1999 HOUSE HUMAN SERVICES

HB 1396

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1396

House Human Services Committee

❑ Conference Committee

Hearing Date January 27, 1999

Tape Number	Side A	Side B	Meter #
2	X		24.9 - 40.9
Committee Clerk Signature	Susann Lindteigen		

Minutes:

Rep. RAEANN KELSCH, District 34, testified and introduced the bill on behalf of Blue Cross Blue Shield of ND.

DAN ULMER, Director of Government Relations, Blue Cross Blue Shield of ND, testified this bill is a result of unintended consequences of last session. The 1997 bill added the terms residential, case management, and rehabilitation. We didn't oppose the bill as long as the days were not extended. One paragraph provided a combination of days - 120 days to actual to 92 partial days. Several insurance companies had different interpretations of the law. Thus, we requested an attorney general opinion. The Attorney General said we have 212 days. The state representative said the intent was not 212 days.

OPPOSITION

None

NEUTRAL TESTIMONY

VANCE MAGNUSON, Insurance Department, testified the problem is the language on Page 2, line 3. It appears to not be connected to line 17 - no more than 46 days. These provisions are more closely related in the original draft. Section C language, statute is 60 days, 120 days partial. It is required because of the word "must." The language change gave an additional benefit.

Rep. CLARA SUE PRICE stated this is a case of "intent." Is there a reason the department didn't point out the "must" language previously? VANCE MAGNUSON stated Blue Cross Blue Shield of ND said to the Attorney General that its not intended.

Hold record open for testimony from Dr. George O'Neill.

Hearing Closed.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1396

House Human Services Committee

❑ Conference Committee

Hearing Date February 8, 1999

Tape Number	Side A	Side B	Meter #
1		X	44.6 - End
2	X		0.0 - 11.5
Committee Clerk Signature Susann Lindtvogen			

Minutes:

DAN ULMER, Director, Government Relations, Blue Cross Blue Shield, testified and introduced two amendments (attached). This is a result of the bill passed in 1997 adding residential treatment in mental health mandate. We had three interpretations - we thought it was 92, the insurance department thought it was 120, and the attorney general's office said it was 212. We think we've resolved the issue thanks to Rep. WANDA ROSE for helping. In terms of the numbers, the days that are available now there's 60 in, 120 partial, and 30 out. What we decided to do in our meetings with the mental health association and department of human services, we would reduce the inpatient to 45, 120 partial straight across, and the combination would occur within residential - we would have 120 residential plus you could trade 23 inpatient days for residential days. Therefore, you would have 166 residential days available. In addition to that we have some changes that need to take place over time in this mandate. The changes are

that we push for an individualized treatment plan and the plan comes forth in a least restrictive most appropriate environment available. Now there is very little formalized plannig given to someone in a psychiatric ward or in the system. One amendment just changes the inpatient to 45, 120 partial, and 166 residential. The other amendment adds the language 14 consecutive days of inpatient treatment the insurance provider shall require individualized treatment plans from the inpatient service provider which indicates that the course of treatment is most appropriate and least restrictive form of treatment available.

GEORGE O'NEILL, Clinical Director of Mental Health, Blue Cross Blue Shield of ND, testified (Testimony attached).

Rep. BRUCE ECKRE asked on page 3, paragraph 2, line 2, of testimony why are you picking the southwest region first? GEORGE O'NEILL stated that the department of human services felt that was the region best equipped at this time to be involved with this project. We did not want to start statewide for logistical reasons. I'm sorry. It is the Bismarck region, the West Central Region.

Rep. CLARA SUE PRICE asked on the amendment is the only difference page 1, line 23? GEORGE O'NEILL stated that's correct. Rep. CLARA SUE PRICE asked do you have a preference of the two amendments? GEORGE O'NEILL stated the addition of the paragraph having to do with requiring individualized treatment plans does not really affect the way that most insurance companies do business today. Most ND insurance companies do utilization review and they require that of the hospital. The only insurance companies that might be affected by that language might be insurance companies outside of North Dakota who perhaps don't bother to do utilization review and therefore would not be requiring treatment plans.

ROSE STOLLER, Executive Director, Mental Health Association of ND, testified in support of the bill. The mental health association, department of human services, and Blue Cross Blue Shield have worked tirelessly to come to a solution on the mental health mandate. We are in support of the bill as amended. In addition, it has support of the ND Children's Caucus and Voices in Partnership for Health Care Reform Coalition.

Rep. ROXANNE JENSEN asked do you have a preference of the two amendments? ROSE STOLLER stated the mental health association is in agreement with either of the amendments as presented. However, I do feel that in the direction we are moving with treatment of persons who have mental illness, the individual treatment plan is an important piece of that.

CONNIE HILDEBRAND, Chair, Research Planning and Legislative Committee, ND Conference of Social Welfare, testified (Testimony and brochure attached).

Rep. ROBIN WEISZ asked which particular set of amendments do you favor? CONNIE HILDEBRAND stated the individual treatment plan.

Hearing Closed.

Committee Discussion.

Rep. ROBIN WEISZ moved to ADOPT AMENDMENT No. 90314.0201

and on page 1, line 23, change "shall" to "may"

Rep. AMY KLINISKE second the motion.

VOICE VOTE: 14 yeas, 0 nays, 1 absent

Further Committee Discussion.

Rep. PAT GALVIN moved DO PASS As AMENDED.

Rep. TODD PORTER second the motion.

ROLL CALL VOTE #3: 14 yeas, 0 nays, 1 absent

CARRIER: Rep. WANDA ROSE

Prepared by the Legislative Council staff for
Representative Rose
February 5, 1999

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1396

Page 1, line 16, after "for" insert "each of the following services:"

Page 1, line 19, overstrike "sixty" and insert immediately thereafter "forty-five"

Page 1, line 21, overstrike "in subsection 25 of" and insert immediately thereafter "under"

Page 1, line 23, after the period insert "After fourteen consecutive days of inpatient treatment, an insurance provider shall require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community."

Page 2, line 1, overstrike "or residential"

Page 2, line 2, overstrike "treatment" and remove the overstrike over "~~the benefits must be provided for a minimum of one hundred~~"

Page 2, line 3, remove the overstrike over "~~twenty~~" and remove "each inpatient day provided in subdivision b may be traded for two"

Page 2, line 4, remove "partial hospitalization days or for two and one-half residential treatment"

Page 2, line 6, overstrike "if" and insert immediately thereafter ". Partial hospitalization must be" and overstrike "in subsection 25 of" and insert immediately thereafter "under"

Page 2, line 9, overstrike ", or by a"

Page 2, line 10, overstrike "residential treatment program"

Page 2, line 13, remove the overstrike over "~~d.~~"

Page 2, line 14, after "~~treatment~~" insert "In the case of benefits provided for residential treatment, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 21.6-36-08 in any calendar year. Residential treatment services must be provided by a hospital as defined under section 52-01-01 and rules of the state department of health; by a regional human service center licensed under section 50-06-05.2 offering treatment for the prevention or cure of mental disorder or other related illness; or by a residential treatment program. For services provided in a regional human service center, charges must be reasonably similar to the charges for care provided by a hospital as defined in this subsection", remove the overstrike over the period and insert immediately thereafter:

"e. Any individual receiving residential treatment services who requires residential treatment service beyond the minimum of one hundred twenty days may trade unused patient treatment benefits provided for under subdivision b.", and remove the overstrike over "~~For the purpose of computing the~~"

Page 2, remove the overstrike over line 15

Page 2, line 16, remove the overstrike over "~~equivalent of two days of treatment by~~", after "~~or~~" insert "a", and remove the overstrike over "~~residential~~"

Page 2, line 17, remove the overstrike over "treatment" and insert immediately thereafter "program", remove the overstrike over "~~; provided, however, that no~~", remove "No", and overstrike "forty-six" and insert immediately thereafter "twenty-three"

Page 2, line 19, overstrike "treatment by partial hospitalization or" and after the second "treatment" insert "services"

Page 2, line 20, replace "d" with "f"

Page 3, line 16, replace "e" with "g"

Page 3, line 20, replace "f" with "h"

Page 3, line 21, after "25-03.2-01" insert "; but only applies to individuals under twenty-one years of age"

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Rose
February 5, 1999

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1396

Page 1, line 16, after "for" insert "each of the following services:"

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Renumber accordingly

Adopted by the Human Services Committee
February 8, 1999

VK
2/8/99
1 of 2

HOUSE AMENDMENTS TO HOUSE BILL NO. 1396 **HUMSER 2-9-99**

Page 1, line 16, after "for" insert "each of the following services:"

Page 1, line 19, overstrike "sixty" and insert immediately thereafter "forty-five"

Page 1, line 21, overstrike "in subsection 25 of" and insert immediately thereafter "under"

Page 1, line 23, after the period insert "After fourteen consecutive days of inpatient treatment, an insurance provider may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community."

HOUSE AMENDMENTS TO HOUSE BILL NO. 1396 HUMSER 2-9-99

Page 2, line 1, overstrike "or residential"

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Page 3, line 16, replace "e" with "g"

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Page 3, line 21, after "25-03.2-01" insert "; but only applies to individuals under twenty-one years of age"

Renumber accordingly

Date: 2-8-99
Roll Call Vote #: 3

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1396

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass As Amended

Motion Made By Pat Galvin Seconded By Todd Porter

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairman	X		Ralph Metcalf	X	
William R. Devlin	X		Carol A. Niemeier	X	
Pat Galvin	X		Wanda Rose	X	
Dale L. Henegar	X		Sally M. Sandvig	X	
Roxanne Jensen					
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter	X				
Blair Thoreson	X				

Total **Yes** 14 No 0
Absent 1

Floor Assignment Wanda Rose

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

REPORT OF STANDING COMMITTEE

HB 1396: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1396 was placed on the Sixth order on the calendar.

Page 1, line 16, after "for" insert "each of the following services:"

Page 1, line 19, overstrike "sixty" and insert immediately thereafter "forty-five"

Page 1, line 21, overstrike "in subsection 25 of" and insert immediately thereafter "under"

Page 1, line 23, after the period insert "After fourteen consecutive days of inpatient treatment, an insurance provider may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community."

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Page 3, line 20, replace "f" with "h"

Page 3, line 21, after "25-03.2-01" insert "; but only applies to individuals under twenty-one years of age"

Renumber accordingly

1999 SENATE HUMAN SERVICES

HB 1396

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1396

Senate Human Services Committee

❑ Conference Committee

Hearing Date MARCH 8, 1999

Tape Number	Side A	Side B	Meter #
Committee Clerk Signature	Carol Kolodychuk		

Minutes:

The committee was called to order by SENATOR THANE. Roll call was taken with all senators present.

The hearing was opened on HB1396.

George O'Neill, Blue Cross/Blue Shield ND, explained the bill and supports it with written testimony. SENATOR DEMERS asked if the residential treatment was only for children and adolescents. MR. O'NEILL answered that the original bill didn't state that only--the bill said residential treatment facilities for licensed facilities only for children and adolescents. Insurance does not have to cover it. There is no mandate, but nothing prohibiting insurance companies from doing it. SENATOR KILZER asked how many patients are we talking about. MR. O'NEILL said that inpatient services included about 600 people; outpatient was larger, but had no definite number.

ROSE STOLLER, Director of Mental Health Association of ND, supports bill. They are looking forward to the pilot program in South Central ND.

RODGER WETZEL, ND Conference of Social Welfare, supports bill with written testimony.

VANCE MAGNUSON, ND Insurance Dept., stated that the department does not object to changes. There are problems 1) Section 2B - 14 consecutive days might construe the wrong intent. This implies a mandate of 14 day when only 3 may be needed. 2) 2D - The section of code quoted there is a reference to substance abuse and has no residential treatment provided in this section of code. SENATOR KILZER asked what would the effect on insurance premiums. MR. MAGNUSON replied that it would not be much additional. Maybe the reduction from 60 days to 45 days would allow a leeway.

ROD LARSON, BC/BS, further answered the question stating the percentage of these claims is 6-7% of total claims. SENATOR THANE asked about it being a minimal effect of insurance policies. MR. LARSON agreed. This bill is only clearing up what is in the law.

There were no neutral or opposition.

SENATOR DEMERS asked if BC/BS was comfortable with amendments. MR. LARSON answered yes, the change could be to 14 days or less. SENATOR KILZER asked if there are patients who max out the insurance benefits. MR. LARSON: Yes, 95-97% would be covered by 45 days. 3-5% may go over that. We pay some because we wanted to do so; not required to do so.

MR. MAGNUSON will draft the amendments for this bill.

The hearing was closed.

Discussion resumed. The amendments from Mr. Magnuson, Dept. of Insurance, were reviewed. There were no problems with the amendment. SENATOR KILZER moved the amendments. SENATOR FISCHER seconded it. Roll call vote carried 6-0-0. SENATOR DEMERS moved a DO PASS AS AMENDED. SENATOR KILZER seconded it. SENATOR KILZER will carry the bill.

The committee was adjourned.

adopted

Prepared by the North Dakota
Insurance Department
March 8, 1999

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1396

Page 1, line 24, remove "After fourteen consecutive"

Page 2, line 1, remove "days of inpatient treatment," and replace the first "an" with "An"

Page 2, line 20, remove "and section 21.6-36-08"

Renumber accordingly

Date: 3/8/99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1396

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number Amend by Soc. Dept

Action Taken Amendment adopted

Motion Made By Sen Kilzer Seconded By Sen Fischer

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment _____

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

Date: 3/8/99
Roll Call Vote #: 2

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1396

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as Amended

Motion Made By Sen DeMers Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment Sen Kilzer

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

Dns. Amendments

REPORT OF STANDING COMMITTEE

HB 1396, as engrossed: Human Services Committee (Sen. Thane, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1396 was placed on the Sixth order on the calendar.

Page 1, line 24, remove "After fourteen consecutive"

Page 2, line 1, replace "days of inpatient treatment, an" with "An"

Page 2, line 20, remove "and section 21.6-36-08"

Renumber accordingly

1999 TESTIMONY

MB 1396

Testimony Before The

HOUSE HUMAN SERVICES COMMITTEE

regarding

House Bill 1396

provided on February 8, 1999

by

George W. O'Neill, Ph.D.
Clinical Director of Mental Health
Blue Cross Blue Shield of North Dakota

Chairman Price, Vice Chair Weisz, and Members of the House Human Services Committee, good afternoon. I am Dr. George O'Neill, Clinical Director of Mental Health for Blue Cross Blue Shield of North Dakota, and a psychologist by profession. I am here today in support of House Bill 1396 as amended. During the previous legislative session, SB2040 was passed, adding psychiatric residential treatment for children and adolescents to the list of mandated benefits for North Dakota residents. Blue Cross Blue Shield of North Dakota did not oppose this bill in its final form. Our understanding at that time was that residential treatment would count against the psychiatric inpatient benefit in the same manner that the partial hospital benefit had been counted. Specifically, the insurance industry counted partial hospital days against the inpatient hospital maximum of 60 days on a two-for-one basis, after reserving fourteen days for inpatient treatment. We believed that the legislative intent of SB2040 was to add residential treatment as a benefit, counting each day against the existing inpatient benefit on a two-for-one basis.

During the rewriting of our subscriber contracts to include residential treatment, a question arose regarding the 14 days to be reserved for inpatient treatment. Our opinion of the law and legislative intent was that the partial hospital/residential benefit could be used only so long as the subscriber had more than 14 days of the inpatient hospital benefit remaining. The Insurance Department disagreed, and interpreted the law to mean that, should a subscriber already have used 14 days of inpatient treatment, the remaining inpatient benefit could be traded two-for-one for partial hospital and/or residential treatment. We believed that the purpose of retaining 14 days of inpatient treatment was to reserve coverage for potential psychiatric emergencies. The Insurance Department did not agree and sought an opinion from the Attorney General's office.

At this point we received a third interpretation of the law. The Attorney General's office agreed that the language is confusing, but interpreted the Code as stating that subscribers were entitled to 120 days of partial hospital and/or residential treatment counted against the

inpatient benefit PLUS an additional 120 days of partial hospital and/or residential treatment, for a total of 240 days. We believed that this interpretation was counter to legislative intent. In fact, it was stated in the Senate Human Services Committee deliberations during the 1997 Legislative Session that the addition of residential treatment would not constitute an additional 120 days of coverage, but was an alternative to the 120 days of partial hospitalization. Certainly the legislators involved in that committee hearing interpreted the law to be referring to a total 120 days, not 240 days.

Currently, we have three interpretations of the law: ours, which reflects the way we and other insurance companies have been doing business ever since partial hospitalization became a mandated benefit; the Insurance Department's interpretation; and the Attorney General's opinion. We drafted language for HB1396 in an attempt to clarify the partial hospital and residential treatment benefit.

Since the introduction of the bill before this committee on January 27, we have been meeting with members of the North Dakota Mental Health Association in an effort to find language we could agree on with regard to the mental health mandate. The amended bill you have before you represents a just and fair compromise we have negotiated with the Mental Health Association. HB1396 requires coverage for 45 days of inpatient psychiatric treatment, 120 days of partial hospitalization treatment, and 120 days of residential treatment. Furthermore, persons receiving residential treatment who exceed the 120 days required by this bill may trade up to 23 days of unused inpatient treatment, counted on a two-for-one basis (that is, each inpatient day may be traded for two days of residential treatment).

Before closing, I would like to bring the members of this committee up to date on a project which BCBSND is conducting, in conjunction with the Department of Human Services, and with input from the Mental Health Association. This project may eventually make all this discussion about numbers of days a moot issue. We have been developing a new concept for behavioral healthcare delivery which provides patients with access to a broader array of services. A number of individuals have had input into this project, including Committee Chairman Clara Sue Price. Others include Representative Roxanne Jensen, Representative Janet Wentz, Senator Tim Mathern, Sharon Gallagher of the Mental Health Association, and Karen Larsen, Director of Mental Health and Substance Abuse at the Department of Human Services.

This plan is based on a number of premises: 1) The majority of mental health patients achieve a good outcome with the present system of care involving outpatient, inpatient, partial hospitalization, and residential treatment. Some patients, however, are not adequately served by this process and become high cost utilizers, known in the public sector as seriously mentally ill (SMI). 2) Research supports the efficacy of intensive case management for the SMI population as well as the efficacy of non-traditional approaches such as case aids, respite care, crisis beds, and "wrap-around services." These services are inexpensive compared to traditional mental health treatment. 3) The public sector is experienced in providing intensive case management and in arranging for these non-traditional approaches. 4) The cost of treating the SMI population

eventually falls to the State as contract limits are met. The State has no opportunity for input into the care of the SMI patient until the benefits are exhausted.

Beginning in July of this year, BCBSND and the State will collaborate in the treatment of the SMI patients in the southwest region of the state as follows: patients who reach "trigger" points (defined as a certain number of institutional days or outpatient hours) will receive an evaluation by the State's Regional Intervention Services Team, or, in the case of children and adolescents, by the Children's Mental Health Care Management Project. Recommendations will be made for treatment, which may include both traditional and non-traditional services. BCBSND and the State will share in the costs of providing the services recommended. This project will eventually be expanded to the other regions of the state.

There are a number of benefits of this approach. BCBSND will able to utilize the expertise of the public sector with regard to SMI and case management. The State will have input into the care of the SMI client earlier in treatment. The public sector and private sector will share resources in the treatment of the SMI population. We will achieve better use of provider resources, particularly in rural areas. Most importantly, patients will have access to a full array of services thereby receiving the best help available for their mental health needs.

HB 1396 as amended is not incompatible with this project and represents continued collaboration between BCBSND, the State of North Dakota, and parties representing the best interests of mental health patients. I urge the committee to recommend passage of HB1396 as amended.

Thank you.

North Dakota Conference of Social Welfare, Incorporated

February 8, 1999

Chairman Price, Vice Chairman Weisz, and Members of the House Human Services Committee:

My name is Connie M Hildebrand and I represent the North Dakota Conference of Social Welfare as Chair of its Legislative Committee. We testify in favor of HB 1396, **as amended**.

Since 1920 the NDCSW has been an advocate for health and social welfare programs for North Dakota citizens. As you will notice by our brochure, an 80-year legacy precedes our testimony of today. Please review the last page of my testimony which lists statewide private agencies, professional associations and advocacy groups which are a part our Conference Legislative Committee.

When one visits the Blue Cross Blue Shield website, this motto greets you, "*Working Together the North Dakota Way.*" We believe that in the case of **amended** HB 1396, Blue Cross Blue Shield did just that.

As advocates or as providers of care for the mentally ill, our membership has closely followed the activities and events surrounding the introduction of HB 1396. We commend the recent efforts of both North Dakota Blue Cross Blue Shield and the North Dakota Mental Health Association. Their cooperative effort through the formal amendment process will assure continued availability of community-based support service for those with severe and persistent mental illness.

We ask that you cast an affirmative vote for HB 1396 **as amended,** so we can continue *working together the North Dakota way.*

Thank you Representative Price, Committee members, for the opportunity to testify.

Submitted:

Connie M. Hildebrand

Connie M. Hildebrand
Chair, Research Planning and Legislative Committee
North Dakota Conference of Social Welfare

North Dakota Conference of Social Welfare, Incorporated

Research Planning and Legislative Committee

Association/Organization	Membership/Size
American Association of Retired Persons ND-AARP	70,000 Members
ARC of North Dakota	1200 Members
Catholic Family Service CFS	36 Employees
Children's Caucus CC	100 Members
Dakota CIL	10 Providers
Family Voices	Mailing List of 500
Lutheran Social Services LSS	500 Employees
Mental Health Association in ND MHA	Mailing List of 3000
National Association of Social Workers ND-NASW	315 Members
ND Addiction Treatment Providers Coalition NDATPC	35 Members
ND Association of Community Facilities NDACF	26 Providers
ND Association of Counties NDACo	600 Members
ND Association of Non-Profit Organizations NDANO	130 Members
ND Catholic Conference NDCC	Mailing List of 4000
ND Chemical Health Partnership NDCHP	Mailing List of 500
ND Conference of Social Welfare NDCSW	500 Members
ND Council on Abused Women's Services CAWS	20 Statewide Programs
ND Nurses Association NDNA	700 Members
ND Professional Association of Treatment Homes PATH	9 Offices 32 Employees
ND Senior Services Project Directors Association NDSSPDA	30 Members
Putting the Pieces Together PPT	Mailing List of 500
St Alexius Medical Center - Mental Health Division	60 Employees
The Village Family Service Center	180 Employees

Resource Entities

ND Department of Health	Administration
ND Department of Human Services	Administration
ND Indian Affairs Commission	Administration
ND Department of Human Services	Child & Family
ND Department of Human Services	Aging
Childrens Services Coordinating Committee	Region VII
Burleigh County Social Service	County
Emmons/McIntosh County Social Service	County
Hettinger County Social Service	County
Ward County Social Service	County

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Our **Aim** is to be the recognized percursor in customer enthusiasm, membership satisfaction, and ongoing quality improvement. We believe that the purposes of this organization are fundamental **Values** to assure personal fulfillment, organizational success, and customer well-being.

Annual Meeting Dates
September 22-24, 1999
[redacted] International Inn
[redacted] Minot, ND

(Rev. 12/98)

Since 1920

North Dakota Conference of Social Welfare Inc.

NDCSW 1998

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Since 1920, the North Dakota Conference of Social Welfare has advocated for a high standard of social service programs for the citizenry of North Dakota. Throughout the past seven decades, the Conference has served as a focal point, providing opportunity for all persons interested in social welfare to discuss needs, methods, principles and activities of their profession. With an emphasis on training and coordination, the Conference has sponsored workshops training courses, and conferences for all segments of the social welfare system. It has been instrumental in bringing together associated groups for joint conferences and workshops, promoting active cooperation between all agencies and institutions--public and private, religious and secular. The Conference is also active in providing input on non-partisan legislative issues which impact the social welfare of our State.

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Membership is open to any individual, organization, or institution interested in social welfare. The North Dakota Conference of Social Welfare holds an annual conference the last week in September. The Governing Board, consisting of a president, president-elect, immediate past-president, executive secretary, and seven directors, is elected from the Conference Membership.

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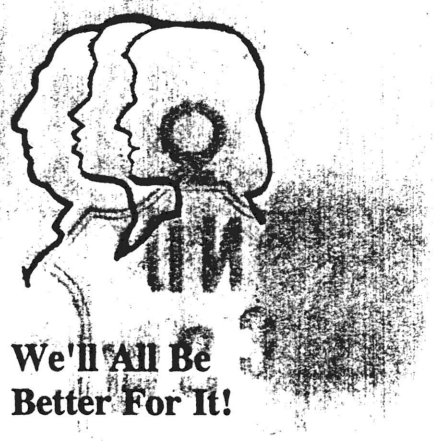
The North Dakota Conference of Social Welfare has been, is and can be a powerful vehicle for affecting change to benefit individuals, as well as, improve our social welfare system. To do so, it needs active involvement and membership of individuals like yourself. Your membership allows participation in all conference agendas including holding office, voting privileges and receiving periodic newsletters that keep you informed of current activities in the field of social welfare. Won't you join us in shaping a part of North Dakota's future?



We'll All Be Better For It!

North Dakota

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Conference of Social Welfare
Application for Membership

(1999 Membership year 11-1-98 thru 10-31-99)

Name/Agency_____

Title_____

Home Address_____

Agency represented_____

County_____

Have you been a member previously? [] Yes [] No

If yes, under what name?

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Membership Dues:

Individual--$15.00
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Agency--$30.00
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Make checks Payable to:
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Mail to:
Connie Zieske
P.O. Box 2209
Minot, ND 58702-2209

Testimony Before The

SENATE HUMAN SERVICES COMMITTEE

regarding

House Bill 1396

provided on March 8, 1999

by

George W. O'Neill, Ph.D.
Clinical Director of Mental Health
Blue Cross Blue Shield of North Dakota

Chairman Thane, Vice Chair Kilzer, and Members of the Senate Human Services Committee, good morning. I am Dr. George O'Neill, Clinical Director of Mental Health for Blue Cross Blue Shield of North Dakota, and a psychologist by profession. I am here today in support of House Bill 1396. During the previous legislative session, SB2040 was passed, adding psychiatric residential treatment for children and adolescents to the list of mandated benefits for North Dakota residents. Blue Cross Blue Shield of North Dakota did not oppose this bill in its final form. Our understanding at that time was that residential treatment would count against the psychiatric inpatient benefit in the same manner that the partial hospital benefit had been counted. Specifically, the insurance industry counted partial hospital days against the inpatient hospital maximum of 60 days on a two-for-one basis, after reserving fourteen days for inpatient treatment. We believed that the legislative intent of SB2040 was to add residential treatment as a benefit, counting each day against the existing inpatient benefit on a two-for-one basis.

During the rewriting of our subscriber contracts to include residential treatment, a question arose regarding the 14 days to be reserved for inpatient treatment. Our opinion of the law and of legislative intent was that the partial hospital/residential benefit could be used only so long as the subscriber had more than 14 days of the inpatient hospital benefit remaining. The Insurance Department disagreed, and interpreted the law to mean that, should a subscriber already have used 14 days of inpatient treatment, the entire remaining inpatient benefit could be traded two-for-one for partial hospital and/or residential treatment. We believed that the purpose of retaining 14 days of inpatient treatment was to reserve coverage for potential psychiatric emergencies. The Insurance Department did not agree and sought an opinion from the Attorney General's office.

At this point we received a third interpretation of the law. The Attorney General's office agreed that the language is confusing, but interpreted the Code as stating that subscribers were

entitled to 120 days of partial hospital and/or residential treatment counted against the inpatient benefit PLUS an additional 120 days of partial hospital and/or residential treatment, for a total of 240 days. We believed that this interpretation was counter to legislative intent. In fact, it was stated in the deliberations of this Committee during the 1997 Legislative Session that the addition of residential treatment would not constitute an additional 120 days of coverage, but was an alternative to the 120 days of partial hospitalization. Certainly the legislators involved in this Committee hearing interpreted the law to be referring to a total 120 days, not 240 days.

Currently, we have three interpretations of the law: ours, which reflects the way we and other insurance companies have been doing business ever since partial hospitalization became a mandated benefit; the Insurance Department's interpretation; and the Attorney General's opinion. We drafted language for HB1396 in an attempt to clarify the partial hospital and residential treatment benefit.

The North Dakota Mental Health Association had some concerns about the benefit levels in HB1396. Therefore, following the introduction of this bill before the House Human Services Committee, we began holding meetings with members of the North Dakota Mental Health Association in an effort to find language we could agree on. The bill you have before you represents a just and fair compromise we have negotiated with the Mental Health Association. HB1396 requires coverage for 45 days of inpatient psychiatric treatment, 120 days of partial hospitalization treatment, and 120 days of residential treatment. Furthermore, persons receiving residential treatment who exceed the 120 days required by this bill may trade up to 23 days of unused inpatient treatment, counted on a two-for-one basis (that is, each inpatient day may be traded for two days of residential treatment).

Before closing, I would like to bring the members of this Committee up to date on a project which BCBSND is conducting, in conjunction with the Department of Human Services, and with input from the Mental Health Association. This project may eventually make all this discussion about numbers of days a moot issue. We have been developing a new concept for behavioral healthcare delivery which provides patients with access to a broader array of services. A number of individuals have had input into this project, including Senator Tim Mathern, Representative Clara Sue Price, Representative Roxanne Jensen, Representative Janet Wentz, Sharon Gallagher of the Mental Health Association, and Karen Larsen, Director of Mental Health and Substance Abuse at the Department of Human Services. Senator Judy DeMers also had input into this project in the early stages.

This plan is based on a number of premises: 1) The majority of mental health patients achieve a good outcome with the present system of care involving outpatient, inpatient, partial hospitalization, and residential treatment. Some patients, however, are not adequately served by this process and become high cost utilizers, known in the public sector as seriously mentally ill (SMI). 2) Research supports the efficacy of intensive case management for the SMI population as well as the efficacy of non-traditional approaches such as case aides, respite care, crisis beds, and "wrap-around services." These services are inexpensive compared to

traditional mental health treatment. 3) The public sector is experienced in providing intensive case management and in arranging for these non-traditional approaches. 4) The cost of treating the SMI population eventually falls to the State as contract limits are met. The State has no opportunity for input into the care of the SMI patient until the benefits are exhausted.

Beginning in July of this year, BCBSND and the State will collaborate in the treatment of the SMI patients in the south-central region of North Dakota as follows: patients who reach "trigger" points (defined as a certain number of institutional days or outpatient hours) will receive an evaluation by the State's Regional Intervention Services Team, or, in the case of children and adolescents, by the Children's Mental Health Care Management Project. Recommendations will be made for treatment, which may include both traditional and non-traditional services. BCBSND and the State will share in the costs of providing the services recommended. This project will eventually be expanded to the other regions of the state.

There are a number of benefits of this approach. BCBSND will able to utilize the expertise of the public sector with regard to SMI and case management. The State will have input into the care of the SMI client earlier in treatment. The public sector and private sector will share resources in the treatment of the SMI population. We will achieve better use of provider resources, particularly in rural areas. Most importantly, patients will have access to a full array of services, thereby receiving the best help available for their mental health needs.

HB1396 is not incompatible with this project and represents continued collaboration between BCBSND, the State of North Dakota, and parties representing the best interests of mental health patients. I urge the Committee to recommend passage of HB1396.

Thank you.

TESTIMONY ON HOUSE BILL 1396

by Rodger Wetzel, representing the North Dakota Conference of Social Welfare

Mr. Chair and members of the committee: My name is Rodger Wetzel. Professionally I serve as the Director of Mental Health, Social Services, and Eldercare at St. Alexius Medical Center. This morning I am testifying on House Bill 1396 on behalf of the North Dakota Conference of Social Welfare. The North Dakota Conference of Social Welfare is a statewide nonprofit organization representing hundreds of public and private staff and organizations who are committed to improving health and human services to our state's at risk populations --- people who are elderly, children, physically disabled, mentally ill, low income, and other vulnerable populations. A list of our legislative committee members supporting this legislation is appended to my testimony. In addition I have appended a copy of our Conference brochure.

The North Dakota Conference of Social Welfare is in support of House Bill 1396.

Many of us North Dakotans still cannot comprehend what it is like to have a mental illness, particularly a serious mental illness. It affects the individual, couple, family, friends, and job. We know now, as a result of medical research, that depression, anxiety, and other mental illnesses often have physical causes, and are not just a personal weakness or character flaw. We understand, for example, that there are changes in brain chemistry during a mental illness, and many of these changes now can be analyzed with the sophisticated technology that is available. That is why many mental illnesses now can be helped through the use of medications which change brain chemistry, as well as counseling therapy. We also know through studies that people who have a mental illness can change their lives ~~when they~~ through appropriate education, prevention, and appropriate treatment. In traditional medicine we have made much progress through research. In mental health we have made much progress as well.

We are in support of provision of House Bill 1396 which requires mental disorder coverage in group health policies and health service contracts. We believe this is a positive step in recognizing the fact that many of us are as vulnerable to experience a mental health problem as we are to a physical health problem.

We believe it is appropriate to provide inpatient treatment, partial hospitalization treatment, residential treatment, and outpatient treatment, as indicated in paragraph 2a. In paragraph 2b a minimum of 45 days inpatient services is required. We would much prefer the 60-day coverage as included in the original bill, however. We are in support of the 120 days of partial hospitalization in 2c.

From my experience we have made much progress to maintain individuals out of inpatient psychiatric settings whenever possible. When it has been necessary to hospitalize someone in an inpatient unit, the goal is generally to transfer them to a partial hospitalization program or outpatient program as soon as possible. This provides services in a less restrictive environment and allows them to maintain contacts with home, family, job and community. In paragraph 2d residential treatment services are addressed. We are seeing the need for residential treatment services for children and adolescents increase in North Dakota, so this provision would assist in addressing this need. In paragraph 2e some inpatient days may be traded for residential treatment days. However, we support leaving the 2~~3~~2 days of inpatient days in the policy. In paragraph 2f (1) we support the minimum of 30 hours of services in an outpatient setting.

In my current position I work with staff and programs which provide mental health services in inpatient units, in four different partial hospitalization programs, and in several types of outpatient mental health programs, such as psychiatry, psychology, social work counseling/ therapy, and counseling provided by a clinical nurse specialist.

Individuals who have mental health problems, including both those who are experiencing a situational mental illness, as well as those who are experiencing a chronic mental illness, continue to be a priority need within the social welfare and mental health continuum. I urge your support of House Bill 1396. I would be happy to answer any questions.

S: mhmgmt/hb1396