NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH AND HUMAN SERVICES COMMITTEE

Thursday, August 5, 2010
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Robin Weisz, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives Robin Weisz, Tom Conklin, Kari L. Conrad, Jeff Delzer, Robert Frantsvog, Curt Hofstad, Richard Holman, Gary Kreidt, Vonnie Pietsch, Alon C. Wieland; Senators Robert S. Erbele, Tom Fiebiger, Judy Lee, Tim Mathern, Jim Pomeroy

Members absent: Representatives Larry Bellew, Mary Ekstrom, Chet Pollert, Louise Potter; Senator Ralph L. Kilzer

Others present: Jim W. Smith, Legislative Council, Bismarck

Senator David O'Connell, member of the Legislative Management, was also in attendance.

See Appendix A for additional persons present.

It was moved by Representative Wieland, seconded by Representative Delzer, and carried on a voice vote that the minutes of the June 16, 2010, meeting be approved as distributed.

UNMET HEALTH CARE NEEDS STUDY

Chairman Weisz called on Ms. Barbara Siegel, Policy Analyst, Child Support Enforcement Division, Department of Human Services, to provide information regarding changes included in the federal health care reform legislation affecting child support collections (Appendix B). Ms. Siegel said she anticipates federal health care reform legislation will affect child support collections, but the extent of the effect is not yet known. She said health care reform enacts policies that address children's health care coverage and establishes parents' responsibility for their children's coverage. She said approximately 23,000 orders for health insurance in North Dakota are associated with cases receiving services through the Title IV-D child support program. She said if health care reform requires all 23,000 orders to be modified, additional resources will be needed. She said in addition to reviewing existing orders, the department would need to develop rules, policies, and procedures to accommodate the new requirements, determine the changes needed to the department's computer system, and provide training and outreach.

In response to a question from Representative Delzer, Ms. Siegel said the provisions of federal health care reform that most directly affect child support collections are effective January 1, 2014.

In response to a question from Senator Fiebiger, Ms. Siegel said state child support guidelines will be reviewed for consistency with federal guidelines.

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, provided information regarding the effect of federal health care reform legislation on the Medicaid program. She said federal health care reform legislation expands Medicaid coverage to those individuals below 133 percent of the federal poverty level and provides coverage to qualified childless adults. She said the primary expansion of Medicaid will occur in the previously ineligible childless adult population. She said the reconciliation bill enacted subsequent to the federal health care reform legislation provided a 5 percent income disregard and effectively expanded Medicaid coverage up to 138 percent of the federal poverty level. She said the Medicaid expansion must be implemented by January 1, 2014. She said the newly eligible recipients will qualify for a 100 percent federal match for calendar years 2014, 2015, and 2016. She said the federal match is adjusted to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and after. She said outreach associated with the expansion of Medicaid, health care exchanges, and individual mandates to acquire health care coverage will identify additional individuals that were eligible for Medicaid prior to the expansion. She said when enrolled, these previously eligible individuals will not qualify for the 100 percent federal match, but rather will be reimbursed based on the state's federal medical assistance percentage (FMAP) in effect at the time of the claim.

Ms. Anderson said federal health care reform legislation extended the children's health insurance program (CHIP) through September 2019. She said when Medicaid expands to 133 percent of the poverty level in 2014, some children currently enrolled in CHIP may qualify for Medicaid. She said the transfer of these children from CHIP to Medicaid will result in a lower federal reimbursement, and the department is seeking guidance regarding whether these children would remain enrolled in CHIP until 2019 or whether they would be transitioned to Medicaid.

Ms. Anderson said federal health care reform legislation also increased the minimum drug rebate from 15.1 percent to 23.1 percent and provided that any amounts over 15.1 percent be paid to the federal government. She said in most cases this represents a

decrease in drug rebates to the states because most states were already receiving more than 15.1 percent.

Ms. Anderson said the department's challenges include:

- Implementing the change in eligibility to 133 percent of poverty level, adjusted for the 5 percent income disregard;
- Identifying previously eligible and newly eligible enrollees; and
- Changing to modified adjusted gross income to determine eligibility for CHIP rather than net income currently used by the state.

Ms. Anderson said states are required to maintain eligibility standards at levels in effect when the bill was signed through December 2013 for adults and through September 2019 for children. She said the Department of Human Services will be required to coordinate Medicaid enrollment with the health insurance exchanges. She said the department's Medicaid management information system and its eligibility system will have to be modified to implement the new eligibility rules and to communicate with the health insurance exchanges.

Ms. Anderson said effective January 1, 2014, Medicaid must cover children in foster care through age 25.

Ms. Anderson said federal health care reform legislation provided for an increase in Medicaid reimbursement for physician services to at least the Medicare level for calendar years 2013 and 2014. She said because of rebasing done by the 2009 Legislative Assembly, the department does not expect this provision to effect payment rates.

Ms. Anderson said states are required to implement the national correct coding initiative for Medicaid by October 1, 2010. She said the department will implement a program planned for the new Medicaid management information system early to be compliant. She said by December 2010 the department must have a recovery audit contract in place with a contractor to provide program integrity reviews for both Medicaid and Medicare. In addition, she said, effective January 1, 2011, the department must collect national provider identifier numbers from providers upon both enrollment and claims. She said this will expand the provider groups from which the department collects the national provider identifier numbers.

Ms. Anderson said effective July 1, 2011, hospitals must identify secondary health care-acquired conditions on admission because the health care-acquired condition provision in the legislation prohibits Medicaid from paying for conditions acquired while the patient is in the hospital.

Ms. Anderson provided a draft summary (Appendix C) of costs associated with the federal health care reform legislation. She said the costs were estimated in May 2010 and include only the costs of mandated changes. She said the costs will change as policy decisions are made and additional guidance becomes available. She said the department estimates the cost of the federal health care reform legislation in the state over the next 10 years to be approximately $749 million, of which $643 million will be paid by the federal government and $106 million from the state general fund. She said the department estimates additional full-time equivalent (FTE) positions will be needed in the Medical Services Division (18 FTE positions), the Economic Assistance Policy Division (3 FTE positions), and in administration and technology support (9 FTE positions). She said the department anticipates the additional FTE positions would be added incrementally between 2010 and 2014. She said when fully staffed in 2014, the estimated total cost, not adjusted for inflation, of all additional FTE positions will be approximately $1.2 million per year.

In response to a question from Representative Conrad, Ms. Anderson said the $48.3 million estimated for total administrative costs over the next 10 years includes a one-time cost of $24.6 million for new eligibility system development. She said administrative costs, including the development of a new eligibility system, are generally reimbursed by the federal government at 50 percent.

Senator Mathern suggested the Department of Human Services provide the assumptions used by the department to prepare the draft summary of costs associated with the federal health care reform legislation, including the estimated number of recipients.

In response to a question from Representative Conrad, Ms. Anderson said in June 2010 approximately 62,000 individuals were eligible for Medicaid in North Dakota.

Ms. Anderson provided information (Appendix D) regarding the number of Native Americans eligible for Medicaid by county. She said the number of unduplicated individuals receiving Medicaid benefits in fiscal year 2009 totaled 77,637, of which 18,321 were Native American.

Mr. Dave Leftwich, Director, Office of Transportation Programs, Department of Transportation, provided information (Appendix E) regarding an update on the status of development of two public transportation coordination pilot projects as provided in 2009 Senate Bill No. 2223. He said the legislation directed the department to focus on public transportation coordination in one region that does not have a city with a population over 35,000 and in another region that has a city with a population exceeding 35,000. He said Jamestown in the south central region and Bismarck in the west central region have been chosen for coordination efforts, and the department has contracted with the Small Urban and Rural Transit Center to conduct the related studies. He said in addition to the studies, the department has contracted with Ulteig Engineering to perform a rural public transit needs assessment. He said information from the studies and the needs assessment will be provided to the 2011 Legislative Assembly.

In response to a question from Representative Weisz, Mr. Leftwich said regional differences require a variety of coordination efforts, and a complete plan will not be in place prior to the 2011 legislative session.

Chairman Weisz announced that the Legislative Council staff distributed to each member written testimony (Appendix F) provided by Mr. Bruce Levi, Executive Director, North Dakota Medical Association, regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to improve health care services in rural North Dakota.

Chairman Weisz called on Mr. Rod St. Aubyn, Director, Government Relations, Blue Cross Blue Shield of North Dakota, Fargo, to provide information (Appendix G) regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to improve health care in rural North Dakota. Mr. St. Aubyn said Medicare and Medicaid are the major payers of health care in North Dakota, especially in the rural areas of the state. He said Blue Cross Blue Shield of North Dakota reimbursements on average are approximately 160 percent of what Medicare reimburses for the same services. He said the shifting of costs to provide for health care costs that exceed government reimbursements has contributed to escalating insurance premiums. He said increased reimbursements provided in the federal health care reform legislation will benefit hospitals in larger communities, but rural hospitals classified as critical access hospitals will not benefit significantly. He said rural facilities continue to struggle financially as regions of the state become more sparsely populated and patient numbers decrease.

Mr. St. Aubyn said medical inflation, new medical technologies, and an aging population also contribute to higher health insurance premium rates. He said when fully implemented, he anticipates the federal health care reform legislation could result in additional health insurance premium increases. He said some of the increases may be offset by premium subsidies.

Mr. St. Aubyn said telemedicine services have been reimbursable by Blue Cross Blue Shield of North Dakota since 1998, but the number of claims has been minimal. He said the most common telemedicine services billed were psychotherapy diagnostic interview, individual psychotherapy, and pharmacologic management. He said other Blue Cross Blue Shield of North Dakota programs designed to improve health care in North Dakota include the MediQHome program and the rural health grant program.

In response to a question from Senator Mathern, Mr. St. Aubyn said most telemedicine providers in the state are located in Grand Forks, Fargo, and Jamestown, but telemedicine patients are located throughout the state.

Ms. Linda Wurtz, Associate State Director, Advocacy, AARP North Dakota, expressed support for the two public transportation coordination pilot projects provided for in 2009 Senate Bill No. 2223. She said regional coordination can increase the opportunities to provide services. She said coordinators can identify and bring together stakeholders, provide research, and facilitate the sharing of technical resources.

Dr. Bill Krivarchka, Director, Eastern North Dakota Area Health Education Center, Mayville, said the University of North Dakota Department of Family and Community Medicine, School of Medicine and Health Sciences, and the College of Nursing have formed a partnership to plan, develop, and implement a North Dakota area health education center program. He said there are two area health education centers in the state, and another is anticipated to begin operation in the next six months. He said area health education centers connect students to health care careers and to the rural, underserved communities in the state through activities developed for kindergarten through postsecondary students, educational programs, clinical rotations, and recruitment and retention of health care providers. He said funding for the program is from a federal Human Resources and Services Administration grant, the University of North Dakota School of Medicine and Health Sciences, and a Dakota Medical Foundation grant. He anticipates state funding will be needed to provide federal matching funds to continue the program in the future.

VOUCHER USE AND PROVIDER CHOICE FOR CLIENTS STUDY

Ms. Nancy McKenzie, Statewide Director, Regional Human Service Centers, Department of Human Services, provided information (Appendix H) regarding the number of Native Americans receiving mental health and substance abuse services in fiscal years 2008 and 2009 living on a reservation compared to the number living off a reservation, the sources of mental health and substance abuse services referrals for each human service center, a summary of major mental health and substance abuse services issues included in the Department of Human Services' stakeholder report, the availability of mental health-related crisis beds in the state, and information comparing the per capita cost of mental health and substance abuse services in North Dakota to other states.

Ms. McKenzie said Native Americans accounted for 10.6 percent of the clients served in the human service centers in 2008 and 11.1 percent of the clients served in 2009. She said clients receiving services at the human service centers are recorded only by county of residence, so information regarding the number of Native Americans receiving mental health and substance abuse services living on a reservation compared to the number living off a reservation is not available.

Representative Conrad suggested the committee receive information regarding the number of Native

Americans served at the human service centers by county of residence.

Ms. McKenzie presented information regarding the sources of mental health and substance abuse services referrals for youth and adults at each regional human service center. She said 11,156 individuals were served in fiscal year 2009. She said the largest referral source is self-referral (23 percent), followed by provider referrals (18 percent) and family referrals (11 percent). She said other referral sources include courts, county social services, and jails.

Ms. McKenzie said capacity continues to be a concern with the state's mental health system. She said the Department of Human Services' stakeholder report identified shortages of mental health professionals, inpatient bed capacity, and residential options and funding for peer support as major mental health and substance abuse services issues to be addressed by the department. She said additional meetings with Department of Human Services' staff, legislators, representatives of private hospitals with behavioral health care services, and others identified the following additional recommendations:

- Develop a standard purchase of service agreement between the Department of Human Services and private hospitals;
- Establish one contracted rate for services (the Medicaid daily rate);
- Enhance available crisis and residential beds in the state to assure treatment at the appropriate level of care;
- Explore alternative models of crisis intervention and case management, particularly for afterhours services; and
- Expand the use of telemedicine to increase client access.

Ms. McKenzie provided a summary by region of mental health and substance abuse residential bed capacity, including crisis beds. She said the beds identified as flex beds are available for use as mental health crisis or substance abuse residential beds.

In response to a question from Representative Conrad, Ms. McKenzie said the department will use information gathered at stakeholder meetings and staff input to determine the number of beds and funding needed. She said the information will be presented to the 2011 Legislative Assembly.

In response to a question from Representative Delzer, Ms. JoAnne Hoesel, Director, Division of Mental Health and Substance Abuse Services, Department of Human Services, said some contracts for treatment beds are not provided through the regional human service centers, and the Division of Mental Health and Substance Abuse Services may contract directly with providers for treatment beds.

Representative Delzer suggested the committee receive information regarding the cost of mental health and substance abuse services beds contracted by the Division of Mental Health and Substance Abuse Services.

Ms. McKenzie said the comparison of the per capita cost of mental health and substance abuse services in North Dakota to other states is difficult because of differences in policies, reporting requirements, agency infrastructure, and data systems. She said the most recent state expenditure information published by the National Research Institute, National Association of State Mental Health Program Directors, indicates North Dakota spent $79 per capita on mental health services and ranks 23rd in the nation in per capita spending. She said expenditure data for the 2010 application year published by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, indicates North Dakota spent $27.88 per capita on substance abuse services, the second highest per capita rate among the nine states in the Central region.

In response to a question from Senator Mathern, Ms. McKenzie said the expenditures per capita for mental health and substance abuse services in Wisconsin are lower than North Dakota. She said Wisconsin has adopted a voucher system as part of a federal access to recovery grant. She said because the per capita rate reported is based only on state expenditures, it is likely the per capita expenditures in Wisconsin are lower because expenditures of federal funds are not included in the costs.

Mr. Tim Blasl, Vice President, North Dakota Hospital Association, provided information (Appendix I) regarding the availability of mental health-related crisis beds in the state. He said hospitals that provide inpatient psychiatric services face funding challenges that have contributed to the closing of inpatient psychiatric units in Dickinson and Williston. He said the closure of these two units has placed increased demands on other providers and has resulted in an inadequate level of service in the western part of the state. He said the North Dakota Hospital Association has formed a committee to study the behavioral health challenges facing hospitals. He said the committee has identified funding of care, physician recruitment, access to the State Hospital, and telemedicine as issues to be addressed. He provided a list of specialty and acute care hospitals that currently provide inpatient psychiatric services in the state.

Ms. Anderson provided information regarding a summary of information (Appendix J) included in quality of life surveys done as part of the Money Follows the Person demonstration grant. She said the quality of life survey is used nationally in all of the Money Follows the Person demonstration grants to measure quality of life just prior to transition, 11 months after transition, and 24 months after transition. She said the survey targets individuals with disabilities and long-term illnesses who are transitioning from institutionalized care to a care setting in the community and is given to all of the Money Follows the Person participants. She provided reports comparing the survey responses received

prior to transition to survey responses received at 11 months after transition. She said there have been no 24-month surveys performed to date.

In response to a question from Senator Mathern, Ms. Anderson said the Money Follows the Person demonstration project is available statewide. She said the department contracts with the Centers for Independent Living to help transition individuals from nursing homes, and the developmentally disabled program administration case management system assists with clients in the developmentally disabled program.

Representative Hofstad suggested the Legislative Council staff prepare a bill draft directing the Department of Human Services to develop a pilot voucher payment program to cover mental health and drug addiction services. Chairman Weisz directed the Legislative Council staff to prepare the bill draft for presentation at the next Health and Human Services Committee meeting.

OTHER COMMITTEE RESPONSIBILITIES

Cost-Benefit Analyses of Health Insurance Mandates

The Legislative Council staff presented a memorandum entitled *History of Cost-Benefit Analyses of Health Insurance Mandates and the Status of Legislative Rules Regarding Bills That Include Health Insurance Mandates*. She said North Dakota Century Code Section 54-03-28 was enacted by the 2001 Legislative Assembly and provides that a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. Prior to each legislative session, the Insurance Commissioner is to recommend a private entity for the Legislative Council to contract with to provide cost-benefit analyses services. The Insurance Commissioner is to pay the costs of all contracted services. She said Section 54-03-28 was amended by the 2003 Legislative Assembly to provide additional requirements for mandates of health insurance coverage. She said legislative measures mandating health insurance coverage may only be effective for the next biennium and are limited to the public employee's health insurance program. For the following Legislative Assembly, the Public Employees Retirement System (PERS) must prepare and request introduction of a bill to repeal the expiration date and expand the mandated coverage to apply to all accident and health insurance policies. In addition, PERS is required to prepare a report which is attached to the bill regarding the effect of the mandated coverage or payment on the system's health insurance program. Because no legislation mandating health insurance coverage has been adopted since these provisions were enacted, PERS has not yet had to complete a report regarding effects of mandated health insurance coverage.

The Legislative Council staff said the 2003-04 and 2005-06 interim Budget Committees on Health Care and the 2007-08 interim Human Services Committee recommended that the Legislative Council contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, and 2009 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of $8,323. In addition, the Insurance Department paid $5,606 to Milliman USA for general project work during the legislative session for total payments of $13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis, and during the 2009 legislative session, the Insurance Department paid a total of $28,070 to Milliman USA for analyses conducted on three bills. All three bills were introduced in the Senate on January 19, 2009; however, Senate Bill No. 2272 regarding parity for health insurance coverage of prosthetics was first reviewed by the Employee Benefits Programs Committee in April 2008. The other two bills--Senate Bill No. 2280 relating to mental health parity and Senate Bill No. 2294 relating to telemedicine--were not considered by the Employee Benefits Programs Committee until January 28, 2009. The 2009 Legislative Assembly appropriated $10,000 to the Insurance Commissioner from the insurance regulatory trust fund for paying for cost-benefit analyses during the 2011 legislative session.

The Legislative Council staff said in September 2008, the 2007-08 interim Legislative Management Committee recommended proposed amendments to House and Senate Rules 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under Section 54-03-28. The proposed amendment provided that a current legislator may submit a mandated health insurance bill to the Employee Benefits Programs Committee no later than April 1 of the year before a regular legislative session. Any new legislator taking office after November 30 of the year preceding the legislative session may submit a mandated health insurance bill for consideration by the Employee Benefits Programs Committee no later than the first Wednesday following adjournment of the organizational session. In December 2008, during the organizational session, the House adopted the proposed amendment to House Rule 402, but the Senate did not.

Chairman Weisz expressed concern regarding the ability to secure timely cost-benefit analyses of late-filed bills.

Representative Delzer said the rule change would allow adequate time for cost-benefit analyses to be performed.

Senator Mathern said eliminating the cost-benefit analysis requirement may allow the Legislative Assembly to react more quickly to changes in the health care industry.

Senator Lee said the cost-benefit analysis requirement allows the Legislative Assembly to be

more deliberative as it addresses the issues of federal health care reform legislation.

Mr. Michael Fix, Life and Health Division Director and Actuary, Insurance Department, provided information (Appendix K) regarding the Insurance Commissioner's recommendation for a private entity to contract with to perform cost-benefit analyses of health insurance mandates during the 2011 legislative session. He said Ingenix Consulting and Milliman, Inc., responded to the department's request for proposal. He said both firms are capable of performing the cost-benefit analyses, but based on the department's analysis of the proposals, the department recommends the Legislative Council contract with Milliman, Inc., to perform the cost-benefit analyses during the 2011 legislative session.

It was moved by Representative Frantsvog, seconded by Representative Conrad, and carried on a roll call vote to accept the Insurance Commissioner's recommendation of Milliman, Inc., as the entity to contract with for cost-benefit analyses during the 2011 legislative session. Representatives Weisz, Conklin, Conrad, Delzer, Frantsvog, Hofstad, Holman, Kreidt, Pietsch, and Wieland and Senators Erbele, Fiebiger, Mathern, and Pomeroy voted "aye." No negative votes were cast.

SERVICES FOR PREGNANT MINORS STUDY

Ms. Carol Cartledge, Director, Public Assistance, Department of Human Services, provided information (Appendix L) regarding the number of alternatives-to-abortion single service visits for a pregnancy test, whether the pregnancy test included counseling, the payment provided for a pregnancy test, and alternatives-to-abortion services provided by age. She said for program reporting purposes, the term "pregnancy test" refers to client intake, including the collection of background information on the client, and a pregnancy test.

Ms. Cartledge said from 2006 through 2010, alternatives-to-abortion services have been provided to females aged 9 through 50. She said the average is between ages 22 and 23, and the most recorded age is 19, except in 2006, when the most recorded age was 18.

In response to a question from Representative Conrad, Ms. Cartledge said providers bill for alternatives-to-abortion services in 15-minute increments.

Representative Conrad suggested the committee receive information regarding services provided at intake and the average length of counseling provided by alternatives-to-abortion services providers.

Ms. Kjersti Hintz, Maternal and Child Health Nurse Consultant, Division of Family Health, State Department of Health, provided information (Appendix M) regarding the age at which parental consent is required for an abortion and the number of abortions provided to individuals requiring parental consent. She said Chapter 14-02.1 requires a physician receive parental consent to perform an abortion on a pregnant woman younger than 18 years old, unless the minor woman is married and has given her consent or the minor woman has received authorization from the juvenile court to obtain an abortion without parental consent (judicial bypass). She said the number of abortions provided to minor women younger than age 18 requiring parental consent ranged from 65 abortions in 2006 to 87 abortions in 2007. She said through May 2010, the number of abortions provided to minor women requiring parental consent was 26.

In response to a question from Senator Mathern, Ms. Hintz said the number of minor women granted a judicial bypass to receive an abortion was 26 in 2006, 40 in 2007, 25 in 2008, 34 in 2009, and 10 through May 2010.

Representative Delzer suggested the committee consider requesting additional information regarding judicial bypass abortions.

Ms. Tara Lea Muhlhauser, Director, Children and Family Services, Department of Human Services, provided information (Appendix N) regarding the number of infant adoptions and the number of adoptions that resulted from removal through the child welfare system. She said during the last eight years, the number of regular infant adoptions, not including child welfare removals, has decreased from 54 in 2001 to 37 in 2008. She said the number of special needs adoptions has increased from 94 in 2001 to 115 in 2008. She said adoption is a two-step legal process, including the termination or relinquishment of birth parent rights and the adoption finalization.

Representative Conrad suggested the committee receive information regarding the payment structure for adoption services and how it differs from foster care payments. In addition, she suggested the committee receive information regarding the ages of the children involved in special needs adoptions and their type of special needs. Chairman Weisz asked the department to provide the information to the committee members.

Ms. Anderson provided information (Appendix O) regarding Medicaid income eligibility levels for pregnant women. She said pregnant women of any age may be eligible for Medicaid if the family income is no greater than 133 percent of the federal poverty level. She said currently the federal poverty level is $2,444 per month for a family of four. She said pregnant women with incomes over 133 percent of poverty may still qualify for Medicaid, but will be responsible for a share of the cost based on the amount of their excess income. She said eligible women receive all medically necessary services. She said eligibility may begin as early as the first month of pregnancy and may continue through the month 60 days after the pregnancy ends. She said once a pregnant woman becomes eligible for Medicaid, any increase in income is disregarded to ensure the woman stays continuously eligible for coverage. She

said there is no asset test for pregnant women, and a baby born to an eligible pregnant woman remains eligible for Medicaid for 12 months.

Ms. Janell Regimbal, Vice President, Children and Family Services, Lutheran Social Services of North Dakota, provided information (Appendix P) regarding a proposed evidence-based program to provide additional education and social services that would enhance the potential for a healthy child and a positive outcome for the minor, including the amount and sources of funding for the proposed program. She proposed five strategies to support pregnant and parenting teens, including expansion of outreach and education, delivery options and decisionmaking counseling, incentives for accessing services for both parents, incentives for post-adoption achievement, and expansion of home-based proactive support services for teen families. She said the proposed strategies were the result of collaboration on the part of alternatives-to-abortion services providers. She said the anticipated cost of these strategies is $2,558,328 annually.

In response to a question from Senator Mathern, Ms. Regimbal said one strategy to consider is to expand the Healthy Families program.

In response to a question from Representative Conrad, Ms. Regimbal said the Healthy Families program home visitation services are currently available in four counties. She said the proposed program would make home visitation services available in all counties.

Mr. Christopher Dodson, Executive Director, North Dakota Catholic Conference, Jamestown, said the information provided by Ms. Hintz regarding the number of abortions provided to minor women younger than age 18 requiring parental consent in the state includes nonresidents. He said the annual average number of abortions provided to resident minor women requiring parental consent was 44 for the period 2005-08. He said the average annual number of abortions provided to resident minor women through the judicial bypass from 2006-09 was approximately 30. He said this is significant when compared to the average number of abortions provided with parental consent of 44. He said the statute requires the motion for judicial bypass to be filed in the county of the minor's residence. He said he believes that in a significant number of cases, the motion for the judicial bypass is accompanied by a request for a change of venue and that most of the judicial bypass cases are heard outside of the minor's county of residence.

Mr. Dodson said adult teens (ages 18 and 19) have similar abortion rates as minor teens, and the adult teens are more difficult to reach. He suggested seeking ways to also provide additional outreach services to adult teens.

In response to a question from Senator Mathern, Ms. Carol K. Olson, Executive Director, Department of Human Services, said the department has recently applied for a grant that would provide funding to provide additional education and social services to pregnant minors. If approved, she said, the department would seek Emergency Commission and Budget Section approval to accept and spend the grant.

In response to a question from Representative Weisz, Ms. Cartledge said the grant is to address unplanned parenthood and domestic violence. She said the grant includes some of the elements of the program strategies proposed. She said the department requested $1.4 million in year one of the grant and $1.3 million in each of years two and three. She said the grant does not require a state match.

In response to a question from Representative Conrad, Ms. Cartledge said the strategies proposed were incorporated in the federal grant request, and the initiatives identified provide evidence-based outcomes. She said the department is working with alternatives-to-abortion services providers to build evidence-based programs into the services they provide. She said alternatives-to-abortion services providers participated in the grant process. She said if the grant is received, the alternatives-to-abortion services providers would be invited to respond to requests for proposals to provide services. She said the grant would be an enhancement to the current appropriation for the alternatives-to-abortion program.

Representative Conrad suggested the committee prepare a bill draft directing the Department of Human Services to develop a program, including the strategies presented by Ms. Regimbal, to be presented to the 2011 Legislative Assembly if the department is not successful in the grant request.

Chairman Weisz asked the Department of Human Services to notify him regarding the grant award. He said a bill draft would only be necessary if the federal funding is not awarded and the committee wished to propose a state-funded program. He said the committee will discuss a possible bill draft at the next meeting if the grant is not approved.

STUDY OF THE EFFECT OF FEDERAL, STATE, AND COUNTY GOVERNMENT FUNDING AND ADMINISTRATION ON THE SOCIAL SERVICE PROGRAMS OF TRIBAL GOVERNMENTS

The Legislative Council staff presented a memorandum entitled *Child Welfare Services on South Dakota Indian Reservations*. She said in 1978 Congress enacted the Indian Child Welfare Act (ICWA). The Act sought to protect and preserve the bond between Indian children and their tribe and culture. In 2004 the South Dakota Legislature created the Governor's Commission on the Indian Child Welfare Act to study the requirements of the ICWA. The commission analyzed South Dakota's compliance with ICWA by involving the National Center for State Courts, in partnership with Native American Legal Services. The final reports were presented to the Governor and the 2005 South Dakota Legislature, and

each report contained numerous recommendations for the state and the tribes to improve the outcomes for Indian children who enter the child welfare system. The commission ceased to exist on December 31, 2004, but was reestablished by executive order of the Governor to assist in the implementation of its recommendations. The executive order directed the commission to focus its efforts on implementation of 30 high-priority recommendations found in the commission's earlier report. Further, the commission was directed to review each of the recommendations to determine, in regard to the implementation of each recommendation, the entity or entities responsible, action plans, timelines, and barriers to implementation. Recommendations acted upon by the state included a statewide ICWA coordinator to help enforce a statewide ICWA compliance plan; improvements in the notice to a tribe of a child custody proceeding; and improvements in the custody and placement of Indian children, including the use of family locators.

The Legislative Council staff said the Division of Child Protection Services and the Casey Family Programs in Pine Ridge and Rosebud entered a memorandum of understanding in April 2004 regarding a collaborative effort for Casey Family Programs to offer family group decisionmaking to families involved with the Division of Child Protection Services from the Pine Ridge and Mission offices. The goal of family group decisionmaking is to facilitate the preservation and stability of families by providing a forum for families to make plans that are designed to ensure the safety, permanency, and well-being of their children and youth when the child has entered or is at risk of entering the child welfare system.

The Legislative Council staff said the ICWA authorizes the state to enter tribal Title IV-E agreements with individual tribes for the care and custody of Indian children. Title IV-E of the Social Security Act also authorizes the state and tribes to enter Title IV-E agreements for the payment of foster care for children determined to be eligible for Title IV-E funding and for administrative funding associated with staffing and training of staff and foster and adoptive parents. There are nine tribes in South Dakota. The state entered a contract with the Sisseton-Wahpeton Oyate Tribe in 1978 and with the Oglala Sioux Tribe in 2008 for the provision of all services, including foster care and child protection services. These tribes receive funding for placement, training, and administration. The state provides services on the remaining seven reservations, except for investigation services for the Standing Rock Sioux Tribe.

The Legislative Council staff said South Dakota state and tribal leaders formed a committee--the Collaborative Circle--to bring together all stakeholders who are committed to improving child well-being outcomes for Native American children in the state, including the tribes, the Division of Child Protection Services, families, consumers, providers, and other partners. The Collaborative Circle meets quarterly, and members have recently identified the following as critical issues to be addressed by the group:

- Enhancing placement resources;
- Establishing transfer protocols; and
- Engaging tribes to contract with the state to provide services.

Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, provided information (Appendix Q) regarding an update on the efforts to facilitate the development of proposals to improve the delivery of human service programs on reservations, including a list of barriers to the development of proposals. He said quarterly meetings will be held to discuss issues and concerns and to identify training and potential partnerships. He said the Department of Human Services will also host a tribal stakeholder meeting every two years to gather input during the budgeting process. He said the first meeting held in July 2010 was productive. He said the stakeholder group continues to address the strategies outlined, and he will continue to work with the stakeholders to strengthen relationships and communications.

Chairman Weisz suggested Mr. Davis provide information regarding the progress of the stakeholder group to the 2011 Legislative Assembly.

Senator Lee suggested the stakeholder group address Medicaid and CHIP (Healthy Steps) outreach to Native American children. She said using these programs to provide health care services to Native American children would allow the tribes to use Indian Health Service funding for the health care needs of its other members.

IMMUNIZATION PROGRAM STUDY

Ms. Laura Olson, Business Manager, PROtect ND Kids, State Department of Health, provided an update (Appendix R) regarding the delay in the processing of the electronic member liable claims. She said the University of North Dakota School of Medicine and Health Sciences met its deadline of June 30, 2010, to process outstanding member liable claims and continues to process the new member liable claims.

In response to a question from Representative Weisz, Ms. L. Olson said all claims have been paid through June 30, 2010, and a two-week processing time has been established on new claims to allow for review of the claims.

Mr. Jerry Nye, Riley & Associates, Minneapolis, Minnesota, provided information (Appendix S) regarding an update on the independent quality improvement evaluation of the state's immunization program. He said there are no specific findings or recommendations because information is still being gathered from those sites involved in the study. He said the study will focus on the following four areas--financial analysis, vaccine procurement and management, data capture (billing and receivable management), and information systems. He said a steering committee will meet in late August to design

the desired process maps. He said a complete analysis of findings and alternative solutions for data capture would be shared with the steering committee in September 2010, and a second meeting of the steering committee would develop a plan for vaccine procurement and management. He said a return to the universal select immunization program may be among the solutions identified by the study.

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, said there are three pools of funding available for immunizations in the state. She said vaccines in the state are available through the:

- Vaccines for Children program, which is federally funded and available to Medicaid, Native American, uninsured, and underinsured children;
- 317 vaccine program, which is also federally funded but is flexible and available to the department for the state's priorities; and
- Private insurance.

Ms. Smith said the federal programs do not provide funding for vaccine, but instead provide vaccines for use in the state. She said the state receives vaccine allotments that are distributed to the providers.

Ms. Smith said three price levels exist for the purchase of vaccine--private rate (most expensive), mid-level rate (negotiated), and federal contract rate (least expensive). She said the department believed the federal contract rate was only available when the vaccine purchase was made with state funding but has learned that other states challenged and were allowed to collect funding from insurance companies to purchase vaccines at the federal contract rate. Based on immunization data collected by the department from July 2009 through June 2010, she said, insurance companies are estimated to save $2.5 million per year if they were allowed to purchase at the federal contract rate instead of the private rate. She said it is necessary under the current Provider Choice program to maintain separate inventories of vaccines. She said this requirement makes inventory management difficult. Under the universal select immunization program, she said, the federal government would estimate the state's allocation of Vaccines for Children vaccines, and the need to maintain separate vaccine inventories would be eliminated. She said the universal select immunization program limits the administration charge for a vaccination to the Medicaid rate, which is lower than the rates charged by some providers. She said the department will continue to research the effect of a return to the universal select immunization program on providers and insurance companies.

In response to a question from Representative Weisz, Ms. Smith said the state would bill the insurance companies for the vaccine. She said in the past the largest insurer in the state has paid for its share of the vaccine, but attempts to bill other insurers were unsuccessful, leaving the state to use 317 vaccine to cover the rest. She said the other insurers make up approximately 20 percent of the market. She said using the 317 vaccine for this purpose would result in less vaccine available for other groups the department has targeted for coverage in the past.

In response to a question from Representative Delzer, Ms. Molly Sander, Immunization Program Manager, State Department of Health, said new vaccines continue to be recommended, and existing vaccines can be recommended for new populations. She said some vaccines are required by legislation, but recommended vaccines are not.

Representative Delzer suggested the committee receive additional information regarding various options to provide immunizations in the state, including the use of the universal select immunization program. Mr. Nye said this information could be included in the quality improvement evaluation of the state's immunization program at no additional cost.

Chairman Weisz instructed Mr. Nye to include consideration of changing to universal select immunization programs in the quality improvement evaluation of the state's immunization program, but to also include other options.

Ms. Sander provided information (Appendix T) regarding the estimated cost to operate a reminder/recall program for immunizations. She said the purpose of the reminder/recall program is to communicate that an individual is due currently or in the future (reminder) or past-due (recall) for one or more recommended immunizations. She said $72,024 of American Recovery and Reinvestment Act of 2009 funding was used to purchase and implement the forecasting and reminder/recall system into the North Dakota immunization information system, including two years of maintenance. She said the annual maintenance cost is $5,000 per year. She said the department anticipates the reminder/recall system will be available in September 2010. She said the reminder/recall could be performed by providers, counties, or the state. She provided estimates of the cost to the State Department of Health to conduct an immunization recall using telephone calls, postcards, or a combination of telephone calls and postcards.

The Legislative Council staff presented a bill draft [10123.0100] relating to pharmacist administration of immunizations and vaccinations to minors. The bill draft amends Section 43-15-01 to allow pharmacists to administer influenza shots to children older than age 5 and other immunizations to children older than age 11.

Mr. Mike Schwab, Executive Vice President, North Dakota Pharmacists Association, said pharmacists wish to collaborate with the State Department of Health to increase immunization rates in the state.

Ms. Sander said many adolescent vaccines are recommended for children between ages 11 and 12, but the bill draft does not include children who are aged 11. She also said the bill draft does not address nasal vaccines.

Chairman Weisz announced that the Legislative Council staff distributed to each member written

testimony (Appendix U) provided by Mr. Levi regarding the bill draft that would allow pharmacists to administer influenza vaccine to children older than age 5 and other immunizations to children older than age 11.

Representative Delzer suggested the Legislative Council staff make the necessary changes to the bill draft to allow pharmacists to administer immunizations to children aged 11 and older and to include the administration of nasal vaccines. Chairman Weisz asked the Legislative Council staff to make these changes to the bill draft.

Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, said the independent quality improvement evaluation has provided valuable information. She said the immunization delivery system has become complex, and she anticipates the study will allow a better understanding of the system's components.

In response to a question from Senator Lee, Ms. Clute said the implementation of any changes to the delivery of immunizations would need to address the vaccine currently in stock and the six-month billing cycle of the public health units.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Weisz anticipates the next committee meeting will be in October 2010.

It was moved by Senator Pomeroy, seconded by Senator Lee, and carried on a voice vote that the Health and Human Services Committee meeting be adjourned subject to the call of the chair.

Chairman Weisz adjourned the meeting at 4:05 p.m.

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Sheila M. Sandness
Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:21