NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Tuesday, July 24, 2012
University of North Dakota School of Medicine and Health Sciences Southwest Campus
Second Floor, 701 East Rosser Avenue
Bismarck, North Dakota

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

Members present: Senators Judy Lee, Spencer D. Berry, Tim Mathern, Gerald Uglem; Representatives Stacey Dahl, Kathy Hogan, Karen Karls, Robert Kilichowski, Jon Nelson, Mark S. Owens, Karen M. Rohr, Mark Sanford

Members absent: Senators Ralph L. Kilzer, John Warner; Representatives Vonnie Pietsch, Robin Weisz

Others present: See Appendix A

It was moved by Senator Mathern, seconded by Representative Rohr, and carried on a voice vote that the minutes of the April 12, 2012, meeting be approved as distributed.

STUDY OF THE FUTURE OF HEALTH CARE DELIVERY IN THE STATE AND THE ABILITY OF THE UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES TO MEET THE HEALTH CARE NEEDS OF THE STATE

Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix B) regarding out-of-state or out-of-country students filling North Dakota residency positions; national board certification pass rates of recent medical school classes and how the rates compare to the national average; the rural opportunities in medical education (ROME) program, including information regarding the program, the number of third-year medical students placed in rural communities, and the number of ROME students choosing to practice in rural communities after graduation; the RuralMed program, including information regarding the program and its success at recruiting, educating, and retaining physicians who will practice family medicine in rural North Dakota; and an update on the status of the Bismarck campus construction project, including an overview of the facility, cost, and local partnerships. Dr. Gwen Wagstrom Halaas, Senior Associate Dean for Academic and Faculty Affairs, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information regarding students'/residents' experiences and rotations in the community health program, including information regarding the program and opportunities for health profession students to work in interdisciplinary teams in rural North Dakota communities.

Dr. Wynne said family medicine, internal medicine, psychiatry, surgery, and transitional residencies are available in North Dakota. He said students planning a specialty residency that is not offered in North Dakota enter a transitional residency for one year and subsequently move out of state to complete the residency elsewhere. He provided a summary of the graduates filling North Dakota residency positions from 2008 through 2012. During that period, he said, approximately 30 percent of the residency positions were filled with University of North Dakota School of Medicine and Health Sciences (School of Medicine) graduates, 23 percent were filled with other United States medical school graduates, 8 percent were filled with United States citizens graduating from international medical schools, and 39 percent were filled with noncitizen graduates from international medical schools. He said North Dakota residencies are below the United States average in percentage of United States graduates filling internal medicine and psychiatry residencies, but exceed the national average in the percentage of United States graduates filling surgery and transitional residencies. He said 46 percent of the graduates filling North Dakota residencies in family medicine are United States graduates, which is near the national average of 51 percent.

In response to a question from Representative Hogan, Dr. Wynne said it is possible the residencies at the Minot campus have a higher number of non-United States graduates because third-year students are not placed at the campus. He said a newly implemented longitudinal integrated clerkship should change this and give third-year students exposure to the residencies available in Minot. He said it is anticipated that the residency demographics in Minot will include more School of Medicine and other United States graduates in the future.

In response to a question from Senator Berry, Dr. Wynne said the Minot program has both benefited and experienced challenges by expansion of patients in Minot. He said challenges include upward pressure on salaries in the area; however, he said, the increased volume and diversity among patients has benefited residents. He said he would provide

additional information to the Legislative Council regarding the increase in patient volume at the Minot campus.

Dr. Wynne provided information regarding the number of graduates completing a residency in North Dakota from 2008-12 that practice in North Dakota. Of the residency graduates entering a practice during this time period, he said, 73 graduates are practicing in North Dakota and 59 are practicing in another state. He added that, since 2010, the number of residency graduates remaining in the state has been increasing, and currently more than 7 out of 10 graduating residents, other than those in the transitional program, are choosing to practice within North Dakota. He said based on data published regarding medical schools with the highest percentage of graduates (1988-97) practicing in rural areas in 2005, the School of Medicine ranked fifth with 28 percent. He said the University of Minnesota Duluth ranked first with 36 percent.

In response to a question from Senator Lee, Dr. Wynne said the School of Medicine uses the demographic standard for rural in published documents, but internally the school defines rural as anywhere in the state except the four major cities.

In response to a question from Senator Lee, Dr. Wynne said he would provide additional information to the Legislative Council regarding the impact of changes to the J-1 visa program on the School of Medicine.

In response to a question from Representative Dahl, Dr. Wynne said the upward trend of residency graduates practicing in North Dakota is likely due to the School of Medicine actively engaging and soliciting graduates during their residency regarding practice opportunities in the state as opposed to a more passive approach. He said growth in the health care systems in the state has also likely contributed.

Dr. Wynne said the United States medical licensing examination (USMLE) consists of four examinations administered in three steps. He said the USMLE Step 1 (Step 1) is administered after completion of the second year of medical school, the USMLE Step 2 Clinical Knowledge (Step 2 CK) and the USMLE Step 2 Clinical Skills (Step 2 CS) are completed during the fourth year of medical school, and the USMLE Step 3 (Step 3) is taken in the first year of residency. He provided the USMLE pass rates for students and residents from 2008-12 but noted that the 2012 scores were unofficial. He said during that period, School of Medicine student pass rates on the Step 1 (93 percent) and Step 2 CK (97 percent) examinations met the national average pass rate, but the School of Medicine pass rate of 100 percent on the Step 2 CS examination exceeded the national average pass rate of 99 percent. He said the School of Medicine resident pass rate of 100 percent on the Step 3 examination also exceeded the national average pass rate of 96 percent. He said average examination scores at the School of Medicine have been trending higher in recent years. He said the average Medical College Admission Test (MCAT) scores of students entering the School of Medicine program have been lower than the national average; however, by graduation the average scores of the same students on licensure examinations have been at or above the national average.

In response to a question from Senator Berry, Dr. Wynne said patient-centered learning is a concept that incorporates two fundamental principles. He said it is patient-centered which means the focus is on the patient instead of disease, and it is small group learning. He said students learn to work in teams to help the patient. He said health care is increasingly relying on a network of providers to care for patients. He said students learn to use a network of providers in an integrated way to provide an efficient, effective, and accessible health care system that delivers optimal health outcomes at less cost.

Dr. Halaas said the Student/Resident Experiences & Rotations in Community Health (SEARCH), funded by the United States Department of Health and Human Services, has been the primary community health program used to prepare students and residents in medicine, nursing, social work, physician assistant, psychology, and dentistry for primary care practice in health professional shortage areas. She said since 1994, 403 students and residents have participated in the SEARCH program and its predecessor program--the Fellowship of Primary Health Care Professionals Program. She said the program places students in the community where they work with other health care professionals, community leaders, and patients. She said students gain an understanding of the health care needs and barriers in the community. She said Project Collaborative Rural Interdisciplinary Service Training and Learning (CRISTAL) has engaged 46 students from several disciplines in a summer internship experience on North Dakota reservations. She said federal funding for Project CRISTAL has been discontinued, and she anticipates funding for the SEARCH program is also likely to be discontinued. She said in addition to funding challenges, formal education in community health centers and other sites requires consistently available clinical preceptors.

Dr. Halaas said the School of Medicine has taught the interprofessional health care course to over 1,900 health professional students since 2006. She said the course teaches students the importance of working in teams and trains them in specific team-based skills. She said the course is required for students in medicine, nursing, occupational and physical therapy, and communication sciences and disorders. She said interprofessional health care course faculty has been engaged to develop advanced experiences for students both on campus and at clinical sites. She said teams of students will experience complex patients, such as those with diabetes, those taking multiple medications, and the aging population in nursing homes. She said barriers include funding and housing, but more often the

challenge is a lack of individuals in the community available to teach the students. She said timing is another challenge, because students from each of the health professional training programs are not always available at the same time and in the same place to participate in the program. She said one of the advantages of the longitudinal clerkship program being developed in Minot is the certainty that there will be a set number of medical students engaged in the community for 12 months. She said students who remain in a community longer are more functional because they learn more about the facility and the patients.

Dr. Wynne said from 2000 through 2012, 79 students participated in the ROME program. He said 11 percent of those participating in the ROME program have chosen residencies in North Dakota and 32 percent practice in the state. He said 51 percent of the ROME participants choose a residency in primary care compared to a national average of 38 percent in 2012. He said 64 percent of ROME students chose primary care or obstetrics and gynecology compared to 44 percent nationally. He said although it seems ROME graduates are more likely to enter family medicine and the other primary care areas than the national average, they are less likely to select a North Dakota residency. However, he said, even though ROME participants are less likely to complete a residency in North Dakota, they are likely to return to the state to practice, and many practice in rural areas of the state.

Dr. Wynne said the RuralMed program provides a full tuition waiver for all four years of medical school if the student agrees to complete a family medicine residency and then practice family medicine in a rural area of the state for five years. He said for purposes of the RuralMed program, rural area is defined as anywhere in the state except Bismarck, Fargo, Grand Forks, and Minot. He said there are currently 11 students enrolled in the RuralMed program and one more is likely to enroll. He said three students, graduating in 2011 and 2012, are currently completing residencies in the state. He said the remaining students enrolled in the program have not yet graduated. He said the funding for this program has been identified for only this purpose, and if there are not enough students enrolled in the program, the funds will not be used. He said as a result, there is a surplus in the program, and if the School of Medicine had more students interested in the program, they could be enrolled. He said it is too soon to draw any meaningful conclusions regarding the success of the program, but the trend is positive.

In response to a question from Senator Berry, Dr. Wynne said students may enroll in the RuralMed program during any year of medical school. He said tuition waivers are retroactive, but there are instances where retroactive reimbursement is not possible. Senator Berry asked Dr. Wynne to provide information to Legislative Council regarding medical students enrolling in the RuralMed program after their first year of medical school and how often it has been possible to apply tuition waivers retroactively. Dr. Wynne said students withdrawing from the program are required to repay the tuition waived.

Dr. Wynne presented a report regarding the new Bismarck facility. He said the Legislative Assembly provided $5.4 million for the construction of the new Southwest Campus facility in Bismarck, and it is anticipated the total cost will be within $5,000 of the budget. He said the State Board of Higher Education authorized an additional $750,000 for furniture, fixtures, and equipment, which is also anticipated to be spent within $5,000 of the total available. He said the School of Medicine partnered with Bismarck Partners, LLP, and Medcenter One Inc., to construct the four-story building. He said the Bismarck Center for Family Medicine Clinic and Pharmacy and the School of Medicine Southwest Campus offices, meeting rooms, and classrooms occupy the first and second floors of the facility. He said Medcenter One administrative offices will occupy the third floor, and the Ritterbush Auditorium and Medcenter One education offices will occupy the fourth floor. He said a condominium agreement, allocating 25 percent to each floor, will manage the general expenses associated with building maintenance. He said the clinic began seeing patients on July 5, 2012.

Dr. Wynne asked the committee to support the full health care workforce initiative, as has been endorsed by the State Board of Higher Education, and one of the three capital construction options.

In response to a question from Senator Mathern, Dr. Wynne said the School of Medicine Advisory Council did not endorse one capital construction option over the others. He said Dr. Hamid Shirvani, Chancellor, North Dakota University System, and the State Board of Higher Education have endorsed Option 1 which includes an 80,103 gross square footage addition with shared education space and the renovation of 42,311 gross square footage of faculty offices and education space and has an estimated cost of $38.5 million. He said this option for the project will be included in the University System budget request.

The committee conducted a tour of the Bismarck Center for Family Medicine Clinic and Pharmacy and the School of Medicine Southwest Campus offices, meeting rooms, and classrooms.

Ms. Laura Glatt, Vice Chancellor for Administrative Affairs, North Dakota University System, presented information (Appendix C) regarding a summary of Western Interstate Commission for Higher Education (WICHE) students receiving tuition support to attend out-of-state schools, including cost, residency requirements, and whether they are required to return to the state to practice. She said professional student exchange programs purchase student slots in selected programs to facilitate access to degrees that meet North Dakota industry needs. She said the programs are not scholarships but rather a means for North Dakota students to access three programs not

offered at University System institutions. She said the state has been purchasing access to veterinary medicine programs since 1959 and added dentistry and optometry programs in 1975. She said students receive a support fee from the University System through WICHE sufficient to reduce their tuition to in-state tuition levels, and at some institutions applicants receive priority consideration for admission. In addition, she said, the University System has statutory authorization to make other arrangements with professional schools. She said non-WICHE partners include the University of Minnesota (dentistry and veterinary medicine), Kansas State University (veterinary medicine), and Iowa State University (veterinary medicine).

Ms. Glatt said applicants must complete the application for resident status with the University System financial aid office, meet the statutory definition of residency for tuition purposes, and be accepted into an approved program at an out-of-state institution. She said during the 2011-12 academic year, 93 students participated in all North Dakota professional student exchange programs (WICHE and non-WICHE) at a total cost of $1.8 million. She said per student support fees for WICHE participants during the 2012-13 academic year are projected to be $16,100 for optometry students, $23,400 for dentistry students, and $30,000 for veterinary medicine students. She said the non-WICHE slots negotiated by the University System are generally cheaper than those available through WICHE. She said 2012-13 projected per student rates for non-WICHE partnerships in veterinary medicine ranged from $11,254 at the University of Minnesota to $26,736 at Kansas State University, and the per student rates for the dentistry partnership at the University of Minnesota are expected to range from $10,543 to $13,087. She said 98 students are projected for the 2012-13 academic year. She said not all qualified applicants receive support. She said acceptance rates for fall 2012 in all programs were 53 percent in veterinary medicine (9 of 17 applicants), 80 percent in optometry (8 of 10 applicants), and 29 percent in dentistry (7 of 24 applicants).

Ms. Glatt said the University System authority to require repayment of professional student exchange program benefits was repealed in 1983, and there is currently no repayment requirement for students who do not return to North Dakota to practice. She said some program participants had difficulty locating employment in the state, and repayment terms were difficult to enforce and collect. She said an evaluation of professional student exchange programs in 2006 indicated that repayment had not significantly affected return rates to North Dakota.

In response to a question from Senator Lee, Ms. Glatt said residency is determined based on the statutory definition of 12 months; however, there is an exemption for students who graduated from a North Dakota high school and other exemptions related to military service. She said it is possible for a graduate of a North Dakota high school to attend a university out of state for four years and still qualify for a professional student exchange program. In addition, she said, a Minnesota graduate could qualify for the professional student exchange program if that student lived in North Dakota for 12 months prior to the beginning of the professional academic term.

In response to a question from Senator Lee, Ms. Glatt said funding for the professional student exchange program is distributed between all types of professional slots, and the University System has flexibility with regard to which program slots are funded. Senator Lee encouraged the University System to consider the demand for various professionals in the state when determining which slots receive tuition support.

Senator Lee suggested the University System review the repayment of tuition support by students who do not return to the state to practice and the ability of a student who leaves the state to establish residency elsewhere to qualify for the professional student exchange program.

In response to a question from Senator Lee, Ms. Glatt said the University System could work with licensing divisions and professional associations to identify those registered that have received support through professional student exchange programs.

Dr. Terry Dwelle, State Health Officer, State Department of Health, provided information (Appendix D) regarding federal health care initiatives, including how they will affect access to health care in the state. He said through prevention and regulation, the State Department of Health protects and enhances the health and safety of the state's environment and its residents. He said the department provides limited direct care services to mostly an uninsured or underinsured population. He said if preventative screenings are covered by insurance and all individuals are either insured or on Medicaid through the Affordable Care Act, department programs will no longer be needed to pay for screening, laboratory work, and diagnosis. He said the focus of department programs would be more heavily on promotion, education, and screening incentives. He said the increase in preventative care and immunizations covered by the Medicaid expansion will likely increase the cost of Medicaid for the state. Regarding immunization, he said, the Affordable Care Act will:

- Through the Medicaid expansion, increase access to vaccines;
- Provide funding for specific immunization projects, such as registries, electronic medical records, local public health billing systems, and vaccine storage and handling;
- Eliminate all cost-sharing for the Medicare population; and
- Require all recommended vaccines be covered at first dollar for all ages; however, insurance plans can still require "in network" providers, a

difficult designation for local public health units to achieve.

Dr. Dwelle said the Affordable Care Act may also increase vaccine administration fees and impact the Vaccines for Children and Section 317 vaccine programs, which may not be necessary if all children are either Medicaid-eligible or insured.

Dr. Dwelle said the Affordable Care Act prohibits excluding children with preexisting conditions, bans coverage rescission, addresses adequacy of coverage, removes annual and lifetime benefit caps, and includes health homes for Medicaid-enrolled children with chronic conditions. However, he said, there may still be issues regarding the provision of services to fill gaps in services available to underinsured children, access to pediatric specialty and subspecialty care, and care coordination to navigate the various systems and services available. He said provisions of the Affordable Care Act that require providers to have meaningful use of electronic health records in order to receive higher payments from Medicare and Medicaid indirectly affect three systems within the department and will require department resources to make the necessary adjustments. He said meaningful use requires records to be complete and accurate, better access for providers and patients, and patients to become actively involved in their own care. He said expanded Medicaid and insurance coverage could also improve provider collections and increased revenue which may lead to expanded access for patients. He said expanded Medicaid and the requirement of essential benefits, including preventative screenings and immunizations, could increase the demand on primary care providers, presenting additional challenges, particularly in rural areas. He said incentives will be necessary to attract primary care physicians to rural and urban areas of the state, and there will be a need to increasingly rely on mid-level professionals to meet the demand for services.

In response to a question from Representative Karls, Dr. Dwelle said he is uncertain what effect provisions of the Affordable Care Act would have on the Comprehensive Health Association of North Dakota (CHAND) program. He said there are concerns that there may still be gaps in coverage under the Affordable Care Act.

In response to a question from Senator Mathern, Dr. Dwelle said the long-term goal is to decrease future health care costs through preventative care; however, expanding preventative care and increased usage will drive up health care costs in the short term.

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, provided information (Appendix E) regarding federal health care initiatives, including how they will affect access to health care in the state. She said the Affordable Care Act requires procedures to be established under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and the children's health insurance program (CHIP) according to the risk of fraud, waste, and abuse within the provider or supplier category. She said the department will issue a request for proposal for a vendor to assist with the implementation of the screening requirements. She said the Affordable Care Act requires states to establish a recovery audit contractor program to audit claims for services furnished by Medicaid providers, and the department has entered a contract with Cognosante which is expected to begin auditing providers in September 2012. She said the Affordable Care Act provided for a 100 percent match for state expenditures for provider incentive payments to encourage Medicaid health care providers to implement electronic health record technology. She said 91 professionals and 16 hospitals applied for the 2011 payment year, and the department expects to provide approximately $7 million of incentive payments before the end of August 2012. She said 28 professionals and six hospitals have registered their intent to meet attestation for Meaningful Use Stage 1. She said entities covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 will be required to use the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10) diagnostic and procedure codes. She said the new Medicaid management information system (MMIS) is expected to be ICD-10-compliant at "go live" in October 2013. Regarding increased payments for certain Medicaid primary care services, she said, the department does not expect to receive the 100 percent federal financial participation (FFP), as the state's Medicaid physician fees were greater than the Medicare fees as of July 1, 2009. She said final rules have not been published for FFP payments for vaccine administration. She said a project supported by the department and submitted by Blue Cross Blue Shield of North Dakota for consideration under the Comprehensive Primary Care (CPC) initiative, a multipayer initiative fostering collaboration between public and private health care payers to strengthen primary care, was not funded. She said the department has also supported Sanford Health's application for funding through the Strong Start initiative which supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns. She said the department is also exploring adult quality grant funding as a means to establish systems to collect and report quality measures and to work with providers to improve the quality of services. She said the Affordable Care Act includes a program to incentivize states to offer home and community-based services as a long-term care alternative to nursing homes. She said the state balancing incentive payment program creates an opportunity for the state to receive a temporary enhanced federal medical assistance percentage (FMAP) for home and community-based services. She said if the department applied, the state must achieve

benchmarks of 50 percent of total Medicaid expenditures from noninstitutional long-term support services no later than October 1, 2015. She said according to Centers for Medicaid and Medicare data for federal fiscal year 2009, the state spent 28 percent of long-term support services on home and community-based services. She said the department plans to include authorization to apply for this funding program as an optional adjustment request in the 2013-15 biennium budget.

In response to a question from Senator Mathern, Ms. Anderson said while some states have imposed deadlines by which Medicaid providers must implement an electronic health records system, there is currently no federal or state deadline for providers in North Dakota.

In response to a question from Representative Hogan, Ms. Anderson said the Medicaid eligibility and enrollment system will replace systems currently available in counties. She said the new system will incorporate all of the different eligibility systems into one. She said the department anticipates Phase 1 of this program will be available in time to connect to the federal health insurance exchange. She said if the federal health insurance exchange receives an applicant that may qualify for Medicaid, the department is notified. She said the deadline for Phase 1 is October 1, 2013, when enrollment in Affordable Care Act exchange programs will begin. She said the Medicaid portion of the project must be completed by December 2015, when the enhanced funding for the project expires.

In response to a question from Representative Nelson, Ms. Anderson said provisions in the Affordable Care Act that address issues related to states collecting and reporting quality measures for adults enrolled in Medicaid are not mandates, but these provisions may be an indication that states could be mandated to collect and report such information in the future.

Senator Mathern expressed concern that the State Board of Higher Education approved the lowest cost option for expansion of the School of Medicine. He suggested the committee take action to support the third option which includes the construction of a new facility at an estimated cost of $124 million. He said the new facility could be an advantage as states compete for health care professionals.

Senator Lee said the committee has not reviewed the projects in depth and would not have the information necessary to endorse a particular plan. She suggested the committee encourage the School of Medicine Advisory Council or the Health Council to review and make a recommendation on the project.

Representative Rohr suggested the committee receive information from the Chancellor regarding the rationale for endorsing the first option for the renovation and construction of the School of Medicine.

Senator Mathern said the School of Medicine Advisory Council would have the most detailed information related to the operation of the School of Medicine and the best-suited to review the three options for remodeling or replacing the School of Medicine facility.

It was moved by Senator Mathern, seconded by Representative Hogan, and carried on a voice vote that the Health Services Committee encourage the University of North Dakota School of Medicine and Health Sciences Advisory Council to review the proposed options for the renovation or construction of the University of North Dakota School of Medicine and Health Sciences facility and report to the Health Services Committee regarding the benefits and concerns of each option and on the council's preferred option.

REGIONAL PUBLIC HEALTH NETWORK PILOT PROJECT STUDY

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [13.0034.02000] relating to changes to the regional public health network program. The Legislative Council staff said the bill draft amends North Dakota Century Code Chapter 23-35.1 relating to regional public health networks. The bill draft was originally presented to the committee in April 2012. Changes have been made to the bill draft as suggested by the regional public health unit task force relating to funding requirements and shared or expanded services.

It was moved by Representative Kilichowski, seconded by Representative Sanford, and carried on a roll call vote that the bill draft relating to regional public health networks be approved and recommended to the Legislative Management. Senators Lee, Berry, Mathern, and Uglem and Representatives Dahl, Hogan, Karls, Kilichowski, Nelson, Owens, Rohr, and Sanford voted "aye." No negative votes were cast.

STUDY OF THE FEASIBILITY OF PLACING THE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Benewah Medical & Wellness Center*. The Legislative Council staff said the Coeur d'Alene Tribe and the city of Plummer, Idaho, collaborated in a joint venture to address the health care needs on the Coeur d'Alene Reservation and in 1987 planned and developed a community-based rural health outpatient care delivery system. A commitment was made by the Coeur d'Alene Tribal Health Authority and the Coeur d'Alene Tribal Council to provide health care services to both the Indian and non-Indian population, and the clinic would serve all persons in the community regardless of their ability to pay. Construction of the medical center was financed by a combination of tribal and community resources, including federal, state, community, and grant funds. While the tribe owns the facility, it is governed by the

Coeur d'Alene Tribal Health Authority, and the board of directors, appointed by the tribal council, consists of tribal and nontribal community members.

The Legislative Council staff said the tribe provides certain public health services on the reservation as part of its Indian Health Service (IHS) P.L. 93-638 Compact. In addition, a small part of the funding received from the Health Resources Service Administration (HRSA) Community Health Center Program relates to public health. The medical center's Community Health Program performs inspections, home health nursing, public health surveillance, nutrition counseling, and health education. Other community health services include environmental health; chronic illness monitoring; nursing assessments; diabetes prevention; maternal-child health care; school health services; transportation for the elderly and disabled to medical appointments; foot care; tobacco cessation counseling; and the women, infants, and children nutrition program.

The Legislative Council staff said the Coeur d'Alene Tribe and the community, through the tribal health authority, have received funding from many sources, including:

- HRSA/Bureau of Primary Health Care (Public Health Service Act 330(e) funding);
- IHS P.L. 93-638 Compact funding;
- Department of Housing and Urban Development block grants;
- Fee-for-service revenue;
- Bureau of Indian Affairs Indian business development grant;
- Corporate support for specialized projects and equipment; and
- Private foundations, such as the Robert Wood Johnson Foundation and the Murdoch Foundation.

The Legislative Council staff said almost one-third of those served are below 200 percent of the federal poverty guidelines. Approximately 50 percent of the clinic's patients are Indian, and 50 percent are non-Indian. Approximately 40 percent have no insurance. Funding for the Benewah Medical & Wellness Center from the HRSA Bureau of Primary Health Care, as part of its Community Health Center Program, has allowed the medical center to provide care on a sliding fee scale basis to the non-Indians in the region. Funding generated by the Coeur d'Alene Casino allows the tribe to buy health insurance for casino and tribal government employees. Indian Health Service P.L. 93-638 Compact funds allow the Benewah Medical & Wellness Center to serve uninsured American Indians at no charge.

The Legislative Council staff said the Coeur d'Alene Reservation is part of the Panhandle Health District in northern Idaho. The tribe partners with the Panhandle Health District in areas of public health where it lacks expertise, such as emergency preparedness. Except for occasional grants for projects or for flood protection or homeland security, the tribe does not receive any ongoing support for public health services from the state.

In response to a question from Senator Lee, Senator Mathern said when he visited the Benewah Medical & Wellness Center, the center indicated although there were issues of sovereignty, the tribe and the community were able to work together to build the facility.

Representative Hogan said the Benewah Medical & Wellness Center model appears to have started as a federally qualified health center (FQHC) to which public health functions were added. She said it seems the Three Affiliated Tribes would need to start with the FQHC and then add public health functions.

Commander Arne Sorenson, United States Public Health Service and Director of Diabetes Prevention Program, Mandan, Hidatsa, and Arikara Nation, provided information (Appendix F) regarding an update of a proposed funding model for a local public health unit that includes the entire reservation, the status of the proposed governance of the local public health unit by the Mandan, Hidatsa, and Arikara (MHA) Nation Health Authority, and the possibility of local public health units serving the Fort Berthold Reservation partnering with the Three Affiliated Tribes to provide public health services on the reservation. He said the MHA Nation Health Authority Board reports directly to the MHA Nation Tribal Business Council. He said the council is prepared to amend the board charter to include responsibility for managing the public health unit, additional appointments from the State Department of Health, and any required reporting. He said representatives of the MHA Nation Health Administration have met with representatives of the State Department of Health and district public health units to discuss governance and funding. He said a local public health unit administered by the MHA Nation Health Authority would provide:

- Cultural competence and coordination of programs that would improve access and quality of services for tribal members;
- Unique billing opportunities, including access to the Medicaid all-inclusive rate for billable services;
- Coordination of public health services with medical services already managed by the tribe;
- Opportunities to coordinate all health programs;
- Improved coordination with State Department of Health programs and services;
- Improvements in the health status and reductions in the health disparities of tribal members;
- An opportunity for the district public health units to focus on the growing population in western North Dakota;
- A better-coordinated emergency response system;

- A link to individuals in need of cancer screenings and other services now covered under the Affordable Care Act; and
- A template for coordination of limited resources to maximize benefits and services for tribal members.

Commander Sorenson said identified funding sources are approximately $200,000 less than the estimated funding needed. He said funding a one-year pilot project would allow time to explore and develop additional funding streams.

In response to a question from Senator Mathern, Commander Sorenson said the tribe is able to establish a tribal public health unit outside of IHS P.L. 93-638 Compact-funded facilities. He said the tribal public health unit would function outside of the tribe's present health care system but would be reporting back to the MHA Nation Health Authority and to the State Department of Health. He said the public health unit would be separate from the tribal health facility, and services would be available to nontribal members.

In response to a question from Senator Mathern, Commander Sorenson said discussions with local public health units bordering the reservation have been positive.

In response to a question from Representative Hogan, Commander Sorenson said the tribe continues to explore FQHC status and the additional federal funding available through that program. He said the tribe, through the IHS, provides some public health services but is seeking additional state funding to expand on those services.

In response to a question from Representative Hogan regarding the percentage of state funding for the tribal public health unit, Commander Sorenson said the budget for one year is $700,000, of which he is seeking state funding of $200,000. He said the tribe's in-kind contribution would be of a similar level.

Representative Hogan said the state contribution to the tribal public health unit would be significantly higher than the state's contribution to other local public health units.

Dr. John Baird, Special Populations Section Chief, State Department of Health, provided information (Appendix G) regarding the status of stakeholder meetings to formulate a plan to enhance public health services on the Fort Berthold Reservation and the effect on local public health units serving the reservation of including a FQHC on the reservation in the definition of a public health unit in Chapter 23-35. He said meetings have been held and have included representatives of the MHA Nation, administrators of three local health units serving the reservation, and representatives of the Elbowoods Memorial Health Center and Common Enterprise Development of Mandan. He said Dr. Donald Warne, Director of the Master of Public Health Program, North Dakota State University, who has particular expertise in tribal health units has also been involved. Dr. Baird said local public health units in the state provided input, and Ms. Kelly Nagel, Public Health Liaison, State Department of Health, drafted a preliminary budget for a tribal health department. He said the budget helped to identify the variety of public health services available on the reservation and highlighted gaps in service. He said there is no overall coordination of public health services. He said stakeholders reviewed a model tribal health and safety code Dr. Warne drafted for Arizona in 2005. He said the model appears to be a good outline, and tribal legal experts will examine the document and provide suggestions at a future meeting. He said it was the consensus of the stakeholders that a separate public health unit for the reservation would not have a significant impact on existing public health units, and existing public health units offered assistance in drafting budgets and governance models. He said several community forums related to the feasibility of a community health center on the reservation have been held by Common Enterprise Development, but he has not seen the results of the study. He said stakeholders will continue to meet to examine tribal codes and state statute changes necessary to form a public health unit on the reservation.

Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, provided information regarding current partnerships with Three Affiliated Tribes to provide public health services on the Fort Berthold Reservation and the potential for any additional partnerships. She said like the local public health units in the area, the tribe needs an increasing number of food and lodging inspections conducted and due to the effect of increased oil activity in the area. She said First District Health Unit is unable to contract with the tribe to perform food and lodging inspections because food and lodging codes are set locally. She said First District Health Unit has offered to provide a copy of its codes to the tribe for its consideration and could provide technical assistance if needed.

In response to a question from Senator Mathern, Ms. Clute said the First District Health Unit provides inspection services in the New Town area but not in the city.

In response to a question from Senator Lee, Ms. Sherry Adams, Executive Officer, Southwestern District Health Unit, Dickinson, said establishing a tribal public health unit on the reservation would not significantly affect Southwestern District Health Unit; however, any decrease in state aid would be detrimental. She said local public health units in the western part of the state have been partnering to address the challenges brought about by the increase in oil activity.

In response to a question from Senator Lee, Ms. Adams said local public health units in the western part of the state are already regionalized, but the regional public health network program could assist local public health units and, if established, the tribal public health unit in the areas of environmental health and nursing.

In response to a question from Senator Lee, Ms. Clute said the regional public health network legislation recommended by the committee will provide opportunities for First District Health Unit. She said environmental health and immunization records are two areas that could benefit.

Senator Mathern suggested the Legislative Council staff prepare a bill draft, based on the work done by Dr. Baird, to allow for a tribal public health unit.

Dr. Baird said that a bill draft to amend Chapter 23-35 to enable a tribal public health unit to form would be sufficient to allow the tribe to begin the process. He said pilot funding would help to establish the tribal public health unit and bring it to the same standards contained in the regional public health network program. He said once the tribal public health unit is established, there are other funding sources that become available.

Ms. Paula Flanders, Director, Bismarck-Burleigh Public Health, Bismarck, commented on the public health accreditation process. She said accreditation is a time-consuming and slow process. She said accreditation requires community assessments and established policies and procedures. She offered to provide policies and procedures adopted by Bismarck-Burleigh Public Health electronically if needed.

It was moved by Senator Mathern, seconded by Representative Hogan, and carried on a voice vote that the Legislative Council staff prepare a bill draft to amend Chapter 23-35 relating to public health units to allow a tribal public health unit to form and to provide funding for a pilot project related to establishing the tribal public health unit.

Senator Lee acknowledged the retirement of Ms. Carol K. Olson, Executive Director, Department of Human Services, and thanked her for her service to the department and to the state.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [13.0106.01000] to extend the current moratoriums on the expansion of nursing facility and basic care beds. The Legislative Council staff said the bill draft extends both of the current moratoriums on the expansion of nursing facility and basic care beds through July 31, 2015.

It was moved by Representative Sanford, seconded by Representative Owens, and carried on a roll call vote that the bill draft relating to the extension of the current moratoriums on the expansion of nursing facility and basic care beds be approved and recommended to the Legislative Management. Senators Lee, Berry, Mathern, and Uglem and Representatives Dahl, Hogan, Karls, Kilichowski, Nelson, Owens, Rohr, and Sanford voted "aye." No negative votes were cast.

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [13.0121.01000] to change the duties of the Health Care Data Committee. The Legislative Council staff said the bill draft changes the name of the Health Care Data Committee to the Health Data Committee. In addition, the bill draft removes provisions that require the committee to compile information related to charges, operating costs, revenues, capital expenditures, and utilization at hospitals in the state and to prepare a report to provide information to the public. The bill draft also repeals Section 23-01.1-02.1 which requires the committee to create a data collection, retention, processing, and reporting system that will allow the distribution of information comparing the average fees charged by physicians practicing in the state and requires insurers, nonprofit health service corporations, health maintenance organizations, and state agencies provide data and information.

Ms. Marlene Kouba, Chair, Health Council, said the amendments remove outdated duties of the Health Care Data Committee. In addition, she said, some of the data is collected by other sources and is a duplication of effort.

It was moved by Representative Karls, seconded by Representative Hogan, and carried on a roll call vote that the bill draft to change the duties of the Health Care Data Committee be approved and recommended to the Legislative Management. Senators Lee, Berry, Mathern, and Uglem and Representatives Dahl, Hogan, Karls, Kilichowski, Nelson, Rohr, and Sanford voted "aye." Representative Owens voted "nay."

Ms. Rebecca Ternes, Deputy Commissioner, Insurance Department, provided information (Appendix H) regarding the Insurance Commissioner's recommendation for a private entity to contract with to perform cost-benefit analyses of health insurance mandates during the 2013 legislative session. She said Section 54-03-28 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. She said the law provides the Legislative Council contract with a private entity to perform the cost-benefit analysis after receiving one or more recommendations from the Insurance Commissioner. She said the Insurance Commissioner has budgeted $15,000 to pay the costs of the contracted services, the same as the amount provided for the 2011 legislative session. She said the Insurance Department has solicited proposals from 13 actuarial firms to provide services as identified in the statute during the period from November 2012 through April 2013. In addition, she said, firms were asked to provide a complete cost-benefit analysis within two weeks of receipt of the initial request made by the Legislative Council for a given mandate and within seven days for each request thereafter related to the same mandate. She said firms have until August 10, 2012, to submit proposals.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Representative Nelson suggested the committee receive information regarding the utilization of the physician, dental, and mid-level loan programs from the State Department of Health, including funding available.

Senator Mathern suggested the committee receive a summary of programs available through the School of Medicine to assist students and that the professional loan programs administered by the State Department of Health be included in the summary.

Senator Lee thanked the School of Medicine Southwest Campus staff for allowing the committee to meet in the new facility.

Chairman Lee said the next committee meeting will be either September 25 or 26, 2012.

It was moved by Representative Nelson, seconded by Representative Hogan, and carried on a voice vote that the meeting be adjourned.

No further business appearing, Chairman Lee adjourned the meeting at 4:19 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:8