne who had looked at the bill, with some definitions that they were concerned about needing the assurance that the state was going to take over. Dr. Warne then suggested that we change some language to ensure the original intent was intact. Jennifer Clark from the Legislative Council also reviewed the language, and found it needed clarifications.

Senator Heckaman does the appropriation remain exactly the same as the first bill? As in fiscal note.

Senator Lee stated it is not the same. Part of this was a disparity between the Department of Health and Department of Human Services and others about how many people might be employed in this situation and how many clients there may be that request services. This is difficult to estimate. The big part for the Department of Health is that they would have to set up this system (\$108,337). The \$1,430,000 for the Department of Human Services would be for the additional services required as a result of these community health workers doing their job with their clients and referring them to services for which they would be eligible.

Senator Kilzer asked when you talk about the Indian - is it tribe or tribes?

Senator Lee indicated that it is plural, more than one. There are people who are called community health representatives who currently work with fellow tribal members in a variety of different ways to make sure they can be dealt with at home rather than be in some other kind of setting.

Senator Kilzer asked if it is in all four or five tribes?

Senator Lee confirmed she believed so and can get more information if needed. It is something that more than one tribe have had interest in. They have tribal members who are providing in-home services for people so they either don't go without or have to be in a more restrictive setting.

Senator Kilzer does not remember hearing testimony about one or more tribes.

Senator Lee explained the reason for the verbiage originally saying community health representative is because that is what they are called on the reservations. We had a hyphen, community health worker - community health representative that was in the original version of the bill, because we wanted to cover both those who work on non-reservation setting and those that are in a reservation setting who do comparable work, but

we do not want to take over the job of those on the reservation. There is a difference in how some of them may be paid. Essentia, in Fargo, is using community paramedics to follow-up as part of their accountable care organization with people who are discharged from the hospital to make sure they are following the discharge plan, resulting in reduced re-hospitalizations. Some of the same type of thing is being done on the reservations. Dr. Warne would be willing to share more information if you are interested.

Senator Kilzer asked if the proposed amendment affect the fiscal note for the upcoming biennium or future biennium.

Senator Lee answered is that we have had no additional discussion regarding the fiscal note, because there was a change in the stated appropriation based on services. This is just talking about the biennium in Section 5, because that is going to include the services, the \$1,400,000 that is there. There is no way to know exactly what is going to happen, as there are likely people who are eligible for services now but are not receiving them because they did not know they could.

Senator Kilzer stated that is basically his question. He has two fiscal notes, one dated January 20, and the second dated February 10th. They have the same amount of money, about \$1,500,000 for the upcoming biennium, and \$11,300,000 of general funds for the next biennium. This was before this proposed amendment was brought forward, but you stated the proposed amendment wouldn't change the fiscal note. Correct?

Senator Lee clarified that she didn't say that. The appropriation sections were not in the original bill. The fiscal notes were projecting an impact that we can't be assure of. Senator Lee deferred to Maggie Anderson (DHS) in regards to how many people will be working as community health workers and how many people they plan to serve, and the potential average cost for the services they are receiving. As more community health workers are in the system, we'd rather see the highest that it might be and have it cost less, than creating a situation where we aren't anticipating an appropriate number for what those services might be. The fiscal note is anticipating with the same rate of growth of the number of workers and the number of people served and average out the type of services they might use.

Senator Heckaman commented that Tribes in her district, this should be a positive program in her area. Often times, many of the individuals lack transportation, so for minor incidents, they use the ambulance into Devils Lake for healthcare services. This program may help alleviate some of those costs that flow into the regular hospital and then they have to write some of those expenses off.

Senator Kilzer asked if this type of service is covered by Indian Health Services?

Senator Lee stated she doesn't have great expertise in Indian Health Services, so deferred to Dr. Warne. Indian Health Services has services for a limited stretch of time; these are people who would be able to visit individuals in their homes so they don't have to go to an Indian Health Service location; there may be community health representatives currently working on the reservations who work with Indian Health Services physicians.

Senator Heckaman stated she is not an expert either, but the experiences she has had in the school setting and how they impact the children and the elders. Senator Heckaman suggested inviting Dr. Warne to the committee.

Maggie Anderson, Department of Human Services stated that they were involved in the discussions, although they have not had time to reflect if they would impact the fiscal note. We have worked with the Department of Health and Dr. Warne as we were trying to develop the February 10 fiscal note. The Department of Health would do the certification of the community health workers. With this amendment, community health representatives could also apply to be a community health worker. The community health representative designation comes from the tribe, so they wouldn't necessarily have to become a community health worker. We assumed that before this amendment, that 50 people would become certified in the second year of the biennium. The reason we picked the second year is because the Department of Health needs time to develop and adopt rules, and Department of Human Services would have to secure the federal HHS-CMS approval for this service and for the funding. Based on the conversations with Dr. Warne, we assumed that we would add four-to-five community health representatives that would become certified each month that would become a community health worker. We further assumed that each of those would have 15 clients. The majority of the funding for the Department of Human Services in 2017-2019 biennium is because we assume that there are elders who are not receiving home and community based services sometimes because they don't feel they have the culturally appropriate conduit for those services. She further assumes that 50% of these people are not currently receiving services, so we built in the cost for those services. We also assumed these individuals are not on the high-end spectrum of the cost for home and community based services, so we used the average cost and cut that in half. Maggie Anderson (DHS) was not in the conversations between Dr. Warne and the Department of Health when the latest amendments were drafted. What we don't know regarding the fiscal note, now that they removed the hyphen between the community health worker and community health representative, whether it is still expected that most of these would be tribal community health representative individuals, because that affects the federal funds. If it is a Tribal 638 service or an Indian Health Service, the Department of Human Services can access 100% federal Medicaid funds for those services. If they are non-tribal, then it is the regular 50% federal match. We are unsure with the amendment if there will be more non-Tribal 638 individuals. Maggie Anderson (DHS) does not anticipate the fiscal note fund request to go down, but there could be a shift with more general funds requested.

Senator Kilzer stated the Department of Health's budget is on the other side, and as he understands it, there is not another free-standing bill someplace. Did this come as an OAR and did you act on it?

Maggie Anderson (DHS) stated it did not come to the Department of Human Services as an optional adjustment request (OAR), and she cannot speak for the Department of Health. They have the primary work for setting up the certification. Our piece is the Medicaid financing. Maggie Anderson (DHS) offered further help to the committee if needed.

Senator Kilzer closed the subcommittee meeting on SB 2321.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2321
2/20/2015
Job # 24200

Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Mueller for Alice Orszag

Explanation or reason for introduction of bill/resolution:

A Subcommittee hearing for DHS (Community health worker)

Minutes:

Testimony 1

Senator Kilzer called the subcommittee to order on Friday, February 20, 2015 at 9:00 am in regards to SB 2321.

PRESENT: Senator Kilzer, Senator Erbele, Senator Mathern.
Lori Laschkewitsch, OMB
Michael Johnson, Legislative Council

Senator Kilzer recapped the history of the bill. SB 2321 comes from the policy committee of human services regarding community health workers. There was a fiscal note of \$1,540,000 of the general fund for the 2015-2017 biennium, and a fiscal note of \$11,300,000 for the 2017-2019 biennium. There was some delay in getting proper wording to the policy committee. Senator Kilzer and Senator Erbele discussed the bill with Dr. Warne. From these discussions, Senator Kilzer provided a new amendment (attach #1) 15.0422.03004. Dr. Warne provided information that there is a program to train the community health workers to the level so they would be reimbursable by Medicaid through the Department of Human Services. This training is slightly higher than QBC's, and lower than a CNA, but they do become certified through the Department of Health. If they are a member of a tribe and work in a tribal setting, they are 100% federally funded. If they are not, and they are Medicaid eligible, then it would be the 50/50 federal/state funding. This hog-house amendment has no fiscal not with it, and changes the situation completely.

Senator Mathern asked if this was what Dr. Warne wanted or what this your conclusion after the discussion. This totally eliminates the program for the biennium, and will not do anything for implementation.

Senator Kilzer was unaware if Dr. Warne has seen the amendment.

Allen Knudson, Legislative Council, indicated they have not shared or discussed with Dr. Warne.

Senator Mathern asked if Dr. Warne was asking to eliminate the program in this bill and request the study.

Senator Kilzer stated that Dr. Warne was very comfortable with a study. These people need to be trained.

Senator Mathern stated this bill was to establish a process this biennium to begin that training program, and with these amendments, nothing would be implemented except the study.

Senator Kilzer restated that Dr. Warne was comfortable with the study. Senator Kilzer invited Maggie Anderson (DHS) to the podium to address the Medicaid component.

Maggie Anderson, Department of Human Services, the community health representatives can currently enroll in Medicaid to provide targeted case management for individuals who need Long Term Care services or what we call high-risk pregnant women. In addition, community health representatives could be qualified service providers, but we do not have anyone at this level of service. Community health representatives are not a state-plan service that is in Medicaid, and is not authorized from the federal government. If the prior amendments would have passed, we would have waited for the Department of Health to adopt their rules to define what the community health representatives who also receive the community health worker certification received, and then Department of Human Services would have developed their state plan around that. If this will be a study, we will participate in the study and see what other states are doing with community health representatives in terms of Medicaid reimbursement beyond the targeted case management. If this is a study, the fiscal note will be changed to \$0.00.

Senator Kilzer are there qualified people to practice at this level in North Dakota to do this work?

Maggie Anderson (DHS) stated there are community health representatives today at the tribes. The community health worker piece was going to be a new certification. Maggie Anderson (DHS) cannot speak as to whether some of the community health representatives are doing some of those tasks that would have been under the designation of "worker". There is no community health "worker" designation today, that would have been new. Currently, there are few community health representatives that are enrolled as a Medicaid provider.

Senator Kilzer stated that the federal reimbursement would have to go through Medicaid.

Maggie Anderson (DHS) responded that in order to capture the 100% federal match, they have to be providing a service that is recognized through Indian Health Services or a Tribal 638 program.

Senator Kilzer asked if Maggie Anderson (DHS) could live this hog-house amendment.

Maggie Anderson (DHS) responded that they will participate in the study if that is what the legislature wishes. It would give us the opportunity to research other states and see how they deal with Medicaid reimbursement for this area.

Senator Kilzer asked Mr. Tom Nehring his opinion.

Tom Nehring, Director of the Division of EMS and Trauma at Department of Health, offered that the difference between a community health representative, who serves the tribal population, where a community health worker would be certified through the Department of Health, could provide those services across the entire state of North Dakota. From the Department of Health's perspective, they are the certifying body. Even though this appears to be a new status for a provider, it basically has been moving in that direction in the past with the community paramedic program which is a pilot project. This would differentiate between levels of care that could be rendered within the home. It is not our bill, so the Department of Health states a neutral position.

Senator Kilzer stated that he was not on the Human Services interim committee, so this is new to him. Dr. Warne did relay his experiences in other states, like Arizona and Alaska, where community health representatives are reimbursed at 100% by the federal government.

Senator Mathern stated that he has no problem with the study if this is the request of Dr. Warne, because it was in the context of his concern that there be another avenue of providing these type of supportive services throughout the state.

Tom Nehring stated that he has spoken with Dr. Warne. Mr. Nehring's belief is that Dr. Warne would prefer to have the community health worker program and the community health representative program in the state of North Dakota so that all populations could be served. As it exists with a community health representative, that is an Indian Health Services program and will serve the tribal populations and disparities that they suffer. The community health worker, which is a three-tiered system, depending on the capabilities of each of the individual and training program and then certification by the department, would be able to provide the services across the state.

Senator Mathern assumes there is general support for this program. Senator Mathern asked Mr. Nehring's opinion if the proper place for action right now by the legislature is a study or an implementation of the program.

Tom Nehring responded that his belief with Dr. Warne, he would prefer the implementation of the program and not a study. He would also likely prefer a study over nothing. Mr. Nehring further stated that he believes Dr. Warne would like to see the implementation begin with the education as a certificate program through the master's of public health at UND and NDSU.

Senator Erbele asked Mr. Nehring if there are people in place to implement within the tribal population so the 100% federal funds could be accessed.

Tom Nehring restated that there are community health representatives currently serving the tribal population. That is the group that has the 100% federal reimbursement. In regards to other people who need to be trained, the implementation process would take some time in the first year of the biennium, as rules would need to be established within the Department of Health, establish testing, establish the curricula, as well as the certification. They would work under the care of a primary care provider. This also allows training of ambulance personnel during their down time, which also helps the survivability of ambulance services for the future.

Senator Kilzer asked isn't it true at the present time the 100% federal funding isn't there because the billing isn't going through Medicaid.

Tom Nehring responded that is true.

Senator Kilzer that is the big item, the billing going through Medicaid for reimbursement.

Tom Nehring deferred to Maggie Anderson (DHS), as he is not qualified to state who can be reimbursed through Medicaid.

Senator Erbele is it possible to do the study and to allow for implementation of a portion of it so it wouldn't cost the state anything?

Tom Nehring responded that he believes it is possible. In the last biennium, there was a pilot project that was done with community paramedics. Without reimbursement, there are current community paramedics in North Dakota who are doing what was expected of them with no reimbursement. There is also a bill in front of the legislature for community paramedics. The pilot project has been successful in training the individuals and starting the implementation.

Senator Kilzer asked Senator Mathern in regards to raising questions about the wording if it would do what you think it should.

Senator Mathern stated that he does not believe the study is the intent of Dr. Warne. Senator Mathern expressed his wish that we could implement some action. The bill, as amended by the Senate Human Services Committee and their further suggested amendments, would be more positive than just a study, and would be his preference.

Senator Kilzer asked how that would affect fiscal note.

Senator Mathern presumes Legislative Council would have access to fiscal impact of amendment 15.0422.03003 and it appears that fiscal note would probably be in the range of \$1,500,000.

Michael Johnson, Legislative Council, responded the fiscal note for the 2015-2017 biennium, there is general fund dollars of \$1,541,787, and in addition there are other funds of \$1,665,953.

Senator Kilzer does that still go up in the subsequent biennium.

Michael Johnson, Legislative Council, in the 2017-2019 biennium, the general fund dollars would be \$11,333,501. Other funds would be \$12,876,744.

Senator Erbele: I am just wondering if there is a way if Dr. Warren could be apprised of this amendment. Is there a method to begin implementation of the tribal component where the state would be held harmless.

Senator Kilzer commented on Senator Mathern's comment about Dr. Warne not approving a study, that is incorrect - he has approved a study. **Senator Mathern** indicated he didn't indicate that Dr. Warne was not in favor of the study, but is that all he wanted.

Senator Kilzer stated that Dr. Warne had worked in Arizona and was aware of Alaska and other states that have 100% federal reimbursement for tribal members who were cared for by the community health representatives. It was his goal that North Dakota become a participate in this program.

Senator Mathern if he thinks this study does that, he supports it.

Senator Erbele the question is still not only the study, but can it be implemented within the tribal communities prior to the next biennium.

Senator Kilzer stated from prior testimony, there are hoops for the people to be certified and for Medicaid to be able to handle this level of practitioners.

Maggie Anderson (DHS) stated that they already enroll community health representatives for Medicaid reimbursement, but not for the expanded scope that was anticipated with this bill. If the legislature wants us to explore, the Department of Human Services work would be with the Department of Health to ensure consistency. We would not require the community health representatives be community health workers. We would work with the board of nursing to make sure that we are not overstepping into their practice. We would need an appropriation, because while the funding for the community health representatives is for Indian Health Services and Tribal 638 program is 100%, the other piece is there are people out there, for example elders, who may need home and community based services, who may not be accessing them today. There will be general funds in those services. The fiscal note assumed the statewide implementation, so there would be an adjustment to the fiscal note. It will be difficult to implement community health workers just on the reservations, because Medicaid has requirements that are called "state-wideness", that these programs have to be implemented statewide or a waiver is required and that is very difficult to do. Maggie Anderson (DHS) assumes it would still take a year to implement the rules.

Senator Mathern an option to consider is limited scope, where we would support the community worker representative work that is happening on the reservation. That would bring in a different fiscal note, and essentially be a pilot program and cost the state considerably less money than this fiscal note, and still do the study.

Senator Kilzer confirmed Senator Mathern's position. So the motion would be to hog-house the bill, and add amendment .03004, and add the implementation for the tribal component.

There was discussion between **Senator Kilzer** and **Senator Mathern** regarding the study and what would be implemented, specifically the tribal component. **Maggie Anderson (DHS)** provided further clarification. You could continue with the study, as the amendment suggests. If you look up Section 2 for the amendments that were adopted on the Senate floor before it came to appropriations, that would be a guide. We would want to remove the reference to community health worker in that section, and replace with something such as the Department of Human Services shall pursue medical assistance coverage to include reimbursement of a certified community health representative. You would still need to decide if you wanted them to work under the direction of a physician. The Senate Human Services Committee felt strongly about Section 3, which requires a report of what services individuals were receiving before the community health representative was involved before Medicaid services and which services and how many new people received home and community based services, so it is likely you would want this information for outcome data. Maggie Anderson (DHS) respectfully requested that Section 4 be kept with the effective date.

Senator Mathern stated he thinks that gets to the intent brought forward by Senator Erbele and narrows the bill just to the workers on the reservation and the study.

Brad Hawk, North Dakota Indian Affairs Commission (NDIAC) I think it does cover a lot of it, a lot of the referrals come from the Indian Health Services Clinics. In regards to the community health representative programs throughout the state, they have been in contact with them for the last few weeks. There was concerns initially, and that was why the amendments were prepared. We can reach out and validate that the latest proposed changes are acceptable.

Senator Mathern asked from your understanding of the bill and the proposed amendment, do you think this is workable? **Mr. Hawk** indicated it is workable but it will take time. He would agree with the delayed implementation date, as proposed.

Senator Mathern moved to DO ADOPT amendments, sections 2,3,4 of the amended bill 15.0422.03003, and make them narrower that they only include certified community health representatives and not the workers, and that the study recommendation is included, 15.0422.03004.

Senator Erbele asked the impact to the fiscal note. **Mr. Knutson** deferred to Department of Human Services.

Maggie Anderson (DHS) stated it will be smaller than the prior fiscal note. We will review and return with a revised fiscal note. Maggie Anderson (DHS) confirmed that it is in the engrossed Section 4.

Senator Mathern confirmed that Section 3 is for a report of outcomes. There will be no cost for that section. Even if we limit the scope to reservations, the consequential cost is

that individuals who are currently not receiving services will become eligible - they are eligible today but have not applied, so that is the fiscal impact.

Senator Kilzer closed the subcommittee meeting.

2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2321
2/20/2015
Job # 24217

- Subcommittee
 Conference Committee

Committee Clerk Signature

Donald Mueller for Alex DeBer

Explanation or reason for introduction of bill/resolution:

A Subcommittee hearing for DHS (Community health worker)

Minutes:

Testimony 1

Senator Kilzer called the subcommittee to order on Friday, February 20, 2015 in regards to SB 2321.

PRESENT: Senator Kilzer, Senator Erbele, Senator Mathern.
Lori Laschkewitsch, OMB
Michael Johnson, Legislative Council

Maggie Anderson (DHS) distributed the revised fiscal note summary (attach #1)

Senator Mathern stated that Mr. Tom Nehring called Dr. Donald Warne about his wishes for SB 2321, which is essentially the same that was discussed. The fiscal note summary has been distributed. With the amendment, the bill before us would be the study and the implementation of the community health representatives, and would require no appropriation. However, there would be a cost, and the fiscal note summary describes this. The amendment has been completed by Legislative Council, and is in the system being drafted.

Maggie Anderson (DHS) stated the fiscal note summary is what our fiscal administration office put together, using the same approach as the statewide but broke this down to just the community health representatives operating in the tribal areas. We assumed that we would start enrolling people July 1, 2016; a growth to where we would have 20 people in state fiscal year 2016. Those 20 individuals would have an average of 9 clients each, and they would visit those clients 4 times per year. We further assumed that 50% of those people would not be receiving home and community based care services. Some of these people need these services but have not been connected to the system. We looked at the cost of home and community based services and further cut those costs by 50%, because we figure this population is not the high-end or they would already be on assistance. For the 2015-2017 biennium, we estimated a little over \$300,000 in general fund, \$450,000 in federal authority for a total of \$754,000. We have built the community health representative

expenditures at 100% federal because we would assume these would be the Indian Health Services and Tribal 638 staff. For the 2017-2019 biennium, we assumed additional growth but used the same methodology. So the estimate is \$2,600,000 in general funds, and a total of \$6,200,000 overall.

Senator Kilzer asked if there would be a reduction in SPED if this went in?

Maggie Anderson (DHS) indicated she did not expect this. In order for us to access the Medicaid funding for the community health representatives, these would be Medicaid eligible individuals. Knowing that individuals must apply for Medicaid first, we would assume that those eligible for Medicaid would be on Medicaid. So we do not anticipate SPED expenditures to be reduced.

Senator Erbele all our increases to the general fund are tied back to Home and Community Based Services.

Maggie Anderson (DHS) responded that is correct. This is based on dialog with Dr. Warne and other tribal health members over the past several years. The Department of Human Services has meetings with Tribal Indian Health Services and various other stakeholders. Home and community based services are matched at a 50/50 funding.

Senator Kilzer closed the subcommittee meeting on SB 2321.

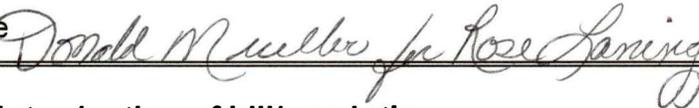
2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2321
2/23/2015
Job # 24252

Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to the certification of a community health worker-community health representative and to medical assistance reimbursement; to provide a report; and to provide an effective date.

Minutes:

1. Amendment # 15.0422.03005

Legislative Council - Michael Johnson
OMB - Lori Laschkewitsch

Senator Kilzer called the sub-committee to order on SB 2321. Senator Erbele and Senator Mathern were also present.

Senator Kilzer handed out amendment 15.0422.03005

Senator Mathern: SB 2321 comes at the request of Dr. Warne and the public health initiatives that he has taken up. This is a way of following up on care that is recommended to people. Some may receive a very expensive drug and then not taking it through the prescribed time so the benefit is gone. This is to provide a mechanism where there are community health workers involved to ensure that what was prescribed is done in the home. This kind of worker will be used on the reservation, off the reservation, and through the emergency health care system. What we have left in SB 2321 is a study in this entire system to make sure that the different aspects in the Health Department, Department of Human Services and Tribal government are working together. We have a limitation of the program implementation to the tribal communities to seek federal funding. There is recognition that this will identify individuals that are eligible for services that have not sought previously. It creates the effective date so that we are doing everything that we can to secure the 100% federal funding. We have a huge concept of community health workers narrowed to the reservation areas and a comprehensive study about the development of community care. This amendment is a hog-house and so it eliminates everything in the bill except for this page 1 of .03005. This one page is all that is left.

Senator Kilzer asked if there is a place in the bill that addresses the Department of Health and the certification process?

Senator Mathern explained that would be in Section 3 where the Department of Health would be involved in that study. This would not require the Department of Health to do the certification. The presumption is that the certification done on the reservation, which can be completed by reservation officials without the action, would be somehow coordinated, so a community health representative and a community health worker in the future may look like the same type of person. This amendment essentially eliminates the responsibility of the Department of Health to create the rules and start the program this next biennium.

Tom Nehring, Director of Emergency Services, Department of Health: One of the fundamental understandings that they need to have is that the 100% federal funded community health representative that can occur today through Indian Health Services. However, based on the study, in the future, they would also have to take the community health worker curriculum and be certified by the Department of Health in order to provide those services outside of the tribal populations.

Senator Mathern: This reflects the conversation with Dr. Warne. Do you see any problem with the amendments?

Dr. Nehring: He has not seen the amendments at this point. (given a copy) As I quickly view this, we would be moving forward with the implementation for tribal populations and with 100% federal funding, and then there would be a legislative study conducted by the Legislative Council with regards to the community health worker program for the future, and he is assuming they would be brought into that study, knowing the background of the curriculum and the three tiered system. He stated he has no difficulty with the amendments as they stand.

Senator Mathern: Stated his desire to adopt the amendment with the hog-house bill as it essentially sets up to make sure all of the different components get coordinated before it is implemented.

Senator Erbele: In the study, there's nothing in it that would force us to adopt anything outside of the tribal communities.

Senator Mathern: No and there is an effective date to give us another year before we start that piece. There's nothing that requires us to do this once the study is finished.

Senator Kilzer: Will there be changes to the fiscal note?

Alan Knudson, Legislative Council: Recalled that Maggie Anderson (DHS) could provide information.

Maggie Anderson, Department of Human Services: With the changes that have been discussed and included in the amendment, the general fund need for the Department of Human Services for 2015-2017 would be \$307,408. The federal dollars needed would be \$446,905. For biennium 2017-2019, those amounts would go to \$2,600,000 and

\$3,600,000 respectively. We will file an amended fiscal note once the bill is officially amended.

Senator Mathern: Do you believe this study requires us to adopt this program in the future?

Maggie Anderson (DHS) responded no. There is nothing that requires us to adopt the program in the future.

Senator Erbele moved the .03005 hog-house amendment as being the new bill for SB 2321 DO PASS. The motion was seconded by **Senator Mathern**.

Roll Call Vote

Senator Erbele - Yes

Senator Mathern - Yes

Senator Kilzer - Yes

Senator Kilzer closed the hearing on SB 2321.

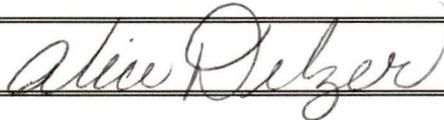
2015 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

SB 2321
2/24/2015
Job # 24276

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A BILL for an Act regarding the certification of a community health worker and to medical assistance reimbursement (DHS) (Do Pass as Amended)

Minutes:

Attachment # 1.

Chairman Holmberg called the committee to order on Tuesday, February 24, 2015, in regards to SB 2321. All committee members were present. Michael Johnson, Legislative Council and Lori Laschkewitsch, OMB were also present.

Senator Mathern: Explained the bill and presented attachment # 1- Proposed Amendment # 15.0422.03005. So you had all of these things coming together. The hog house amendment says let us do this, in the first couple of years, on the reservation where there is 100% reimbursement from the federal government for that new worker. And then let's do a study on how all of these kinds of programs can work together in the future and not mandate this program for the state of North Dakota on non-reservation property. There is a small fiscal note because when these workers would visit those on the reservation, some of the people will be in need of services that the state provides. If you start looking at what's good for people, you will find some needs. This policy bill of the Human Service committee has been worked on and they approve of this amendment. Our subcommittee also approved it.

Senator Mathern moved the Amendment . 2nd by **Senator O'Connell**.

Senator Gary Lee: You mentioned the fiscal note. I don't see one. Is there one that is available?

Senator Mathern: I'm sure there is one some place. At one time, it was \$12 some million. I think we're down to about \$1 million.

Chairman Holmberg: There is a fiscal note that is dated 2/10, which would be pre this amendment.

Alan Knudson: When we were working on these amendments, the department testified that for the 15-17 biennium , the general fund impact would be \$307,408. Federal funds would be \$446,905; and then the 17-19 biennium, the general fund impact would be \$2.6 million; federal funds \$3.6 million. There's not an official fiscal note yet because the amendments have not yet been adopted

Senator Gary Lee: I thought the speaker to amendment indicated these were all federal funds.

Senator Mathern: The hiring of the community health representative, which is the staff person on the reservation, is all federal funds; however, when that staff person is out visiting people, they will probably find people that need a state service. The state and federal government match. Mr. Knudson's fiscal note discussion about \$300,000, that is state dollars and that is related to the service that someone gets after the representatives been there. The representative may go there to make sure these people take their diabetes medication, and that representative is totally federally funded. While there, they may find they need another service, and then that referral may be a state and federal matched might include state services of that amount..

Senator Carlisle: Is this factored in with your human service budget? You folks are aware in your subcommittee?

Senator Kilzer: It's not a budget item in the department of human services, but the reason for the bill in the first place is to get the 100% federal funding it has to be billed through Medicaid, and Medicaid, of course, is with the human services.

Senator Carlisle: You're okay with the amendment?

All in favor of the amendment, say aye. Carried.

Senator Kilzer: I move the bill. 2nd by Senator Mathern.

Chairman Holmberg: Call the roll on a Do Pass as Amended on SB 2321.

A Roll Call vote was taken. Yea: 13; Nay: 0; Absent: 0.

Senator Mathern will carry the bill.

The hearing was closed on SB 2321.

February 20, 2015

TV
2/24/15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAL ASSISTANCE COVERAGE - TRIBAL COMMUNITY HEALTH REPRESENTATIVE SERVICES. The department of human services shall seek federal medical assistance coverage for tribal community health representative services if the representative provides for the coordination of care and education services and if the services are provided under the supervision of a physician, a physician's assistant, a registered nurse, an advanced practice registered nurse, a behavioral health professional, an optometrist, or a dentist for the period beginning with the effective date of this Act and ending June 30, 2017.

SECTION 2. REPORT. The department of human services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment by community health representatives and on medicaid service utilization of clients receiving services from tribal community health representatives. The department of human services shall compare medicaid service utilization before and after the medicaid enrollment of community health representatives.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying the feasibility and desirability of implementing a community health worker-community health representative program to assist with optimizing individual and family health and dental outcomes through services which include informal and motivational counseling and education; interventions to maximize social support; participation in care coordination; participation in case management; facilitation of access to health care, dental care, and social services; and health and dental screenings. The study must consider the requirements for licensing or certifying community health workers including education, experience, and training requirements and review the availability of medical assistance coverage for services provided by community health workers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective on July 1, 2016, or on approval from the centers for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health representative, whichever occurs later."

Renumber accordingly

Date: 2-24-15
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2371

Senate Appropriations Committee

Subcommittee

Amendment LC# or Description: 15.0422.03005

- Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
Other Actions: Reconsider _____

Motion Made By Mather Seconded By O'Connell

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Heckaman		
Senator Bowman			Senator Mather		
Senator Krebsbach			Senator O'Connell		
Senator Carlisle			Senator Robinson		
Senator Sorvaag					
Senator G. Lee					
Senator Kilzer					
Senator Erbele					
Senator Wanzek					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

voice vote passed

Date: 2-24-15
 Roll Call Vote #: 2

**2015 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2321**

Senate Appropriations Committee

Subcommittee

Amendment LC# or Description: _____

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Kilzer Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Heckaman	✓	
Senator Bowman	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator O'Connell	✓	
Senator Carlisle	✓		Senator Robinson	✓	
Senator Sorvaag	✓				
Senator G. Lee	✓				
Senator Kilzer	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 13 No _____

Absent _____

Floor Assignment Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2321, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2321 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

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SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective on July 1, 2016, or on approval from the centers for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health representative, whichever occurs later."

Renumber accordingly

2015 HOUSE HUMAN SERVICES

SB 2321

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2321
3/16/2015
24884

- Subcommittee
 Conference Committee



Explanation or reason for introduction of bill/resolution:

Direct the DHS to seek federal medical assistance coverage for tribal community health representation services.

Minutes:

Attachment 1, 2, 3

Chairman Weisz: Opened the hearing on SB 2321.

Sen. Tim Mathern: From District 11 in Fargo introduced the bill. (See Testimony #1)

Rep. Fehr: Beyond certification is there any consideration in terms of a licensure requirement at some point? I am also wondering is this different than what we over the years have referred to as case managers and often refer to as care coordinators or is this more of a pair of professional type of person?

Sen. Mathern: The original bill had a licensing component where the Department of Health would in fact license the individual and it would be a new certification license that we do not yet have in place. That has been eliminated and we now have a study component. This actually is a more nuanced case manager to specifically relate to the medical treatment that is suggested by the medical provider. I think what we are learning is to the degree that we can actually be more specific we are actually being more efficient.

Chairman Weisz: On the fiscal note there is a small portion of that cost is actually for the CHR. The bulk of this is for the increase services that will be found to be needed cored?

Sen. Mathern: You are correct. That is the key here. The federal funds with actually pay for this person doing this work.

Melissa Olson: Testifying on behalf of Dr. Donald Warne in support of the bill. (See Testimony #2)

Dr. Chris Burd ~ Tribal Community Health Consultant and Coordinator of the Community Health Worker: Testified in support of the bill. (See Testimony #3)

Rep. Mooney: What is an IHS?

Dr. Burd: Indian Health Service.

Chairman Weisz: I am still not quite clear on the differences between CHW and a CHR. Some cases they seem like they are the same and other cases they are different.

Dr. Burd: Community Health Workers is a broad term in terms of a person who is a professional, goes out and does all kinds of activities. They work with professional people who guide them as partners. That can happen in any community. If you go into the department of labor's classification system and you type in community health representative it is going to pop you into community health workers and health educators. The umbrella term is community health worker and depending on the context of where they work they get a different title. Community health representative is the original title given to Indian CHW's. CHW is really a newer term. CHR has been around for 47 years.

Rep. Fehr: Explain how the CHR or CHW interact with the public, do they only take referrals or do they go door to door?

Dr. Burd: CHR's are responsive to the health needs of their community. They are the liaison person between the formal care system at IHS and the community based services that are there. They will do all of the above. They check on elderly people and make sure they have their medications picked up from the IHS clinic. They will know that somebody needs a ride to Bismarck for an appointment; they make sure transportation gets arranged. They talk with providers at the clinic for follow ups. There is no home health at the reservations. The hospitals only send people out 50 miles. We had a young woman who had a stroke a couple years ago and received no services at Standing Rock because she was beyond 50 miles. The CHR's then jump in and try to figure out how to get her up town for her therapy and so forth. Mr. Eagle does a program on domestic violence prevention. It is all the social and determinants of health that the CHR's address. They cross between the medical world and the social world and they are always the first ones on the scene when there is a suicide. They call the person who is trusted, goes to that home and sits for hours with that family. They are kind of this all-purpose health provider and they work around the clock, through the weekends. They staff first aid stations as the Pow-Wows. Their training needs to be ramped up, I think, because of their important role. They do the very best they can and that is why we decided years ago to work with Sitting Bull college. Their role is too important to be left with we can do a little bit of training here and there. Under the Snider Act of 1921, Power Professional Community Health representatives are covered in terms of Indian communities. They are to be out there doing health education, preventative services, but because of the flat plumbing there has been no way to grow them so we have 2.5 million acres at Standing Rock across two states and they have about eight CHR's in the field. It is almost impossible. So you do a lot of crisis management and they are very good cases managers, they can juggle and prioritize. I have worked with other tribes in North Dakota and a number of tribes in South Dakota I have done training with CHR's. There is a certain bread that they just come in there and they are attracted to the work and they do a heck of job. I feel personally that we would like to get the Associate Degree up at and running in Sitting Bull College because they deserve that degree. They have training all along, they have the experience, they need to have something that is

tangible that they could transfer if they wanted to go into nursing or social work but they cross both worlds the medical and the social and all those social determinates of health that are now in the public health that is what they hit. They don't even know that they are doing it and I don't think they realize the importance sometimes because they are the paraprofessional in the community so they don't always rise to the level of recognition. People have taken them for granted quite a bit. Back in 1997 when we had that big flood the CHR's were the ones out on the roads when they shouldn't have been trying to get people to dialysis or getting food out to the elderly people who had none in their home. I know I get passionate about his but I am very impressed with the work that the CHR's do.

Rep. Fehr: It sounds like they do everything from outreach nursing to other paraprofessional kinds of work and yet the discussion starts from trying to develop a profession or a certification and it is really confusing trying to get our hands around it. Is this intended to go in different directions so there is a paraprofessional; there is more of a certified professional or something else at some point?

Dr. Burd: We would like to see a layer where they would be a cohort with CHR programs. That could do the preventative services and the teaching and the health education not by the seat of their pants but they would be very well trained to do that and that is why they have courses in our curriculum like chronic disease management, health promotion so they get the right information from the right sources. There could be in each program some health educators who would be reimbursable and we would be able to do the follow up after a hospitalization. Mr. Eagle Shield got called out they sent someone home with a whole oxygen apparatus. That is not training CHR's normally get so because of his paramedic background he was able to go over to the home and hook everything up and make sure the guy was going to be alright. The disconnect between services outside the reservation and coming back to the reservation where we need some work, where we need to get that disconnect connected. I think there could be within the CHR program people who focus on the elderly, people who focus on preventive services, people who focus on targeted case management so within that there would be certain CHR's with a professional role. They make it more training but technically they should all have a baseline training that is the same, but then you might take them a little further depending on the role they are going to fill. We are trying to be sure everybody has first aid CPR this summer and get everybody updated on that. If someone really makes the commitment that they would like to get that associate degree in community health worker I would think that they would be the people that would take the lead in the future to run the programs around the great plans area.

Rep. Fehr: There is discussion about expanding community paramedics and part of that discussion of course there is talk about how to make sure they are closely connected to the physicians urgent care workers having phone connection, audio visual connection maybe other kinds of things like that. At some point are we looking at how to connect community care or representatives with the next layer or next level emergency services?

Dr. Burd: In face CHR's are often the first person on that gets called. Those in formal connections are there. If IHS has someone that a CHR has just picked up from the clinic and they need follow up on their medications or follow up with another visit they need the coordination to get ahold of a family member that is done. There is an ongoing communication at all times. There is the nutrition for the elderly program. There is all the

communication about elders who need care. Technically CHR's aren't supposed to hands on care but they do a lot of hand on care for elderly because we don't have a QSP agency set up yet. They would be the one usually if the ambulance goes out the CHR from the district is there.

John Eagle Sheild ~ Director Standing Rock CHR Program: One of our workers, we have a health representative assigned to each committee on Standing Rock mainly because they know the people. One day one of our workers made a home visit to an elderly gentleman and he was sitting there very forlorn and he asked in our own language, what's the matter? The gentlemen said "well they told me I have diabetes." Right away he was ready to give all his health education information to him and he eventually did that but before he did that the guy showed him his bottle of medicine and said "they only gave me 30 days to live." So while talking to him one by one his family came in, so during a session everybody got information on diabetes and that is kind of the matter of how we go house to house depending on the topic. By contrast we had a young gentleman in one of the medical centers up here set up by IHS. He came in to have a shunt put in his arm prior to dialysis and his family came with him and in our culture you have family and you have family and you have extended family. Well the security told some of the family that some of you are going to have to leave the nurses need room to move. So he said if my family has to leave I am going to leave too and he did and he expired awhile after that. By contrast we both have to learn from each other here. Our people need services, a lot of people need services and we would just like to be able to continue to do that.

Chairman Weisz: How are you getting your references? Is there a formal process in place now or is it a hit and miss?

Eagle Shield: Over the years we have developed a profile of each of our communities so we know individuals that have chronic health problems. It helps to know your people. We know all the newborns that are coming back. We are working with cancer, cancer awareness, and cancer prevention. IHS user population has close to 1,500 men that have used IHS services over a three year period of time and then you are off the list. Currently we have about 400 men that we see on Standing Rock. Our question is where are the other 1,100? Our work is still cut out for us and we have other health issues that we need to work on too.

Rep. Muscha: When you say we, do you mean IHS office that keeps records?

Eagle Shield: Our tribal CHR program.

Tom Gehring ~Division Director of Division of Emergency Medical Services at the ND Department of Health: This bill came out of the Senate human services committee with pretty much what you see at this point in time. I would consider this to be a bill that enables community health representatives in the state of North Dakota. The original bill had basically a tiered level of approach. CHW, CHR we see pretty much on the same level. Obviously a CHR serves the tribal populations; they are also CHW's. We would then see a CHW in the state of North Dakota serving the rest of the population in North Dakota. The other two levels were the EMT/ AEMT (advances emergency technician) who is also a community health worker and ultimately the community paramedic. I think it is important to

note that that is now contained in this bill in a study. Originally it was enabling legislation for that group as well too. Very simply community health representative is a federal program serving tribal populations; they are also community health workers. Community health workers and those other two levels that I talked about were essentially levels within the State of North Dakota at which a curriculum would be developed and those types of things. We made the decision within the Health Department that we are going to combine community health worker with EMS so they have a further medical background as well.

NO OPOSITION

Hearing Closed.

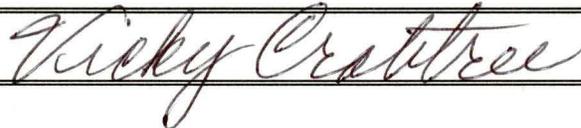
2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2321
3/30/2015
Job #25586

- Subcommittee
 Conference Committee

Committee Clerk Signature



Minutes:

Chairman Weisz: Let's look at 2321. Maggie would you come up please? Assuming we put in the CHRs that \$600,000 and some is in the bill, they will find more that is already eligible for Medicaid and get them services. Right?

M. Anderson: Director of DHS. Right.

Chairman Weisz: Which I would agree with. Do you look at the big picture? Now you have more people there to make sure they get the services?

M. Anderson: If we were to look at that and we don't. We have been meeting with the Tribes Indian Health Services and various other entities a number of years. We meet quarterly and we discuss a lot of issues. One of them is that they have elders who may qualify for home and community based services and not necessarily comfortable accessing those services through the existing system. A portion of the money that is needed in this bill, we are projecting to receive 100% federal funding from the centers for Medicare and Medicaid service for a new service. That would be the federal portion of the federal dollars. And that is to pay the CHR piece. Let's say if we had 50 people who didn't access the services before now and say they come in 5 years from now for services and perhaps their needs are greater; now we will not only see home and community based services costs and likely see some acute health care costs as well. We are asked to do a fiscal note for two years and so for the next biennium we know our outlay of money is actually to be greater because we have to cover those services. We won't see decreases in the next two years.

Rep. Rich Anderson: What do you mean by some elders not being comfortable using the current system?

M. Anderson: They may be that they prefer a Native American provider and not comfortable with a non-Native American.

Chairman Weisz: Has this money been available through this program for the CHR? Is this something new on the federal end?

M. Anderson: The 100% federal match for this has been available when a service is provided by Indian Health Services to people who come into Indian Health Services. As long as Indian Health Services or the Tribe, it came be a Tribal 638 program as well which is when the Tribe takes over the Indian Health Services piece. As long as it is provided by one of those entities and it is included in their calculation then we can access 100% federal dollars for them. There is an effective date on this bill and it is effective upon us receiving approval.

Rep. Fehr: I motion a Do Pass on SB 2321 and re-referred to Appropriations.

Rep. Mooney: Second.

Chairman Weisz: Was this an OAR Maggie?

M. Anderson: No.

Rep. Rich Becker: I'm a little unclear. Are there enough Tribal people to be train or effectively utilize the dollars provided? I'm not sure I can support the bill.

Chairman Weisz: A \$139,515 that would be 100% federally funded. That is what would qualify. Whatever is available in the other portion is whatever it costs it costs. They made an estimate of how many clients and the average cost of the client and it came up with the 307 state and 307 federal. When it comes to Medicaid and we have 50 clients, we are going to pay for them.

Rep. Seibel: I see this as a preventative medicine. I will support this.

ROLL CALL VOTE: 12 y 1 n 0 absent

Bill Carrier: Rep. D. Anderson

Date: 3-30-15
 Roll Call Vote #: 1

**2015 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2321**

House Human Services Committee

Subcommittee

Amendment LC# or Description: _____

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By Rep. Fehr Seconded By Rep. Mooney

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad		✓	Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Rep. D. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2321, as reengrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed SB 2321 was rereferred to the **Appropriations Committee**.

2015 HOUSE APPROPRIATIONS

SB 2321

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2321
4/3/2015
25798

- Subcommittee
 Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

Minutes:

No attachments

Chairman Jeff Delzer: Opened the meeting.

Representative Robin Weisz spoke on the bill. This bill allows funding for CHRs (Community Health Representatives). It's a definition on the tribal reservation. The feds pay 100% of the funding for these CHRs. We received a lot of testimony justifying the use of the CHRs and there has been no cost to the state. There is \$307,000 general fund money and \$446,000 federal fund money coming from the expanded use of the Medicaid system. While the program is 100% federally funded but those CHRs work with their own tribal members and many will not work with non-tribal people so they aren't getting the care or getting qualified to do it. The fiscal note reflects the fact that if that CHR goes out there and tells them they aren't taking their diabetes medication and they're having circulation issues so they could lose their leg they could get them in and get the services so that has a cost of Medicaid.

Chairman Jeff Delzer: Are they supposed to use Indian health services?

Representative Weisz: They, as citizens of North Dakota, qualify for all the Medicaid services that you or I do.

Chairman Jeff Delzer: It's their choice of which they would use.

Representative Weisz: Yes and generally if they don't qualify for Medicaid then they are probably using the Indian Health services. That's the reason you see a fiscal note because when these CHRs I think long term it will save the state money from the standpoint of it being a lot better to get them in the hospital before they have to amputate the leg than wait and pay the cost of all that.

Chairman Jeff Delzer: Are we doing any of these anywhere?

Representative Weisz: No. These are similar to a QSP.

Chairman Jeff Delzer: If the feds are paying for it there are none of the tribes currently doing it?

Representative Weisz: That's why the bill is here so we can do it. They have the community health workers that are employed but this would allow the funding for the training which is 100% federal.

Chairman Jeff Delzer: Is it limited to reservation members?

Representative Weisz: The services are not limited. The CHRs are specific programs on the tribe. A CHR is a tribal representative; a community health representative within the tribal reservation.

Chairman Jeff Delzer: Did the tribes come in asking for this?

Representative Weisz: The tribes are definitely in support of this and so were the human services.

Chairman Jeff Delzer: This says the feds can pay for it. They should be able to access that money without having to have state law available for this because they are currently eligible for Medicaid.

Representative Weisz: We have to decide what qualifies for Medicaid. The feds said we can do this so we say we can access this money and that's what this bill does. There is an estimate; they assume 20 individuals will become certified. Each one will have nine clients, four visits and so on. That's the reason there is a cost to the state because it's the Medicaid portion.

Representative Schmidt: Last session we approved the pilot project for Standing Rock Sioux Tribe to do something very similar to this. Is this an offshoot of that study? Whatever resulted from that study?

Representative Weisz: I think there are some parallels. Maybe the feds have now realized the issues with the tribe.

Representative Nelson: The fiscal note reflects expanded Medicaid utilization. Some of that population would fit in to the expanded Medicaid coverage which is paid differently. Did you ask whether there was a component of expanded Medicaid that was figured in that fiscal note or was it all Medicaid reimbursement?

Representative Weisz: The fiscal note was based on Medicaid. We didn't ask if there would be a population of say the expansion group that would move in under this.

Representative Nelson: I would think that would be a segment of the population that would qualify for that. The provisions with the tribes are different as far as the application for that but I don't know where that enrollment is with the general population.

Representative Weisz: The assumption was that all of these clients would be Medicaid eligible because that is the population these CHR's are going to be working with.

Chairman Jeff Delzer: Do the tribes work under the same rules on Medicaid expansion?

Representative Weisz: Any tribal member is eligible for Medicaid if they meet the requirements. In addition to that there is Indian Health Services.

Chairman Jeff Delzer: They don't even fill out federal tax forms, do they?

Representative Weisz: I can't answer that question.

Representative Hogan: Are other states using this program?

Representative Weisz: This is relatively new that they will fund this at 100% for these CHR's.

Representative Boe: Are these representatives going to help with paperwork for their billing?

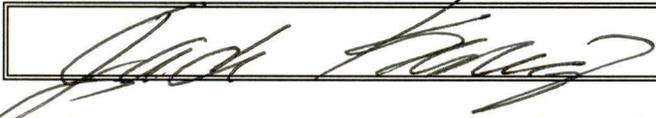
Representative Weisz: Their job is to work through the whole array of what's necessary for that client to help them get the services they need. They are not providing the care but they are making sure they get the care. The elder tribal members will not work with the QSP or have a social worker. Now you have someone from tribe that knows their community and what's going on. This is to help coordinate services within their tribal community to make sure that person is getting taken care of and getting the services they need.

2015 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2321
4/8/2015
25951

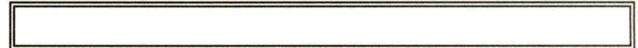
- Subcommittee
 Conference Committee



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

Minutes:



Chairman Jeff Delzer: This is a bill that looks like it allows the human services to seek federal coverage for tribal community representative. The fiscal note has to deal with more services being requested on the reservations because of uses and I do not believe there was anything put in the budget for this bill. So the bill before us would allow requests from the department to seek the federal medical coverage for those people. Apparently the feds were ok with that part of it. I would guess we would have to pay some part at some point in time. This is for the amount on expenditures for more use if I am not mistaken.

Vice Chairman Keith Kempenich: I am going to move a Do Not Pass on SB 2321

Representative Thoreson: Seconded

Chairman Jeff Delzer: I will support this. I don't know whether the human service committee has to have the bill. This would require them to do it, I don't know if they have to do it. I don't know if they have to have this language to even consider doing it if they wanted to. If we were going to do this I would have thought we should have put it in the budget.

Vice Chairman Keith Kempenich: In the fiscal note they are looking at 20 individuals and most of it is dealing with the tribal members who qualify for 100 percent of the federal funds. It is going to cost the state 307,000 dollars to do this.

Representative Hogan: I am going to oppose the Do Not Pass. The tribal areas are such medically underserved areas. The thing about this model is there aren't many physicians available; there aren't very many nurse practitioners. This would allow access to mid-level health provider really in way that tribal members often don't get health service. It is a good model of services and I think we should think about supporting it.

House Appropriations Committee
SB 2321
4/8/2015
Page 2

Motion for a Do Not Pass.

Motion made by Representative Kempenich.

Seconded by Representative Thoreson.

Total yes 16. No 6. Absent 1.

Motion Carries.

Floor assignment Representative Kempenich.

Date: 4/8/15
 Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES

BILL/RESOLUTION NO. 2321

House: Appropriations Committee

Subcommittee

Amendment LC# or Description: _____

Recommendation: Adopt Amendment
 Do Pass Do Not Pass Without Committee Recommendation
 As Amended Rerefer to Appropriations
 Place on Consent Calendar
 Other Actions: Reconsider _____

Motion Made By: Kempenich Seconded By: Thoreson

Representatives	Yes	No	Absent
Chairman Jeff Delzer	✓		
Vice Chairman Keith Kempenich	✓		
Representative Bellew	✓		
Representative Brandenburg	✓		
Representative Boehning	✓		
Representative Dosch	✓		
Representative Kreidt	✓		
Representative Martinson	✓		
Representative Monson	✓		
Representative Nelson	✓		
Representative Pollert	✓		
Representative Sanford	✓		
Representative Schmidt	✓		
Representative Silbernagel	✓		
Representative Skarphol		✓	
Representative Streyle	✓		
Representative Thoreson	✓		
Representative Vigesaa		✓	
Representative Boe		✓	
Representative Glassheim			AB
Representative Guggisberg		✓	
Representative Hogan		✓	
Representative Holman		✓	
TOTALS	16	6	1

Floor Assignment: Kempenich

If the vote is on an amendment, briefly indicate intent: _____

REPORT OF STANDING COMMITTEE

SB 2321, as reengrossed: Appropriations Committee (Rep. Delzer, Chairman)
recommends **DO NOT PASS** (16 YEAS, 6 NAYS, 1 ABSENT AND NOT VOTING).
Reengrossed SB 2321 was placed on the Fourteenth order on the calendar.

2015 TESTIMONY

SB 2321

Attach #1
01/27/15
SB 2321

SB 2321
January 27, 2015

Madam Chairman Lee and members of the Senate Human Service Committee,

My name is Tim Mathern. I am the senator from District 11 in Fargo and here to introduce SB 2321-the Community Health Worker-Community Health Representative bill. In short this bill sets the certification standards for a profession of health care workers within the purview of the Department of Health and provides for reimbursement through our medical assistance program.

Note the services listed in section 1, a through g. The goal is that this worker would be the direct patient contact in the community in order to enhance the efficacy of health care delivery in our state.

This bill comes to you at the request of North Dakota's public health masters program staff and other partners around the state. They are here to testify to the need and operation of such a program. Please work with them in amendments if needed as you also have other bills that deal with the expanded role of community focused care.

Madam Chairman and members of the Committee, we are learning that the best medicine offered in hospitals and clinics is only as good as the implementation of the suggested care in people's homes. I believed that this new worker model has the potential to make sure that health care services are meeting their intended purpose and not wasted.

I ask for a do pass recommendation from your committee.

Attach 2
01/27/15
SB2321

Testimony
SB 2321

Senate Human Services Committee

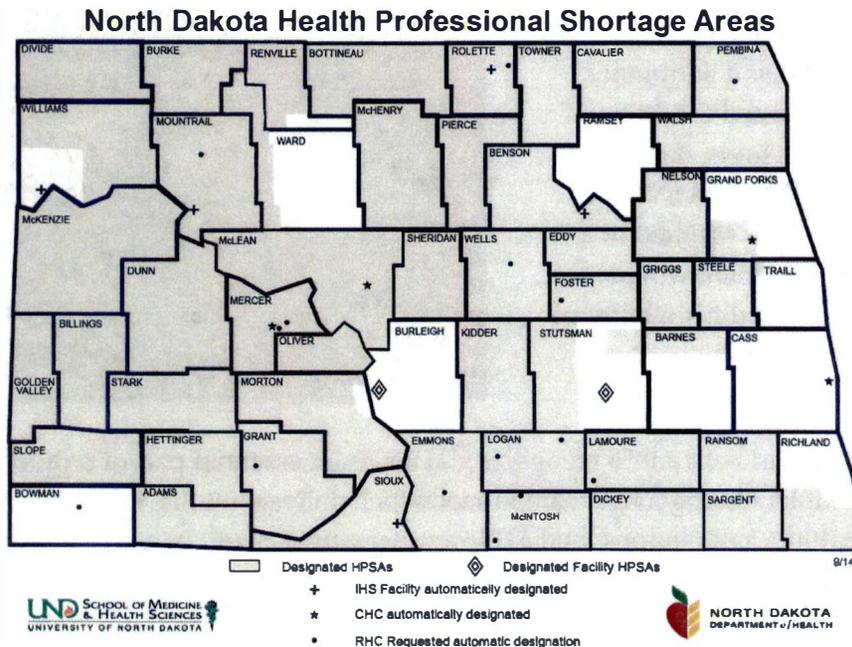
Senator Judy Lee, Chairman

January 27, 2015

Chairman Lee and members of the Senate Human Services Committee, I am Donald Warne, and I am a family practice physician and the Director of the Master of Public Health Program at North Dakota State University. I am here to speak in support of SB 2321, which was introduced by Chairman Lee and Senator Mathern.

I Introduction

Shortages in the supply of many types of health workers is a nationwide problem, and it is a considerable public health issue in North Dakota. The majority of North Dakota is designated as a Health Professions Shortage Area, and the shortage of health workers is particularly significant in North Dakota's rural and tribal communities. Ideally, we would have enough doctors, nurses, dentists, nurse practitioners and other providers to deliver appropriate health services in a culturally attuned manner to all North Dakotans. The reality is, we do not. One of the roles of public health is to assess health situations, identify strategies to improve the health of populations, and to link people to needed health services. We have an opportunity in North Dakota to create a mechanism to help fill the gaps of health service delivery by establishing the Community Health Worker Certification Program and reimbursement system. These efforts will be closely coordinated with the existing Community Paramedic program in North Dakota.

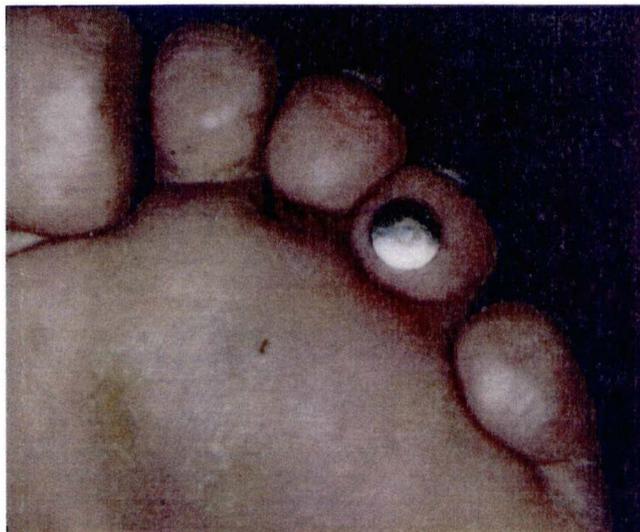


2.2

Community health workers (CHWs) are trusted members of a community who receive specialized training to help improve individual and community health outside of traditional health care settings. CHWs empower individuals and communities for better health by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. A trusting relationship enables the CHW to serve as a liaison between health and social services and the community member. This facilitates access to services and improves the quality, cultural competence, and outcomes of health services. In North Dakota, we have several programs that help to fill services gaps including patient navigators, targeted case managers, home visitors, community health representatives and others. However, North Dakota does not yet have a comprehensive system to train, certify and reimburse most of these providers. Establishing a CHW certification program and reimbursement system in North Dakota will help improve the quality of care our residents receive.

As a physician, I saw the important role and value the CHW contributes to the medical team: I was practicing family medicine at the Gila River Indian Community in Arizona, and a patient was brought in to me accompanied by a CHW. This patient had diabetes and he had stepped on a thumbtack. Due to neuropathy and numbness in his foot caused by the progression of his diabetes, he did not feel the tack. The CHW who was with him had discovered the tack while in the patient's home, doing a routine foot exam. Had the CHW not been an integral part of our medical team, we cannot be sure how much time would have passed before the patient would have sought care in the clinic.

Routinely in that community, people would have similar issues that begin as minor injuries and then progress into severe infections, amputations, disability, lost quality of life, and significant health care costs to the system. In this situation, the outcome was positive: the patient received debridement and antibiotics for his wound and learned the value of conducting self-foot exams. Another outcome, one without the intervention of the CHW, could have resulted in a lower leg amputation which would have negatively impacted his quality of life and cost a significant amount of money.



Nationwide there is a movement to recognize CHWs as an essential part of a primary care team with the goal of implementing a new care model which delivers on the Triple Aim: (1) better outcomes; (2) healthier populations; and (3) lower per capita costs. Many states are currently developing their own models that will utilize CHWs in communities of need. Several states, including Alaska, Colorado, Massachusetts, Michigan, New Mexico, Oregon and Minnesota

already have successful CHW programs. Results from CHW demonstration projects are showing excellent returns on investment.

II Return on Investment Estimates for CHW Demonstration Projects (2006-2012)

State	Project Title	Project Description	Cost Savings Estimate
Michigan	Spectrum Health Grand Rapids, MI	Maternal and child health, hypertension, diabetes, nutrition, healthy lifestyles; work in schools, hospitals, communities	\$2.53 in savings for every \$1.00 of cost
Michigan	Muskegon Community Health Project/Mercy Health Community Benefit Program, Muskegon, MI	Enrollment and home visits positively impacted health outcomes for individuals with diabetes	CHWs recovered \$350,000 in 2009 by enrolling patients in Medicaid
New Mexico	Molina Healthcare of New Mexico	CHWs work with high emergency department (ED) usage patients and low treatment adherence	\$4.00 savings for every \$1.00 of cost
Colorado	Denver Health	Underserved populations on issues including appropriate outpatient service utilization	\$2.28 saving for every \$1.00 invested in the program
Massachusetts	Childhood Asthma	Targeted parents of Children with asthma - repeat ED visits, and few encounters with primary care provider	\$4.00 for every \$1.00 invested. Annual pediatric asthma-related hospital admissions and ED visits period fell by 45%, and 50%
New Mexico	Chronic Disease and ED visits	448 Medicaid enrollees / high users of ED with poorly controlled chronic disease	\$4.00 for every \$1.00 invested. ED visits decreased from 5.9 visits per month to 1.8.

III Community Health Worker Tiered Model in North Dakota

In North Dakota, CHWs will work as part of a team-based primary care system. Management of services and medical oversight will be provided by primary care providers, including physicians and nurse practitioners. The scopes of work for CHWs will be coordinated with the *Community Paramedic* program and will include a tiered system with CHWs, EMTs with CHW certification, and Community Paramedics. CHWs may also participate in *Primary Care Case Management* teams. The Division of Emergency Medical Services and Trauma will assess standards and will provide the Certification credential.

CHW/Community Paramedic Scope of Work

Tier Level	CHW Type	Home/Community Assessments	Case Management	Health Education	Medical Referrals	Supportive care	Home-based clinical services	Mental health screening	Home-based advanced clinical services
I	CHW/CHR								
II	EMT with CHW								
II	Community paramedic								

Note: CHW – community health worker; CHR= community health representative; EMT= emergency medical technician

IV Roles for CHWs to Improve Health Outcomes in North Dakota

Topic	Data	Roles for Community Health Workers
Healthcare Navigation	As of July 2014 11.5% of North Dakotans were uninsured and less than 10% of AIs were enrolled in an insurance plan	Assist community members in finding a medical home and specialty services as appropriate. Serve as navigators to help individuals enroll in Medicaid and other health insurance
Infant Mortality Rate (IMR)	North Dakota has significant disparities in American Indian (AI) IMR. The AI IMR is double that of the general population.	Provide in-home visits and link to prenatal care services, infant care education, breastfeeding, and immunization
Cardiovascular Disease (CVD)	Heart disease is the leading cause of death; 64% of adults are overweight or obese; 22% of the population are smokers.	Provide in-home visits to check blood pressure, provide basic smoking cessation education, and link to appropriate health services
Hypertension (HTN)	29.1% of North Dakotans have been diagnosed with HTN	Provide in-home visits to check blood pressure
Cancer	Cancer is the second leading cause of death	Provide case management and medical referral services for cancer screening and appropriate follow-up
Type 2 Diabetes	7.4% of adults in North Dakota have been diagnosed with Type 2 Diabetes	Provide in-home visits to check blood sugar and medication compliance. Provide basic diabetes education
Asthma	Over 10% of North Dakotans have been diagnosed with asthma at some point in their lifetime	Provide in-home case management visits and check peak flows. Assist in monitoring medication compliance
Mental Health Services	Significant mental health provider shortages exist in North Dakota	Provide in-home visits to screen for depression and suicide ideation and link to health services

V. Evaluation Plan

The success of the Community Health Worker state-wide project will be evaluated based on developmental, implementation and quality assurance outcomes:

Developmental Criteria

- Statewide CHW stakeholder group is expanded and develops a statewide strategy.
- Data system is in place to track clinical outcomes per intervention site.
- The CHW program and EMS system are well-integrated, including communications, medical oversight, and transportation.

- Certified CHW curriculum is developed based on existing curricula and national standards.
- Reimbursement processes are coordinated with ND Medicaid and CMS.
- Comprehensive statutory authority and administrative rules support CHW program infrastructure, planning, provision, oversight, and future development.

Implementation Criteria

- There is a thorough description of the epidemiology of the medical conditions targeted by the CHW program in the service area using both population-based data and clinical databases.
- The CHW program assesses and monitors its value to its constituents in terms of disease prevalence, outcomes, and cost-benefit analysis.

Quality Assurance Criteria

- CHW program leaders use a process to establish, maintain, and continuously evaluate and improve the CHW program in cooperation with key stakeholder groups.

VI Sustainability Plan

Through SB 2321, North Dakota will establish a Certified CHW program and reimbursement process through Medicaid and potentially other payer systems. Reimbursement rates and processes are being discussed with CMS. CHW reimbursement processes will be closely coordinated with the Community Paramedic program.

VII Conclusion

In closing, here in North Dakota, we have seen how the role of a community paramedic can help to fill gaps in our health system. Now we have the opportunity to include the role of the certified CHWs to help fill additional gaps, increase access to services, reduce overall medical costs, and improve the quality of life for more North Dakotans. The return on investment by incorporating CHWs into the health system is both financially and clinically valuable. Thank you for letting me provide information about the beneficial roles CHWs can have in helping to fill the gaps in our health system. I am happy to answer any questions.

Attach # 3
SB2321
01/27/15
J# 22588

Testimony

ND Department of Human Services

Human Services Committee

Senator Judy Lee, Chair

January 27, 2015

History of Work with CHR (Community Health Representative) Programs

Chairwoman Lee and members of the Human Services Committee, I am Christine Burd, Tribal Community Health Consultant and presently Coordinator for the Community Health Worker (CHW) Curriculum at the Sitting Bull College of the Standing Rock Sioux Tribe. I have come to share information on the progress and continuing development of CHW/CHR training that has been ongoing with Tribes over the past 18 years in the Great Plains Area. (For clarification of the discussion, it might be helpful to establish that CHRs are considered a type of CHW under the classification system of the U.S. Department of Labor). I have worked with CHR training and Tribal Health projects in the Aberdeen Area (now the Great Plains Area) since 1997, after completing my Doctoral degree in Community Health Sciences from the University of Manitoba.

At the time I began training and curriculum work for CHRs (as well as grant-writing for Tribal communities), I was also on faculty at the College of Nursing at the University of North Dakota. I taught for nearly 20 years at the undergraduate level, and was also the faculty responsible for teaching Epidemiology in the graduate program for several semesters. I worked very closely with the RAIN Program (Recruiting American Indians into Nursing) at UND, serving as the Program Director for one year, and do continue to have an ongoing collaboration with them and with colleagues at the National Resource Center on Native American Aging.

Since 2006 when I left UND to work exclusively with Tribal communities in the Great Plains region, I have worked closely on the planning, development, and funding of community-based health projects at Cheyenne River Sioux Tribe, Spirit Lake Sioux Tribe, and Standing Rock Sioux Tribe. One of the federal grants we worked on with Spirit Lake Nation has been in place for 5 years, and it has successfully developed a career path and training for dozens of American Indian health care providers for all the ND Tribes. Each of the projects we have had successfully funded over the years has included training and collaboration with CHR programs, as well as other Tribal outreach programs that utilize CHWs.

Relevance to S.B. 2321 and Concern about Lack of Consultation with CHRs

We were surprised to see that S.B. 2321 has been introduced. I have spent many weeks at the Standing Rock Sioux Tribe in recent months on community projects, grant-writing, and training for CHRs. I completed the teaching of a "Chronic Disease Management" course for CHWs/CHR's at the Sitting Bull College this past fall semester. I also recently attended the Great Plains CHR Association meeting in Rapid City in November, 2014 as an invited speaker. The reason we were surprised to see S.B. 2321 being introduced is the fact that at no time (despite many conversations with CHR Program Directors and employees about training concerns) has this legislation been brought up or discussed in recent months.

In fact, I was on consultation visits at Standing Rock for several days in the past two weeks, planning for additional CHR training, and submitting a funding request so we can help other Tribes in the Great Plains Area to send their CHR's to the 5 credit training we are planning at Sitting Bull College this summer. (Sitting Bull College has a new CHW curriculum that can lead to a Certificate or Associates Degree). There is also a new directive from the Indian Health Service (IHS) about the new online modules required for CHR Basic Certification Training. We will be addressing the material from the official IHS CHR Basic Certification modules in our course at Sitting Bull College in summer of 2015.

This week, I am working with the Chairman of the Health, Education and Welfare Committee (HEW) of the Standing Rock Tribal Council, in developing their resolution for the type of training that the Tribe would like CHRs to have. There is an interest that a "face to face" classroom component be included for CHRs as adult learners with varied learning styles, to complement the online modules provided for CHR Certification by the Indian Health Service at the national level.

The Chairman of the HEW Committee had not been made aware that there was a bill introduced related to CHR training last week until Monday, Jan. 26. In short, we have always worked with Tribal entities in developing and delivering CHR training, so hence the surprise that S.B. 2321 is being introduced without these important Tribal parties seeming to be informed. I am in ongoing communication with the President of the Great Plains CHR Association who is currently on staff at Standing Rock, and he also has no knowledge of this legislative action, nor does the Spirit Lake CHR Program Director (whom we are collaborating with on the Targeted Case Management option for CHRs, leading to Medicaid reimbursement).

Medicaid Reimbursement Potential for CHWs/CHRs

We have been pursuing CHR reimbursement through Medicaid, and in fact a Medicaid State Plan Amendment to allow CHRs to provide Targeted Case Management was finally forged and approved in 2012. The approval followed after years of planning with Tribal representatives, the ND Human Services/Medical Services staff and the Native American Contact for the Centers for Medicare/Medicaid Services (CMS) Region VIII. That initiative has been delayed due to the lack of licensed professionals available at Standing Rock who could serve to work with the CHR program in an ongoing manner on the Targeted Case Management Assessment process.

However, as of last week, Standing Rock has hired a licensed health professional who will be available on a regular basis to the CHR Program to assist with

Targeted Case Management. Our plan now is to follow-up with the ND Home & Community-Based Services (HCBS) Director in the Medical Services Branch, who had previously agreed to set up the required training for the licensed professional who would help the CHRs with the Targeted Case Management process when hired.

Recent History of Meetings with ND Dept. of Human Services

On October 7, 2014, five members of the Standing Rock HEW Committee, the Tribal Health Director, the CHR Program Director, Brad Hawk (ND Indian Affairs Commission) and myself met in Bismarck with Julie Schwab and Karen Tescher from ND Department of Human Services, Medical Services Division. The purpose of the meeting was to successfully clarify the state-tribal agreement for Targeted Case Management, that is, that this service would be "billable" by CHRs, in accordance with the Tribe's resolution at the "all inclusive rate" that is allowed for a Tribal health program, under P.L. 638 Indian Self-Determination and Education Act .

It was also clarified at this meeting, that HCBS staff would train the professional health provider who would be available to the CHR program to oversee the assessment for Targeted Case Management. The HCBS staff is familiar to the ND CHR Programs, as they provided formal state-required training for CHRs to deliver Targeted Case Management services under the 2012 State Plan Amendment.

A request was also made later in October for a meeting with the Medical Services Branch to ask if the State of ND might consider reimbursement of CHRs for "preventive services". (A point of clarification: In January, 2014 a change in preventive policy went into place from the Centers for Medicare and Medicaid Services (CMS) that would allow: 1) CHWs to provide preventive services under specific guidelines, and 2) would allow for Medicaid reimbursement for the CHWs to provide these services). The follow-up meeting was not ever held with the Medical Services Division, as we were told it would be a few weeks due to

previous obligations. In the meantime, the Standing Rock HEW Committee has been working towards arranging a time to meet with Medicaid Directors for both ND and SD to pursue this discussion under the new CMS Preventive Policy. *(Standing Rock land crosses state borders, therefore, it is necessary for the Standing Rock Sioux Tribe to negotiate with both ND and SD on these issues).*

Training and Reimbursement Items

As we have studied and collaborated on developing high quality training that would allow CHWs/CHRs to receive reimbursement for services (as well as allow them to earn a degree as a recognized health care provider) we have sought consultation, had discussions, and attended webinars with leaders who are knowledgeable and have been instrumental at the national level in working with states who are pursuing CHW certification. Below are several items that are pertinent to this study and consultative process:

- CHRs were the prototype for CHWs in the U.S. CHRs have been in service to American Indian communities for close to 47 years as CHWs for Tribes.
- CHRs have always had their training provided under the auspices and approval of the Indian Health Service, hence the development of the newly released CHR Basic Certification Modules
- We have been advised (including by CMS) to continue to pursue additional reimbursement potential (for example, for preventive services) for CHRs under Medicaid by following the template that we have already successfully developed with the state of ND through the Medicaid State Plan Amendment process for Targeted Case Management

Concerns related to S.B. 2321

The main concerns we have with S.B. 2321 are the following:

- Serious questions related to an apparent lack of Tribal-State Consultation with ND CHR Directors, Tribal Health Directors and HEW Committees

relating to how ND State CHW certification requirements would affect Tribally hired and directed CHRs and potential Medicaid reimbursement

- Tribes have unique needs for the type of CHW required in Tribal communities. CHRs are included in the Department of Labor's SOC Classification under "CHW". So, any state legislation that affects CHWs, will also affect CHRs. How will state requirements interface with Tribal needs?
- Will the state of ND have jurisdiction over CHRs who work for Tribal communities? It is very difficult to find and train CHR workers in rural communities, will the State provide CHW training for the Tribes in a timely manner?
- Standing Rock has 5 communities in the state of SD. Will the CHRs for the SRST Tribe who work in SD have different requirements for training, certification, and practice than their colleagues in the same CHR program on the "ND side" of the reservation?
- What will actually be the training and certification requirements for CHRs?

Thank you for your consideration of this testimony.

Respectfully Submitted,

Christine M. Burd, RN, PhD,

PROPOSED AMENDMENTS TO SENATE BILL NO. 2321

Attachment
SB2321
01/27/15

Page 1, line 3, after "reimbursement" insert "; and to provide an effective date"

Page 4, after line 16, insert:

"SECTION 3. EFFECTIVE DATE. Section 2 of this Act becomes effective on July 1, 2016, or upon approval from the centers for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health worker-community health representative, whichever occurs later."

Renumber accordingly

Attach #1
 SB 2321
 02/09/2015
 J# 23467

Fiscal Note Summary

Bill / Resolution No. SB2321

15-17 Biennium							Project Number
	FTE	Total	General	Federal	Other		
Salaries and Wages		\$ -					
Operating Expenses		-					
Capital Assets		-					
Capital Construction Carryover		-					
HSBS Services		2,813,628	1,406,825	1,406,803			
CHR/CHW Expenditures		285,775	26,625	259,150			
HSC and Institutions		-					
Grants - Medical Assistance		-					
Total	0.00	\$ 3,099,403	\$ 1,433,450	\$ 1,665,953	\$ -		
17-19 Biennium							
HSBS Services		22,111,372	11,055,687	11,055,685			
CHR/CHW Expenditures		1,989,638	168,579	1,821,059			
Total	0.00	\$ 24,101,010	\$ 11,224,266	\$ 12,876,744	\$ -		

Section 2 of this bill requires the Department of Human Services (DHS) to expand Medicaid coverage to include reimbursement for certified community health worker-community health representatives (CHRs). To calculate the estimated costs for Section 2, the Department assumed a start date of July 1, 2016. This would allow the health council time to adopt rules for the certification, allow time for individuals to become certified, and allow time for DHS to secure CMS approval of the service and funding. DHS estimated that 50 individuals would become certified in the second year of the 15-17 biennium. Added 4 to 5 CHR's each month starting July 1, 2016 through the end of the 2015-2017 biennium. DHS also assumed that each CHR would have 15 clients and each client would have four visits (encounters) from the CHR annually. DHS assumed 40% of the CHRs would work with Tribble members and would qualify for 100% federal funding through Medicaid and this estimate is based on receipt of CMS approval for that funding. The estimated cost of the CHR services for the 2015-17 biennium will be \$285,775 of which 26,625 is general fund and 259,150 are federal funds. In addition, DHS estimated that one half of the clients would become newly enrolled for Medicaid-funded home and community-based services. The estimated cost of the home and community-based services for the 2015-17 biennium is \$2,813,628 of which 1,406,825 is general fund and 1,406,803 are federal funds. There is also a potential impact on the Counties in the 17-19 biennium due to the number of individuals who would require medicaid eligibilty determinations, however the dollar amount of the impact is undeterminable at this time.

Testimony

SB 2321

Senate Appropriations Committee

Senator Ray Holmberg, Chairman

February 17, 2015

SB 2321

2-17-15

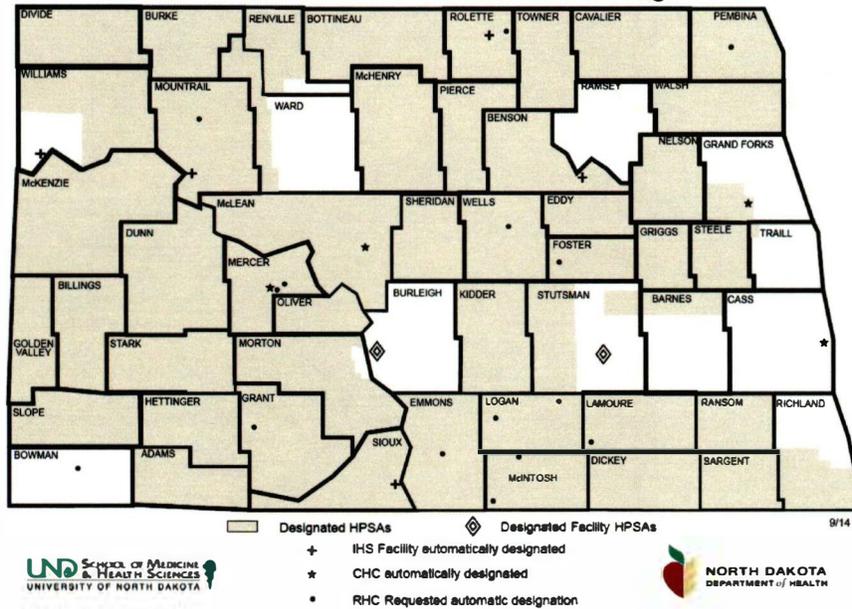
1

Chairman Holmberg and members of the Senate Appropriations Committee, I am Anita Brock, Policy Director of the American Indian Public Health Resource Center at North Dakota State University. I am testifying on behalf of Dr. Donald Warne, a family practice physician and the Director of the Master of Public Health Program at North Dakota State University. I am here to speak in support of SB 2321, which was introduced by Senator Judy Lee and Senator Tim Mathern.

I Introduction

Shortages in the supply of many types of health workers is a nationwide problem, and it is a considerable public health issue in North Dakota. The majority of North Dakota is designated as a Health Professions Shortage Area, and the shortage of health workers is particularly significant in North Dakota's rural and tribal communities. Ideally, we would have enough doctors, nurses, dentists, nurse practitioners and other providers to deliver appropriate health services in a culturally attuned manner to all North Dakotans. The reality is, we do not. One of the roles of public health is to assess health situations, identify strategies to improve the health of populations, and to link people to needed health services. We have an opportunity in North Dakota to create a mechanism to help fill the gaps of health service delivery by establishing the Community Health Worker Certification Program and reimbursement system. These efforts will be closely coordinated with the existing Community Paramedic program in North Dakota.

North Dakota Health Professional Shortage Areas



Community health workers (CHWs) are trusted members of a community who receive specialized training to help improve individual and community health outside of traditional health care settings. CHWs empower individuals and communities for better health by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. A trusting relationship enables the CHW to serve as a liaison between health and social services and the community member. This facilitates access to services and improves the quality, cultural competence, and outcomes of health services. In North Dakota, we have several programs that help to fill services gaps including patient navigators, targeted case managers, home visitors, community health representatives and others. However, North Dakota does not yet have a comprehensive system to train, certify and reimburse most of these providers. Establishing a CHW certification program and reimbursement system in North Dakota will help improve the quality of care our residents receive.

As a physician, I saw the important role and value the CHW contributes to the medical team: I was practicing family medicine at the Gila River Indian Community in Arizona, and a patient was brought in to me accompanied by a CHW. This patient had diabetes and he had stepped on a thumbtack. Due to neuropathy and numbness in his foot caused by the progression of his diabetes, he did not feel the tack. The CHW who was with him had discovered the tack while in the patient's home, doing a routine foot exam. Had the CHW not been an integral part of our medical team, we cannot be sure how much time would have passed before the patient would have sought care in the clinic.

Routinely in that community, people would have similar issues that begin as minor injuries and

then progress into severe infections, amputations, disability, lost quality of life, and significant health care costs to the system. In this situation, the outcome was positive: the patient received debridement and antibiotics for his wound and learned the value of conducting self-foot exams. Another outcome, one without the intervention of the CHW, could have resulted in a lower leg amputation which would have negatively impacted his quality of life and cost a significant amount of money.



Nationwide there is a movement to recognize CHWs as an essential part of a primary care team with the goal of implementing a new care model which delivers on the Triple Aim: (1) better outcomes; (2) healthier populations; and (3) lower per capita costs. Many states are currently developing their own models that will utilize CHWs in communities of need. Several states, including Alaska, Colorado, Massachusetts, Michigan, New Mexico, Oregon and Minnesota already have successful CHW programs. Results from CHW demonstration projects are showing excellent returns on investment.

II Return on Investment Estimates for CHW Demonstration Projects (2006-2012)

State	Project Title	Project Description	Cost Savings Estimate
Michigan	Spectrum Health Grand Rapids, MI	Maternal and child health, hypertension, diabetes, nutrition, healthy lifestyles; work in schools, hospitals, communities	\$2.53 in savings for every \$1.00 of cost
Michigan	Muskegon Community Health Project/Mercy Health Community Benefit Program, Muskegon, MI	Enrollment and home visits positively impacted health outcomes for individuals with diabetes	CHWs recovered \$350,000 in 2009 by enrolling patients in Medicaid
New Mexico	Molina Healthcare of New Mexico	CHWs work with high emergency department (ED) usage patients and low treatment adherence	\$4.00 savings for every \$1.00 of cost
Colorado	Denver Health	Underserved populations on issues including appropriate outpatient service utilization	\$2.28 saving for every \$1.00 invested in the program
Massachusetts	Childhood Asthma	Targeted parents of Children	\$4.00 for every \$1.00

		with asthma - repeat ED visits, and few encounters with primary care provider	invested. Annual pediatric asthma-related hospital admissions and ED visits period fell by 45%, and 50%
New Mexico	Chronic Disease and ED visits	448 Medicaid enrollees / high users of ED with poorly controlled chronic disease	\$4.00 for every \$1.00 invested. ED visits decreased from 5.9 visits per month to 1.8.

III Community Health Worker Tiered Model in North Dakota

In North Dakota, CHWs will work as part of a team-based primary care system. Management of services and medical oversight will be provided by primary care providers, including physicians and nurse practitioners. The scopes of work for CHWs will be coordinated with the *Community Paramedic* program and will include a tiered system with CHWs, EMTs with CHW certification, and Community Paramedics. CHWs may also participate in *Primary Care Case Management* teams. The Division of Emergency Medical Services and Trauma will assess standards and will provide the Certification credential.

CHW/Community Paramedic Scope of Work

Tier Level	CHW Type	Home/Community Assessments	Case Management	Health Education	Medical Referrals	Supportive care	Home-based clinical services	Mental health screening	Home-based advanced clinical services
I	CHW/CHR								
II	EMT with CHW								
II	Community paramedic								

Note: CHW – community health worker; CHR= community health representative; EMT= emergency medical technician

IV Roles for CHWs to Improve Health Outcomes in North Dakota

Topic	Data	Roles for Community Health Workers
Healthcare Navigation	As of July 2014 11.5% of North Dakotans were uninsured and less than 10% of AIs were enrolled in an insurance plan	Assist community members in finding a medical home and specialty services as appropriate. Serve as navigators to help individuals enroll in Medicaid and other health insurance
Infant Mortality Rate (IMR)	North Dakota has significant disparities in American Indian (AI) IMR. The AI IMR is double that of the general population.	Provide in-home visits and link to prenatal care services, infant care education, breastfeeding, and immunization
Cardiovascular Disease (CVD)	Heart disease is the leading cause of death; 64% of adults are overweight or obese; 22% of the population are smokers.	Provide in-home visits to check blood pressure, provide basic smoking cessation education, and link to appropriate health services
Hypertension	29.1% of North Dakotans have been	Provide in-home visits to check blood pressure

(HTN)	diagnosed with HTN	
Cancer	Cancer is the second leading cause of death	Provide case management and medical referral services for cancer screening and appropriate follow-up
Type 2 Diabetes	7.4% of adults in North Dakota have been diagnosed with Type 2 Diabetes	Provide in-home visits to check blood sugar and medication compliance. Provide basic diabetes education
Asthma	Over 10% of North Dakotans have been diagnosed with asthma at some point in their lifetime	Provide in-home case management visits and check peak flows. Assist in monitoring medication compliance
Mental Health Services	Significant mental health provider shortages exist in North Dakota	Provide in-home visits to screen for depression and suicide ideation and link to health services

V. Evaluation Plan

The success of the Community Health Worker state-wide project will be evaluated based on developmental, implementation and quality assurance outcomes:

Developmental Criteria

- Statewide CHW stakeholder group, including tribal entities, is expanded and develops a statewide strategy.
- Data system is in place to track clinical outcomes per intervention site.
- The CHW program and EMS system are well-integrated, including communications, medical oversight, and transportation.
- Certified CHW curriculum is developed based on existing curricula and national standards.
- Reimbursement processes are coordinated with ND Medicaid and CMS.
- Comprehensive statutory authority and administrative rules support CHW program infrastructure, planning, provision, oversight, and future development.

Implementation Criteria

- There is a thorough description of the epidemiology of the medical conditions targeted by the CHW program in the service area using both population-based data and clinical databases.
- The CHW program assesses and monitors its value to its constituents in terms of disease prevalence, outcomes, and cost-benefit analysis.

Quality Assurance Criteria

- CHW program leaders use a process to establish, maintain, and continuously evaluate and improve the CHW program in cooperation with key stakeholder groups.

VI Sustainability Plan

Through SB 2321, North Dakota will establish a Certified CHW program and reimbursement process through Medicaid and potentially other payer systems. Reimbursement rates and processes are being discussed with CMS. CHW reimbursement processes will be closely coordinated with the Community Paramedic program.

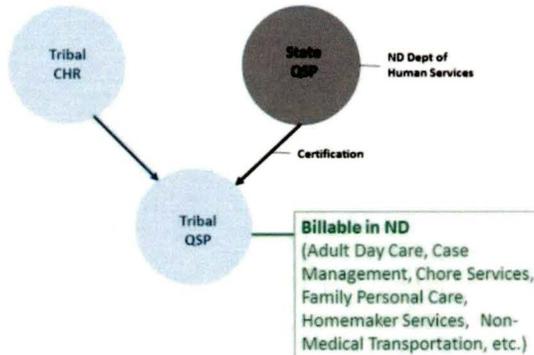
VII Conclusion

1.5

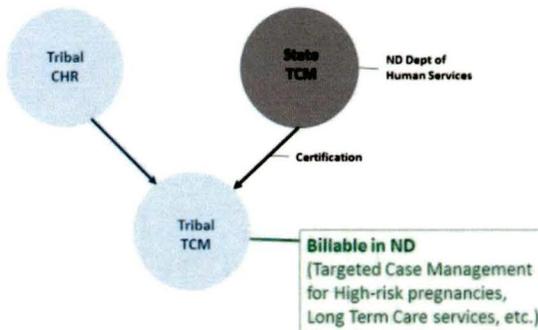
In closing, here in North Dakota, we have seen how the role of a community paramedic can help to fill gaps in our health system. Now we have the opportunity to include the role of the certified CHWs to help fill additional gaps, increase access to services, reduce overall medical costs, and improve the quality of life for more North Dakotans. The return on investment by incorporating CHWs into the health system is both financially and clinically valuable. Thank you for letting me provide information about the beneficial roles CHWs can have in helping to fill the gaps in our health system. I am happy to answer any questions.

Certification and Reimbursement Structure for Community Health Representatives as Qualified Service Providers, Targeted Case Management Providers and Community Health Workers

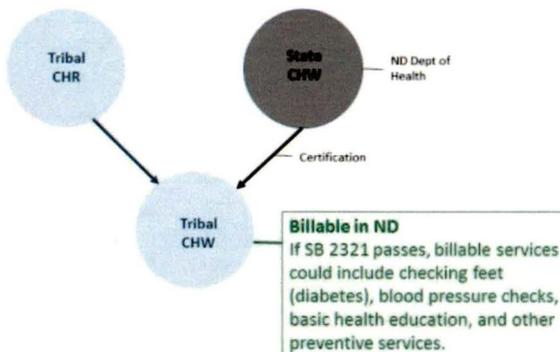
1. CHR and Qualified Service Providers (QSPs)



2. CHR and Targeted Case Managers (TCMs)



3. CHR and Community Health Workers (CHWs)



Attach#1
02/18/2015
SB2321
J# 24067

Sixty-fourth
Legislative Assembly
of North Dakota

Introduced by

Senators Mathern, J. Lee

1 A BILL for an Act to create and enact chapter 23-48 and a new section to chapter 50-24.1 of the
2 North Dakota Century Code, relating to the certification of a community health
3 ~~worker community health representative~~worker and to medical assistance reimbursement; to
4 provide for a report; to provide a continuing appropriation; and to provide an effective date.

5 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

6 **SECTION 1.** Chapter 23-48 of the North Dakota Century Code is created and enacted as
7 follows:

8 **23-48-01. Definitions.**

9 The definitions in this section are applicable to this chapter.

- 10 1. "Certified community health ~~worker community health representative~~worker" means a
 11 community health worker community health representativean individual who is
 12 certified under this chapter, ~~applies an understanding of the experience, language,~~
 13 ~~and culture of the populations that the individual serves, and provides, as part of a~~
 14 ~~health care team, direct services that are aimed at optimizing individual and family~~
 15 ~~health and dental outcomes, and which may include:~~
 - 16 ~~a. Informal and motivational counseling and education;~~
 - 17 ~~b. Interventions to maximize social supports;~~
 - 18 ~~c. Participation in care coordination;~~
 - 19 ~~d. Participation in case management;~~
 - 20 ~~e. Facilitation of access to health care, dental care, and social services;~~
 - 21 ~~f. Health and dental screenings; and~~
 - 22 ~~g. Other services as permitted by rule~~ to provide community health services.
- 23 2. "Community health ~~worker community health~~representative" means an individual
 24 who:

- 1 ~~a. Is a trusted, knowledgeable, front line worker;~~
- 2 ~~b. Lives in or has familiarity with the community in which the individual provides~~
- 3 ~~services;~~
- 4 ~~c. Bridges cultural and linguistic barriers;~~
- 5 ~~d. Promotes access to health care and health coverage;~~
- 6 ~~e. Helps to improve health outcomes; and~~
- 7 ~~f. Serves as a critical link between the community in which the individual provides~~
- 8 ~~services and the health care system, thereby reducing health care access~~
- 9 ~~disparities, enhancing health care quality and affordability, and empowering~~
- 10 ~~individuals and communities in the pursuit of better health~~ Indian health service
- 11 ~~recognizes as a community health representative in order to provide quality~~
- 12 ~~outreach health care services and health promotion and disease prevention~~
- 13 ~~services to American Indians and Alaskan natives within the community health~~
- 14 ~~representative's community.~~

15 3. "Community health services" may include direct services aimed at optimizing
16 individual and family health and dental outcomes which may include:

- 17 a. Informal and motivational counseling and education;
- 18 b. Intervention to maximize social supports;
- 19 c. Participation in care coordination;
- 20 d. Participation in case management;
- 21 e. Facilitation of access to health care, dental care, and social services; and
- 22 f. Health and dental screenings.

23 4. "Department" means the state department of health.

24 **23-48-02. Administration.**

- 25 1. The department shall develop and administer a program to provide for the certification
- 26 of community health ~~workers~~ community health representatives ~~workers.~~
- 27 2. The health council shall adopt rules to implement the program. The rules must
- 28 address:
- 29 a. Education, experience, ~~and training,~~ and examination requirements to qualify for
- 30 certification under this chapter;
- 31 b. ~~Continuing education standards~~ Standards for certification renewal;

- 1 c. Grounds for certification denial, suspension, revocation, and reinstatement; and
- 2 d. Fees for certification and certification renewal.
- 3 3. The state health officer may issue a cease-and-desist order to a person violating this
- 4 chapter or rules adopted under this chapter.

5 **23-48-03. Certified community health ~~worker-communityworker~~ - Certified community**
6 **health representative - Use of designation.**

- 7 1. ~~Before an~~An individual ~~practices as, claims to be, or uses~~may not practice as, claim to
- 8 ~~be, or use~~ a letter designation indicating ~~that~~ the individual is a certified community
- 9 health ~~worker-community health representative,worker,~~ unless the individual ~~must be~~is
- 10 certified in accordance with this chapter.
- 11 2. A certified community health worker who is a community health representative may
- 12 practice as, claim to be, and use a letter designation indicating the individual is a
- 13 certified community health worker. A community health representative may not practice
- 14 as, claim to be, or use a letter designation indicating the individual is a certified
- 15 community health representative unless the individual is certified in accordance with
- 16 this chapter.
- 17 3. Except as provided under subsections 1 and 2, this chapter does not prohibit an
- 18 individual who is not certified under this chapter from providing community health
- 19 services or from practicing as and claiming to be a community health worker or a
- 20 community health representative.

21 **23-48-04. Criminal history record check.**

22 The department shall check or cause to be checked the criminal history record of each
23 applicant for certification and may check or cause to be checked the criminal history record of
24 each applicant for recertification. An applicant who is denied certification based on information
25 obtained through a criminal history record check may appeal the denial at the applicant's
26 expense.

27 **23-48-05. Fees - Continuing appropriation.**

28 The department shall deposit fees collected under this chapter in the department's
29 operating fund and these fees are appropriated on a continuing basis to the state department of
30 health for the purpose of funding the implementation of this chapter.

1 **23-48-06. Initial certification – Waiver of criteria.**

- 2 1. An applicant for certification shall submit to the department an application and
3 associated fees at the time and in the manner required by the department.
- 4 2. ~~The department may waive~~ if an applicant fails to meet one or more certification criteria
5 in the case of an individual who provides, the department may certify the applicant
6 upon receipt of satisfactory evidence of health care training, work experience, or other
7 education, comparable to the certification standards required by this chapter.
- 8 3. ~~An individual seeking a waiver of criteria in accordance with~~ The department may not
9 issue a certificate under subsection 2 ~~shall demonstrate, unless the applicant~~
10 demonstrates familiarity with the community health ~~worker community health~~
11 ~~representative~~ worker program in this state and ~~shall agree~~ agrees to limit the
12 individual's practice to this state.
- 13 4. A certificate issued under this section is valid for three years.

14 **23-48-07. Certification - Renewal.**

- 15 1. An applicant for certification renewal shall submit to the department an application and
16 associated fees for certification renewal. Each individual is responsible for ensuring
17 that the renewal of certification is completed in a timely manner.
- 18 2. The department shall issue a renewal certificate that is valid for three years to each
19 qualified applicant.
- 20 ~~3. As a condition of certification renewal, the department shall require an applicant to~~
21 ~~complete ten hours of approved continuing education each year.~~

22 **23-48-08. Certified community health worker community health representative –**

23 **Scope of practice.**

- 24 1. ~~A~~ The scope of practice of a certified community health ~~worker community health~~
25 ~~representative may engage only in~~ worker is limited to those activities authorized in this
26 chapter and rules adopted under this chapter. While practicing as a certified
27 community health ~~worker community health representative~~ worker, an individual may
28 not engage in or perform any act or service for which another professional certificate,
29 license, or other legal authority is required.
- 30 2. This chapter does not prevent or restrict the practice, service, or activities of any
31 individual simultaneously certified as a community health worker and licensed,

1 certified, registered, or otherwise authorized to engage in the practice of another
2 profession in this state, if that individual does not use, while engaged in the authorized
3 practice of another profession, any name, title, letter designations, or any other
4 designation indicating that the individual is a certified community health
5 ~~worker community~~worker or certified community health representative.

6 **SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created
7 and enacted as follows:

8 **Medical assistance coverage - Certified community health ~~worker community health~~**
9 **representativeworker.**

10 Medical assistance coverage must include reimbursement of a certified community health
11 ~~worker community health representative~~worker, as provided for under chapter 23-48, if the
12 individual provides for the coordination of care and education services and if the services are
13 provided under the supervision of a physician, a physician's assistant, a registered nurse, an
14 advanced practice registered nurse, a behavioral health professional, an optometrist, or a
15 dentist.

16 **SECTION 3. REPORT TO THE LEGISLATIVE ASSEMBLY.** The department of human
17 services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment
18 by community health ~~workers-community health representatives~~workers and on medicaid
19 service utilization of clients receiving services from community health ~~workers-community health~~
20 ~~representatives~~workers. The department of human services shall compare medicaid service
21 utilization before and after the medicaid enrollment of community health ~~workers-community~~
22 ~~health representatives~~workers.

23 **SECTION 4. EFFECTIVE DATE.** This Act becomes effective on July 1, 2016, or upon
24 approval from the center for medicare and medicaid services for the department of human
25 services to secure one hundred percent federal funding of the medicaid costs for the services of
26 the community health ~~worker community health representative~~worker, whichever occurs later.

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

- Page 1, line 3, replace "worker-community health representative" with "worker"
- Page 1, line 3, after "provide" insert "for"
- Page 1, line 4, after the semicolon insert "to provide a continuing appropriation;"
- Page 1, line 10, replace "worker-community health representative" with "worker"
- Page 1, line 10, remove "a"
- Page 1, line 11, replace "community health worker-community health representative" with "an individual"
- Page 1, line 12, remove ", applies an understanding of the experience, language, and culture of the"
- Page 1, remove lines 13 through 21
- Page 1, line 22, replace "g. Other services as permitted by rule" with "to provide community health services"
- Page 1, line 23, remove "worker-community-health"
- Page 1, remove line 24
- Page 2, replace lines 1 through 10 with "Indian health service recognizes as a community health representative in order to provide quality outreach health care services and health promotion and disease prevention services to American Indians and Alaskan natives within the community health representative's community"
- Page 2, line 11, after "3." insert "Community health services" may include direct services aimed at optimizing individual and family health and dental outcomes which may include:
- a. Informal and motivational counseling and education;
 - b. Intervention to maximize social supports;
 - c. Participation in care coordination;
 - d. Participation in case management;
 - e. Facilitation of access to health care, dental care, and social services;
and
 - f. Health and dental screenings.
- 4."
- Page 2, line 14, replace "workers-community health representatives" with "workers"
- Page 2, line 17, remove "and"
- Page 2, line 17, after "training" insert ", and examination"
- Page 2, line 19, replace "Continuing education standards" with "Standards"

2.2

Page 2, line 24, replace "worker-community" with "worker - Certified community"

Page 2, after line line 25 insert:

"1."

Page 2, line 26, replace "Before an" with "An"

Page 2, line 26, replace "practices as, claims to be, or uses" with "may not practice as, claim to be, or use"

Page 2, line 26, remove "that"

Page 2, line 27, replace "worker-community health representative," with "worker, unless"

Page 2, line 28, replace "must be" with "is"

Page 2, after line 28, insert:

"2. A certified community health worker who is a community health representative may practice as, claim to be, and use a letter designation indicating the individual is a certified community health worker. A community health representative may not practice as, claim to be, or use a letter designation indicating the individual is a certified community health representative unless the individual is certified in accordance with this chapter.

3. Except as provided under subsections 1 and 2, this chapter does not prohibit an individual who is not certified under this chapter from providing community health services or from practicing as and claiming to be a community health worker or a community health representative."

Page 3, line 4, after "Fees" insert "- Continuing appropriation"

Page 3, line 6, after "fund" insert "and these fees are appropriated on a continuing basis to the state department of health for the purpose of funding the implementation of this chapter"

Page 3, line 7, remove "- Waiver of criteria"

Page 3, line 10, replace "The department may waive" with "If an applicant fails to meet"

Page 3, line 10, remove "in the case of an"

Page 3, line 11, replace "individual who provides" with ", the department may certify the applicant upon receipt of"

Page 3, line 13, replace "An individual seeking a waiver of criteria in accordance with" with "The department may not issue a certificate under"

Page 3, line 13, remove "shall"

Page 3, line 14, replace "demonstrate" with ", unless the applicant demonstrates"

Page 3, line 14, remove "worker-community health"

Page 3, line 15, replace "representative" with "worker"

Page 3, line 15, replace "shall agree" with "agrees"

Page 3, remove lines 24 and 25

Page 3, line 26, remove "**Certified community health worker-community health representative** -"

Page 3, line 28, replace "A" with "The scope of practice of a"

Page 3, line 28, remove "worker-community health representative may engage"

Page 3, line 29, replace "only in" with "worker is limited to"

Page 3, line 30, remove "worker-community health"

Page 4, line 1, replace "representative" with "worker"

Page 4, line 9, replace "worker-community" with "worker or certified community"

Page 4, line 12, remove "**worker-community health**"

Page 4, line 13, replace "**representative**" with "**worker**"

Page 4, line 15, replace "worker-community health representative" with "worker"

Page 4, line 19, after "**REPORT**" insert "**TO THE LEGISLATIVE ASSEMBLY**"

Page 4, line 21, remove "workers-community health"

Page 4, line 22, replace "representatives" with "workers"

Page 4, line 23, replace "workers-community health representatives" with "workers"

Page 4, line 25, replace "workers-community health representatives" with "workers"

Page 4, line 29, replace "worker-community health representative" with "worker"

Renumber accordingly

February 18, 2015

*Attach #1
SB 321
02/18/15 pm
J# 24096*

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

- Page 1, line 3, replace "worker-community health representative" with "worker"
- Page 1, line 3, after "provide" insert "for"
- Page 1, line 4, after the semicolon insert "to provide appropriations;"
- Page 1, line 10, replace "worker-community health representative" with "worker"
- Page 1, line 10, remove "a"
- Page 1, line 11, replace "community health worker-community health representative" with "an individual"
- Page 1, line 12, remove ", applies an understanding of the experience, language, and culture of the"
- Page 1, remove lines 13 through 21
- Page 1, line 22, replace "g. Other services as permitted by rule" with "to provide community health services"
- Page 1, line 23, remove "worker-community-health"
- Page 1, line 24, remove the underscored colon
- Page 2, replace lines 1 through 10 with "Indian health service recognizes as a community health representative in order to provide quality outreach health care services and health promotion and disease prevention services to American Indians and Alaskan natives within the community health representative's community."
- Page 2, line 11, after "3." insert: "Community health services" may include direct services aimed at optimizing individual and family health and dental outcomes which may include:
- a. Informal and motivational counseling and education;
 - b. Intervention to maximize social supports;
 - c. Participation in care coordination;
 - d. Participation in case management;
 - e. Facilitation of access to health care, dental care, and social services;
and
 - f. Health and dental screenings.
- 4."
- Page 2, line 14, replace "workers-community health representatives" with "workers"
- Page 2, line 17, remove "and"
- Page 2, line 17, after "training" insert ", and examination"

1.2

Page 2, line 19, replace "Continuing education standards" with "Standards"

Page 2, line 24, replace "**worker-community**" with "**worker - Certified community**"

Page 2, after line line 25 insert:

"1."

Page 2, line 26, replace "Before an" with "An"

Page 2, line 26, replace "practices as, claims to be, or uses" with "may not practice as, claim to be, or use"

Page 2, line 26, remove "that"

Page 2, line 27, replace "worker-community health representative," with "worker, unless"

Page 2, line 28, replace "must be" with "is"

Page 2, after line 28, insert:

"2. A community health representative may pursue community health representative certification under this chapter.

3. Except as provided under subsection 1, this chapter does not prohibit an individual who is not certified under this chapter from providing community health services or from practicing as and claiming to be a community health worker or a community health representative."

Page 3, line 7, remove "**- Waiver of criteria**"

Page 3, line 10, replace "The department may waive" with "If an applicant fails to meet"

Page 3, line 10, remove "in the case of an"

Page 3, line 11, replace "individual who provides" with ", the department may certify the applicant upon receipt of"

Page 3, remove lines 13 through 17

Page 3, line 18, remove "**Certification -**"

Page 3, line 19, remove "1."

Page 3, remove lines 22 through 25

Page 3, line 26, remove "**Certified community health worker-community health representative -**"

Page 3, line 28, replace "A" with "The scope of practice of a"

Page 3, line 28, remove "worker-community health representative may engage"

Page 3, line 29, replace "only in" with "worker is limited to"

Page 3, line 30, remove "worker-community health"

Page 4, line 1, replace "representative" with "worker"

Page 4, line 9, replace "worker-community health representative" with "worker"

Page 4, line 12, remove "**worker-community health**"

Page 4, line 13, replace "representative" with "worker"

Page 4, line 15, replace "worker-community health representative" with "worker"

Page 4, line 19, after "REPORT" insert "TO THE LEGISLATIVE ASSEMBLY"

Page 4, line 21, remove "workers-community health"

Page 4, line 22, replace "representatives" with "workers"

Page 4, line 23, replace "workers-community health representatives" with "workers"

Page 4, line 25, replace "workers-community health representatives" with "workers"

Page 4, after line 25 insert:

"SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$108,337, or so much of the sum as may be necessary, to the state department of health for the purpose of establishing a certification process for community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017. The state department of health is authorized one full-time equivalent position for purposes of implementing this Act.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$1,433,450, or so much of the sum as may be necessary and from special funds derived from federal funds the sum of \$1,665,953 to the department of human services to defray the costs of home and community-based services provided by certified community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Page 4, line 29, replace "worker-community health representative" with "worker"

Renumber accordingly

Attch 2
SB 2321
02/18/15
J# 24096

Sixty-fourth
Legislative Assembly
of North Dakota

ENGROSSED SENATE BILL NO. 2321

Introduced by

Senators Mathern, J. Lee

1 A BILL for an Act to create and enact chapter 23-48 and a new section to chapter 50-24.1 of the
2 North Dakota Century Code, relating to the certification of a community health
3 ~~worker-community health representative~~worker and to medical assistance reimbursement; to
4 provide for a report; to provide appropriations; and to provide an effective date.

5 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

6 **SECTION 1.** Chapter 23-48 of the North Dakota Century Code is created and enacted as
7 follows:

8 **23-48-01. Definitions.**

9 The definitions in this section are applicable to this chapter.

10 1. "Certified community health ~~worker-community health representative~~worker" means a
11 community health ~~worker-community health representative~~an individual who is
12 certified under this chapter, ~~applies an understanding of the experience, language,~~
13 and culture of the populations that the individual serves, and provides, as part of a
14 health care team, direct services that are aimed at optimizing individual and family
15 health and dental outcomes, and which may include:

- 16 ~~_____ a. Informal and motivational counseling and education;~~
- 17 ~~_____ b. Interventions to maximize social supports;~~
- 18 ~~_____ c. Participation in care coordination;~~
- 19 ~~_____ d. Participation in case management;~~
- 20 ~~_____ e. Facilitation of access to health care, dental care, and social services;~~
- 21 ~~_____ f. Health and dental screenings; and~~
- 22 ~~_____ g. Other services as permitted by rule to provide community health services.~~

23 2. "Community health ~~worker-community health representative~~" means an individual
24 who:

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Legislative Assembly

- 1 ~~a. Is a trusted, knowledgeable, front line worker;~~
- 2 ~~b. Lives in or has familiarity with the community in which the individual provides~~
- 3 ~~services;~~
- 4 ~~c. Bridges cultural and linguistic barriers;~~
- 5 ~~d. Promotes access to health care and health coverage;~~
- 6 ~~e. Helps to improve health outcomes; and~~
- 7 ~~f. Serves as a critical link between the community in which the individual provides~~
- 8 ~~services and the health care system, thereby reducing health care access~~
- 9 ~~disparities, enhancing health care quality and affordability, and empowering~~
- 10 ~~individuals and communities in the pursuit of better health.~~ Indian health service
- 11 ~~recognizes as a community health representative in order to provide quality~~
- 12 ~~outreach health care services and health promotion and disease prevention~~
- 13 ~~services to American Indians and Alaskan natives within the community health~~
- 14 ~~representative's community.~~

15 3. "Community health services" may include direct services aimed at optimizing

16 individual and family health and dental outcomes which may include:

- 17 a. Informal and motivational counseling and education;
- 18 b. Intervention to maximize social supports;
- 19 c. Participation in care coordination;
- 20 d. Participation in case management;
- 21 e. Facilitation of access to health care, dental care, and social services; and
- 22 f. Health and dental screenings.

23 4. "Department" means the state department of health.

24 **23-48-02. Administration.**

- 25 1. The department shall develop and administer a program to provide for the certification
- 26 of community health workers-community health representativesworkers.
- 27 2. The health council shall adopt rules to implement the program. The rules must
- 28 address:
 - 29 a. Education, experience, and training, and examination requirements to qualify for
 - 30 certification under this chapter;
 - 31 b. Continuing education standardsStandards for certification renewal;

1 c. Grounds for certification denial, suspension, revocation, and reinstatement; and

2 d. Fees for certification and certification renewal.

3 3. The state health officer may issue a cease-and-desist order to a person violating this

4 chapter or rules adopted under this chapter.

5 **23-48-03. Certified community health worker-communityworker - Certified community**
6 **health representative - Use of designation.**

7 1. Before anAn individual practices as, claims to be, or usesmay not practice as, claim to
8 be, or use a letter designation indicating that the individual is a certified community
9 health worker-community health representative;worker, unless the individual must beis
10 certified in accordance with this chapter.

11 2. A community health representative may pursue community health representative
12 certification under this chapter.

13 3. Except as provided under subsection 1, this chapter does not prohibit an individual
14 who is not certified under this chapter from providing community health services or
15 from practicing as and claiming to be a community health worker or a community
16 health representative.

17 **23-48-04. Criminal history record check.**

18 The department shall check or cause to be checked the criminal history record of each
19 applicant for certification and may check or cause to be checked the criminal history record of
20 each applicant for recertification. An applicant who is denied certification based on information
21 obtained through a criminal history record check may appeal the denial at the applicant's
22 expense.

23 **23-48-05. Fees.**

24 The department shall deposit fees collected under this chapter in the department's
25 operating fund.

26 **23-48-06. Initial certification--Waiver of criteria.**

27 1. An applicant for certification shall submit to the department an application and
28 associated fees at the time and in the manner required by the department.

29 2. The department may waivelf an applicant fails to meet one or more certification criteria
30 in the case of an individual who provides, the department may certify the applicant

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Legislative Assembly

1 upon receipt of satisfactory evidence of health care training, work experience, or other
 2 education, comparable to the certification standards required by this chapter.
 3 ~~3. An individual seeking a waiver of criteria in accordance with subsection 2 shall~~
 4 demonstrate familiarity with the community health worker-community health-
 5 representative program in this state and shall agree to limit the individual's practice to
 6 this state.
 7 ~~4. A certificate issued under this section is valid for three years.~~

23-48-07. Certification--Renewal.

9 ~~1. An applicant for certification renewal shall submit to the department an application and~~
 10 associated fees for certification renewal. Each individual is responsible for ensuring that the
 11 renewal of certification is completed in a timely manner.
 12 ~~2. The department shall issue a renewal certificate that is valid for three years to each~~
 13 qualified applicant.
 14 ~~3. As a condition of certification renewal, the department shall require an applicant to~~
 15 complete ten hours of approved continuing education each year.

~~23-48-08. Certified community health worker-community health representative --~~

Scope of practice.

18 1. ~~A~~The scope of practice of a certified community health worker-community health-
 19 representative may engage only inworker is limited to those activities authorized in this
 20 chapter and rules adopted under this chapter. While practicing as a certified
 21 community health worker-community health representativeworker, an individual may
 22 not engage in or perform any act or service for which another professional certificate,
 23 license, or other legal authority is required.
 24 2. This chapter does not prevent or restrict the practice, service, or activities of any
 25 individual simultaneously certified as a community health worker and licensed,
 26 certified, registered, or otherwise authorized to engage in the practice of another
 27 profession in this state, if that individual does not use, while engaged in the authorized
 28 practice of another profession, any name, title, letter designations, or any other
 29 designation indicating that the individual is a certified community health
 30 worker-community health representativeworker.

1 **SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created
2 and enacted as follows:

3 **Medical assistance coverage - Certified community health worker-community health-**
4 **representativeworker.**

5 Medical assistance coverage must include reimbursement of a certified community health
6 worker-community health representativeworker, as provided for under chapter 23-48, if the
7 individual provides for the coordination of care and education services and if the services are
8 provided under the supervision of a physician, a physician's assistant, a registered nurse, an
9 advanced practice registered nurse, a behavioral health professional, an optometrist, or a
10 dentist.

11 **SECTION 3. REPORT TO THE LEGISLATIVE ASSEMBLY.** The department of human
12 services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment
13 by community health workers-community health representativesworkers and on medicaid
14 service utilization of clients receiving services from community health workers-community health
15 representativesworkers. The department of human services shall compare medicaid service
16 utilization before and after the medicaid enrollment of community health workers-community
17 health representativesworkers.

18 **SECTION 4. APPROPRIATION.** There is appropriated out of any moneys in the general
19 fund in the state treasury, not otherwise appropriated, the sum of \$108,337, or so much of the
20 sum as may be necessary, to the state department of health for the purpose of establishing a
21 certification process for community health workers, for the biennium beginning July 1, 2015, and
22 ending June 30, 2017. The state department of health is authorized one full-time equivalent
23 position for purposes of implementing this Act.

24 **SECTION 5. APPROPRIATION.** There is appropriated out of any moneys in the general
25 fund in the state treasury, not otherwise appropriated, the sum of \$1,433,450, or so much of the
26 sum as may be necessary and from special funds derived from federal funds the sum of
27 \$1,665,953 to the department of human services to defray the costs of home and
28 community-based services provided by certified community health workers, for the biennium
29 beginning July 1, 2015, and ending June 30, 2017.

30 **SECTION 6. EFFECTIVE DATE.** This Act becomes effective on July 1, 2016, or upon
31 approval from the center for medicare and medicaid services for the department of human

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- 1 services to secure one hundred percent federal funding of the medicaid costs for the services of
- 2 the community health worker-~~community health representative~~worker, whichever occurs later.

SB2321
2-19-15
#1

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

- Page 1, line 3, replace "worker-community health representative" with "worker"
- Page 1, line 3, after "provide" insert "for"
- Page 1, line 4, after the semicolon insert "to provide appropriations;"
- Page 1, line 10, replace "worker-community health representative" with "worker"
- Page 1, line 10, remove "a"
- Page 1, line 11, replace "community health worker-community health representative" with "an individual"
- Page 1, line 12, remove ", applies an understanding of the experience, language, and culture of the"
- Page 1, remove lines 13 through 21
- Page 1, line 22, replace "g. Other services as permitted by rule" with "to provide community health services"
- Page 1, line 23, remove "worker-community-health"
- Page 1, line 24, remove the underscored colon
- Page 2, replace lines 1 through 10 with "Indian health service recognizes as a community health representative in order to provide quality outreach health care services and health promotion and disease prevention services to American Indians and Alaskan natives within the community health representative's community."
- Page 2, line 11, after "3." insert: "Community health services" may include direct services aimed at optimizing individual and family health and dental outcomes which may include:
- a. Informal and motivational counseling and education;
 - b. Intervention to maximize social supports;
 - c. Participation in care coordination;
 - d. Participation in case management;
 - e. Facilitation of access to health care, dental care, and social services;
and
 - f. Health and dental screenings.
- 4."
- Page 2, line 14, replace "workers-community health representatives" with "workers"
- Page 2, line 17, remove "and"
- Page 2, line 17, after "training" insert ", and examination"

Page 2, line 19, replace "Continuing education standards" with "Standards"

Page 2, line 24, replace "**worker-community**" with "**worker - Certified community**"

Page 2, after line line 25 insert:

"1."

Page 2, line 26, replace "Before an" with "An"

Page 2, line 26, replace "practices as, claims to be, or uses" with "may not practice as, claim to be, or use"

Page 2, line 26, remove "that"

Page 2, line 27, replace "worker-community health representative," with "worker, unless"

Page 2, line 28, replace "must be" with "is"

Page 2, after line 28, insert:

"2. A community health representative may pursue community health worker certification under this chapter.

3. Except as provided under subsection 1, this chapter does not prohibit an individual who is not certified under this chapter from providing community health services or from practicing as and claiming to be a community health worker or a community health representative."

Page 3, line 7, remove " **- Waiver of criteria**"

Page 3, line 10, replace "The department may waive" with "If an applicant fails to meet"

Page 3, line 10, remove "in the case of an"

Page 3, line 11, replace "individual who provides" with ", the department may certify the applicant upon receipt of"

Page 3, remove lines 13 through 17

Page 3, line 18, remove "**Certification -**"

Page 3, line 19, remove "1."

Page 3, remove lines 22 through 25

Page 3, line 26, remove "**Certified community health worker-community health representative -**"

Page 3, line 28, replace "A" with "The scope of practice of a"

Page 3, line 28, remove "worker-community health representative may engage"

Page 3, line 29, replace "only in" with "worker is limited to"

Page 3, line 30, remove "worker-community health"

Page 4, line 1, replace "representative" with "worker"

Page 4, line 9, replace "worker-community health representative" with "worker"

Page 4, line 12, remove "**worker-community health**"

Page 4, line 13, replace "representative" with "worker"

Page 4, line 15, replace "worker-community health representative" with "worker"

Page 4, line 19, after "**REPORT**" insert "TO THE LEGISLATIVE ASSEMBLY"

Page 4, line 21, remove "workers-community health"

Page 4, line 22, replace "representatives" with "workers"

Page 4, line 23, replace "workers-community health representatives" with "workers"

Page 4, line 25, replace "workers-community health representatives" with "workers"

Page 4, after line 25 insert:

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$108,337, or so much of the sum as may be necessary, to the state department of health for the purpose of establishing a certification process for community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017. The state department of health is authorized one full-time equivalent position for purposes of implementing this Act.

SECTION 5. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$1,433,450, or so much of the sum as may be necessary and, from special funds derived from federal funds, the sum of \$1,665,953 to the department of human services to defray the costs of home and community-based services and services provided by certified community health workers, for the biennium beginning July 1, 2015, and ending June 30, 2017."

Page 4, line 8, remove "one hundred percent"

Page 4, line 29, replace "worker-community health representative" with "worker"

Renumber accordingly

February 19, 2015

#1

Sub

2321

2-20-15

24200

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study."

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying the feasibility and desirability of implementing a community health worker-community-health representative program to assist with optimizing individual and family health and dental outcomes through services which include informal and motivational counseling and education; interventions to maximize social support; participation in care coordination; participation in case management; facilitation of access to health care, dental care, and social services; and health and dental screenings. The study must consider the requirements for licensing or certifying community health workers including education, experience, and training requirements and review the availability of medical assistance coverage for services provided by community health workers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly."

Renumber accordingly

Fiscal Note Summary

SB2321 Subcom
2-20-15
#10
J#24217

Bill / Resolution No. SB2321

	FTE	Total	General	Federal	Other	Project Number
Salaries and Wages		\$ -				
Operating Expenses		-				
Capital Assets		-				
Capital Construction Carryover		-				
HCBS Services		614,798	307,408	307,390		
CHR/CHW Expenditures		139,515	-	139,515		
HSC and Institutions		-				
Grants - Medical Assistance		-				
Total	0.00	\$ 754,313	\$ 307,408	\$ 446,905	\$ -	
17-19 Bienium						
HCBS Services		5,178,431	2,589,213	2,589,218		
CHR/CHW Expenditures		991,488	0	991,488		
Total	0.00	\$ 6,169,919	\$ 2,589,213	\$ 3,580,706	\$ -	

	CHR's	Native	Non Native	Recipients	50% receive HCBS @ 50% of average cost
SFY 2016	20	20		180	90
SFY 2017	40	40		360	180
SFY 2018	60	60		540	270

Section 2 of this bill requires the Department of Human Services (DHS) to expand Medicaid coverage to include reimbursement for community health representatives (CHRs). To calculate the estimated costs for Section 2, the Department assumed a start date of July 1, 2016. This would allow time for DHS to secure CMS approval of the service and funding. DHS estimated that 20 individuals would enroll in the second year of the 15-17 biennium. Added 1 to 2 each month starting July 1, 2016 through the end of the 2015-2017 biennium. DHS also assumed that each CHR would have 9 clients and each client would have four visits (encounters) from the CHR annually. DHS believes that the reimbursement for the CHR would qualify for 100% federal funding through Medicaid and this estimate is based on receipt of CMS approval for that funding. The estimated cost of the CHR services for the 2015-17 biennium will be \$139,515. In addition, DHS estimated that one half of the clients would become newly enrolled for Medicaid-funded home and community-based services. The estimated cost of the home and community-based services for the 2015-17 biennium is \$614,798 of which 307,408 is general fund and 307,390 are federal funds.

February 20, 2015

SB 2321 SubC

2-23-15

#1

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAL ASSISTANCE COVERAGE - TRIBAL COMMUNITY HEALTH REPRESENTATIVE SERVICES. The department of human services shall seek federal medical assistance coverage for tribal community health representative services if the representative provides for the coordination of care and education services and if the services are provided under the supervision of a physician, a physician's assistant, a registered nurse, an advanced practice registered nurse, a behavioral health professional, an optometrist, or a dentist for the period beginning with the effective date of this Act and ending June 30, 2017.

SECTION 2. REPORT. The department of human services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment by community health representatives and on medicaid service utilization of clients receiving services from tribal community health representatives. The department of human services shall compare medicaid service utilization before and after the medicaid enrollment of community health representatives.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying the feasibility and desirability of implementing a community health worker-community health representative program to assist with optimizing individual and family health and dental outcomes through services which include informal and motivational counseling and education; interventions to maximize social support; participation in care coordination; participation in case management; facilitation of access to health care, dental care, and social services; and health and dental screenings. The study must consider the requirements for licensing or certifying community health workers including education, experience, and training requirements and review the availability of medical assistance coverage for services provided by community health workers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective on July 1, 2016, or on approval from the centers for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health representative, whichever occurs later."

Renumber accordingly

/
2-24-15

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2321

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to direct the department of human services to seek federal medical assistance coverage for tribal community health representative services; to provide for a legislative management study; to provide for a report; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAL ASSISTANCE COVERAGE - TRIBAL COMMUNITY HEALTH REPRESENTATIVE SERVICES. The department of human services shall seek federal medical assistance coverage for tribal community health representative services if the representative provides for the coordination of care and education services and if the services are provided under the supervision of a physician, a physician's assistant, a registered nurse, an advanced practice registered nurse, a behavioral health professional, an optometrist, or a dentist for the period beginning with the effective date of this Act and ending June 30, 2017.

SECTION 2. REPORT. The department of human services shall provide a report to the sixty-fifth legislative assembly on the medicaid enrollment by community health representatives and on medicaid service utilization of clients receiving services from tribal community health representatives. The department of human services shall compare medicaid service utilization before and after the medicaid enrollment of community health representatives.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY. During the 2015-16 interim, the legislative management shall consider studying the feasibility and desirability of implementing a community health worker-community health representative program to assist with optimizing individual and family health and dental outcomes through services which include informal and motivational counseling and education; interventions to maximize social support; participation in care coordination; participation in case management; facilitation of access to health care, dental care, and social services; and health and dental screenings. The study must consider the requirements for licensing or certifying community health workers including education, experience, and training requirements and review the availability of medical assistance coverage for services provided by community health workers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.

SECTION 4. EFFECTIVE DATE. Sections 1 and 2 of this Act become effective on July 1, 2016, or on approval from the centers for medicare and medicaid services for the department of human services to secure one hundred percent federal funding of the medicaid costs for the services of the community health representative, whichever occurs later."

Renumber accordingly

1.1

/ SB 2321
3-16-15

SB 2321
March 16, 2015

Chairman Weisz and members of the House Human Service Committee,

My name is Tim Mathern. I am the senator from District 11 in Fargo and here to introduce SB 2321-the Community Health Worker-Community Health Representative bill. In short this bill began as setting the certification standards for a profession of health care workers within the purview of the Department of Health with reimbursement through our medical assistance program.

With Senate amendments the program is now limited to our Native American reservations. The goal is that this worker would be the direct patient contact in the community in order to enhance the efficacy of health care delivery in our state.

This bill comes to you at the request of North Dakota's public health masters program staff and other partners around the state. They are here to testify to the need and operation of such a program.

Mr. Chairman and members of the Committee, we are learning that the best medicine offered in hospitals and clinics is only as good as the implementation of the suggested care in people's homes. I believed that this new worker model has the potential to make sure that health care services are meeting their intended purpose and not wasted.

I ask for a do pass recommendation from your committee.

#2 SB2321
3-16-15

Testimony

SB 2321

House Human Services Committee

Representative Robin Weisz, Chairman

March 16, 2015

Chairman Weisz and members of the House Human Services Committee, I am Melissa Olson, program manager at North Dakota State University's Master of Public Health Program. I am testifying on behalf of Dr. Donald Warne, a family practice physician and the Director of the Master of Public Health Program at North Dakota State University. I am here to speak in support of SB 2321, which was introduced by Senator Judy Lee and Senator Tim Mathern.

I Introduction and Background

Shortages in the supply of many types of health workers is a nationwide problem, and it is a considerable public health issue in North Dakota. The majority of North Dakota is designated as a Health Professions Shortage Area, and the shortage of health workers is particularly significant in North Dakota's rural and tribal communities. Ideally, we would have enough doctors, nurses, dentists, nurse practitioners and other providers to deliver appropriate health services to all North Dakotans. The reality is, we do not, as illustrated in the map below.



Multiple key stakeholder groups in North Dakota have come together to address the gaps in health service delivery by creating access to federal medical assistance funds for community health representatives (CHRs) working with tribal communities. This bill will also allow for the study of the feasibility and desirability of implementing a community health worker (CHW) program in other parts of the state to improve access to services and outcomes.

CHWs and CHRs are trusted community members who receive specialized training; they help improve individual and community health outside of traditional health care settings. They empower individuals and communities for better health by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, social support and advocacy. A trusting relationship enables CHWs and CHRs to serve as liaisons between health and social services and the community member. This facilitates access to services and improves the quality, cultural competence, and outcomes of health services.

In North Dakota, we have several programs that help to fill health service gaps including community paramedics, patient navigators, targeted case managers, home visitors, community health representatives and others. However, North Dakota does not yet have a comprehensive system to train, certify and reimburse most of these providers. Studying the feasibility of establishing a CHW certification program and reimbursement system in North Dakota will help us understand how effective this approach will be in improving the quality of care our residents receive.

Dr. Warne saw the important role and value the CHW contributed to the medical team: he was practicing family medicine at the Gila River Indian Community in Arizona, and a patient was brought to him accompanied by a CHW. This patient had diabetes, and he had stepped on a thumbtack. Due to neuropathy and numbness in his foot caused by the progression of his diabetes, the patient did not feel the tack. The CHW who was with him had discovered the tack while in the patient's home, doing a routine foot exam. Had the CHW not been an integral part of the medical team, we cannot be sure how much time would have passed before the patient would have sought care in the clinic.

Routinely in that community, people would have similar issues that began as minor injuries and then progress into severe infections, amputations, disability, lost quality of life, and significant health care costs to the system. In this situation, the outcome was positive: the patient received debridement and antibiotics for his wound and learned the value of conducting self-foot exams. Another outcome, one without the intervention of the CHW, could have resulted in a lower leg amputation which would have negatively impacted his quality of life and cost a significant amount of money.



Nationwide there is a movement to recognize CHWs as an essential part of a primary care team with the goal of implementing a new care model focused on: (1) better outcomes; (2) healthier populations; and (3) lower per capita costs. Many states are currently developing their own

models that will utilize CHWs in communities of need. Several states, including Alaska, Colorado, Massachusetts, Michigan, New Mexico, Oregon and Minnesota already have successful CHW programs. Results from CHW demonstration projects are showing excellent returns on investment:

II Return on Investment Estimates for CHW Demonstration Projects (2006-2012)

State	Project Title	Project Description	Cost Savings Estimate
Michigan	Spectrum Health Grand Rapids, MI	Maternal and child health, hypertension, diabetes, nutrition, healthy lifestyles; work in schools, hospitals, communities	\$2.53 in savings for every \$1.00 of cost
Michigan	Muskegon Community Health Project/Mercy Health Community Benefit Program, Muskegon, MI	Enrollment and home visits positively impacted health outcomes for individuals with diabetes	CHWs recovered \$350,000 in 2009 by enrolling patients in Medicaid
New Mexico	Molina Healthcare of New Mexico	CHWs work with high emergency department (ED) usage patients and low treatment adherence	\$4.00 savings for every \$1.00 of cost
Colorado	Denver Health	Underserved populations on issues including appropriate outpatient service utilization	\$2.28 saving for every \$1.00 invested in the program
Massachusetts	Childhood Asthma	Targeted parents of Children with asthma - repeat ED visits, and few encounters with primary care provider	\$4.00 for every \$1.00 invested. Annual pediatric asthma-related hospital admissions and ED visits period fell by 45%, and 50%
New Mexico	Chronic Disease and ED visits	448 Medicaid enrollees / high users of ED with poorly controlled chronic disease	\$4.00 for every \$1.00 invested. ED visits decreased from 5.9 visits per month to 1.8.

III Conclusion

In closing, here in North Dakota, we have seen how community paramedics and other providers can help to fill gaps in our health system. Now we have an opportunity to help fill additional gaps of health service delivery by 1) Establishing access to federal medical assistance coverage for tribal CHRs and 2) Studying the feasibility of implementing a CHW program across the rest of North Dakota. Incorporating CHRs and CHWs into the health system is both financially and clinically valuable. Thank you for letting me provide testimony on behalf of Dr. Warne regarding the roles CHRs and CHWs can have in helping to fill the gaps in our health system. I am happy to answer any questions.

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Testimony Re: SB 2321

ND House Of Representatives: Human Services Committee

Chairman Robin Weisz

March 16, 2015

Introduction

Honorable Chairman Weisz and members of the Human Services Committee, I am Christine Burd, a Tribal Community Health Consultant and presently Coordinator for the Community Health Worker (CHW) Curriculum at the Sitting Bull College of the Standing Rock Sioux Tribe. I am happy to have the chance to attend this hearing with friends from Standing Rock Sioux Tribe, with whom I have been working for nearly 20 years to improve community-based services.

As a Community Health Consultant for the Tribe, I would like to offer a strong endorsement for SB 2321. I am supportive of this bill because of my confidence that SB 2321 can offer Community Health Representative (CHR) programs the pathway they have needed to significantly decrease the long-standing health disparities in American Indian communities. CHRs have been the "vital link" to health care access and services in Tribal Nations for over 45 years. I am confident that expansion of their unique, culturally informed, "grass-roots" health services can make a critical difference in the health of Tribal communities throughout ND.

In 1995 when I began training CHRs and grant-writing for Tribal communities, I was also on faculty at the College of Nursing at the University of North Dakota. I taught for nearly 20 years at the undergraduate level, and was also the faculty responsible for teaching Epidemiology in the graduate program for several semesters. I worked very closely with the nationally recognized RAIN Program (Recruiting American Indians into Nursing) at UND, serving as the Program

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Director for one year, and do continue to have an ongoing collaboration with them, as well as with colleagues at the National Resource Center on Native American Aging.

Since 2006 when I left UND to work exclusively with Tribal communities in the Great Plains region, I have worked closely on the planning, development, and funding of community-based health projects at Cheyenne River Sioux Tribe, Spirit Lake Sioux Tribe, and Standing Rock Sioux Tribe. One of the federal grants we worked on with Spirit Lake Nation has been in place for 5 years, and it has successfully developed a career path and training for dozens of American Indian health care providers for all the ND Tribes. Each of the projects we have had successfully funded over the years has included training and collaboration with CHR programs, as well as other Tribal outreach programs that utilize CHWs.

Continuing Training of CHRs for Community Health Services

In December of 2013, Sitting Bull College approved a curriculum leading to either an Associate's Degree or a 9 month College Certificate for CHWs. This curriculum has built upon ongoing CHR training offered in collaboration with the Sitting Bull College since 1997. This coming summer, we will be offering the third course in the new CHW curriculum, addressing: CHR-specific roles; community-based diabetes prevention/management; and integrating the updated national certification training required by the Indian Health Service as of December, 2014.

Medicaid Reimbursement Potential for CHWs/CHR

We have been pursuing the option for CHR-expanded roles for a number of years. In fact a ND Medicaid State Plan Amendment (**SPA**) to allow CHRs to provide Targeted Case Management (**TCM**) was finally forged and approved in 2012. The approval followed after years of planning with Tribal representatives, the ND Human Services/Medical Services staff and the Native American Contact for the

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Centers for Medicare/Medicaid Services (CMS) Region VIII. The TCM initiative is now ready to begin at Standing Rock and Spirit Lake Nation, and we are indebted to the ND HCBS Department which has continued to provide the assistance necessary to the completion of the required TCM training for CHRs.

Points related to Continuing Education for CHRs

While continuing our ongoing implementation of the CHW curriculum at Sitting Bull College, we have also sought consultation and attended webinars presented by national leaders who have been instrumental in guiding the process of state certification of CHWs around the U.S. Based on what we have learned, below are pertinent points relevant to the continued study of CHW/CHR roles and subsequent training needs:

- CHRs have historically had their training standardized and provided under the auspices and approval of the Indian Health Service. As above, IHS has recently released an updated online version of the *CHR Basic Certification Modules*. This training is *mandatory* for all CHRs across the nation.
- The “CHR” nomenclature is specific to the CHWs who work in American Indian communities, and who already have a standardized certification training under Indian Health Service. The use of specific names for CHWs in certain contexts is akin to the CHWs in Hispanic communities being called “Promotoras de Salud”, that is, “health promoters”. The point is, that CHRs are already “CHWs” in Indian Country.
- In implementing increasingly responsible roles in health care, we have long recognized that CHRs need additional training in an ongoing fashion, hence our collaboration over these many years with Sitting Bull College.
- We also have believed that the important work and dedication of CHRs is deserving of a professional recognition of CHRs as essential health care workers in Tribal communities. Hence, the pathway for CHRs to earn a

degree in their field (or to provide a “launch pad” into the Licensed Practical Nursing degree), is of great benefit, both for individual CHRs, as well as for their communities.

- As we finally reached the successful approval of the Targeted Case Management (**TCM**) role for ND CHRs, we had been advised by CHW consultants to continue to pursue additional reimbursement potential for CHRs under Medicaid. We were further advised that it may be beneficial for us to continue following the template that we have already successfully developed with the State of ND through the Medicaid State Plan Amendment (SPA) process for **TCM** by CHRs.

Concerns/Need for More Information related to the Re-Engrossed S.B. 2321

A few concerns/questions have arisen as S.B. 2321 has been progressing through the 64th Legislative Session. We would like to have more information related to the following:

- Tribes remain supportive and invested in the TCM role for their CHRs. We would like to be reassured that the TCM role allowable under the 2012 Medicaid SPA will not be disrupted by the new legislation proposed in SB 2321.
- In SECTION 1 of the Second Engrossment document, we would like clarification of the term “coordination of care”. At this time, the TCM role by CHRs is already focused on “coordination of care”. Does SB 2321 change anything in the status of the current TCM-related State Plan Amendment?
- In SECTION 1 of the Second Engrossment document, we would like clarification of the term “education services”. We would like to request that the Tribal Colleges in ND be included in discussions that will relate to any required CHW training for CHRs who will be in expanded, Medicaid

reimbursable roles. This would be in keeping with the importance of Tribal Colleges/Universities (TCUs') as indicated in a 2012 Presidential Executive Order (#13592): *My Administration is also committed to improving educational opportunities for students attending TCUs. TCUs maintain, preserve, and restore Native languages and cultural traditions; offer a high quality college education; provide career and technical education, job training, and other career building programs; and often serve as anchors in some of the country's poorest and most remote areas.*
<http://www.ed.gov/edblogs/whiaiane/tribes-tcus/tribal-colleges-and-universities/>

- Related to SB 2321-related "education services":
 - Will the education services (provided by CHRs under the "supervision" of a designated health professional) be clearly delineated?
 - Will the definition of the "education services" be decided *with input and consultation* with Tribal Stakeholders, including: CHR Directors; Tribal Health Department Directors; and Primary Providers in the Indian Health Service clinics in Tribes that choose to have their CHRs in the expanded role outlined by S.B. 2321?
 - Since type 2 diabetes with its many complications is a highly prevalent condition in American Indian communities, and since *nutrition education is a critical treatment and prevention element for diabetes and other prevalent chronic diseases*, is it possible to include *Licensed Dieticians* among the designated health professionals who may supervise CHRs in the "coordination of care and education services"?
 - Once federal medical assistance coverage for CHR services is obtained, and "coordination of care and education services" are clearly defined, will CHRs be reimbursed for "coordination

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of care and education services” for eligible Medicaid clients until June 30, 2017?

- Will CHRs be allowed to continue billing for defined “coordination of care and education services” beyond June 30, 2017? How will that be decided? Will Tribal “stakeholders” (as described above) be invited as participants in the decision-making for their Nations?
- In SECTION 3 of the Second Engrossment document, will the Legislative Management Study during the 2015-16 interim include formal input from, and consultation with Tribal CHR Directors, Tribal Health Department Officials, Health, Education, & Welfare (HEW) Committee members of the Tribal Councils, and Tribal Colleges?

Thank you for your consideration of this testimony.

Respectfully Submitted,



Christine M. Burd, RN, PhD