

BUDGET COMMITTEE ON HEALTH CARE

The Budget Committee on Health Care was assigned the following four study responsibilities:

1. Section 9 of House Bill No. 1004 directed a study of the State Department of Health plan for a community health grant program.
2. House Concurrent Resolution No. 3046 directed a study of the various challenges facing the delivery of health care in this state, including changes in hospital reimbursements, technological innovations, and the regionalization of services.
3. House Concurrent Resolution No. 3070 directed a study of health care access, quality, and cost to determine essential health care services, critical providers, and access sites, and to identify geographic, demographic, and economic issues relating to health care. This resolution also directed the State Health Council to conduct public hearings on health care issues and report its findings to this committee.
4. Senate Concurrent Resolution No. 4004 directed a study of the possibility of creating an incentive package to assist rural communities and nursing facilities in closing, significantly reducing bed capacity, or providing alternative long-term care services.

The committee was also assigned the responsibility to receive reports from:

- The Department of Human Services describing enrollment statistics and costs associated with the children's health insurance program. (North Dakota Century Code (NDCC) Section 50-29-02)
- The Department of Human Services and the State Board of Nursing regarding progress in preparing a joint recommendation relating to nurse licensure exemptions for the administration of medication. (Section 3 of 1999 House Bill No. 1403)

Committee members were Representatives Clara Sue Price (Chairman), Byron Clark, Audrey Cleary, William R. Devlin, David Drovdal, Serenus Hoffner, Keith A. Kempenich, Deb Lundgren, Carol A. Niemeier, Todd Porter, Wanda Rose, Dale C. Severson, and Ken Svedjan and Senators Judy L. DeMers, Tom Fischer, Ralph Kilzer, Marv Mutzenberger, Randy A. Schobinger, and Russell T. Thane.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 2000. The Council accepted the report for submission to the 57th Legislative Assembly.

COMMUNITY HEALTH GRANT PROGRAM

Section 9 of 1999 House Bill No. 1004 directed the State Department of Health to develop a comprehensive plan for a community health grant program and to submit the plan to the Legislative Council during the 1999-2000 interim. The community health grant program is to use moneys available in the community health trust fund, established to receive 10 percent of the tobacco settlement payments. The Legislative Council was directed to study the plan and report its findings and recommendations to the 2001 Legislative Assembly. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

Background

As a result of a multistate settlement agreement negotiated between various states' attorneys general and tobacco manufacturers, North Dakota will receive annual distributions of tobacco settlement proceeds. During the 1999-2001 biennium, North Dakota's tobacco settlement distributions are anticipated to be approximately \$52.2 million. North Dakota may receive as much as \$775 million over the next 25 years from the settlement.

The 1999 Legislative Assembly established a plan for the use of these moneys through the passage of House Bill No. 1475 (NDCC Section 54-27-25). Section 54-27-25 establishes a tobacco settlement trust fund into which must be deposited all moneys received by the state pursuant to Sections IX (payments) and XI (calculation and disbursement of payments) of the master settlement agreement. All moneys deposited in the fund and all interest earned on those moneys must be transferred within 30 days as follows:

- Ten percent to a community health trust fund to be administered by the State Department of Health. The State Department of Health may use moneys in the fund, as appropriated by the Legislative Assembly, for community-based and other public health programs, including those with an emphasis on preventing or reducing tobacco usage. The interest earned on moneys in the community health trust fund is deposited in the general fund.
- Forty-five percent to the common schools trust fund to become a part of the principal of that fund. The interest earned on moneys in the common schools trust fund is used for distributions to schools or added to the fund's principal, at the discretion of the Board of University and School Lands.

- Forty-five percent to the water development trust fund to be used to address the long-term water development and management needs of the state. The interest earned on moneys in the water development trust fund is deposited in the general fund.

Tobacco Settlement Trust Fund and Community Health Trust Fund Analysis

The committee reviewed estimated revenues and expenditures for the tobacco settlement trust fund for the 1999-2001 biennium:

Tobacco Settlement Trust Fund	1999-2001 Biennium	
Beginning balance		\$0
Add estimated revenues		
Tobacco settlement revenues		52,183,788
Total available		\$52,183,788
Less estimated expenditures and transfers		
Transfers to the community health trust fund (10 percent)	\$5,218,378	
Transfers to the common schools trust fund (45 percent)	23,482,705	
Transfers to the water development trust fund (45 percent)	23,482,705	
Total estimated expenditures and transfers		\$52,183,788
Estimated ending balance		\$0

The committee reviewed estimated revenues and expenditures for the community health trust fund for the 1999-2001 biennium:

Community Health Trust Fund	1999-2001 Biennium
Beginning balance	\$0
Add estimated revenues	
Transfers from the tobacco settlement trust fund	5,218,378
Total available	\$5,218,378
Less estimated expenditures	
No appropriations were made to the State Department of Health for the 1999-2001 biennium	\$0
Estimated ending balance	\$5,218,378

Centers for Disease Control and Prevention Recommendations

The committee learned the United States Centers for Disease Control and Prevention (CDC) has established "best practices" guidelines to help states plan and carry out effective tobacco use prevention and control programs. The CDC also established recommended funding ranges to guide states in the development of these programs. The funding ranges are shown below for each of the nine "best practices." Each funding range is calculated based on a formula established by the CDC using a combination of minimum or base funding and per capita funding based on the state's population. For North Dakota, the proposed funding ranges for all components total \$12.73 to \$25.82 per capita, or approximately \$8.2 to \$16.5 million, per year. The CDC "best practices" address the following nine components of comprehensive tobacco use prevention and control programs:

Program	Range of Estimated Annual Cost

Community programs to reduce tobacco use	\$1,299,000 - \$2,482,000
Chronic disease prevention and early detection programs to reduce the burden of tobacco-related diseases	\$2,787,000 - \$4,162,000
School tobacco use prevention and cessation programs	\$999,000 - \$1,498,000
Enforcement of tobacco control policies	\$426,000 - \$817,000
Statewide tobacco use prevention and cessation projects to provide technical assistance to local programs, promote media advocacy, implement smoke-free policies, and reduce minors' access to tobacco products	\$257,000 - \$641,000
Counter-marketing programs	\$641,000 - \$1,923,000
Statewide tobacco cessation assistance programs	\$687,000 - \$2,865,000
Surveillance and evaluation system to monitor the performance of tobacco control programs	\$710,000 - \$1,439,000
Administration and management system to facilitate the coordination of program components, the involvement of multiple state agencies and levels of local government, and the involvement of statewide voluntary health organizations and community groups	\$355,000 - \$720,000
Total	\$8,161,000 - \$16,547,000

The committee received testimony from representatives of the Red River Health Promotion Council, Fargo; MeritCare Health System, Fargo; the Center for Tobacco Cessation, Fargo; the American Heart Association; and the American Cancer Society in support of the implementation of all or a portion of the CDC "best practices." The committee also received testimony from representatives of the Central Valley Health Board, Jamestown; MeritCare Health System; and the American Heart Association supporting the use of the entire 10 percent allocation from the tobacco settlement trust fund for tobacco control programs.

State Department of Health Plan and Responses

A representative of the State Department of Health identified alternative uses for moneys in the community health trust fund, including:

1. Implementing the recommendations of the CDC relating to the establishment of a comprehensive statewide tobacco use prevention and control program.
2. Increasing state aid to local public health units.
3. Developing a comprehensive community or school health grant program.
4. Funding a preventive medicine center of excellence at the University of North Dakota School of Medicine and Health Sciences.
5. Enhancing emergency medical services.
6. Increasing state funding for immunization programs.
7. Providing additional epidemiological support to local public health units.
8. Providing funding for the employment of four additional environmental health practitioners to support local public health units.
9. Providing funding for the Family Health Care Center in Fargo.
10. Developing a statewide public health data management system.
11. Providing a contingency fund for public health emergencies.
12. Developing elderly health programs.

The State Department of Health subsequently submitted a two-part plan for a community health grant program--one for the use of moneys accumulating in the community health trust fund during the 1999-2001 biennium and one for the use of moneys to be deposited in the fund during the 2001-03 and future bienniums.

Regarding the use of moneys accumulating in the community health trust fund during the 1999-2001 biennium, the State Department of Health plan provides that the estimated balance of \$5.2 million be used to:

1. Maintain a balance in the community health trust fund to provide cash flow for grants, which may be necessary based on the anticipated timing of transfers to be received from the tobacco settlement trust fund.
2. Provide a contingent appropriation of \$1 million per biennium for public health emergencies.

Regarding the use of moneys to be deposited in the community health trust fund during the 2001-03 and future bienniums, the State Department of Health plan provides that the estimated \$5 million per biennium be used for:

1. A **Healthy Schools grant program** funded at \$2 million per biennium, or approximately \$9 per student per year. The State Department of Health would authorize a grant only after a local board of health and a local school board sign a memorandum of agreement concerning preventive health programs to be funded. The proposed grant program may require matching funds of \$1 of local funds for every \$2 or \$4 of grant funds.
2. A **Healthy Families grant program** funded at \$2 million per biennium, or approximately \$1.50 per state resident per year. The State Department of Health would authorize a grant only after the local boards of health and all interested parties in a community health region develop a plan that identifies the priority needs of the region, the programs to be funded, and the method of evaluating the programs. The proposed program may require matching funds of \$1 of local funds for every \$4 of grant funds.
3. A **Healthy Communities grant program** funded at \$1 million per biennium. The healthy communities grant program could be used to:
 - a. Increase state aid to local health districts from \$3,000 to \$7,000 per county per year, excluding per capita payments.
 - b. Provide a \$25,000 per year grant to each health region to augment federal funding provided by the CDC for local tobacco program specialists and to plan, implement, and evaluate regional programs.
 - c. Provide \$88,000 per year for statewide training, improvement of data management programs, and evaluation of the community health grant program.

The committee received testimony from representatives of the North Dakota Association of Elementary School Principals and North Dakota School Nurses supporting increased funding for school nurse programs. The committee received testimony from a representative of the Fargo Cass Board of Health indicating support for the State Department of Health plan for the use of moneys in the community health trust fund. Testimony received from a representative of the First District Health Unit, Minot, supported the use of a portion of the moneys in the community health trust fund for public health emergencies.

Recommendations

The committee recommends [Senate Bill No. 2028](#) to provide that the interest earned on moneys deposited in the community health trust fund remains in that fund. Currently the interest is deposited in the general fund. An average balance of \$5.2 million, the estimated July 1, 2001, balance in the community health trust fund, will generate interest income of approximately \$510,000 per biennium, assuming a rate of return of 4.9 percent per year. Actual interest earnings depend on the fund balance and the timing of collections and distributions from the fund.

The committee recommends [Senate Bill No. 2029](#) to provide that the interest earned on moneys deposited in the water development trust fund be transferred to the community health trust fund. Currently the interest is deposited in the general fund. An average balance of \$23.5 million, the estimated July 1, 2001, balance in the water development trust fund, will generate interest income of approximately \$2.3 million per biennium, assuming a rate of return of 4.9 percent per year. Actual interest earnings depend on the fund balance and the timing of collections and distributions from the fund.

The committee also recommends the 57th Legislative Assembly:

- Support the State Department of Health plan for the establishment of Healthy Schools, Healthy Families, and Healthy Communities grant programs with moneys to be deposited in the community health trust fund during the 2001-03 and future bienniums.
- Use a portion of the moneys accumulating in the community health trust fund during the 1999-2001 biennium for:

Statewide tobacco counter-marketing programs.

Training and educational program materials for schools and communities to assist in the establishment and operation of tobacco use prevention and cessation education programs.

HEALTH CARE DELIVERY, ACCESS, QUALITY, AND COST

House Concurrent Resolution No. 3046 directed the Legislative Council to study the various challenges facing the delivery of health care in this state, including changes in hospital reimbursements, technological innovations, and the regionalization of services. House Concurrent Resolution No. 3070 directed the Legislative Council to study health care access, quality, and cost to determine essential health care services, critical providers, and access sites and to identify geographic, demographic, and economic issues relating to health care. House Concurrent Resolution No. 3070 also directed the State Health Council to conduct

public hearings throughout the state to elicit the public's input regarding health care needs and services and to report its findings to the appropriate Legislative Council committee. The Legislative Council assigned these responsibilities to the Budget Committee on Health Care. The committee combined these study responsibilities.

Background

The health care industry in North Dakota is faced with challenges originating at both the state and national levels. At the national level, the Balanced Budget Act of 1997 had a far-reaching impact on various elements of the health care industry, including hospitals and home health care providers. At the state level, challenges originate from the state's changing demographics--an aging population with more sparsely populated rural areas. While some areas of the state have limited access to health care services, there is overlap and duplication in the health care delivery systems in other areas of the state. In addition, a concern exists that past and anticipated future increases in health care insurance premiums create an economic burden and make health insurance unaffordable to many of the state's citizens.

As an example of recent increases in health insurance premium rates, the following schedule shows actual increases in the monthly premiums for health insurance benefits for state employees for the 1993-95 to 1999-2001 bienniums and estimated increases for the 2001-03 biennium:

Biennium	Monthly Premium	Biennium to Biennium Percentage Change
1993-95	\$254	
1995-97	\$265	4.3%
1997-99	\$301	13.6%
1999-2001	\$350	16.3%
2001-03 (projected)	\$427	22.0%

North Dakota's population has evolved from primarily rural to primarily urban, resulting in more sparsely populated rural areas. The following table shows changes in the state's population and the percent of the population living in rural areas (which includes communities of less than 2,500 persons) and urban areas from 1950 to 1990:

Census Year	State Population	Percent Rural	Percent Urban
1950	619,636	73.4%	26.6%
1960	632,446	64.8%	35.2%
1970	617,761	55.7%	44.3%
1980	652,717	51.2%	48.8%
1990	638,800	49.4%	50.6%

From 1990 to 1999 the number of hospitals in North Dakota has decreased. However, the number of hospital beds, including swing beds, has decreased at an even higher rate, as shown on the following table:

Year	Number of Hospitals		Hospital Beds	
	Number	Percent Change	Number	Percent Change
1990	52		3,921	
1999	46	(11.5%)	3,176	(19.0%)

Provider Reimbursements

Hospitals

The committee learned the Balanced Budget Act of 1997 has resulted and will continue to result in significant reductions in Medicare revenues for North Dakota hospitals. Rural hospitals may be the most severely impacted by the funding reductions because many rural hospitals receive a large portion of their patient revenue from Medicare reimbursements.

Also of concern to North Dakota hospitals and health care consumers is the significant difference in Medicare, Medicaid, and commercial insurance payments for patients undergoing similar procedures. The following schedule shows, for 1997, the differences in Medicare, Medicaid, and commercial insurance payments received by North Dakota hospitals for treating patients receiving services in the five most common major diagnostic categories:

Major Diagnostic Category	Average Medicaid Payments	Average Medicare Payments	Average Commercial Insurance Payments
Circulatory system	\$10,390	\$6,941	\$11,127
Respiratory system	\$4,498	\$4,986	\$7,037
Pregnancy and childbirth	\$2,071	Not Applicable	\$2,238
Musculoskeletal system	\$6,243	\$6,155	\$6,876
Digestive system	\$4,253	\$5,572	\$5,500

There are significant differences between rural and urban hospitals in the amount of reimbursement received through Medicaid and Medicare, but there are also differences in the cost of providing services. The committee considered the following information relating to the treatment of pneumonia, based on recent unaudited Medicare cost reports for various urban and rural facilities in the state:

	Treatment for Pneumonia				
	Average Cost	Average Medicaid Reimbursement	Average Medicaid Reimbursement as a Percentage of Cost	Average Medicare Reimbursement	Average Medicare Reimbursement as a Percentage of Cost
Selected urban facilities	\$4,301	\$3,402	79.1%	\$4,421	102.8%
Selected rural facilities	\$3,102	\$2,276	73.4%	\$4,030	129.9%

The committee learned the Balanced Budget Act of 1997 will also impact special purpose hospitals, such as the State Hospital. The State Hospital receives Medicaid disproportionate share funding for providing care for indigent and uninsured patients. The Department of Human Services anticipates the Balanced Budget Act of 1997 will result in a decrease in the State Hospital's Medicaid disproportionate share funding from \$1.2 million in fiscal year 1998 to approximately \$400,000 in fiscal year 2003.

The committee considered the various payment systems used to provide reimbursements to hospitals and clinics. Since fiscal year 1984, the Health Care Financing Administration has used a prospective payment system to provide federal Medicare reimbursements to hospitals. Under a prospective payment system, payments to hospitals are based on a fixed amount for each hospital admission, based on the patient's condition and treatment. The characteristics of a patient's condition and treatment are defined in a diagnostic-related group (DRG). Under a prospective payment system, hospitals that are able to provide care at average costs and maintain a sufficient volume of service will produce a profit.

Prior to 1987, Medicaid inpatient hospital services in North Dakota were reimbursed using a retrospective payment system. A retrospective payment system provides initial payments based on an estimate of the hospital's cost of providing a service. Payments are eventually adjusted to reflect the hospital's actual cost. Due to the uncertainty involved for both providers and payers, the lengthy settlement process, and the increased administrative costs associated with such a system, a prospective payment process was implemented in 1987 for inpatient Medicaid hospital services in North Dakota.

The committee learned outpatient Medicaid hospital services in North Dakota are reimbursed using a retrospective payment system. A representative of the Department of Human Services reported that due to the inefficiencies of the retrospective

payment system, the department was considering developing and implementing a prospective payment system for outpatient Medicaid hospital services. The department considered two payment classification systems for use in the prospective payment system--ambulatory patient groups and ambulatory payment classifications. Due primarily to the fact ambulatory patient groups have been in existence for 10 years and ambulatory payment classifications are new and untested, the department decided to base the new prospective payment system on ambulatory patient groups. The committee received testimony from a representative of the North Dakota Health Care Association indicating a concern that the proposed payment system would create administrative difficulties for hospitals due to the fact the Health Care Financing Administration is in the process of developing a prospective payment system for outpatient Medicare services using ambulatory payment classifications.

The committee asked the Legislative Council chairman to request that the Department of Human Services discontinue the development of a prospective payment system for outpatient Medicaid services using ambulatory patient groups, that all changes to the current payment system for outpatient Medicaid services be delayed to allow the development and testing of ambulatory payment classifications by the Health Care Financing Administration, and that the department consider using ambulatory payment classifications in the development of a prospective payment system for outpatient Medicaid services in North Dakota. The Legislative Council chairman subsequently sent a letter requesting the Department of Human Services to discontinue the development of the system using ambulatory patient groups.

Home Health Care

The committee learned that in an effort to control the rate of growth in expenditures for home health care, Congress imposed limits on Medicare payments for home health services through enactment of the Balanced Budget Act of 1997. The subsequent interim payment system resulted in a 38 percent reduction in Medicare reimbursements for home health services from 1997 to 1998. Medicare reimbursements for home health care were reduced by another 20 percent for fiscal year 1999. Nationwide, 30 percent of all home health care agencies have closed since January 1998. In North Dakota three agencies have closed.

The committee learned the Health Care Financing Administration plans to implement a new prospective payment system for Medicare home health care services. Testimony was received from representatives of the home health care industry relating to the uncertain impact of the proposed payment system.

Nurse Practitioners

The committee learned that Medicaid reimbursement for nurse practitioner services in North Dakota is accomplished through the following methods:

- Certified pediatric and family nurse practitioners can directly bill the Medicaid program for any service that is billable within the scope of their practice.
- Other nurse practitioner services can be billed as a physician service by the supervising physician through the use of a modifier that indicates the service was provided by a nurse practitioner.

The committee received testimony from a clinical nurse specialist indicating clinical nurse specialist services provided in Minnesota are directly reimbursable through the Minnesota Medicaid program, but similar services provided in North Dakota are not directly reimbursable. The committee also received testimony from a family nurse practitioner indicating the requirement that only a primary care provider can make direct referrals for Medicaid services restricts access to health care for Medicaid patients due to the limited number of primary care providers in some areas of the state. In North Dakota all Medicaid patient services must be coordinated through a primary care provider, which must be either a physician or a rural health clinic.

Critical Access Hospitals

In order to mitigate the negative effects the enactment of the Balanced Budget Act of 1997 has had on small hospitals, Congress created the Medicare rural hospital flexibility program under which limited service hospitals known as critical access hospitals are designated. Critical access hospitals may receive increased Medicare reimbursements through the use of a cost-based retrospective reimbursement system rather than a prospective payment system. The Tioga Medical Center was the first North Dakota hospital to receive the critical access designation. The committee learned a rural hospital may be designated as a critical access hospital if it:

1. Is located in a state that has a critical access hospital plan approved by the Health Care Financing Administration. (North Dakota's plan was approved in December 1998.)
2. Is operated as a public or nonprofit facility.
3. Is located at least 35 miles from another hospital or is designated as a necessary provider.
4. Offers 24-hour emergency care.
5. Provides no more than 25 beds, with no more than 15 beds used for acute care services.
6. Keeps patients no longer than 96 hours unless approved by a peer review organization.

7. Belongs to a rural health network with agreements for patient transfer and emergency services.

Access and Utilization

Access to and utilization of preventive care services are indicative of the quality of a health care system. In North Dakota, approximately 85 percent of pregnant women receive prenatal care during their first trimester as compared to a national average of 82 percent. Approximately 83 percent of the state's two-year-old children have been immunized, compared to a national average of 78 percent.

The committee learned that geographic access to health care providers is fairly good in North Dakota as over 90 percent of the state's population is within 21 miles of a hospital. Although geographic access does not appear to be a significant problem in most areas of the state, the declining rural population is a cause for concern for health care providers in some areas. In many rural areas, emergency medical service providers are finding it difficult to recruit enough volunteers to serve the aging population. Many rural clinics are suffering from similar problems in recruiting staff. Related to the issue of recruiting health care staff to serve in rural areas, the committee learned the University of North Dakota School of Medicine and Health Sciences has implemented the rural opportunities for medical education program to provide an eight-month experience in rural primary care to third-year medical students. The program allows medical students to live and train in nonmetropolitan communities.

A combination of declining population in rural areas, a population that is more mobile and therefore willing to travel to population centers to access health care, and the general trend in health care to increase the provision of outpatient services has resulted in a significant decrease in the number of inpatient hospital days recorded in the state's rural hospitals. The committee learned that from 1976 to 1997, 15 of North Dakota's rural hospitals experienced an average decrease of 71 percent in the annual number of inpatient hospital days. More recently, from 1990 to 1997, the number of Medicare inpatient days for all North Dakota hospitals decreased by 21 percent, from 280,000 to 221,000 days per year.

The committee received information on the location and services provided at each hospital in the state. There are 46 general hospitals and three specialized hospitals (one rehabilitation and two psychiatric) in the state.

Health Insurance

The committee learned a 1998 study conducted by the State Department of Health indicated the percentage of North Dakotans without health insurance declined slightly from 9.9 percent in 1993 to 8.6 percent in 1998. During the 1999-2001 biennium, the department conducted a survey of health care access by farm and ranch families. The survey indicated of the 1,571 farm and ranch households selected for the survey, six percent reported having no health insurance. One in four households reported at least one member of the household had some type of public health insurance coverage (Medicare, Medicaid, or Healthy Steps). The survey responses indicated many farm and ranch families are concerned about having to cancel their health insurance due to the high cost, and they are concerned about the inadequacy of the coverage they are able to afford.

The committee learned during the 1990s, the overall consumer price index increased approximately two percent per year, while the medical component of the consumer price index increased by approximately four percent per year. During that period, allowable charges by Blue Cross Blue Shield of North Dakota increased approximately 5.5 percent per year.

The committee learned recent increases in the amount spent by health care consumers for prescription drugs has caused concern among health care payers. Blue Cross Blue Shield of North Dakota reported during the past three years, per member per month charges for prescription drugs have increased 49 percent, due primarily to:

1. An increase in the number of prescription drugs available to consumers.
2. New drug treatment options for certain illnesses.
3. An increase in prescription drug usage by consumers.
4. Increased demand for certain drugs created by direct-to-consumer advertising by drug manufacturers, resulting in inflated prices for those drugs.

The committee learned the Department of Human Services proposed rules to require the prior authorization of Medicaid pharmaceutical services for three classes of drugs--anti-ulcers, antiarthritics, and antihistamines. The department estimated the prior authorization of these pharmaceutical services would result in savings of at least \$200,000 per year for the Medicaid program. However, due to opposition to the proposed rules, the department rescinded the rules and is considering introducing legislation to be considered by the 2001 Legislative Assembly relating to the prior authorization of Medicaid pharmaceutical services.

The committee learned the State Department of Health may be eligible to receive a grant from the United States Health Resources and Services Administration to conduct a one-year study to identify the characteristics of the uninsured in North

Dakota and to develop proposals to provide health insurance coverage to all state residents. By motion, the committee communicated its support for the department's proposed grant application.

Other Health Care Issues

Nursing Facility Survey Process

The committee learned in North Dakota, each nursing facility is surveyed or reviewed every 9 to 15 months by the State Department of Health. Although there are no fees charged to a nursing facility for the survey, the facility does incur costs for staff time occupied during the survey process.

The committee learned due to concerns regarding the nursing facility survey process, the North Dakota Long Term Care Association plans to develop a proposal to be considered by the Health Care Financing Administration to implement a pilot survey system in North Dakota. The pilot system would involve surveyors working collaboratively with nursing facilities to review care, identify problem areas, develop improvement strategies, evaluate the effectiveness of strategies, and establish expectations and timeframes for progress.

Educational Loan Repayment Programs

The committee received information on the need to expand existing educational loan repayment programs to address shortages in nurses and dentists in North Dakota. Two educational loan repayment programs are authorized in North Dakota--the educational loan repayment program for physicians (NDCC Chapter 43-17.2) and the educational loan repayment program for nurse practitioners, physician assistants, and certified nurse midwives (NDCC Chapter 43-12.2). The committee learned that in many areas of the state, it is difficult to recruit nurses to fill positions in hospitals, nursing homes, clinics, and other health care facilities. Only 288 licensed dentists are practicing in North Dakota, and most are located in the larger cities. The result is limited access to dental health services in many rural areas of the state. The committee learned from a representative of the State Department of Health that expanding the loan repayment programs to include nurses and dentists may be one way to address the shortages in those areas of the health care industry.

Emergency Medical Services

The committee learned in many areas of North Dakota, emergency medical services coverage is provided by volunteers. Although it is increasingly difficult to find volunteers in many areas, the role of emergency medical services may expand as some rural hospitals close. Federal policies relating to reimbursement for emergency medical services provide for reimbursement on a fee-for-service basis and pay only if transportation is provided. It may be inappropriate for the provision of emergency medical services to be based on a fee-for-service reimbursement system in rural areas because the services need to be available even when not being used. A funding model similar to that used to provide fire protection and law enforcement services was suggested by the State Department of Health as a more appropriate model to be used to fund emergency medical services in rural areas.

Health Council Hearings

The committee received testimony from a representative of the State Department of Health regarding public hearings conducted by the State Health Council and public input received at those meetings. At the time of the department's presentation to the committee, the State Health Council had conducted hearings in six of the eight regional planning areas. Public comments primarily related to the need to maintain hospital services and recruit health care personnel in rural areas and the 1999 Legislative Assembly's allocation of tobacco settlement proceeds.

Long-Range Plan for Health Care

The committee received testimony from a representative of Blue Cross Blue Shield of North Dakota regarding the need to assess future health care needs and population changes to ensure continued access to health care for all North Dakotans. It was suggested to the committee the Legislative Assembly should direct the State Health Council to develop a plan for North Dakota health care in the year 2020.

Recommendation

As indicated above, the committee reviewed the Department of Human Services proposal to implement a new payment system for outpatient Medicaid services. The committee asked the Legislative Council chairman to request that the Department of Human Services discontinue the development of a prospective payment system for outpatient Medicaid services using ambulatory patient groups, that all changes to the current payment system for outpatient Medicaid services be delayed to allow

the development and testing of ambulatory payment classifications by the Health Care Financing Administration, and that the department consider using ambulatory payment classifications in the development of a prospective payment system for outpatient Medicaid services in North Dakota. The chairman of the Legislative Council sent a letter to the Department of Human Services regarding the committee's request.

INCENTIVES FOR LONG-TERM CARE ALTERNATIVES

Senate Concurrent Resolution No. 4004 directed the Legislative Council to study the possibility of creating an incentive package to assist rural communities and nursing care facilities in closing, significantly reducing bed capacity, or providing alternative long-term care services. This study was assigned to the Budget Committee on Health Care.

Background

The closure of a long-term care facility in a rural community can have a significant impact on the community similar to the loss of other local businesses, schools, or hospitals. Consequently, financial assistance may be needed when a facility closes or reduces bed capacity. Financial assistance may also be needed to enable facilities to make a transition to providing alternative long-term care services.

The size of North Dakota's existing long-term care infrastructure and the state's changing demographics must be considered when planning for the delivery of long-term care services in the future. North Dakota has 75.05 nursing facility beds per 1,000 elderly (age 65 and over) while the national average is fewer than 50 beds per 1,000. North Dakota institutionalizes approximately 10.3 percent of its elderly population, the highest percentage in the nation.

In North Dakota there are 89 nursing care facilities, providing over 7,000 nursing care beds, and 43 basic care facilities, providing over 1,400 basic care beds. The average occupancy rate for nursing care facilities is 92 percent, and the average occupancy rate for basic care facilities is less than 85 percent. Of each 100 occupied nursing care beds, approximately 55 beds are paid for through the state Medicaid program.

Task Force on Long-Term Care Planning

During the 1997-99 biennium, the Legislative Council's Budget Committee on Long-Term Care received a report from the Task Force on Long-Term Care Planning, a task force appointed by the Governor to assist in designing a cost-effective long-term care system in North Dakota. The task force report concluded the payment system used to fund long-term care lacks the incentives needed to encourage providers to deliver alternative services or to reduce licensed bed capacity. The task force continued its study during the 1999-2000 interim. Although the 1997-98 interim task force had determined that incentives should be made available to encourage long-term care facilities to reduce institutional capacity and develop alternative services, the 1999-2000 task force determined it was premature for the task force to begin a study of the development of such incentives because the Department of Human Services was considering similar issues in the implementation of the provisions of 1999 Senate Bill No. 2168 (see the following section entitled "**Intergovernmental Transfer Program**").

Section 3 of 1999 Senate Bill No. 2036 directed the Department of Human Services and the State Department of Health to prepare a recommendation for consideration by the 57th Legislative Assembly describing the conversion of current basic care and assisted living facilities into an integrated long-term housing and service delivery system entitled assisted living. The Task Force on Long-Term Care Planning, which includes representatives of both agencies, addressed this issue and developed recommendations that were presented to the committee. The recommendations provided that the current definitions and regulations relating to basic care should be retained and that an integrated assisted living delivery system not be developed. The committee determined the task force recommendations did not meet the requirements of 1999 Senate Bill No. 2036 because the recommendations did not provide for the combining of the basic care and assisted living service delivery systems.

The committee expressed concern the recommendations developed by the Task Force on Long-Term Care Planning were not in compliance with the requirements of Section 3 of 1999 Senate Bill No. 2036 and asked the Legislative Council chairman to request the Department of Human Services and the State Department of Health prepare a recommendation, to be considered by the 57th Legislative Assembly, describing the conversion of basic care and assisted living facilities into an integrated long-term housing and service delivery system.

Intergovernmental Transfer Program

The 1999 Legislative Assembly passed Senate Bill No. 2168, which established a health care trust fund for making grants and loans for projects that provide alternatives to nursing facility care. The bill also authorizes a funding mechanism, known as intergovernmental transfer, to increase federal Medicaid funding available to the state and provide a source of moneys to be deposited in the health care trust fund. The amount of federal funds to be deposited in the health care trust fund is based on the

average difference between Medicare and Medicaid rates for all nursing facilities in the state multiplied by the total number of Medicaid resident days in all nursing facilities. Payments based on this calculation are made to the two government-owned nursing facilities in the state. The amounts paid to the two nursing facilities are subsequently transferred back to the state, less a \$10,000 transaction fee retained by each facility, and deposited in the health care trust fund.

The 1999 Legislative Assembly appropriated \$8.6 million of federal funds (\$4.3 million for loans and grants to nursing facilities and \$4.3 million for the service payments for the elderly and disabled (SPED) program) from the health care trust fund for the 1999-2001 biennium. During the 1999 legislative session, the department significantly underestimated the amount of funds available through the intergovernmental transfer program. The total amount to be deposited in the health care trust fund during the 1999-2001 biennium is now estimated to be \$43.2 million, \$34.7 million more than originally estimated.

The committee considered information relating to other states currently accessing federal funds through intergovernmental transfer programs. The committee also received testimony regarding projects proposed to be funded through the health care trust fund.

The committee received testimony from a representative of the Department of Human Services relating to the need for a statewide health care needs assessment study. When distributing loans and grants from the health care trust fund, the department must make decisions regarding the appropriate number of long-term care alternative facilities and the level of services that should be provided in each region of the state. A representative of the department indicated that to assist the department in making these decisions, a statewide study should be conducted to examine the future need for long-term care services, as well as other health care services such as hospital, emergency, mental health, dental, and pharmacy services, in each region of the state. The committee learned the Department of Human Services anticipates using moneys generated through the intergovernmental transfer process to conduct a statewide study of long-term care needs. The department will attempt to have the study completed prior to the 2001 legislative session.

The committee received information relating to several projects proposed or in the process of being completed to provide alternatives to nursing facility services, including a cooperative project in Carrington and New Rockford. The cooperative project was proposed to provide an enhanced continuum of care and to reduce the number of skilled care beds in the two communities. The committee learned due to financial difficulties encountered by the facilities, a delay in implementing some aspects of the project, and difficulty accessing loan and grant funds through the health care trust fund, the projects will probably proceed on a smaller scale than originally planned.

The committee received testimony from representatives of the Department of Human Services, the long-term care industry, and the North Dakota Long Term Care Association supporting various uses for the additional funds anticipated to be available through the intergovernmental transfer program, including:

- Encourage community and statewide planning and the development of efficient integrated health care delivery systems.
- Provide low-interest loans or grants to long-term care facilities for remodeling and updating.
- Conduct a statewide health and long-term care needs assessment study to provide a vision and plan for health care in the future.
- Provide a benefits package to long-term care employees similar to the benefits package provided to state employees. (The estimated cost of the health insurance benefits package, as determined by a representative of the North Dakota Long Term Care Association, for the 60.5 percent of full-time employees in North Dakota long-term care facilities who are currently participating in an employer-sponsored health insurance plan is approximately \$13.8 million per biennium.)
- Fund a quality improvement survey program for nursing facilities.
- Buy out nursing facilities that choose to close.
- Establish a trust fund to provide future funding for programs such as Healthy Steps, the children's health insurance program.

A statewide task force was established to consider the appropriate use for the moneys generated through the intergovernmental transfer program and to examine other issues relating to the program. The Intergovernmental Transfer Statewide Task Force includes legislators and representatives of the Department of Human Services, the North Dakota Long Term Care Association, and the communities involved in the program. The committee learned the task force's preliminary recommendations are that moneys in the health care trust fund be used for:

- Incentive payments, up to a total of \$9 million, to encourage nursing facilities to reduce the number of licensed nursing care beds by 600.
- Loans for nursing facility alternative construction and renovation projects at an annual interest rate of two percent rather than at two percentage points below the market rate.
- A Medicaid reimbursement rate adjustment for all nursing facilities, beginning January 1, 2002, for salary or benefit enhancements in the amount of \$1.50 per full-time equivalent employee per hour.
- Facility transaction fees in the total amount of \$500,000 for the five transactions anticipated during the 1999-2001 and 2001-03 bienniums for each of the two government nursing facilities involved in the transfer process (1999 Senate Bill No.

2168 authorized a transaction fee of \$10,000 per facility per transaction).

The committee learned the Health Care Financing Administration has proposed rules to limit states' ability to access federal funds through the intergovernmental transfer program. For this reason, the future availability of these funds is uncertain. Under the proposed rules, North Dakota would have a five-year transition period to bring the state's Medicaid program into compliance with the new rules. In addition, certain moneys already claimed by the Department of Human Services have been challenged by the Health Care Financing Administration. On August 31, 2000, the Health Care Financing Administration informed the Department of Human Services it did not agree with the method used by the department to calculate North Dakota's first-year payment. The Health Care Financing Administration has indicated that North Dakota claimed \$13 million more than its plan allowed. The department, however, believes its claim was in accordance with its approved plan. The department intends to appeal the Health Care Financing Administration decision.

Recommendations

As indicated above, the committee received a report from the Task Force on Long-term Care Planning regarding the conversion of basic care and assisted living facilities. The committee expressed its concern the recommendations developed by the Task Force on Long-Term Care Planning were not in compliance with the requirements of Section 3 of 1999 Senate Bill No. 2036 and asked the Legislative Council chairman to request the Department of Human Services and the State Department of Health prepare a recommendation, to be considered by the 57th Legislative Assembly, describing the conversion of basic care and assisted living facilities into an integrated long-term housing and service delivery system. The Legislative Council chairman communicated the committee's request to the Department of Human Services and the State Department of Health.

The committee recommends the 57th Legislative Assembly consider requiring that moneys generated through the intergovernmental transfer process and deposited in the health care trust fund be used for projects and programs relating to the long-term care industry, including the funding of projects that provide alternatives to nursing facility services and projects that reduce nursing facility bed capacity.

CHILDREN'S HEALTH INSURANCE PROGRAM

Section 12 of 1999 Senate Bill No. 2012 established a children's health insurance program and provided that the Department of Human Services must present to the Legislative Council an annual report regarding the program, including enrollment statistics and associated costs. The Legislative Council assigned this duty to the Budget Committee on Health Care.

Background

The 1999 Legislative Assembly established a children's health insurance program to provide health insurance to low-income children not eligible for Medicaid. Section 12 of 1999 Senate Bill No. 2012 authorized the program and provided an income eligibility limit of 140 percent of the federal poverty level. This section also provided that the insurance coverage must be provided through contracts with private insurance carriers, must include copayments and deductibles, and must provide coverage for medical services such as psychiatric and substance abuse services, prescription medications, preventive screening services, preventive dental and vision services, and prenatal services.

Testimony

The committee learned the Department of Human Services signed a contract with Blue Cross Blue Shield of North Dakota to provide the health insurance coverage for the children's health insurance program named the Healthy Steps program. The contract covers the period October 1, 1999, through June 30, 2001, and provides for a premium rate of \$108.60 per member per month to be paid by the state. The premium rate is based on copayments of \$2 for each prescription, \$50 for each hospital admission, and \$5 for each emergency hospital visit. Federal regulations require that for certain population groups, such as American Indians, no copayments are charged. The monthly premium for those children is \$109.56. Eligibility for the Healthy Steps program is for 12 months, provided the child does not turn 19, leave the household, obtain other health insurance coverage, or fail to report information requested by the department in the fourth and eighth months.

The Department of Human Services estimated approximately 3,800 children are eligible for coverage under the Healthy Steps program at the income limit of 140 percent of poverty level. During the 1999 legislative session, the department estimated approximately 2,000 of those children would be enrolled in the program by the end of fiscal year 2000. The actual number enrolled by the end of the first fiscal year of the biennium was approximately 1,900 children. The department currently estimates approximately 3,000 children will be enrolled in the program by the end of the 1999-2001 biennium.

Outreach programs have been implemented by the Department of Human Services to increase the number of children enrolled in the program. The committee learned the Children's Services Coordinating Committee received a grant from the Robert Wood

Johnson Foundation to establish a "covering kids" program as part of a nationwide initiative to assist in identifying and enrolling children in the program, to simplify the enrollment process, and to coordinate the various health insurance programs available to low-income children.

Some health care providers in North Dakota have experienced difficulty collecting reimbursement from the Indian Health Service for services provided to patients determined to be eligible but not enrolled in the Healthy Steps program. The Indian Health Service is a payer of last resort and will not cover services if the patient is eligible for any other coverage. However, the Healthy Steps program only provides payment if coverage was applied for prior to the service being provided. The committee received testimony from a representative of the Indian Health Service indicating the Indian Health Service has increased efforts to encourage the enrollment of tribal members in the Healthy Steps program and denies coverage only if the tribal member has received benefits counseling and has been told the member is eligible for coverage under the Healthy Steps program but has not applied for coverage.

The Caring Program for Children, a program founded by Blue Cross Blue Shield of North Dakota to provide free primary and preventive health and dental care coverage to North Dakota children, has experienced a decline in the number of children enrolled. Children previously enrolled in the Caring Program for Children but eligible for the Healthy Steps program have been referred to the Healthy Steps program because of the more comprehensive health insurance coverage provided through that program.

The committee discussed the possibility of expanding eligibility for the Health Steps program by increasing the allowable income limitation. The committee learned if the limitation on allowable income is increased from 140 to 170 percent of the federal poverty level, and if 75 percent of eligible children are enrolled, the additional cost for the 2001-03 biennium would be approximately \$3.4 million, of which \$820,000 would be from the general fund. Federal funds available to North Dakota for the children's health insurance program are listed below:

Federal Fiscal Year Ending	North Dakota's Allocation
September 30, 1998	\$5,041,000
September 30, 1999	\$5,017,000
September 30, 2000	\$5,656,000

The federal government allows states two years to spend their federal funds allocation. Therefore, North Dakota had until September 30, 2000, to spend its federal fiscal year 1998 allocation of \$5,041,000. The Department of Human Services estimates approximately \$1.8 million of the federal fiscal year 1998 allocation was spent. As a result, approximately \$3.2 million of North Dakota's federal fiscal year 1998 allocation was not spent and will no longer be available to the state.

Although the Department of Human Services has taken steps to simplify the complexity of the Medicaid eligibility application form, the asset limitation requirements add complexity to the application. The committee learned if the asset limitation for children and pregnant women is eliminated from Medicaid eligibility requirements, the department could combine the Healthy Steps and Medicaid eligibility applications. The committee also learned although income eligibility for the Healthy Steps program is determined on an annual basis, it is determined on a monthly basis for the Medicaid program.

A representative of the Department of Human Services provided an estimate of the fiscal impact of eliminating the asset limitation for Medicaid eligibility for children and pregnant women. It was estimated 1,367 children would become eligible for the Medicaid program if the asset limitation was eliminated. The estimated cost for the 2001-03 biennium of eliminating the asset limitation for children and pregnant women would be \$1,852,256, of which \$565,286 would be from the general fund.

The department also provided an estimate of the fiscal impact of changing the Medicaid income review period from monthly to annually. It was estimated for federal fiscal year 1998, an additional 3,225 children, would have remained enrolled in the Medicaid program if the income review period had been changed from monthly to annually. The estimated cost for the 2001-03 biennium of changing the Medicaid income review period from monthly to annually would be approximately \$5.3 million, of which \$1.6 million would be from the general fund.

The committee learned changing the income review period from monthly to quarterly would provide some administrative efficiencies but at a lower cost than the proposed change to an annual review period. At the time of the committee's last meeting, no estimate was available regarding the cost of changing from a monthly to a quarterly income review period.

Considerations and Recommendations

The committee considered but did not recommend a bill draft that would have:

- Eliminated the asset limitation for Medicaid eligibility for children and pregnant women (consistent with the Healthy Steps program).
- Changed from monthly to annually the Medicaid income review period for children and pregnant women (consistent with the Healthy Steps program).

The committee did not recommend eliminating the asset limitation for Medicaid due to concern that the result would be an increase in Medicaid enrollment and a decrease in enrollment in the Healthy Steps program.

The committee recommends [House Bill No. 1036](#) to provide for a quarterly rather than annual income review period for children and pregnant women receiving Medicaid benefits.

NURSE LICENSURE EXEMPTIONS FOR MEDICATION ADMINISTRATION

Background

Section 1 of 1999 House Bill No. 1403 adds a new subsection to NDCC Section 43-12.1-04 to provide a temporary exemption (through July 31, 2001) from the Nurse Practices Act to certain persons who provide medication administration. The bill directs the Department of Human Services and the State Board of Nursing to prepare a joint recommendation relating to the temporary exemption. The bill directs the Department of Human Services and the State Board of Nursing to report to the Legislative Council during the 1999-2000 interim regarding the progress made in preparing the joint recommendation. The Legislative Council assigned this responsibility to the Budget Committee on Health Care.

Testimony

The committee received a report from the Department of Human Services and the State Board of Nursing regarding their joint recommendation. The joint recommendation provides that the temporary exemption provided for in 1999 House Bill No. 1403 should be made permanent for certain facilities certified by the Department of Human Services. The statutory changes required to implement this recommendation will be contained in a bill to be introduced by the State Board of Nursing for consideration by the 57th Legislative Assembly. The bill will include a new subsection to NDCC Section 43-12.1-04 to provide a permanent exemption from the Nurse Practices Act for:

The administration of medications, other than by the parenteral route, by staff of a residential treatment center for children licensed under chapter 25-03.2, a treatment or care center for developmentally disabled persons licensed under chapter 25-16, or a residential child care facility licensed under chapter 50-11 certified by the department of human services.

Recommendation

The committee accepted the joint recommendation submitted by the Department of Human Services and the State Board of Nursing and recommends the 57th Legislative Assembly support the recommendation to provide a permanent exemption from the Nurse Practices Act relating to the administration of medication by the staff of certain facilities certified by the Department of Human Services.

BUDGET TOURS

The committee conducted budget tours in the Bottineau area and in Minot. The agencies toured were the International Peace Garden, Dunseith; Minot State University - Bottineau and the Forest Service, Bottineau; Minot State University, North Central Research Extension Center, State Fair Association, and North Central Human Service Center, Minot. The committee received information relating to the status of each agency's 1999-2001 biennial budget, major items anticipated to be included in the 2001-03 biennial budget request, and major capital project needs. The committee also toured the Minot Vocational Adjustment Workshop, Inc., and received information on the programs and services offered by that facility. The tour group minutes are available in the Legislative Council office and will be compiled in a report presented to the Appropriations Committees during the 2001 legislative session.